

# Immunization Billing by Local Health Departments:

## New York State Strategic Plan

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## Contents

1. Introduction .....	4
2. Background .....	4
Why Should Public Health Clinics Bill for Immunization Services? .....	4
The Current State of LHD Immunization Billing Practices and the Insurance Landscape in NYS .....	5
New York Public Health .....	5
LHD Immunization services .....	6
Third Party Payer Landscape .....	8
Health insurance and Public Health Law issues related to billing by LHDs .....	9
First-Dollar Coverage: .....	9
Network Requirements: .....	9
Out-of-Network Coverage: .....	9
Public Health Law and LHD billing practice .....	9
3. Strategic Planning Process .....	10
Involvement of Stakeholders .....	10
Assessing the Capacity of LHDs to Bill for Immunization Services .....	11
Effective Billing Practices .....	11
Strengths, Weaknesses, Opportunities and Threats related to LHD Billing Practices .....	13
Billing Improvement Strategy .....	14
Billing Improvement Solutions .....	14
Costs .....	16
4. Moving Forward .....	18
Attachment A: Summary of the Public Consulting Group Cost Analysis .....	20
Attachment B: Preliminary NYSACHO webinar topics .....	24

## Executive Summary

*Immunization Billing by Local Health Departments: New York State Strategic Plan* describes an immunization service billing strategy to assist the 57 local health departments (LHDs) outside of New York City to bill third party payers to generate additional revenue and to efficiently use local public health resources.

With funding from the American Recovery and Reinvestment Act, the New York State Department of Health conducted a strategic planning process to identify and address the barriers to third party billing for immunization services provided by local health departments. Research conducted on the current status of third party billing indicated that New York's LHDs provide a small but important percentage of the annual immunizations provided to NYS residents, and that many of the children and adults seen by LHDs already have or are potentially eligible for insurance coverage for immunization services. An analysis of six LHDs' capacity for billing, the costs required for effective billing and a summary of the necessary policies and procedures for successful business reimbursement practices compiled by Public Consulting Group Inc. of Boston (PCG) for this project revealed that while some LHDs had established policies and procedures to conduct billing, others had limited capacity to collect appropriate reimbursement.

The strategic plan used the information collected by PCG to detail the basic steps that Local Health Departments providing immunizations must address to ensure compliance with federal and state programs. These include collecting insurance information from all patients, determining patient payer mix, collecting out of pocket fees based on a sliding fee scale, promoting medical homes, and submitting claims to public insurance programs. As part of these requirements, the Department will expect LHDs to implement procedures to ensure that publicly purchased vaccine is not administered to ineligible patients.

The plan also offers comprehensive billing solution options that LHDs may consider based on the volume of immunizations they provide. These options include the use of the New York State Immunization Information System (NYSIIS) as a billing data repository to collect and store billing data needed to generate claims, and securing a local or web-based patient management information system for billing functions. These information systems enable LHDs to either manage their own billing operations or contract with an external organization to bill third party payers.

The Department received a Prevention and Public Health Fund grant in 2011 to assist LHDs to implement third party billing solutions. The grant will support modifications to NYSIIS to allow billing data collection and storage. The grant will also support efforts of the New York State Association of County Health Officials to organize technical assistance work groups to assist LHDs select and implement billing solutions. Finally, the grant will support limited one time only grant funding for those LHDs interested in implementing a billing solution.

The New York State Department of Health hopes that this strategic plan and implementation grant will assist LHDs to address challenges and improve their billing operations, establish cost effective billing practices, negotiate contracts with insurance plans, and generate third party billing revenue to better support important public health investments in communities.

## 1. Introduction

With funding from the American Recovery and Reinvestment Act (ARRA) received in September 2009, the New York State Department of Health began a strategic planning process to identify and address the barriers to third party billing for immunization services provided by the 57 local health departments (LHDs) in the state, outside of New York City. The Department assembled a Steering Committee of LHDs and other stakeholders to guide the project. The Department conducted preliminary research on the current status of third party billing by LHDs in New York State.<sup>1</sup> A consultant, Public Consulting Group Inc. of Boston (PCG), performed an in-depth analysis of six LHDs' capacity for billing according to defined immunization elements for successful billing practice, and developed a cost analysis of revenue and expenses related to the billing process. This paper describes the planning process and findings, along with a summary of New York State Department of Health and LHD action steps for implementation of this plan.

**The strategic plan describes an immunization service billing strategy to assist the 57 upstate LHDs to bill third party payers to generate additional revenue and to efficiently use local public health resources.** This document reviews the New York State Department of Health strategy for working with LHDs to enable efficient and appropriate billing and the planning process used to develop the strategy. This comprehensive immunization service billing plan addresses all major facets of the reimbursement process. Responding to diverse local needs, the plan recognizes multiple strategies that LHDs may employ in organizing third party billing practices. All options reflect Vaccine for Children Program (VFC), Article 6 General Public Health Work program, Medicare and Medicaid requirements. Acknowledging that public health is a primary LHD mission, the Department aims to balance access to vaccines with revenue generation.

The Department was awarded a two-year Affordable Care Act Prevention and Public Health Fund grant that began on September 1, 2011 to implement the billing strategy. The Department will partner with the New York State Association of County Health Officials (NYSACHO) and LHDs to achieve results that meet both State and Local needs.

## 2. Background

### ***Why Should Public Health Clinics Bill for Immunization Services?***

Billing for immunization of insured individuals makes sense as a way to save money for federal, state, and local governments, assure proper stewardship of public funds and promote public and private payer participation in financing New York's immunization program. The 2010 Patient Protection and Affordable Care Act (PPACA) is expected to increase the proportion of the population with insurance coverage for immunizations, strengthening the rationale for LHD billing operations.

**LHDs Play an Important Role as Immunizers:** Although immunization is a service best provided in patients' "medical homes", LHDs play an important role in achieving immunization objectives. At least 30 percent of doses administered to children at LHDs in 2009 were to children who did not have insurance coverage for those doses. New York's LHDs organize and host vaccination clinics as the vaccinators of last resort and as part of their responsibility to respond to outbreaks of vaccine

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<sup>1</sup> For the purposes of this document, third party payer refers to any organization, public or private that pays or insures health or medical expenses on behalf of beneficiaries or recipients.

preventable diseases in their communities. In addition, LHDs maintain capacity to provide mass prophylaxis in emergent situations. During the 2009 H1N1 pandemic influenza vaccination campaign in New York State, LHDs had the capacity to immunize large numbers of people in a short period of time.

