HMA

HEALTH MANAGEMENT ASSOCIATES

# *Maximizing Insurance Payment for Covered HIV/STI Services Performed by Public Health Agencies and their Partners*

PREPARED FOR THE OREGON HEALTH AUTHORITY

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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# Introduction

With the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, more individuals gained access to insurance. The plan was, and is, that an individual's insurance would cover the cost of prevention and care services provided by public health agencies, so direct federal funding for these services, such as human immunodeficiency virus and sexually transmitted infection (HIV/STI) prevention and care services, would no longer be needed. As such, direct federal funding for these point-of-contact public health services has declined. According to the Oregon Health Insurance Survey, nearly 94% of Oregonians are insured. Thus, it is appropriate that those insurance plans cover services for their enrollees rather than using limited public health funds.

At this time, the Oregon Health Authority (OHA) still provides financial resources to local public health authorities (LPHAs), community-based organizations, and the Oregon State Public Health Lab for a variety of services covered by insurance– including HIV/STI prevention, screening, diagnosis, case management, and treatment services—to maintain individuals in medical care. As federal funding for these services continues to decline, this is unsustainable for the public health system.

To achieve a sustainable future for Oregon's public health system, the OHA's Public Health Division's HIV/STD/TB Section (HST) intends to better understand and implement appropriate billing practices for the insured population receiving HIV/STI prevention and care services from public health entities. To that end, HST retained Health Management Associates (HMA) to assess insurance billing policies and payment requirements for the prevention and treatment of Oregonians diagnosed with or at risk of contracting HIV/STI.

The purposes of the billing assessment are to:

- Understand insurance payment policies and other cost saving opportunities for services currently funded by OHA's public health program
- Inform forthcoming guidance and recommendations to modernize billing for HIV and STI prevention and care services
- Ensure the payers' encounter data used to measure quality and access and assess the risk profile of the population has the highest level of integrity by accurately reflecting the services members are receiving

Following this billing assessment, HMA will develop a training program to ensure LPHAs and their subcontracted partners ("HIV/STI Providers" through the remainder of this report) are maximizing their billing potential for HIV/STI services. Our analysis has also uncovered opportunities for enhancing insurer payments that are outside of improved billing practices from HIV/STI Providers, which we will explore in the Recommendations section of this report.

# Background

One of the fundamental roles of public health is to control the spread of communicable disease, including HIV/STI. Oregon's public health system is primarily county-based, with counties holding

delegated local public health authority. The LPHAs receive funding from federal, state, and county governments.

There are 36 counties in Oregon and 33 LPHAs. The models for HIV/STI service delivery vary by LPHA. Some offer all services in-house, others embed clinics within their health departments, and others contract with community health centers (federally qualified health centers/FQHCs) to deliver HIV/STI services.

The LPHAs' contracts with the OHA outline their HIV/STI service delivery responsibilities under Program Elements 1 (State Support for Public Health), 7 (HIV Prevention Services), and 10 (STD Client Services). These services include case investigation, partner services, HIV/STI testing, STI treatment, and other clinical services. In addition to the services that all LPHAs are required to provide under their contracts with OHA, six of the 33 LPHAs have five-year (2018-2022) HIV Early Intervention Services & Outreach (EISO) contracts. These grants are to provide time-limited, intensive services for people diagnosed with HIV, early syphilis, and rectal gonorrhea in thirteen counties to quickly link them to prevention and treatment services.

In 2015, the Oregon Legislature passed the Public Health Modernization bill (HB 3100) and invested $30 million in the initiative. The initial purpose of the initiative was to ensure all 33 LPHAs across the state could provide a baseline level of foundational programs (communicable disease control, environmental public health, prevention & health promotion, and access to clinical preventive services) and a foundational set of capabilities (assessment & epidemiology, emergency preparedness & response, communications, policy & planning, leadership & organizational competencies, health equity & cultural responsiveness, and community partnership development). HIV/STI prevention and treatment services span three of the four foundational program areas and many of the foundational capabilities. Ensuring these fundamental public health services are provided in the most effective and efficient manner will be key in the State's efforts to modernize its public health system.

## Process and Organization

HMA worked with the HST to develop a project work plan for development of the HIV/STI insurance billing assessment. In general, it included review of existing regulations governing Medicaid and

***HIV/STI Billing Assessment Work Plan***

| Task Name | Responsible | Start | Draft | Finish |
|---|---|---|---|---|
| Regulatory review and coding analysis | Janet Meyer Subcontractor | 07/1/20 | 03/31/21 | 5/31/21 |
| Public health entity data collection | Michael Anderson-Nathe | 7/1/20 | | 1/31/21 |
| Payer data collection | Janet Meyer | 10/01/20 | 01/31/21 | 03/31/21 |
| Assess use of public health lab for testing services | Janet Meyer | 09/15/20 | | 03/31/21 |
| Finalize Overall Task 1 report with findings and recommendations | | 1/1/21 | 3/19/21 | 3/31/21 |

commercial payment for HIV/STI prevention and treatment services that may be provided by LPHAs or their delegates, interviews with both public and private payers and EISO contractors and their partners, and a review of available billing codes by a certified medical coder. The table below details our work plan for development of this billing assessment report.

The report itself is categorized into payer (insurer) and HIV/STI provider (LPHA) sections, each of which includes a description of their respective stakeholders, methods, and findings. Overall recommendations for maximizing insurance billing for HIV/STI services provided by public health agencies and their contractors follows the analysis.

# HIV/STI Provider Analysis

## Provider Stakeholders

### EISO Contractors

In 2018, OHA awarded contracts to six local public health authorities to deliver HIV early intervention services and outreach (EISO) in 13 Oregon counties and in partnership with the Confederated Tribes of Siletz. These contracts provide almost $20 million over five years for testing people for HIV, linking them to care if they test positive (or referring them to prevention services, if negative), and ensuring continuity of care through initial viral suppression and transfer into HIV case management services[1]. For the purposes of this project, HST prioritized working with Oregon's current EISO contractors with the expectation that any recommendations or findings would be applicable across all of Oregon's LPHAs and their contractors delivering HIV/STI services. Throughout this report, when we refer to "HIV/STI Providers", we are including EISO grantees, LPHAs, and any contractors who are providing HIV/STI services in a public health setting.

***HIV/STI Providers Interviewed for this Project***

| EISO contractor | EISO Subcontractor | Other HIV/STI Providers |
|---|---|---|
| Deschutes County Health Department | Crook County Health Department<br>Jefferson County Health Department | |
| Jackson County Health Department | | Planned Parenthood of Southern Oregon |
| Lane County Health Department | HIV Alliance | Planned Parenthood of Southern Oregon |
| Lincoln County Health Department | Benton County Health Department<br>Confederated Tribes of Siletz Indians<br>Linn County Health Department | |
| Marion County Health Department | HIV Alliance | |
| Multnomah County Health Department | Clackamas County Health Department<br>Washington County Health Department<br>Cascade AIDS Project<br>Neighborhood Health Center | |

1 https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVPREVENTION/Pages/EISO.aspx

## HIV/EISO contractor Services

HIV EISO contractors are funded to deliver two primary services: *Outreach* and *HIV Early Intervention Services*. The primary goals for *outreach services* include identifying individuals that do not know their HIV status and refer them to resources to learn their status, and connecting people living with HIV but who are out of care into HIV care. Generally, outreach activities occur outside of public health clinic environments and in community-based settings frequented by members of any populations at disproportionate risk for HIV infection. Individuals who do not know their HIV status are either referred to HIV testing or receive rapid HIV testing services at the outreach site. Additional outreach services funded by EISO include:

