Introduction and Background

Introduction

Most of Missouri's Local Public Health Agencies (LPHAs) were formed under Chapter 205, Revised Statutes of Missouri, which allows counties to enact a property tax to support public health services and elect a board of trustees to set policies. Other LPHAs are governed by locally elected bodies and receive funding from city and county general revenue. Missouri's 115 LPHAs are autonomous of the state public health agency (Missouri Department of Health and Senior Services).

The LPHAs work directly with the Missouri Department of Health and Senior Services (DHSS) through contracts to deliver public health services in local communities; however, funds that support many of these services are decreasing while costs are continuing to rise. LPHAs are looking at new and different ways to sustain these crucial public health services in their communities. This is forcing a culture shift from one of offering free services for everyone to operating under a business model and charging a fee for services. Many, if not all LPHAs, do not have the financial infrastructure to continue to provide services at no cost.

Fast Fact

57% of Missouri's LPHAs bill private / commercial insurance companies.

Research cited in the *Pediatrics* supplement "Primary Care Physician Perspectives on Reimbursement for Childhood Immunizations" indicates that almost half of the physicians in the study delayed purchasing vaccines due only to financial concerns.[1] Increased costs of managing an increasingly expensive vaccine inventory is one reason why physicians are seriously considering whether to stop providing immunizations. This implies that some children will be left at risk for vaccine-preventable diseases or seek services from the LPHA.

As it stands, LPHAs are operating on a two-tiered financing system in which some clients receive services, such as immunizations, but others do not. This is attributable in large part to different eligibility requirements for public and private insurance programs.

According to a Fiscal Year 2015 Infrastructure and Practices Survey distributed by the DHSS' Center for Local Public Health Services (CLPHS) and administered to all 115 Missouri LPHAs:

- 93% bill Medicaid for vaccine administration
- 86% bill Medicaid for client services
- 71% bill Medicare for client services
- 57% bill private / commercial insurance for client services

The ability to bill Medicare, Medicaid and private / commercial insurance carriers will aid LPHAs in protecting more Missourians from vaccine-preventable diseases.

Billables Project Background

The Centers for Disease Control and Prevention (CDC) awards federal dollars to states to administer the Vaccines for Children (VFC) program and Section 317 vaccine program of the Public Health Service Act.

VFC is an entitlement program designed to protect children against vaccine-preventable diseases. The program covers children who are Medicaid-eligible, uninsured, American Indian or Alaska Native and underinsured (i.e., insurance plan that does not cover immunizations, does not cover specific vaccines or has a fixed dollar limit or cap for immunizations – this does not include those who have an unmet deductible).

Section 317 of the Public Health Services Act authorizes the federal purchase of vaccines to vaccinate children, adolescents and adults. This funding has typically been used to immunize underinsured children not eligible for VFC and uninsured adults. Section 317 funding has not kept pace with the cost of vaccines and is no longer considered a viable funding source for those not covered under the VFC program. In September 2008, the National Vaccine Advisory Committee (NVAC) made the recommendation to the CDC that "States and localities should develop mechanisms for billing insured children and adolescents served in the public sector"[2]. The recommendation from NVAC prompted the CDC to no longer allow fully-insured children to receive vaccines through the use of Section 317 funding.

Through the American Recovery and Reinvestment Act (ARRA) of 2009, CDC launched the Immunization Billables Project, an effort to assist LPHAs with billing private / commercial insurance companies. The project began with 14 awardees, and was expanded by 14 in 2011 and seven in 2012. An additional 21 awardees were funded through the Affordable Care Act, Prevention and Public Health Fund (PPHF).

Prevention and Public Health Fund Award

In September 2011, the Bureau of Immunization Assessment and Assurance (now titled the Bureau of Immunizations) was awarded a grant from the CDC to develop a plan that enables LPHAs to bill Medicare, Medicaid and private / commercial insurance for immunization services.

Stakeholder Meeting

The Bureau of Immunizations (BI) convened a stakeholder workgroup in July 2012 to discuss the billing project and establish strategies for implementation. The workgroup members consisted of representatives from the Missouri Association of Local Public Health Agencies; Missouri Department of Social Services' MO HealthNet Division; Missouri Department of Insurance, Financial Institutions and Professional Registration's (DIFP's) Division of Market Regulation; DHSS' CLPHS; and 17 LPHAs representing urban, suburban and rural areas.

The workgroup identified six models to pilot test for sustainable billing options for Missouri's LPHAs. The billing models chosen by the workgroup included Availity, HeW (formerly Health-e-Web), hospital partnerships, TransactRx, Upp Technology (purchased by Harris Public Health Solutions) and VaxCare.