**Cost of Providing Immunizations in New York:** The costs of immunizing children and adults can place a burden on the scarce resources of public health agencies. In 2010, immunization services at the 57 upstate LHDs cost almost \$13.3 million in state and local funds. State funding is provided in the form of Immunization Action Plan grants and State Aid for local public health activities. This figure includes all of the costs borne by LHDs to provide vaccine and any private stock vaccine bought by LHDs, but does not include the cost of public vaccine supplied by New York State and the Federal government.

**Many LHD Patients Have a Means to Pay:** Many of the children and adults seen by LHDs either already have insurance or are potentially eligible for insurance coverage for immunization services. New York State Insurance Law requires full insurance coverage of childhood vaccines. Public programs including Medicaid, Family Health Plus (FHP) and Child Health Plus (CHP), as well as Vaccines For Children (VFC), fund immunizations for individuals with limited financial means. The 2010 Patient Protection and Affordable Care Act (PPACA) is expected to further increase the proportion of the population with insurance coverage for immunizations by increasing the number of insured individuals and requiring coverage of preventive services, including immunization, for both adults and children.

**Compliance:** Finally, there are a number of laws and program requirements that require LHDs to bill for services. LHDs provide services and receive funding through public programs. Compliance with the various program requirements, as indicated in this report, requires LHDs to bill as appropriate.

### ***The Current State of LHD Immunization Billing Practices and the Insurance Landscape in NYS***

*There are many factors that determine the ability of LHDs to bill for immunizations services: local delivery and billing practices for a range of public health services, immunization service volume, and the public and commercial insurance markets.*

#### **New York Public Health**

**Autonomy:** New York LHDs are locally governed and, in part, locally funded. Although the New York State Department of Health reimburses LHDs a portion of their expenditures for defined public health programs and LHDs receive grants for public health programs, LHDs have a great deal of autonomy in determining how they will meet community needs.

**Billable Public Health Services:** Immunization is one of the public health services that can be billed to insurers and in some cases patients. LHDs continue to provide clinical and other services with associated third party billing. Some LHDs continue to provide Early Intervention (EI) Services<sup>2</sup>. A number of LHDs provide family planning clinic services, some of which can be billed. Tuberculosis patients cannot be charged out-of-pocket fees, though claims can be submitted to insurance companies on their behalf. LHDs are interested in billing for rabies vaccination and lead poisoning testing, although these services are small. Some services provided by LHDs cannot be billed to third party payers; particularly sexually transmissible disease services.

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<sup>2</sup> The Early Intervention (EI) Program offers a variety of therapeutic and support services to infants and toddlers with disabilities and their families.

Many of New York's LHDs are reducing the number of clinical services offered and are reducing associated billing resources. Most LHDs have eliminated primary and preventive care health clinics. While 38 of the state's 57 LHDs currently operate Certified Home Health Agencies (CHHAs) that provide health services in the home, over half of those are considering or actively selling those agencies, losing Medicare and Medicaid billing resources.

### LHD Immunization services

**New York State Department of Health Immunization Program and LHD Roles:** Each LHD in NYS receives a grant from the Department to support increasing vaccination rates, tracking of immunization information, and education and outreach. In addition, LHDs receive State Aid to offset the cost of immunization services that they provide. LHDs and all other providers are required to use the NYS Immunization Information System (NYSIIS) to record vaccines administered to children less than 19 years of age.

**Immunization Service Billing:** Most LHDs have some experience with immunization service billing. In a New York State Department of Health 2009 survey, more than 75% of the LHDs reported submitting claims to insurance companies for immunizations services. In addition, the same survey found at least half of the LHDs reported receiving Medicaid reimbursement for immunization services.

**Public Vaccine for Children:** LHDs participate in the Vaccines for Children (VFC) program, a federal program that provides vaccines at no charge to eligible children less than 19 years of age. LHDs must purchase their own supplies of vaccine for administration to children who are not eligible for publicly purchased vaccine. The Department uses state funds to extend the eligibility for publicly purchased vaccine to more persons than those meeting federal eligibility guidelines. While there is no cost in acquiring VFC vaccine, the costs of administering public vaccine can be charged to the patient or their insurance, bearing in mind that patients cannot be turned away for their inability to pay. Medical providers including LHDs are required to report eligibility information on VFC doses administered to the Department.

**LHD Immunization Service Volume:** New York's LHDs provide a small but important percentage of the annual immunizations provided to NYS residents. Data from the NYSIIS indicated that LHDs provided more than 116,000 doses in 2009 or 4.4% of the total immunization doses provided to children younger than 19 years of age. Figure 1 shows the numbers of doses and VFC eligibility groups for doses provided by each LHD. Of the total doses provided to children, at least 20,000 or 5.9% of all doses were administered to children with public or commercial insurance (Figure 2). An additional 52% of doses were categorized as *Unknown VFC Eligibility* which indicates that insurance status was not recorded or not reported. LHDs administered more than 111,000 doses of vaccine to adults in 2009, of which at least 47,000 doses were administered to insured individuals. The information reported here is limited by the incomplete collection and reporting of dose based eligibility and insurance coverage data.<sup>3</sup>

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<sup>3</sup> Data from the New York Immunization Information System was used for childhood dose information and a New York State Department of Health survey of LHDs was used for adult dose data: both sources were from the year 2009.

County	Commercial Insurance	NYS VFC Eligible		Unknown Eligibility
		Public Insurance	No Insurance	
Albany	156	96	1,178	72
Allegany	105	74	865	540
Broome	14	8	856	12
Cattaraugus	113	186	347	97
Cayuga	8	16	232	11
Chautauqua	105	1,122	1,311	79
Chemung	42	205	851	5
Chenango	7	303	583	56
Clinton	2	-	6	688
Columbia	10	22	421	158
Cortland	5	2	185	-
Delaware	2	16	88	19
Dutchess	75	187	1,288	12
Erie	1,226	1,048	1,033	755
Essex	42	242	460	234
Franklin	99	23	84	66
Fulton	25	17	67	12
Genesee	1	4	199	135
Greene	62	43	136	16
Hamilton	21	56	19	48
Herkimer	362	316	398	357
Jefferson	522	143	937	114
Lewis	341	368	1,281	26
Livingston	39	72	286	2,111
Madison	1	23	1,092	179
Monroe	459	241	145	3,242
Montgomery	39	42	133	5
Nassau	1	-	-	59
Niagara	106	485	979	1,124
Oneida	208	2,781	902	25
Onondaga	316	1,339	1,422	13
Ontario	536	144	269	36
Orange	4	21	2,104	12
Orleans	79	175	99	287
Oswego	247	1,094	323	12
Otsego	9	30	89	86
Putnam	197	66	537	483
Rensselaer	12	120	171	158
Rockland	60	312	1,928	159
Saint Lawrence	28	184	1,055	41
Saratoga	56	144	432	180
Schenectady	1	160	430	130
Schoharie	2	19	84	8
Schuyler	19	258	81	16
Seneca	31	47	532	405
Steuben	8	77	407	3,375
Suffolk	483	202	5,331	43,662
Sullivan	6	130	471	159
Tioga	21	50	157	104
Tompkins	2	-	855	3
Ulster	173	213	565	20
Warren	126	3	186	14
Washington	38	58	211	34
Wayne	85	123	639	60
Westchester	3	9	111	695
Wyoming	12	16	113	86
Yates	111	162	783	84
<b>Totals</b>	<b>6,863</b>	<b>13,297</b>	<b>35,747</b>	<b>60,579</b>