- Case investigation and partner services for any person living with HIV with a new syphilis or gonorrhea diagnosis
- Follow up and reconnecting individuals previously diagnosed with HIV but who have fallen out of HIV care
- Referrals to early intervention services, HIV testing services, and partner services to:
    - Individuals who do not know their HIV status but have a new syphilis and/or rectal gonorrhea diagnosis
    - Individuals with a new HIV or STI diagnosis identified through EISO activities

*HIV Early Intervention Services (EIS)* seek to identify people living with HIV, refer them to services, link them to care and provide health education and literacy training to assist them in navigating HIV care and support services. HIV EIS include:

- HIV testing services to populations at elevated risk of HIV through outreach testing and HIV testing of individuals with a new syphilis or rectal gonorrhea diagnosis
- Initial contact and EISO enrollment for persons living with HIV referred by OHA Surveillance
- Assessment and referral of client needs related to sexual health, STI testing, HIV Prevention, services, and basic life challenges that may interfere with participation in care services
- Health literacy and education to clients in relevant areas impacting positive care outcomes like navigating HIV services, adherence to antiretroviral therapy, viral suppression, and other educational needs
- Linkage to care activities designed to connect people to care within 30 days of initial referral and ensuring participation in at least two visits for HIV medical care

## HIV Prevention Services (Program Element 7)

In addition to HIV EISO services, the OHA funds LPHAs to deliver HIV prevention services through Financial Assistance Agreements. Program and service deliverables are described in the contractual Program Elements and negotiated through the Conference of Local Health Officials. Program Element 7 covers HIV Prevention Services and is awarded to the seven counties with the highest incidence and

prevalence of HIV, which currently include Multnomah, Washington, Clackamas, Lane, Marion, Jackson, and Deschutes counties.

HIV prevention services are addressed in Program Element #7 and outline the following minimum components that LPHAs must provide:

1. HIV testing services with the goal of identifying individuals living with HIV
    a. HIV testing services including rapid, conventional, and confirmatory testing
    b. Referrals for services and care
2. Comprehensive HIV-related prevention services for persons living with/diagnosed with HIV
    a. Partner services for those newly and previously diagnosed individuals
    b. Linkage to medical care, treatment, and prevention services
    c. Supporting retention in medical care, treatment, and prevention services
3. Comprehensive HIV-related prevention services for HIV negative persons at high risk for HIV infection
    a. Increased awareness of and access to HIV pre-exposure prophylaxis (PrEP)
4. Community-level HIV prevention activities
    a. Condom distribution
    b. Distribution of culturally appropriate and linguistically responsive HIV education materials
    c. Community outreach and mobilization
    d. Syringe exchange/harm reduction (optional and subject to local approval)

## Methods

To inform this analysis of billing opportunities for HIV/STI services provided by public health entities, HMA conducted an online survey followed by interviews with HIV/STI Providers to better understand their current billing practices and needs.

### HIV/STI Provider Survey

HMA conducted a standardized 74-question survey via an online platform (Qualtrics XM). Questions were structured as multiple choice and fill-in-the-blank and focused on four primary domains: 1) HIV/STI Provider Service Models, 2) Client Insurance and Payer Relationships, 3) Billing Infrastructure, 4) and Health and Equity Impacts. For the complete survey instrument, please see Appendix A.

A total of 15 of the 17 HIV/STI Providers responded to the survey, resulting in a response rate of 88%. Please see Appendix B for a list of respondents. While one of the respondents did not include identifying information, they did complete the survey questions and their responses have been included in this analysis. The HST Section emailed the survey to HIV/STI Providers in early November 2020 and provided an online survey link. HIV/STI Providers completed the survey between November 2020 and December 2020. The HST Section and HMA conducted follow up communication via email and phone outreach to HIV/STI Providers to maximize HIV/STI Provider response rate.

### HIV/STI Provider Interviews

Following the HIV/STI Provider survey, HMA reached out to all HIV/STI Providers to conduct interviews via Zoom videoconference calls. The interviews were approximately 30 to 60 minutes in length and tailored to gain a deeper understanding of HIV/STI Provider survey responses. Similar to the survey, interviews focused on the following four domains: 1) HIV/STI Provider Service Models, 2) Client Insurance and Payer Relationships, 3) Billing Infrastructure, 4) and Health and Equity Impacts.

HMA conducted interviews with a total of 12 of the 17 HIV/STI Providers between December 2020 and January 2021. HIV/STI Providers identified relevant staff to participate in interviews, including clinical, finance, and billing representatives. A list HIV/STI Providers interviewed is provided in Appendix B.

## Findings

Findings are discussed below within four key domains for understanding HIV/STI current billing practices, areas of support needed, and successes that may be leveraged:

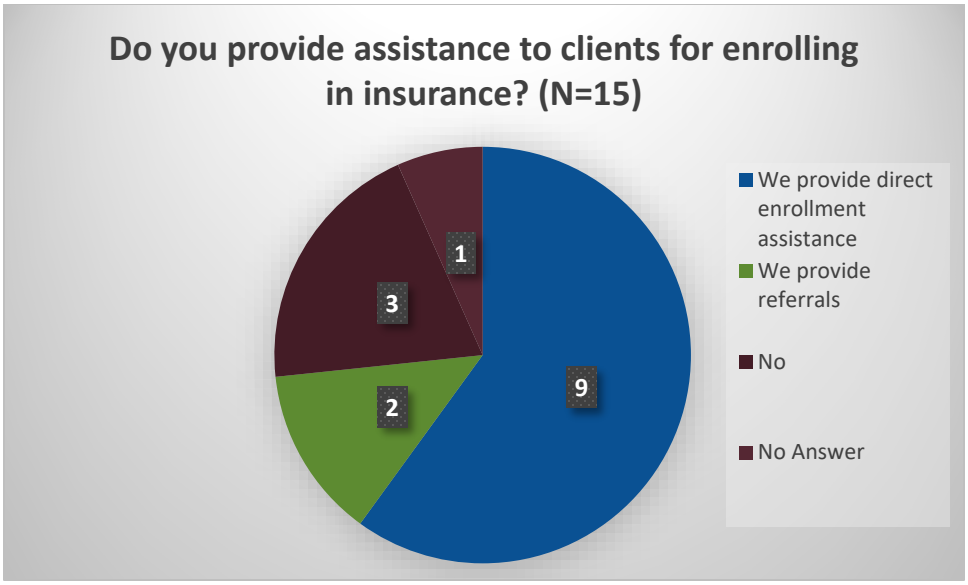
1. HIV/STI Provider Service Models
2. Client Insurance and Payer Relationships
3. Billing Infrastructure
4. Health and Equity Impacts

### HIV/STI Service Models

Most of the HIV/STI grantees are providing HIV EISO services through their public health departments and referring clients for further confirmatory testing and treatment services to their county's clinical services divisions (e.g., county based FQHCs), the client's primary care provider (PCP) if they have one, or other community clinics. HIV EISO services within public health programs focus on mobile HIV outreach, testing, and education services delivered in the community, to the highest risk populations, with the lowest barriers processes, and with very little infrastructure to support insurance billing, as discussed further below. Staffing at outreach testing sites tends to be trained lay health workers, or non-licensed/certified staff.

HIV/STI Providers described their HIV EISO services as being delivered offsite at community locations reaching highest risk populations for HIV. These offsite locations were decidedly non-clinical and more often places where members of their priority populations already gather. Examples include migrant farms, homeless shelters, bathhouses, or other public sex environments (PSEs) catering to men who have sex with men (MSM), or harm reduction or needle exchange outreach sites.

The primary services offered included HIV outreach and education, rapid HIV screenings, and with a few sites offering Hepatitis C screenings. If a rapid HIV screening comes back as a preliminary positive, a few grantees conduct their own confirmatory testing onsite (if they are staffed by a public health nurse or other staff with phlebotomy training), otherwise clients are referred to clinical settings, or to their primary care provider (PCP) if they had one and were willing to go, for confirmatory testing. In addition, many EISO Partners (11 of 15) provide direct insurance enrollment assistance or referrals for clients requesting this support.