Twenty-five LPHAs were selected to pilot the billing models chosen by the workgroup. These LPHAs were selected based on the CLPHS' infrastructure survey responses, geographical locations and demographics.

Billing Project Pilot

In November 2012, the 25 LPHAs began the pilot test of five of the six billing models identified by the stakeholder workgroup. The pilot billing models included Availity, HeW, TransactRx, Upp Technology and VaxCare. After further exploration, it was determined that the hospital partnership concept identified by the stakeholder workgroup was not feasible for this project.

Each LPHA contracted with the BI in order to participate in the pilot. The original contract period began on November 1, 2012 and was scheduled to last six-months, ending on April 30, 2013. The original six-month contract was extended to allow the 25 LPHAs to work through barriers to obtaining contracts with private / commercial insurance carriers.

During the pilot phase, 25 LPHAs pilot tested billing models chosen by the stakeholder workgroup for one year for sustainability.

Through contracts with the BI, each of the 25 pilot LPHAs were required to conduct a survey of all clients visiting the LPHA for immunization services; establish infrastructure and determine appropriate mechanisms to bill third-party payers using the billing model; provide a cost analysis to determine the sustainability of the established billing program; and evaluate the billing program. The client survey, cost analysis and standard evaluation forms developed by the BI for use in the pilot are included in the *Appendices* of this toolkit.

The LPHAs were able to receive reimbursements for costs associated with establishing a billing program such as staff time; billing model service fees; contracting fees associated with service providers; computers; printers; general office supplies; Internet services; and software to use for testing selected billing models.

The BI provided technical assistance to the LPHAs throughout the contract period. Monthly conference calls were held to offer the pilot agencies an opportunity to network with one another and obtain any needed guidance from the BI.

Insurance Summit

Two of the largest barriers faced by the LPHAs during the pilot were credentialing and establishing contracts with private / commercial insurance companies. In response, the BI, in collaboration with DIFP, held an Insurance Summit in July 2013. The Insurance Summit gathered representatives from the LPHAs participating in the billing pilot project and top health insurance companies. The health insurance companies in attendance included: Aetna, Anthem Blue Cross Blue Shield, Assurant Health, Blue Cross Blue Shield of Kansas City, Cigna, Coventry Health Care, Cox Health Plans, Humana, United HealthCare and WellPoint.

The overall goal of the Insurance Summit was to identify solutions and strategies in developing modified contracts and/or credentialing to allow LPHAs to bill private / commercial health insurance companies for immunization services.

Implementation of Strategic Plans for Billing for Immunizations Services Award

The BI received the CDC Billables Implementation Grant award in October 2014. This grant was the second phase of the CDC Planning Grant that was received by DHSS and piloted in 2011-2012.

A needs assessment was distributed to the LPHAs to gather data on current immunization billing practices and future needs for the new grant selection. Sixty-eight LPHAs responded to the needs assessment with 45 expressing interest in participating in the implementation project. Nine of the interested LPHAs participated in the first planning grant.

A billing model webinar was held in February 2015 for LPHAs with four billing models participating. The billing models were HeW, TransactRx, Upp Technology and VaxCare. After reviewing essential services and updated costs of the previously used billing models and reviewing the needs assessments, three of the models remained in the pilot and one new vendor was added with a total of four vendors/models participating in the implementation pilot: HeW, TransactRx, Vaxcare, and EmdeonOne (purchased by Change Healthcare).

During the implementation phase, 27 LPHAs received one-year contracts tailored to meet individual needs.

With the number of LPHAs interested and information gathered from the needs assessment, contracts were tailored to meet individual needs and maximize grant dollars. In August 2015, one-year contracts were rewarded to 27 LPHAs.

As in the first planning grant, LPHAs were able to receive reimbursements for costs associated with establishing a billing program such as staff time; billing model service fees; contracting fees associated with service providers; computers; printers; freezers to store vaccine; general office supplies; Internet services; and software. One of the 27 contracts was awarded to Madison County Health Department to serve as a subject matter expert since the LPHA was successful in setting up and sustaining a billing process that was generating revenue for the LPHA. Madison County also developed and presented a training session entitled “Policy and Procedures for Commercial Insurance Billing.”

In October 2015, a training session was held along with an open forum panel that included the Madison County LPHA consultant, MoHealthNet Provider Relations staff, DIFP partner, and United Health Care representatives. The training was open to all LPHAs with 60 participants.

Monthly conference calls were held with the 27 contracted LPHAs to discuss progress, challenges and best practices. Once a quarter, the conference call was open to all LPHAs to participate and learn what was occurring with the implementation project. This allowed LPHAs that were already billing to share and gather information, and allowed the non-billing LPHAs to learn about the process and what their peers were accomplishing around the state. BI provided technical assistance to the LPHAs throughout the contract period.