**Figure 1: LHD administered doses to children less than 19 years of age by Insurance and VFC Categories, 2009.**

**Source: NYSIIS**

Note: The VFC No insurance category includes American Indian and Alaskan Natives. The table lists those with public insurance and those with commercial insurance. Those with commercial insurance are not VFC eligible.

**Figure 2: Percentage of doses administered by LHDs grouped by VFC eligibility and insurance coverage status for children less than 19 years of age, 2009, excluding H1N1 vaccine; source: NYSIIS**

Insurance Status	Subtotals	Totals
Commercial Insurance	5.9%	5.9%
VFC Eligible, Public Insurance		11.5%
Medicaid	10.6	
Child Health Plus	0.9%	
VFC Eligible, No Insurance		30.7%
Uninsured	20.6%	
Under Insured	10.0 %	
American Indian/Alaskan Native	0.1%	
Unknown VFC Eligibility and Insurance Coverage	52.0%	52.0%

### Third Party Payer Landscape

LHDs serve patients with insurance; including many with public insurance. New York State has been committed to expanding insurance coverage through public programs with comprehensive benefits, including immunizations. Medicaid serves enrollees through two different health care delivery systems, managed care and fee for service. As of November 2011, 980,000 beneficiaries, or 80 percent of the Medicaid population outside of NYC, were enrolled in one of twenty managed care plans.<sup>4</sup> Another 150,505 adults were enrolled in Family Health Plus (FHP) and 265,916 children were enrolled in Child Health Plus (CHP). Healthy New York is a program through which eligible individuals (98,160 outside New York City in 2011) can purchase subsidized insurance through licensed managed care plans. The Medicare program enrolls members in traditional fee-for-service insurance as well as managed care plans, known as Medicare Advantage. In 2011, New York had close to 2 million Medicare eligible persons outside New York City with 357,000 enrolled in Medicare Advantage plans.<sup>5</sup>

Managed care plays an important role in the New York State public and commercial health insurance market. In 2011, 65.8 % of all New Yorkers were enrolled in a managed care plan.<sup>6</sup> To serve members of a managed care plan and claim reimbursement, a network contract is required in most circumstances. LHDs can claim reimbursement without a contract for Medicaid and FHP enrollees, as detailed under Network Requirements in the next section.

LHDs that serve commercially insured patients will encounter a wide variety of insurance products including managed care plans and traditional indemnity type plans. Many New Yorkers who have health insurance through their employers receive their care from some type of a managed care plan that distinguishes between network and non-network providers with incentives to use network providers. Many New Yorkers receive health benefits through employers who have self-insured arrangements.

<sup>4</sup> Medicaid Managed Care monthly reports, [http://www.health.ny.gov/health\\_care/managed\\_care/reports/enrollment/monthly/](http://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/)

<sup>5</sup> Medicare Advantage refers to the Medicare managed care program. Kaiser Family Foundation, Medicare Health and Prescription Drug Plan Tracker: <http://healthplantracker.kff.org/>.

<sup>6</sup> NYS Managed Care Plan 2011 Performance Report (QARR). Includes public and commercial HMO and commercial PPO plans. Total includes New York City.



Although state and federal laws require health insurance to cover immunizations without out-of-pocket costs, some self-insured plans are exempt from these laws. Detail is provided under First Dollar Coverage in the next section.

### ***Health insurance and Public Health Law issues related to billing by LHDs***

New York State Insurance Law regulates interactions between medical providers and insurers. The laws describe providers', including LHDs', rights and obligations when pursuing reimbursement for services. It is possible for a proactive LHD to obtain reimbursement if the LHD is able to appropriately interact with health plans. Few provisions treat LHDs differently from other providers. Below is a review of some important legal concepts in health insurance relating to LHDs.

#### **First-Dollar Coverage:**

New York State Insurance Law, Sections 3216, 3221 and 4303, ensures coverage for specified childhood vaccines with no patient liability in the form of deductibles, co-payments or co-insurance, known as first-dollar coverage, since 1994. This means many children with insurance have full coverage for recommended immunizations. However, employer sponsored health benefits may fall into a class that are not regulated by the State and are thus exempt from this law. First-dollar coverage is expected to expand for all age groups under the 2010 Patient Protection and Affordable Care Act to cover Advisory Council on Immunization Practices recommended vaccines effective September 23, 2010.<sup>7</sup> Grandfathered health plans, as defined by PPACA, remain exempt from the federal first-dollar provision.

#### **Network Requirements:**

Generally, providers must contract with managed care plans in order to be reimbursed. Insurance plans may refuse providers' requests for inclusion as in-network providers. One exception to network limitations exists for LHDs serving Medicaid enrollees. The Medicaid Managed Care contract<sup>8</sup> between insurers and the New York State Department of Health requires that plans reimburse LHDs for certain public health services provided to Medicaid Managed Care enrollees, including immunizations. The contract states that LHDs do not require provider contracts with the insurers for this reimbursement.

#### **Out-of-Network Coverage:**

Managed care coverage for services of physicians who are not part of the plan's network is limited. First-dollar provisions for immunization coverage only apply if patients seek services at in-network providers. Out-of-network providers, including LHDs, must clearly understand the out-of-network payment policies for each individual served, not merely for each plan since plans may have multiple products with multiple benefit packages and out-of-network provisions. It is good practice for LHDs to establish clear policies and notify patients of their financial responsibility before services are rendered. Generally, commercially insured patients will need to pay out-of-pocket when receiving out-of network services.