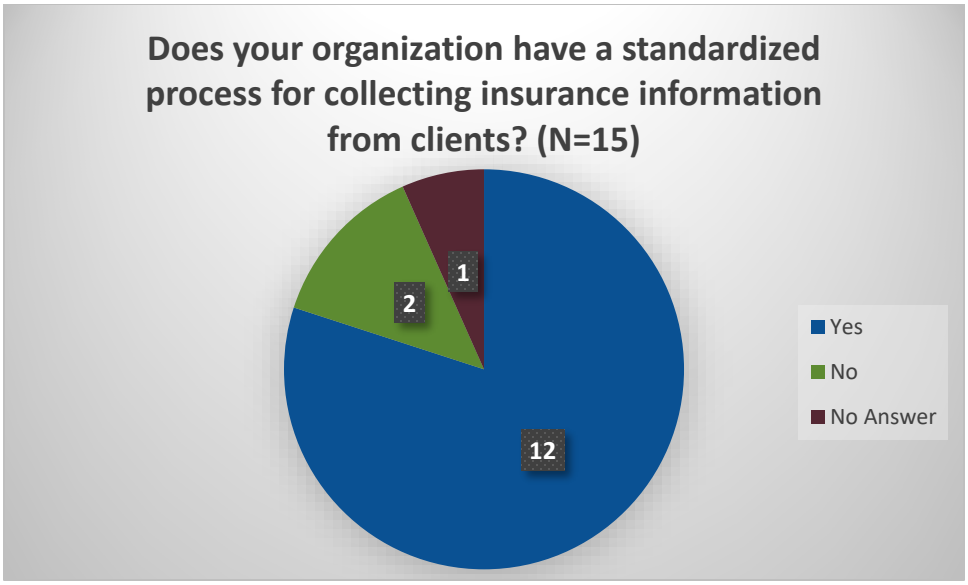



These outreach testing sites are designed to be low barrier to ensure everyone has access to HIV testing. In particular, low barrier testing sites are designed to combat the historical distrust some communities have of the health care systems and government, the limited time people have or are willing to spend with a provider due to the setting or other constraints, or financial concerns and constraints. This has translated into outreach HIV testing services with very short interactions with clients and collection of limited personal information.

## Client Insurance and Payer Relationships

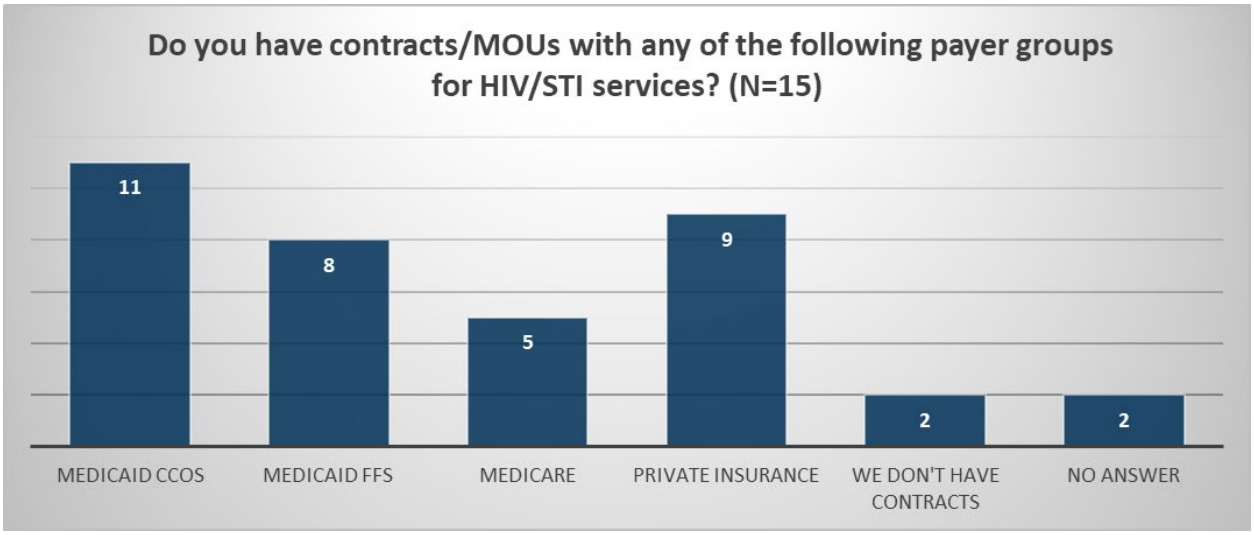
### *Client Insurance Information*

In alignment with a low barrier model, most of the outreach testing sites are not screening clients for insurance coverage and are not entering patient information into any form of electronic health record system. In some cases, EISO staff gather client name and minimal information needed to search the Medicaid Management Information System (MMIS) for client Medicaid eligibility. While insurance information is not generally gathered through HIV EISO prevention services, most HIV/STI Providers (12 of the 15 surveyed) indicated standardized processes for gathering client insurance information when they seek LPHA clinical care.




### *Payer Contracts*

The majority of HIV/STI Providers (11 of 15) indicated they have contracts with public or private insurance payers, although these contracts are generally specific to HIV/STI services delivered through county clinical services divisions or FQHCs, rather than the EISO services delivered by grantees. Among the 15 HIV/STI Providers responding to the survey, 11 indicated contracts with Medicaid Coordinated Care Organizations (CCOs), nine have contracts with private insurance, eight have Medicaid Fee for Service (FFS) contracts; and five have Medicare contracts.




## Billing Infrastructure

The majority of HIV/STI Providers indicated they have billing staff and are reimbursed for HIV/STI services under their payer contracts, but these responses generally reflected reimbursement for HIV/STI services provided through county clinical divisions or FQHCs, rather than EISO services provided through the public health division. Whereas county clinical services divisions have insurance billing capacity and infrastructure, contracts with payers, and program infrastructure supportive of billing practices, this is

not necessarily the case with the county public health programs where HIV EISO services are primarily housed. In two cases, county public health departments are leveraging their clinical service billing infrastructure and systems to bill for public health services, such as nurse home visiting programs or immunizations. Under these arrangements the public health division is responsible for billing infrastructure costs and must factor in these costs to determine the value of billing for services.

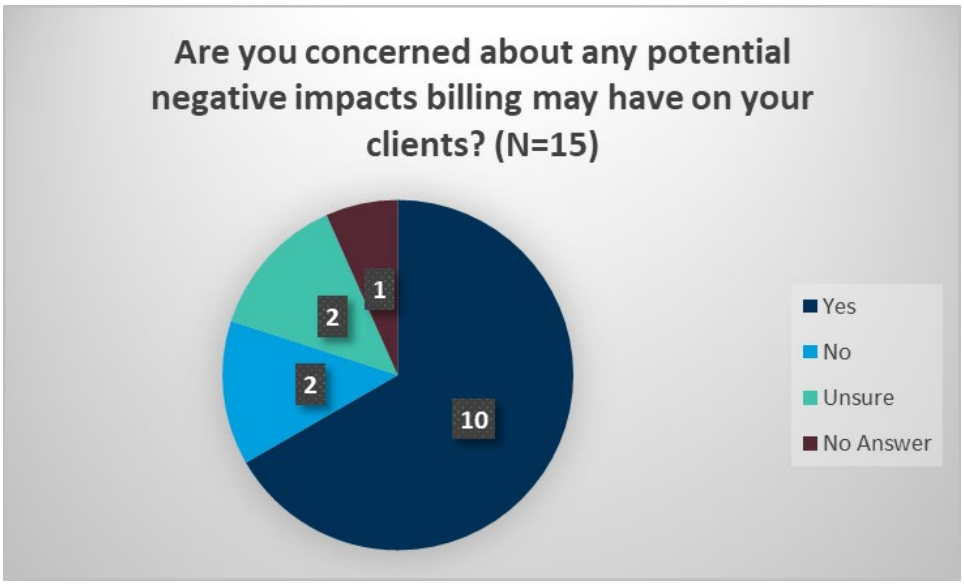
HIV/STI Providers reported that they currently do not bill for EISO services or rapid HIV testing administration or kits. Rather, these services are being funded by EISO and HIV prevention PE 7funds or through private donations and foundations. We note that HIV/STI Providers generally submit lab tests to the Oregon State Public Health Lab (OSPHL), and OSPHL will bill an insurer identified by the submitter if the HIV/STI Provider indicates type of insurance and OSPHL is able to obtain reimbursement from that insurer. However, HIV/STI Providers do not bill for the specimen collection fee.