#### **Public Health Law and LHD billing practice**

Public Health Law and regulations clarify the responsibilities of LHDs with regard to billing. For example, Section 2304 of Public Health Law and State Sanitary Code 10 NYCRR Section 23.2 regulations stipulate that diagnosis and treatment for sexually transmitted disease must be provided free of charge, so LHDs cannot charge patients or third party payers for these services. Public Health Law Article 6 and 10

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<sup>7</sup> <http://www.healthcare.gov/news/factsheets/2010/09/affordable-care-act-immunization.html>

<sup>8</sup> [http://www.health.ny.gov/health\\_care/managed\\_care/providers/index.htm#model\\_contracts](http://www.health.ny.gov/health_care/managed_care/providers/index.htm#model_contracts), Section 10-18

NYCRR Part 40 regulations related to the General Public Health Work program describe the conditions under which LHDs can receive state aid reimbursement for public health services. This set of laws and regulations require that LHDs “make every reasonable effort to collect payments for public health services provided”. LHDs must establish fee schedules for clinical services, and must establish and use sliding fee scales.

### 3. Strategic Planning Process

The following sections describe the planning process and detail the State’s billing and revenue improvement strategy.

#### *Involvement of Stakeholders*

In spring 2010, the Department recruited partners with interest in the ability of LHDs to bill for immunization services to participate on a Strategic Planning Steering Committee. Steering Committee members included:

- New York State Department of Health
- External Organizations:
  - New York State Association of County Health Officials (NYSACHO),
  - New York State Health Plan Association, and
  - New York City Department of Health and Mental Hygiene, Bureau of Immunization.
- LHD Representatives:
  - Albany County Department of Health,
  - Broome County Health Department,
  - Columbia County Department of Health,
  - Madison County Department of Health,
  - Niagara County Department of Health, and
  - Yates County Health Department.

The full Steering Committee met twice to discuss the project. In addition, small group discussions took place with all members to get in-depth perspectives on goals and barriers in the project. The Steering Committee met with the consulting team from the Public Consulting Group (PCG) in a full meeting and in small group interviews to provide the consultant with specific insight on the project. LHD representatives provided additional input early in the planning process and at key points during the development of the plan to ensure their needs were addressed.

The stakeholders brought a variety of perspectives to the table, reflecting their positions in the public health system of New York State. LHD representatives had different perspectives: some were already active in billing and interested in strengthening their operations, while others came with less experience and were exploring the prospects for third party billing. For example, a large urban county health department with many years of billing experience contributed useful information about system solutions to the process. A representative from a small LHD that serves an uninsured population with minimal opportunity for third party revenue contributed insight on small volume provider concerns.

The New York Health Plan Association served as a conduit of information for many of New York’s health plans, enabling the planning process to be informed by the health plans and to raise the profile of LHD issues among the plans.

The implementation solutions and strategies for moving forward from the strategic planning process were shared with NYSACHO members in a presentation in October 2011. The NYSACHO Board of Directors, LHDs represented on the steering committee and those that participated in site visits (discussed below) were also asked for feedback on the draft of this plan and provided written comments. These comments have been integrated into the implementation strategy.

### ***Assessing the Capacity of LHDs to Bill for Immunization Services***

The Department sought to describe current local immunization and other billing practices and policies that affect an LHD’s ability to successfully pursue third party reimbursement. This objective was met through

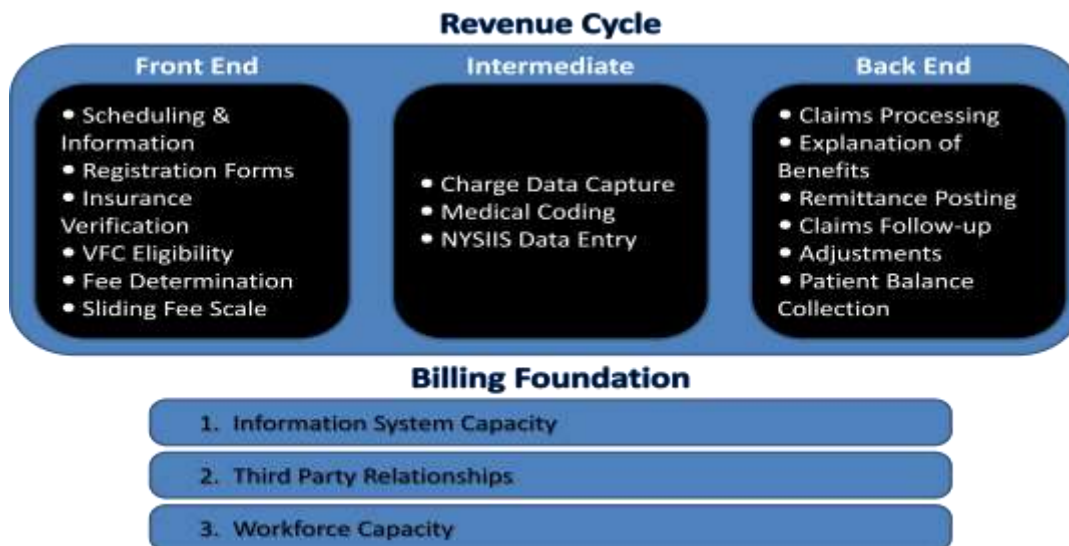
- An initial survey of all 57 LHDs in NYS,
- A review of policies and procedures that affect billing,
- Interviews with stakeholders,
- The development of the elements for successful immunization billing practice, and
- Six site visits to examine billing processes and assess the strengths and weaknesses of existing LHD operations.

The section below describes these processes and their findings.

#### **Effective Billing Practices**

Public health programs have typically not focused on revenue generation, and not all programs have the systems in place to manage reimbursement. LHDs face challenges in effectively meeting the public health law requirements and also implementing business practices for collecting revenue. PCG provided a summary of the necessary policies and procedures for successful business reimbursement practices. The document summarizing the elements for successful immunization billing practice is a report based on the work provided by PCG that describes the revenue cycle and foundational aspects of successful billing practice, including information systems, relationships with third party payers, and personnel resources. The elements for successful immunization billing practice are summarized in the following section.

**Figure 3: Elements for Successful Immunization Billing Practice**



As described by the PCG, the **Revenue Cycle** is comprised of the financial processes associated with each patient visit, from registration to billing, receipt of reimbursement and closing each fee balance. The processes are categorized into three parts: front end processes, intermediate processes and back end processes.

*Front End Processes* include scheduling, patient registration, VFC eligibility determination, insurance determination and verification, collection of co-pays, deductibles or self-pay amounts and sliding fee application. The information gathered at this stage of the process is critical to ensure that insurance claims are not denied for reasons such as invalid insurance coverage, service authorization not obtained or service not covered under the member's benefit plan.

*Intermediate Processes* include the capture of service information in an electronic or manual encounter form. This includes procedure and diagnosis codes as well as other data elements required for billing third-party payers and NYSIIS data entry. Correct coding is important for submission of accurate reimbursement claims.

*Back End Processes* consist of claims creation and submission, posting payments to open accounts, claims follow-up and patient billing statements. In addition, back-end processes include those steps in account reconciliation and closure of each fee balance.

Providers need internal reporting tools and control mechanisms in place to ensure all claims are properly adjudicated and routine reports are created to monitor billing processes and outcomes.

The **foundation** of successful billing includes three components:

1. *Information System Capacity*: LHDs need an information system or service that can provide:
  - Single-point patient data entry,
  - Useful for multiple clinical service areas within an LHD,
  - Efficient NYSIIS data transmission,
  - Electronic claim submission,
  - Availability of service data for billing functions,
  - Account reconciliation,
  - Financial and statistical reporting capabilities, and
  - Data import and export capabilities.
2. *Third party relationships*: To obtain reimbursement for immunizations provided to enrolled patients, LHDs need to develop relationships with insurance plans, including:
  - Network agreements with insurance plans,
  - Credentialing of LHD practitioners with insurance plans so that LHDs can be reimbursed as network providers, and
  - Clearinghouse Agreements to enable streamlined LHD communication with payers. These services may be free or require contract agreements.
3. *Workforce Capacity and Capability*: LHDs need sufficient personnel resources to:
  - Handle scheduling and registration,
  - Submit claims, post payments and address outstanding accounts,
  - Handle electronic claims, enrollment process and submit paperwork for electronic funds transfer (EFT) deposits from payers,
  - Manage the health plan contracting and credentialing effort, and
  - Handle IT support for software implementation, maintenance and troubleshooting.

## Strengths, Weaknesses, Opportunities and Threats related to LHD Billing Practices

Site visits enabled PCG and the New York State Department of Health to observe strategies used by six LHDs to perform the functions described in the elements for successful billing practice. The Department selected a representative cross-section of volunteer LHDs in terms of size and third party billing experience to participate in the site visits. PCG and a New York State Department of Health representative visited Albany, Allegany, Cortland, Greene, Monroe and Oneida county health departments. The site visits provided an opportunity to assess strategies currently in use in a range of LHDs (the “as is” picture) compared to the elements for successful billing practice (the “desired state”). The results of site visit interviews led to an assessment of Strengths, Weaknesses, Opportunities and Threats (SWOT) to successful third party billing practice.

### *Current Strengths of LHDs*

- Clinical focus with an emphasis on removing barriers to care,
- Effective use of NYSIIS to document immunizations and manage vaccine inventory, and
- LHDs with a history of insurance billing have success.

### *Current Weaknesses of LHD Operations*

- Lack of an integrated practice management information system (PMIS) to manage data across all LHD public health services,
- Lack of strong insurance data capture on the front end including verification of coverage on the date of service leading to inaccurate billing and reporting, and lower reimbursement success rates,
- Instances of providing free care without assessing insurance status or hardship,
- Multiple clinical areas within a single LHD maintain multiple systems,
- Addressing back end functions (such as claims payment, rejected claim follow-up and patient balance billing) in an ad-hoc manner, leading to gaps and inefficiencies, and
- LHDs have an insufficient number of managed care contracts for commercially insured patients who come to LHD for services.

### *Opportunities for Future Improvements*

- LHDs exhibited interest in learning how to implement effective systems,
- Centralized business and clinical operations of different programs and services within LHDs would make billing operations more efficient,
- Regional or centralized Practice Management Information Systems for LHDs could provide benefits,
- Multi-LHD agreements to consolidate specific functions across LHDs to share back-end processes, collectively purchase IT or collectively contract with insurers could provide efficiencies, and
- Implementation of comprehensive fee policies will enable LHDs to ensure access to those with limited means and limit the need for individual fee waivers. This objectivity will be valuable in demonstrating appropriate use of public health funding.

### *Threats to Improvement Efforts*

- Local county administration means that each county must have its own billing system,
- New claiming mechanisms may be subject to limitations of the current operating environment,
- Lack of resources (clinical & administrative staff, technology, training), and
- LHD service volume may not support cost-effective billing solutions.

## ***Billing Improvement Strategy***

This plan details multiple billing improvement options for LHD implementation of immunization billing, allowing for the great diversity among LHDs. Based on their SWOT analysis, PCG undertook a cost analysis to document resources necessary for LHDs to implement successful billing systems. PCG appraised the costs for implementing each of the specified approaches to billing, and considered volume thresholds that define whether or not each approach is cost effective.

The analyses completed by the New York State Department of Health and PCG indicated that many LHDs are already billing for their services and that the New York State landscape permits LHD billing operations. Based on these findings, the Department concluded that improvements in LHD billing are possible and can be effective in increasing insurance revenue for LHDs. The Department is using PCG's billing improvement options as the basis of its LHD billing improvement strategy described below.

In developing this strategy, the Department made certain core assumptions based on the billing landscape and the analyses conducted:

- Based on the finding that most LHDs are already engaged to some degree in third party billing, the Department expects incremental LHD changes and financial benefits to expanding billing processes.
- Immunization reimbursement systems in New York appear complex for LHDs given the relatively low volume of billable units.
- Technical assistance is needed to support the expansion of billing, so the strategic plan addresses dissemination of third party billing information to LHDs.
- Multiple billing improvement options are needed to meet a wide range of LHD needs. In particular, options are needed that recognize very low volume LHDs.
- Because public health is the primary mission of the LHDs, the strategy needs to balance revenue generation with access to vaccines, avoiding approaches that would limit access.
- Improvements related to billing, especially in data collection, will improve clinic management and vaccine reporting.
- Billing improvement is relevant to many services for which third party reimbursement can be obtained; therefore, this process has relevance to many billable LHD clinic services.

## **Billing Improvement Solutions**

### **Basic requirements for all LHDs**

The Department will expect all LHDs to perform certain functions related to third party billing. LHDs with low vaccine volume and no other potential third party billing may implement these practices and choose not to implement any other billing activities. The basic requirements are detailed below and ensure that compliance with state and federal programs such as the General Public Health Work Program, the Vaccines for Children program and public third party payer requirements is maintained.

- 1. Collect Insurance information:** When a patient schedules an appointment or walks in for an appointment, all LHDs should ask the patient or guardian for any third party coverage information. LHDs need third party payer information collected at every encounter to determine a child's eligibility for VFC, comply with Article 6 and provide patients with the necessary documentation to pursue reimbursement of their out of pocket medical expense. The Department expects LHDs to use the NYSIIS billing data repository function to assist in this function if they do not have another information system with third party payer information collection capacity. More information on the NYSIIS billing data repository function is described in billing improvement option 1 below.