## Equity Impacts

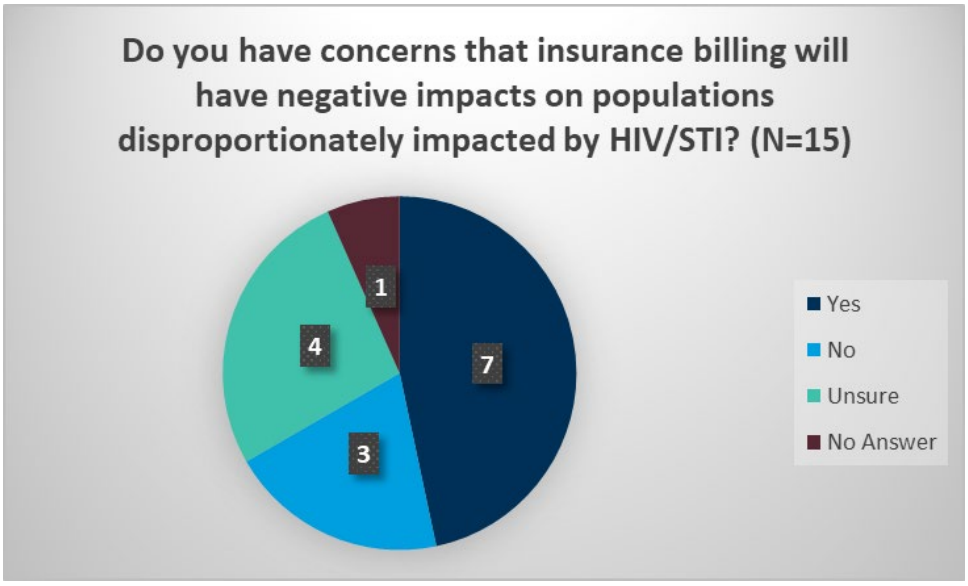
To advance a public health commitment to maximize and ensure equitable access to HIV/STI prevention programs and services, along with recognition of the unique stigma associated with HIV, the majority of HIV EISO programs and services have been deliberately designed to be low barrier. Low barrier delivery models facilitate access through collection of limited personal information and minimizing the time for each encounter. Several of the grantees expressed concerns over the potentially disparate and negative impacts that moving towards an HIV insurance billing model could bring to the communities they serve. Specific populations of concern cited by grantees include:

- People who inject drugs (PWID) or who have substance use issues – due to concerns over stigma and legality of illicit drug use, PWID are hesitant to disclose personal identifying information and/or have a very limited time available for HIV testing services. Staff report prioritizing limited time on HIV counseling and risk reduction instead of collecting patient information.
- Men who have sex with men (MSM) – MSM, especially those who do not identify as MSM and are engaging in sex with other men and may be in heterosexual relationships or MSM who are not publicly out about their sexual orientation, may not want to disclose their personal identifying information or their sexual risk information in a way that may get back to their employer, spouse/significant other, or family members.
- Youth – young people who may be insured under a parent or legal guardian, or who may be residing with a parent or legal guardian, and who do not want their sexual risk/sexual health or personal health information disclosed to their parents.
- Undocumented population – people who are undocumented or lack legal residency documents who do not want to share information that might get them in trouble or jeopardize their living situation.

The HIV/STI Provider concerns include a fear that these populations will stop seeking testing services either out of real or perceived loss of anonymity due to having to disclose more information; receiving a bill, explanation of benefits, or some other formal documentation at their homes; and/or perception of being tracked in a database tied to the government.




Respondents were asked if they were concerned about potential negative impacts that billing would have on their clients. Ten respondents said yes, and two respondents said no. Two said they were unsure, and one respondent did not answer this question.




Respondents were then asked if they had concerns that insurance billing would have negative impacts on the populations who are already disproportionately impacted by HIV/STI. Seven respondents said yes, and three said no. Four respondents were unsure, and one respondent did not answer this question.

## Gaps and Challenges

Based on the findings from the HIV/STI Provider surveys and interviews, HMA has identified six key challenges that must be addressed to advance insurance billing for HIV/STI services. These challenges

represent gaps in the necessary infrastructure or capacity for insurance billing as well as barriers to be mitigated to eliminate negative impacts on clients and the HIV/STI Providers.

### *Misinformation/Lack of Information*

Throughout our interviews with the HIV/STI Providers, it became clear that many of the HIV/STI Providers were operating under misinformation or lack of information as it relates to insurance billing for HIV/STI services.

- Many of the partners interviewed suggested that their low barrier service model resulted in a lack of information necessary to bill insurance. In particular, this meant not asking for insurance information or obtaining a photocopy of insurance cards. In reality, collecting patient name and DOB is often sufficient to determine if they have Medicaid and then bill for those services.
- The cost-sharing aspect of insurance billing was a concern for staff even when asked about billing Medicaid, which represents the majority of payers for clients accessing HIV EISO services. Oregon Medicaid does not participate in cost sharing so there are no copays for providers to collect, and clients are not billed for any of these services. Additionally, as HIV testing is covered as an Essential Health Benefit, there is no cost sharing nor lifetime cap on insurance coverage for HIV testing services for most commercial insurance. This means that even private payers would not bill clients or require copays to be collected for HIV testing services. However, health plans that send out explanation of benefits (EOBs) would still send an EOB for the service.
- Many HIV/STI service partners expressed confusion over what HIV/STI services could be billed and under what circumstances. In particular, there is confusion over what level of provider and in what settings HIV/STI outreach and testing services can be billed. Similarly, some HIV/STI Providers use the title of Community Health Worker (CHW) as a job classification, which is not the same thing as being a state Certified CHW.
- Some grantees reported confusion over whether or not they were allowed to bill for HIV testing services since they were grant funded activities, or for test kits that were being provided by OHA.

### *Low Barrier Model*

The main populations served by EISO and HIV prevention funded programs are higher risk populations who, for a variety of reasons, prefer not to access HIV/STI services in clinical/FQHC settings. The low barrier service model currently utilized by EISO contractors allows them to reach these higher risk populations with HIV/STI services. Staff expressed concern that moving towards an HIV insurance billing model would conflict with their low barrier service model and result in high-risk populations choosing not to receive testing services. Whether real or perceived, this barrier must be overcome to receive full buy-in and support of HIV/STI testing partners.

### *Client Confidentiality*

Eight of 12 (75%) HIV/STI Providers report concerns over client confidentiality of HIV/STI services as a barrier to moving towards an insurance billing model. In particular, staff report some populations indicating concerns over their insurer or employer being notified of their HIV/STI services, which would

identify them as having some specific risk for HIV/STI. Additionally, staff report that issues of confidentiality arise due to fears of explanation of benefits (EOBs) being sent to patients at their home. This is of particular concern for younger populations who may be residing with family and MSM who may also be in heterosexual relationships. While Medicaid providers do not send out EOBs as a matter of practice, even staff within public health programs still expressed concerns over EOBs being sent out for HIV/STI services.