2. **Determine Payer Mix:** All LHDs should compile insurance information and determine their payer mix for immunization services, identifying the major potential sources for reimbursement. LHDs can use this information to determine the most cost effective billing approach. This information also indicates which managed care contracts to pursue.
3. **Establish and Implement an Out of Pocket Patient Fee Process:** In accordance with Public Health Law Article 6, LHDs must bill patients for vaccines and administration fees as appropriate. LHD should have approved fees and sliding fee scales.
4. **Promote Medical Homes:** LHDs should establish policies that encourage the use of medical homes. LHDs should also utilize local Facilitated Enrollment counselors to promote access to care among those patients eligible for public programs.
5. **Submit Claims to Public Insurance Programs:** All public health clinics must claim reimbursement for the services they provide for publicly insured individuals. All LHD clinics must be enrolled as Medicaid and Medicare providers and should verify eligibility and conditions of coverage including enrollment in managed care for the date immunization services are provided. Public Health Law Article 6, Medicare and Medicaid regulations underlie this requirement.

### **LHD Billing Improvement Options**

In addition to the five basic requirements, PCG outlined five major options for implementing third party billing at LHDs in New York. These billing improvement options represent structures through which LHDs can successfully implement third party billing to address the elements for successful immunization billing practice summarized earlier in this document and detailed in the PCG elements for successful immunization billing practice report. The five options are as follows:

1. **NYSIIS Data Repository:** NYSIIS will be adapted for use as a third party billing data collection tool. The Department does not expect LHDs with satisfactory information systems to use NYSIIS for billing purposes. This will be useful to those LHDs with very low volumes of third party billing and will only be useful for immunization services.

This option anticipates the use of the NYSIIS billing data repository to collect all necessary billing information. This data is necessary for LHDs to generate and submit claims, which is most effectively done with the use of a basic clearinghouse. A basic clearinghouse is an entity that processes claim submissions, checks for errors and transmits claims to multiple payers securely. LHDs using this system will still handle all revenue cycle back end functions. The NYSIIS system does not include back end claim tracking, accounting or reporting functions.

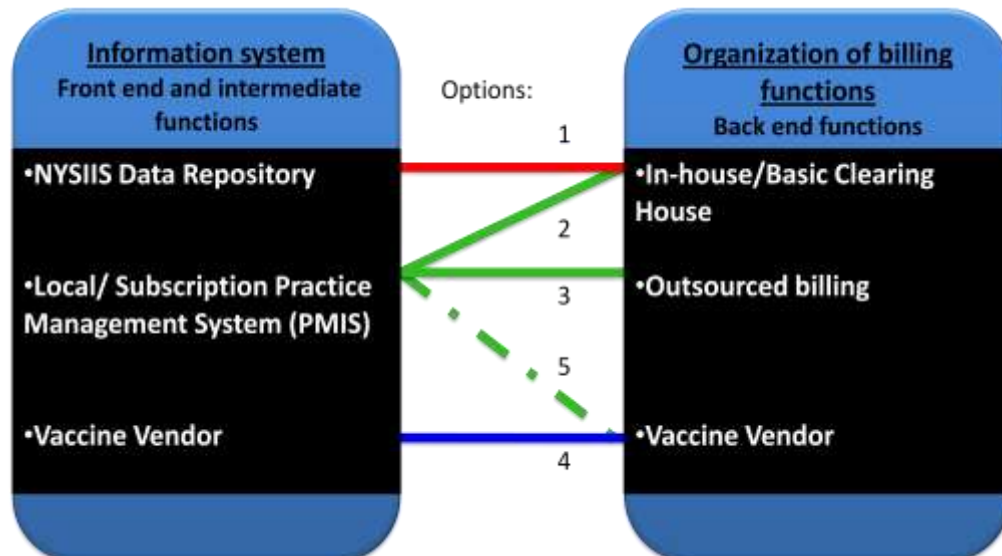
The Department has contracted with HP Enterprise Services to add insurance data collection functions to NYSIIS. *This is the lowest cost option.*

2. **Locally hosted or subscription-based practice management information system (PMIS)/internal billing:** A PMIS is an electronic data management tool that assists medical practices in capture and management of medical service and insurance data. This option assumes that LHDs will obtain access to a PMIS through a web-hosted system subscription or in-house system license purchase. LHDs can use a PMIS to manage claims formatting, submission tracking and follow up and payment posting. The PMIS can also improve internal processes such as registration and scheduling. If a LHD selects an appropriate system, the LHD can use the PMIS for all LHD clinical services. The LHD using this model retains responsibility for all back end claims management with assistance from PMIS tools. Basic clearinghouse services can be combined with a PMIS for claiming efficiency. *This is a medium cost option.*

3. **Locally hosted or subscription-based PMIS, outsourced billing:** This option includes the same features of option 2, but assumes a contract with an external vendor that manages all back end revenue cycle functions. The benefit of this option is the LHD obtains the use of a PMIS to improve internal processes such as registration and scheduling and the LHD obtains the services a company that specializes in third party billing. The PMIS will eliminate duplicate data entry and facilitate data transfer to NYSIIS and the contracted billing agency. Such contracts generally include all of the functions of a full service-clearing house such as eligibility verification, rejection analysis, secondary claims processing and patient statement services. *This is a medium cost option.*
4. **Vaccine vendor billing:** This option assumes an external vendor will handle vaccine purchasing as well as all of the revenue cycle back end functions. The vaccine vendor assumes all of the risk associated with the purchase and shipment of the vaccines. In addition, the vendor is responsible for handling patient self-pay statements. The LHD is responsible for vaccine storage and handling and LHD staff-administer all vaccines. The LHD enters immunization service data directly into the vendor application. This option is currently available for common routine private stock vaccines; it is not available for rabies vaccine, travel vaccine, public vaccines (including VFC) or other LHD services. A major drawback of this option is that vaccine vendors only manage private stock routine vaccines, which leaves LHDs with responsibility for reimbursement for public stock, including VFC, Medicaid fee for service, Medicaid Managed Care and CHP. *This is a low cost option.*
5. **Locally hosted or subscription-based PMIS /vaccine vendor:** This option combines advantages of a PMIS (option 2 or 3) and vaccine vendor (option 4). This option also has the drawbacks of the vaccine vendor option. The LHD would need to select a PMIS that is compatible with the vaccine vendor information system. *This is a medium cost option.*

Figure 4 below summarizes the potential options for third party billing implementation, relative to the functions of the Revenue cycle.

**Figure 4: LHD billing improvement options and the revenue cycle functions**



### Costs

The cost analysis for the five billing improvement options described above, completed by PCG, details the types of costs incurred in the implementation of each of the options. The analysis estimates the costs for each of these options and the immunization service revenue required to break even and to pay



for the implementation. See Attachment A for PCG cost assumptions, option advantages and disadvantages, and breakeven analysis comparison. According to the PCG analysis, LHDs that bill only for immunizations would need to bill for at least an estimated 504 doses annually to break even.<sup>9</sup>

There are a few key points to consider in the use of the cost analysis.

- The costs provided are based on complete implementation, although many counties currently have some of the components partially or completely addressed.
- In low volume LHDs, systems will pay for themselves only if put in place in multiple LHDs coordinating and sharing resources, or if low volume LHDs are able to absorb incremental third party billing workload among existing staff.
- The analysis considers only immunizations; inclusion of other services in the billing improvement options is possible and will impact fiscal considerations for implementation.

Lastly, most LHDs lack full patient population information, including insurance plan information on each dose administered. LHDs will need to collect and analyze this information in sufficient detail to fully evaluate options (including whether full implementation is viable) and decide on implementation priorities. A number of LHDs were able to take advantage of an ARRA-funded opportunity to purchase computing supplies to assist in the data collection that will underlie these decisions.

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<sup>9</sup> The analysis was based on the cost of billing and the reimbursement for administering a dose of vaccine. The reimbursement value for administering each dose was determined by using the prices established by the Vaccines for Children Program (90% of the maximum allowed reimbursement, \$17.85). This was estimated to be \$16 per dose administered. The cost of the vaccine itself was not considered since LHDs break even on this purchase.

## 4. Moving Forward

The first step for LHDs is to collect information necessary to determine their payer mix. This will assist in the decision making process.

It is likely that LHDs will phase in implementation of third party billing. In particular, contracting with insurers will take time. LHDs may determine from their patient profiles that particular insurers represent too low of a volume to pursue contracting. Under these conditions, the LHD may be unable to bill select third party payers for certain out-of-network services. Thus, LHDs may continue to bill some insured patients out of pocket. This scenario is expected and must be factored into the decision-making process.

The Department will assist individual LHDs to support the implementation of third party billing strategies on a local level. The Department will:

- Contract with HP Enterprise Services to develop the insurance data capture functionality for NYSIIS described in this report,
- Contract with NYSACHO to lead technical assistance (TA) sessions for groups of interested LHDs. The TA groups will help LHDs select the best options to augment their billing systems. TA groups are intended to be ongoing LHD resources to mentor, problem solve, and exchange billing information. Some topics that the groups are likely to address are included in Attachment B,
- Provide LHDs with a worksheet based on the PCG Cost Analysis that can be used as a part of their decision-making process and return on investment calculation to select an immunization billing improvement option,
- Provide interested LHDs, through a competitive process, with one-time funding to support some of the costs of implementing an immunization billing improvement option,
- Identify insurance identification and eligibility verification tools for use by LHDs. Such online or telephone service tools, available from insurers and other third parties at no or some cost, can be used to confirm that coverage information is accurate, to determine whether services are included in the benefit package and the costs if any for which patients are responsible,
- Explore the feasibility of a centralized medical billing clearinghouse agreement through which interested LHDs can submit claims for reimbursement. The costs of this tool would be borne by the LHDs using the service,
- Provide assistance as requested to those counties seeking to implement county specific solutions or form coalitions through which resources are pooled, and
- Investigate the potential for use of incentives to improve third party revenue.

Key stakeholders can also facilitate successful implementation.

CDC can:

- Develop policies to facilitate the procurement and use of privately purchased vaccine in public health agencies.

NYSACHO can:

- Support the ongoing TA groups,
- Use list serves, conference calls, electronic bulletin boards and other methods to enable LHDs to share information among billing staff, and
- Communicate with community partners, particularly insurers, to improve the recognition of the role of public health in providing safety net services.

Insurers and other stakeholders can:

- Recognize and support the role of LHDs in providing timely immunization services to the public, and
- Communicate with LHDs to promote the transition of patients seeking services at LHDs to traditional medical providers.

## Attachment A: Summary of the Public Consulting Group Cost Analysis.

The information provided in this appendix is based on the cost analysis report provided by Public Consulting Group, Inc. PCG provided the cost analysis as part of their evaluation of New York State LHD third party billing for immunizations.

**Figure 5: Advantages and Disadvantages of the Five Billing Improvement Options**

	Option	Advantages	Disadvantages
Low Startup Cost	1. NYSIIS Data Repository	Low cost option Familiarity of LHDs staff with the system No local IT purchase Reduce duplicate data entry	Not applicable to non-immunization billable program services Requires LHD personnel for back-end processes
	4. Vaccine Vendor	Low cost option Vendor manages all purchasing of private vaccines and LHD does not have to purchase vaccines No local IT purchase	LHD would still need to bill for VFC eligible services Not applicable to non-immunization billable program services
Medium Startup Cost	2. Locally Hosted or Subscription (Web) based Practice Management Information System (PMIS) / Internal Billing	Potential to minimize duplicate data entry for encounter forms and NYSIIS For Subscription (Web) based PMIS limited need for IT presence	For locally hosted PMIS, requires more LHD IT presence Requires LHD personnel for back-end processes Steeper learning curve for internal staff to understand billing operations
	3. Locally Hosted or Subscription (Web) based PMIS/ Outsourced Billing	Potential to minimize duplicate data entry for encounter forms and NYSIIS For Subscription (Web) based PMIS, limited need for IT presence Vendor brings immediate billing know-how	For locally hosted PMIS, requires more LHD IT presence
	5. Locally Hosted or Subscription (Web) based PMIS/ Vaccine Vendor	Potential to minimize duplicate data entry for encounter forms and NYSIIS For Subscription (Web) based PMIS, limited need for IT presence	For locally hosted PMIS, requires more LHD IT presence LHD would still have to bill for VFC eligible services Not applicable to non-immunization billable program services.

**Breakeven Analysis Comparison**

Each of the options has a breakeven point that represents the number of immunization services that have to be billed and paid by third party payers before the LHD breaks even on its initial investment and operating costs both in year one and in year two. Other clinic service revenues will affect these breakeven points.

As shown in the chart below, the low cost options have lower breakeven points in year one than the medium cost options. However, in year two, the breakeven point for the different options are much closer together because the cost of implementation in year one includes one-time only costs such as information system purchase and configuration, computer and printer purchase and costs associated with initial contracting and credentialing efforts.