### *Cost (cost-sharing, bills)*

Staff also report concerns over potential cost-sharing components of insurance billing, including the infrastructure requirements for public health staff to collect payment at time of services or navigate payer systems, inability of clients to afford cost-sharing, and concerns over clients receiving bills or EOBs at home, which could jeopardize client confidentiality.

### *Staff/Organizational Capacity Impact*

Several grantees reported concerns over impacts of moving towards an insurance billing model for HIV/STI services including:

- The additional time required and increased staff burden to collect patient information necessary to do billing
- The additional staff demands required to process insurance claims and appeal denials
- The additional training required for staff on asking for insurance information, training for providers to chart appropriately, and setting up insurance billing systems to collect payment
- The potential costs of staffing HIV/STI outreach and testing services with the required level of providers to bill insurance
- A required paradigm and cultural shift among public health staff who view the role of public health as ensuring free and low barrier access to services
- Current grantees are not using certified CHWs to deliver HIV EISO services. While some partners use specially trained staff to deliver HIV/STI testing, these staff are not certified CHWs with the State. Some grantees have expressed the desire to use certified CHWs but have had difficulty hiring them. Since CHWs are an approved provider type for billing certain HIV/STI services, expanding to CHWs would allow for HIV/STI Providers to bill for these services.

### *Worth the Squeeze?*

Given the above challenges, one question kept coming up among grantees: Will the revenue generated from additional insurance billing offset the cost and impacts? For most grantees, moving towards insurance billing would require utilizing a different level of provider, increasing staff capacity for billing, establishing and implementing new workflows, and accessing electronic health record (EHR) systems, all of which comes with additional costs. Revenue from increased insurance billing must be sufficient to offset these additional costs to be worth the effort.

### Successes and Strengths

While our surveys and interviews uncovered significant challenges and barriers, we also heard about successes and strengths that could be leveraged to support increased insurance billing or shared among HIV/STI Providers as best practices and learnings across health departments.

#### *Existing Infrastructure*

Almost all of the HIV/STI Providers had existing and extensive insurance billing infrastructure and capacity in other parts of their organizations. For local health departments, this was most often in their county clinical divisions where current practices already include billing for HIV/STI services. Infrastructure and capacity included: policies, procedures, and workflows for collecting insurance billing information; existing contracts with public and private payers; information technology infrastructure necessary for billing; and staffing. This existing infrastructure could be leveraged with public health services including HIV/STI services.

#### *LPHAs Billing for Other Public Health Services*

As mentioned above, many of the local public health partners providing HIV/STI services through HIV EISO and prevention funding are not currently billing for these services. While for some of them this is likely due to their staffing model or location of services, for others this is simply due to lack of insurance billing infrastructure, which could be remedied if public health used the county clinical infrastructure. Through our interviews with the HIV/STI Providers, we found examples of local public health partners using their county's clinical services billing infrastructure to bill for other public health services. In particular, this was used to bill for nurse home visiting programs and immunizations. Additionally, we learned through the payer interviews described below that Klamath, Josephine, and Coos county public health departments are currently billing CCOs for immunizations and family planning services *without* a clinical services partner. Both models could be expanded to cover HIV/STI services within those counties and replicated in other counties.

## Payer Analysis

Billing opportunities for HIV and STI prevention and care must be well understood and implemented to maximize the future availability of public health funds and ensure that public health is truly the payer of last resort. Following is a summary of HMA's research and evaluation of potential funding sources from the insurance, or payer, market for services provided through the EISO program. With 94% of Oregonians having health insurance, it is essential that public health maximize payments from insurance coverage when possible.

## Payer Stakeholders

For purposes of this document, we are defining payer stakeholders as either Medicaid CCOs, commercial payers, or Medicare Advantage Plans operated by commercial payers. We have not identified the Oregon Health Authority itself as a payer stakeholder, although more than 100,000 OHP enrollees are assigned to the OHA "Open-Card" or fee-for-service program. We assume that billing improvements identified through CCO and commercial payers will be applicable to OHA Open-Card clients.

### Coordinated Care Organizations

CCOs are networks of all types of health care providers (physical health care, addictions and mental health care, and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (OHP-Medicaid). CCOs are not required to have an insurance license and are regulated by the Oregon Health Authority. In 2019, 25.4% of Oregonians were covered by the Oregon Health Plan and 90% of those were enrolled in CCOs. Since the State of Emergency for the COVID 19 Pandemic was declared on March 8, 2020, OHP enrollment has increased more than 17% to 1,268,802 enrollees. Five CCO payers[2] operate eight CCOs in the same county-based service areas supported by the EISO contractors. Those five CCO payers represent 69% of OHP enrollment statewide. These include Health Share of Oregon, Intercommunity Health Network, Jackson Care Connect, PacificSource Community Solutions, and Trillium Community Health Plans.

### Commercial Payers

Commercial health insurance is provided and administered by non-governmental entities and is funded by policyholders' monthly premiums, either directly by the policyholder, through an individual's employer, or through a union, pension, or trust. Commercial payers are regulated by the Department of Consumer and Business Services. Despite the substantial subsidy provided by governmental entities for insurance policies sold to individuals through the Health Insurance Exchanges (Marketplaces), that enrollment is considered part of the commercial payer sector. In 2019, 53.4% of Oregonians were covered by commercial payers, including those enrolled through the Marketplace. In consultation with HST, HMA identified six commercial payers, representing 75% of the Oregon health insurance enrollment. These included Kaiser Permanente, Moda Health, PacificSource, Providence Health Plan, Regence BCBS, and United Healthcare.

## Methods

Our environmental scan included a combination of document review and stakeholder interviews. We also contracted for a certified clinical coding analysis to identify codes for which publicly funded entities could bill and under which circumstances. We detail findings from the environmental scan in the Findings section below.

### Regulatory Review

For the payer analysis, we reviewed federal and state statutes and regulations, as well as contract language governing publicly funded payer contracts. This included regulations concerning the types of services that can be billed for under different programs, as well as the types of providers who are eligible to bill under various programs.

### Coding Analysis

HMA entered into an independent contractor agreement with Provider Consulting Solutions, Inc. (PCS) to provide services from a certified medical coder to advise and review our work product. This additional professional oversight helps to ensure compliance with coding guidelines and integration of medical

[2] There are 16 CCOs in Oregon with 12 CCO Payers because PacificSource Community Solutions operates four CCOs and Trillium Community Health Plan operates 2 CCOs.

coding and policy changes into our billing process recommendations to achieve the maximum reimbursement available under the law.

Based on the service categories provided by HST Section, PCS developed a coding guide (Appendix C to define the relevant HCPCS Code(s) that encompass the activity, who can provide the service, and whether the codes are typically reimbursable.

### Oregon State Public Health Lab

We evaluated the billing and collections process for services provided by the Oregon State Public Health Laboratory (OSPHL) through analysis of billing records and conversations with OSPHL staff.

### Interviews

Between November 2020 and January 2021, HMA corresponded with and interviewed staff at 12 Medicaid payers representing 16 CCOs and six commercial payers including their affiliated Medicare Advantage plans. There were numerous follow-up phone calls and emails to verify and validate missing or unknown information at the time of the interviews.

Annick Benson, HST Section Manager, and HMA worked with the OHA to schedule and coordinate a presentation to the CCO Operations Workgroup on October 27, 2020. The purpose of this presentation was to orient the CCOs to the project, respond to any questions, and share the plan for gathering additional information from the CCOs.

Ms. Benson subsequently sent letters of introduction to the CCOs and commercial payers previously identified for the project. These letters (Appendix D) explained the project's goals and next steps. HMA followed up with emails to schedule interviews with the CCOs and commercial payers.

The goal of the payer interviews was to understand their policies and approaches in the following areas:

- All 16 CCOs and six commercial payers were asked about their current relationships with LPHAs related to contractual or participating provider status, credentialing requirements, and payment policies for covered services rendered.
- The eight CCOs (five CCO payers) operating in the service areas for the HIV/STI Providers were also asked to confirm contract status, credentialing arrangements, and payment policies for additional identified subcontractors, such as Neighborhood Health Clinics, operating in their service areas.
- All 16 CCOs and six commercial payers were asked to confirm whether they are currently receiving claims from LPHAs and for which services, the payment methodology for services rendered by LPHAs, the policy for issuing EOBs[3] or Claims Paid Notices to enrollees, and contracting approach and payment arrangements for CHWs.

[3] EOBs sent to the client's home present a significant confidentiality concern for HIV/STI screening and treatment services.

# Findings

Below are the findings from the Payer environmental scan process outlined above.

## Regulatory Review

### *Federal Regulations*

With the enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, numerous rights and protections were defined that make health insurance coverage fairer and easier to understand, along with subsidies (through "premium tax credits" and "cost-sharing reductions") to make it more affordable. The law also expanded the Medicaid program to cover more people with low incomes. The ACA included a ban on denying coverage, or being dropped from coverage, because of a pre-existing health condition, like asthma, cancer, or HIV. The ACA also prohibits insurers from cancelling or rescinding coverage because of mistakes made on an application and from imposing lifetime caps on insurance benefits. These changes are significant because prior to the ACA, many people living with HIV or other chronic health conditions experienced obstacles in getting health coverage, were dropped from coverage, or avoided seeking coverage for fear of being denied. Importantly, the ACA also instituted requirements addressing essential community providers (ECPs) and essential health benefits (EHBs).

The ACA regulation defines ECPs as providers that serve predominantly low-income, medically underserved individuals, and specifically include providers described in section 340B of the Public Health Service (PHS) Act and the Social Security Act. Issuers that offer plans on the Health Insurance Exchanges (sometimes called Marketplaces) now have a requirement under the ACA to include in their network a sufficient number and geographic distribution of providers that serve predominately low-income, medically underserved individuals. In 2021, 75% of the contracted LPHA's and their partners are recognized as ECPs.

Health insurers must meet ECP requirements for inclusion in qualified health plan (QHP) networks for coverage offered on the ACA marketplace. QHP issuers are required to:

- Contract with at least 20% of ECPs in the plan's service area to participate in its provider network
- Offer contracts in good faith to at least one ECP in each ECP category of each county in the service area, where available
- Offer contracts in good faith to all available American Indian health care providers in the plan's service area

Included in the ACA health care reform legislation is the requirement that all Medicaid expansion populations and individual and small group major medical plans effective on or after January 1, 2014 must include coverage for these 10 essential health benefits—EHBs—with no annual or lifetime dollar limit:

- Ambulatory patient services
- Emergency services
- Hospitalization

- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

Many of the EHBs are especially important for people living with HIV/AIDS (PLWHA) and people with or at risk for sexually transmitted infections:

- Health plans subject to these regulations *must* cover "medically necessary" HIV and STI testing (i.e., indicated due to risk) and *may* cover routine HIV testing (screening regardless of risk). As of 2015, 42 states, including Oregon, and DC report requiring Medicaid plans, QHPs, and other health plans regulated by the State to cover routine HIV testing, while eight only cover medically necessary testing
- States must also cover pre-exposure prophylaxis (PrEP), the drug used to prevent HIV among those at increased risk
- Under the ACA, state Medicaid programs are incentivized to cover a full suite of preventive services, including routine HIV testing and PrEP (starting in 2021), without cost-sharing in exchange for a 1% increase in the federal matching rate for those services. Oregon is one of 15 states that has been approved for this increase in exchange for offering these services without cost-sharing, so CCOs do not require prior-authorization or cost sharing for HIV prevention services.

### *State Regulations*

HMA reviewed the Oregon Revised Statutes and Oregon Administrative Rules for guidance on payments for services provided by LPHAs for clients with Medicaid coverage. These statutes and rules only directly address OHP beneficiaries.

### Payment for Services Provided by Local Health Departments

The governing statute for Services Provided by Local Health Departments as it relates to CCOs is found in ORS 414.153 and states:

> In order to make advantageous use of the system of public health care and services available through local health departments and other publicly supported programs and to ensure access to public health care and services through contract under ORS chapter 414, the state shall:
>
> (1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between coordinated care organizations and publicly funded providers for authorization of payment for point of contact services in the following categories:
>
> (a) Immunizations;
>
> (b) Sexually transmitted infections; and

(c) Other communicable diseases;

(2) Allow members of coordinated care organizations to receive from fee-for-service providers:

(a) Family planning services;

(b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention services; and

(c) Maternity case management if the Oregon Health Authority determines that a coordinated care organization cannot adequately provide the services;

(3) Encourage and approve agreements between coordinated care organizations and publicly funded providers for authorization of and payment for services in the following categories:

(a) Maternity case management;

(b) Well-child care;

(c) Prenatal care;

(d) School-based clinics;

(e) Health care and services for children provided through schools and Head Start programs; and

(f) Screening services to provide early detection of health care problems among low-income women and children, migrant workers, and other special population groups

The relevant Oregon Administrative Rule, OAR 410-147-0080(6) requires CCOs to contract with publicly funded providers:

> (7) CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Applicants shall confirm that these agreements have been developed unless good cause can be shown…

### Traditional/Community Health Workers

The American Public Health Association defines a Community Health Worker as a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This definition aligns very closely with many of the direct service providers in the EISO grant funded projects. Medicaid rules strictly govern the providers that can bill Medicaid to ensure beneficiaries are receiving high quality care and to avoid fraud, waste, and abuse. Separate from the ACA, in 2013 the Centers for Medicare and Medicaid Services (CMS) amended federal preventive services Medicaid regulations to allow Community Health Workers (CHWs) and other non-licensed providers to deliver preventive services and allow reimbursement by state Medicaid programs when the services are recommended by a physician or other licensed provider. The OHA has included this in its 1115 Waiver.[4]

[4] CMS Center for Medicaid and CHIP Services Bulletin, Update on Preventive Services Initiatives, available at https://www.medicaid gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf; CMS Presentation "Medicaid Preventive Services Regulatory Change" Division of Benefits and Coverage, Disabled and Elderly Health Programs Group, Center for Medicaid and CHIP Services, April 2014, available at

In 2013, the Oregon legislature passed House Bill 3407 that established the Traditional Health Workers (THW) Commission within the OHA to adopt by rule criteria and descriptions for CCOs to use with respect to health workers who are not licensed by the State and training and education requirements for those workers. The THW Commission then developed a certification process for CHWs.

To qualify for reimbursement under the OHP, CHWs must be certified by the OHA through successful completion of an approved training program and enrolled in the State's central registry. CHWs must complete 80 hours of training from an approved training program and meet required competencies to become certified. CCOs can collect the names of CHWs from contracted entities and validate their certification in the State's registry. CCOs also report the names of CHWs as contractually required when reporting network adequacy to OHA. Costs for training programs to achieve certification average $1,100 and may be paid by the entity or provider employing the CHW.

To be eligible for payments with Medicaid funds, either directly from OHA or via CCOs, a licensed provider must order the services and must order that they be provided by a CHW. Once the CHW is certified and registered with the THW Registry, they must obtain a unique National Provider Identifier (NPI) and enroll as a "non-payable rendering provider" in Oregon Medicaid. According to the Oregon Administrative Rules Chapter 410, Division 180, Traditional Health Workers:

> CHWs "must be supervised by existing licensed practitioners and perform services for them within the licensed practitioner's scope of practice. Licensed health providers are responsible for the work that they order, delegate, or supervise when health care professionals work under their supervision. The state assures that only the Licensed Health Care Professional will bill for services. For purposes of this State Plan a Licensed Health Care Professional (LHCP) includes Physicians*, Certified Nurse Practitioners, Physician Assistants, Dentists, Dental hygienists with an Expanded Practice Permit, Ph.D. Psychologists, PsyD Psychologists, LCSW Social Workers and Licensed Professional Counselors. (*covered in the state plan under physician services)" ... a) Community Health Worker services are provided under the supervision of LHCP … The state assures that only the Licensed Health Care Professional will bill for services."