**Figure 6: Break Even Comparison of All Billing Improvement Options – Year 1 & 2**

Startup Cost Tier	Option	Estimated Break Even Point: Number of Doses		
		Year 1	Year 2	Two-Year Total
Low Cost	1. NYSIIS Data Repository	846	597	1,444
	4. Vaccine Vendor	721	546	1,267
Medium Cost	2. Locally hosted PMIS/Internal Billing	1,046	597	1,644
	2. Subscription PMIS /Internal Billing	933	663	1,596
	3. Locally hosted PMIS/Outsourced Billing	1,211	504	1,715
	3. Subscription PMIS/Outsourced Billing	1,056	624	1,680
	5. Locally hosted PMIS/Vaccine Vendor	1,115	546	1,661
	5. Subscription PMIS /Vaccine Vendor	921	696	1,617

**Figure 7: Annual net revenue (gross revenue minus cost) based on 900 billed doses and \$16 per dose administration reimbursement, Year 1 and 2**

Startup Cost Tier	Option	Net billing revenue		
		Year 1	Year 2	Average
Low Cost	1. NYSIIS Data Repository	\$846	\$4,770	\$2,808
	4. Vaccine Vendor	\$1,431	\$2,835	\$2,133
Medium Cost	2. Locally hosted PMIS/Internal Billing	(\$2,304)	\$4,770	\$1,233
	2. Subscription PMIS /Internal Billing	(\$531)	\$3,789	\$1,629
	3. Locally hosted PMIS/Outsourced Billing	(\$3,114)	\$3,960	\$423
	3. Subscription PMIS/Outsourced Billing	(\$1,557)	\$2,763	\$603
	5. Locally hosted PMIS/Vaccine Vendor	(\$1,719)	\$2,835	\$558
	5. Subscription PMIS /Vaccine Vendor	(\$171)	\$1,629	\$729

**Cost Model Assumptions**

Each LHD will have to apply these cost assumptions to its unique situation. The Department will work with LHDs through the NYSACHO TA groups to discuss how LHDs can determine whether the potential revenue generated can justify the costs associated with billing. Cost estimates were supplied by PCG.

**Assumptions:**

*System Costs & Licensing Fees:* The purchase of local PMIS licenses represents a one-time investment of \$3,000 in system cost or \$600 per concurrent user. A concurrent user represents one end user that is in the system at any given time. For instance, a 5 concurrent user license means that up to 5 people can access the system at the same time. This estimate is based on market prices for common PMIS software packages. These systems may also have annual support and update fees.

*Annual Fee:* This cost relates to web-based PMIS in which a monthly or annual subscription fee is required. The estimated cost for a subscription, which could be shared, would be \$400 per month. This includes system setup, electronic claiming, automated payment posting and insurance verification services. This estimate reflects market prices and information supplied by Albany County Department of Health on its selection of a web-based information system in the year 2010.

*System Review & Configuration:* These costs are associated with configuring the applications for each practice. Activities performed in this area include building data tables such as provider files, CPT codes, diagnosis codes, fee schedules and insurance plans. It is estimated that this process takes approximately 20 hours per LHD. The expectation is the system vendor will handle this function for the LHDs at a rate of \$100 per hour.

*Outside Services:* This fee applies mainly to the Billing Vendor and Vaccine Vendor options. For the Billing Vendor option a fee of \$6 per dose is estimated. A fee of \$8 per dose is estimated for the Vaccine Vendor option. Vaccine Vendor pricing was supplied by a Vaccine Vendor company representative.

*Computer & Printer:* These costs are based on the average retail price for PCs and printers from computer retailers. These are entry level computers with basic features and minimal processing power but sufficient to connect the PC's to the LHD network. Each LHD is expected to purchase one PC (\$1,000) and printer (\$400) at a combined amount of \$1,400.

*Billing Staff:* The cost model assumes billing and collections staff costs will range from ¼ Full Time Equivalent (FTE) to ½ FTE depending on service volume. The staffing cost is estimated at \$34 per hour including benefits (\$24 per hour salary plus 40% for benefits), based on LHD salaries in the capital district. The increase in staff resources is estimated as follows:

	Outsourced Billing	Internal Billing	NYSIIS	Vaccine Vendor
Low Cost Option			1/2 FTE	1/4 FTE
Medium Cost Option	1/4 FTE	1/2 FTE		1/4 FTE

*Credentialing & Contracting:* The credentialing and contracting cost can vary widely depending on the payers and how they operate their contracting and credentialing departments. It is estimated the contracting and credentialing start-up effort will require approximately 60 hours per LHD, representing one provider and 3 payers per LHD. The staffing cost is estimated at \$42 per hour including benefits (\$30 per hour salary plus 40% for benefits). Ongoing credentialing is estimated at 16 hours per LHD.

*Clearinghouse:* Clearinghouse charges typically range from \$75 to \$125 per provider per month for 400 to 500 claims. This translates into an estimated cost of \$0.25 per claim. The cost was then adjusted to reflect LHD claiming volume. There are some no-fee clearinghouses available to providers. However, the

no-cost clearinghouses provide basic services while fee for service clearing houses offer enhanced services such as a user interface to fix claims and reporting modules for providers to run claim and rejection reports. PCG consulted pricing tables from commonly utilized clearinghouses to determine this estimate.

*Personnel & Training:* These costs were determined through conversations with vendors and general prior experience offering billing system training sessions. Training will take approximately 2 days for LHDs that select the PMIS or web-based subscription system. System vendors generally perform this training at about \$100 per hour.

*Cost of Vaccines:* The cost of vaccines is not counted in the calculation of billing revenue. It is assumed that LHDs will break even on the billing of vaccines because VFC vaccine is provided at no cost to the LHD, administration fees are billable for all patients and vaccine fees are billable for commercially insured patients. These sources will fund the cost of vaccines.

*Cost of Preparing Medicaid Cost Reports:* Under New York State Law, Article 28, LHDs are required to submit a Medicaid cost report. Therefore the expense to prepare cost reports is not specific to immunization services or third party billing and not reflected in the cost analysis for this report.

## **Attachment B: Preliminary NYSACHO webinar topics**

### NYSACHO Immunization Services Billing

#### Technical Assistance Work Group

#### Possible Topics

- Review of elements for successful immunization billing practice.
- Evaluating options to improve immunization and other LHD service billing.
- Estimating potential revenue from immunization billing operations.
- Using appointments to gather front-end data in advance of services.
- NYSIIS Immunization billing data entry: new opportunities.
- Options for insurance eligibility identification and verification.
- Presentation of clearinghouse and outsourced billing improvement options.
- Medicaid/Medicare cost reporting.
- Practice management information systems.
- LHD staffing for third party billing operations.
- Establishing fees including sliding fee scales, assessing immunization related costs, client billing, and hardship policies.
- Negotiating contracts with health plans
- Using credentialing databases.
- Billing without a contract.
- Cost effective vaccine purchasing.