When a CHW is the rendering provider, OHA or the CCO will allow the code to be paid. The billing provider must be a clinic or supervising medical provider. Many of the EISO services are eligible for CHW billing codes including those summarized below, and the CHW Billing Guide is shown in Appendix E:

| | | |
|---|---|---|
| 99401 | $27.50 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes |
| 99402 | $45.51 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes |
| 99403 | $62.43 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes |

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf.Words

| | | |
|---|---|---|
| 99404 | 79.94 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes |
| 98960 | $18.78 | Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient |
| 98961 | $9.02 per patient | (see 98960); for 2-4 patients |
| 98962 | $6.56 | (see 98960); for 5-8 patients |

### *CCO Contracts*

From their inception, the OHA intended that CCOs have cooperative relationships with LPHAs, Local Mental Health Authorities (LMHAs), and Area Agencies on Aging and Disabilities that are operating in their service areas. When CCOs were implemented in 2012, primary components of their global budgets and shared accountability arrangements included Medicaid-funded public health services. The OHA required the CCOs to enter into memorandums of understanding (MOUs) with these public agencies such that there would also be shared community needs assessments and care coordination for beneficiaries.

The CCOs entered into new contracts with OHA on January 1, 2020, and the requirements of ORS 414.153 and OAR 410-141-3705(7)(a-b) are not in the 2020 or 2021 CCO contracts. The OHA Health Services Division has stated that the CCOs are still required to follow those requirements as directed by the Order of Precedence rule since the requirements are in statute and rule. (Note that the above referenced OAR is actually addressing CCO selection criteria, so it would have been verified during the procurement and readiness review process.)

CCOs are also required to submit an annual report of their cooperative agreements with publicly funded programs to identify which programs the CCO has relationships with. However, the current report format does not require the CCO to note which services identified in OAR 410-141-3705(7) the program is providing, and the pre-populated options in the table also do not identify the services listed in 410-141-3705(7). The pre-populated options are: LMHA, CMHP, Type B AAA, State APD district offices, and local public health authority (LPHA). The services listed in 410-141-3705(7) likely fall under “local public health authority”, but again, the options do not get to the level of the specific services in 410-141-3705(7).

## Coding Analysis

Insurance companies pay for services that are described by a Current Procedural Terminology (CPT)® code or Healthcare Common Procedure Coding System (HCPCS) code and performed by a licensed practitioner or for work performed under the supervision of a licensed practitioner. Services are paid based on a fee associated with each CPT® or HCPCS code. In some instances, a set of services will be reimbursed at a “bundled” rate rather than on a fee-for-service basis. A bundled payment covers multiple services and may include services provided by two or more providers for a single episode of care. The American Medical Association develops the CPT® codes and the Centers for Medicare & Medicaid Services (CMS) develops the HCPCS codes to describe services performed by health care

providers. Individual insurance companies and state Medicaid programs are free to develop a set of reimbursement and payment guidelines and are not required to cover all services described by a CPT® or HCPCS code.

All services require a medically necessary International Statistical Classification of Diseases and Related Health Problems (ICD-10) diagnosis code to be reimbursed. A medical practice or LPHA could provide a service that is covered and described by a CPT® code or HCPCS code but not have the allowable (proper) diagnosis code that justifies reimbursement by the payer.

The following table provides a high-level summary of the findings from the coding analysis relative to services provided in the EISO Program. Specific technical billing guidelines will be provided in subsequent work products.

***Coding Analysis Summary***

| Service Category | STD/HIV Activity Definition | Payable Codes | Provider Type | Amount |
|---|---|---|---|---|
| **Education, Information and Referral** | Provide education to patient on the nature of their infection. | 98960-98962 | Prescribed by a licensed physician or NP, can be rendered by a CHW | $18.78 (1 person) Group Visit Rates Available |
| | Refer patient for additional prevention services, if needed (e.g., alcohol and drug treatment, HIV PrEP, PEP access, etc.). | The activity is included as an element of E/M[5], preventive, or counseling visit. | N/A | N/A |
| | Refer patient to other services, if needed (e.g., mental health/behavioral health, other social services). | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | | | | |
| **Screening/Evaluation** | Offer screening for additional STDs and HIV. Offer vaccinations for Hepatitis A&B if not previously received by patient. | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | | | | |

[5] E/M stands for "evaluation and management," and denotes CPT codes that fall into this category of common services.

| | | | | |
|---|---|---|---|---|
| **Testing & Diagnosis** | Provide STD and HIV testing as well as any additional testing required to confirm a diagnosis | Payable to Reference Lab | . | See OSPHL Fee Schedule |
| | Provide STD and HIV testing as well as any additional testing required to confirm a diagnosis | Payable to Clinician collecting specimen:<br><br>Venipuncture 36415 | If seen by a licensed provider on the date of the specimen collection or collected under a standing order, can be collected by anybody trained to draw the specimen | $2.10 |
| | | | | |
| **Treatment (Partner is registered and treated as a patient in their own right)** | Treat patient for STD if not already treated or link them to medical care and treatment. | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | Treat partners found to be positive for an STD or link them to medical care and treatments | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | | | | |
| **Counseling (Partner is registered and treated as a patient in their own right)** | Counsel patient about reducing their risk for acquiring or transmitting infection to others. | G0445[6]<br><br>96156 - 96159[7i] | G0445 must be provided by physician, NP, or PA<br><br>HBAI can be provided by a QMHP, LCSW, or LPC | $19.28 (G0445)<br><br>Assessment $68.96<br>Intervention $47.15/$16.64<br>Group Intervention $6.96/$3.27 |

[6] High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes
[7] Health Behavior Assessment and Intervention (HBAI) codes are used when assisting patients to overcome emotional / social barriers to their physical disease management and self-management of chronic disease. These codes address a wide range of physical health issues, including HIV. HBAI codes are not used for mental health services. They apply to services that address psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment / management of patients with physical health problems.

| | | | | |
|---|---|---|---|---|
| | | | | |
| | Counsel partner(s) about reducing their risk for acquiring HIV infection and other types of STDs. Refer them for additional prevention services, if needed | G0445<br><br>96156 - 96171 | G0445 must be provided by physician, NP, or PA<br><br>HBAI can be provided by a QMHP, LCSW, or LPC | $19.28 (G0445)<br><br>Assessment $68.96<br>Intervention $47.15/$16.64<br>Group Intervention $6.96/$3.27 |
| | | | | |
| **Case Investigation and Partner Services** | Conduct interview with patient to elicit information about their sexual partners to conduct confidential partner notification. | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | Notify partner(s) of their exposure. | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | Offer partners STD/HIV testing | The activity is included as an element of E/M, preventive, or counseling visit. | N/A | N/A |
| | | | | |
| **Monitoring PLWHA** | Patient follow up for recommended re-testing per CDC and OHA guidance | Chronic Care Case Management Services w/o Patient Visit (generally non-face-to-face):<br>99487 - 99491 | Must be billed under: Physician, Nurse Practitioners, Physician Assistant, Nurse | Complex $63.22<br>Add'l 30 Min $30.62<br><br>Chronic 20 min $31.48<br>Chronic 30 min $57.66 |
| | | | | |
| **Targeted Case Mgmt** | Provide ongoing HIV case management services to assist person in adhering to HIV treatment | Program not eligible unless County/Government Agency provides General Funds for Federal Match | N/A | N/A |

## Oregon State Public Health Laboratory (OSPHL)

Since 2014, the OSPHL has contracted with a billing vendor to bill for communicable disease testing services. The current billing service is through Public Consulting Group, Inc. (PCG) and this vendor appears to perform effectively in collecting payments from clinics, laboratories, and insurance companies. Claims are submitted to insurance companies weekly. Invoicing to clinics or other laboratories are sent to submitting facilities monthly. Public agencies and private non-profit agencies submitting specimens to OSPHL may apply for waived or reduced testing fees.

### *CCO Lab Billing and Reimbursement*

In 2019, the OHA included a requirement in the CCO contracts making the OSPHL a contracted lab for all CCOs. This opened up billing opportunities for OSPHL beyond the previous contracted insurer list. In fiscal year 2020, OSPHL collected $927,500 for HIV/STI testing from payers and providers. CCOs accounted for 55% ($510,000) of total payments to OSPHL for HIV/STI testing, and commercial insurers accounted for 5% ($46,500). In other words, the CCO payments accounted for almost 90% of insurance payments made to OSPHL. Public health agencies, school-based health centers, and safety net clinics accounted for the remaining 40% ($371,000) of payments to OSPHL for HIV/STI testing. These were not billed to any insurance, but it is likely that many of these services were provided to Medicaid members and could have been billed to a CCO. In addition to the $927,500 collected from payers and providers, the HST Section reimbursed OSPHL $343,200 for HIV/STI testing. These specimens were submitted by HIV/STI Providers without insurance information or other means to pay for the cost of the lab tests. It is likely that a significant portion of the $343,200 from HST and the $371,000 from providers could be covered by CCOs for eligible OHP members.

The current process for CCO billing relies on the agency submitting the specimen to identify whether the client is covered by the OHP and to provide the CCO information where the client is enrolled. If the client is seeking confidential services due to extenuating circumstances, the agency is not required to include the coverage and enrollment information. If the submitter does not provide the patient's coverage information with the specimen, the OSPHL does not query the OHA Medicaid MMIS or other centralized eligibility verification applications, such as One Health Port, to seek additional payment information that may be available on the patient.

### *Non-OHP and Commercial Payers Lab Billing and Reimbursement*

In FY 2020, the OSPHL billed and was paid by 27 payers ranging from Medicare Advantage Plans to Washington State's Apple Health (Medicaid) program. There are many services available for eligibility verification that can inform the OSPHL or PCG of a client's coverage information. This opportunity to increase collections would need to be balanced with concerns around confidentiality due to the requirement for commercial payers and Medicare Advantage plans to issue EOBs.

All the commercial payers interviewed were aware of the OSPHL and the role it plays in the health care system. Most stated that they believed they have a contract in place or that they already pay claims to OSPHL. This may be due to the heightened visibility of OSPHL due to the Coronavirus pandemic as it does not appear there are, in fact, contracts in place as of this time. Further probing led the interviewer to believe the payer could support paying for services rendered because the "business risk is limited to communicable diseases." (All commercial payers prefer to have routine lab services for non-

communicable diseases to be sent to their preferred contracted laboratories, some of which are owned by the payer.) The OSPHL already bills a wide variety of commercial payers including Regence BCBS and Kaiser Permanente, as well as Medicare Advantage plans sponsored by MODA, Providence, and United HealthCare. Currently, the revenue collected from these commercial payers is small as a percent of total revenue collected; however, there may be an opportunity to increase that revenue in the future.

### *OSPHL Fee Schedule*

For many safety net or public health providers, it is especially important to maintain a fee schedule that sets prices greater than the typical allowed amount established by the payer. This is because the payer will always pay the lesser of what was billed compared to the maximum allowed amount on the fee schedule. For example, if a provider bills $40 for a service and the CCO fee schedule will pay as much as $60 for the service, the CCO will pay $40. This means the provider has lost the opportunity to collect an additional $20 for that service.

The OSPHL manages several fee schedules depending on the entity ultimately accountable for the services. HMA evaluated the billed amounts for the OSPHL Fee Schedules against the allowed, or maximum, amounts for the OHA "Open Card" fee schedule. Most of the CCOs use that fee schedule as their base for non-contracted providers, some use it for all of their providers, and others pay contracted providers considerably more than the OHA fee schedule. The ideal state is to have the OSPHL fee schedule greater than the allowed fee schedule for OHA. Following is a summary of these findings.

***Comparison of OSPHL Fee Schedule to OHP Fee Schedule***

| OSPHL Fee Schedule | Percent Difference to Target* Schedule |
|---|---|
| Category A – Full Fee | Range of 37% - 38% Greater Than Target |
| Category B – LPHA | Thirteen tests with no fee, the remainder are either 72% below or 37% above |
| Category C – Public Health partners | With the exception of Chlamydia (72% below Target) and HIV Screen Final (20% below Target), and six tests with no Fee, the remainder were 37% Greater Than Target |
| Category D – Private/Full Fee submitters | With the exception of six tests with no Fee, the remainder were 37% Greater Than Target |

* Target is comparing OSPHL fee to OHA Open Card Fee Schedule

The process for adjusting the OSPHL fee schedule is complex and, based on this analysis, does not appear necessary. The Category A fee schedule ideally situates OSPHL to garner the maximum amount of payments based on the current OHA fee schedule.

## Interviews

### *CCO Interviews*

In interviews with the 16 CCOs currently operating across Oregon, there was universal understanding and agreement that the CCOs are required to pay for covered services for eligible enrollees billed by LPHAs for point of contact services for immunizations, family planning, STI, HIV, and other communicable disease screening and treatment. In addition, CCOs are required to pay safety net providers (county public health, FQHCs, Rural health clinics, FQHC "Look Alike", and IHS/Tribal Clinics) regardless of contractual relationship for covered services rendered to eligible members without

authorization or referral requirements. This is relevant because the EISO Contractors often subcontract with safety net providers for service delivery.

For the purposes of this project, we will focus on the results of the interviews for the eight CCOs operating in the EISO Service Areas. Additional recommendations and findings for the remaining CCOs will be summarized separately.

| Contracted LPHA | Partners | CCOs in Service Area |
|---|---|---|
| **Deschutes County Health Department** | Crook County Health Department<br>Jefferson County Health Department | PacificSource Community Solutions |
| **Jackson County Health Department** | | Jackson Care Connect |
| **Lane County Health Department** | HIV Alliance | PacificSource Community Solutions<br>Trillium Community Health Plan |
| **Lincoln county Health Department** | Benton County Health Department<br>Confederated Tribes of Siletz Indians<br>HIV Alliance<br>Linn County Health Department | Intercommunity Health Network |
| **Marion County Health Department** | Polk County Health Department | PacificSource Community Solutions |
| **Multnomah County Health Department** | Clackamas County Health Department<br>Washington County Health Department<br>Cascade AIDS Project | Health Share of Oregon[ii]<br>Trillium Community Health Plan |

As noted above, all CCOs recognized their responsibility to pay for point of care services rendered by public health departments and the majority of the CCOs reported good relationships and reliable claims submission from the public health departments in their service area. A notable result from the interviews with all CCOs, including those operating in the EISO service areas, was that there were very few claims in their system for services related to HIV/STI screening and treatment delivered by public health departments. The majority of claims they were receiving from public health departments were for immunizations, family planning, and other communicable disease screening. The table below summarizes the interview responses from the eight CCOs operating in the EISO Service Areas.

### *CCOs in EISO Service Areas*

| | |
|---|---|
| **Health Share of Oregon*** | **Contract Status**: Clackamas, Multnomah, and Washington counties have Memorandums of Understanding with CCO. Neighborhood Health and Prism Health are not contracted with the CCO because the CCO does not have a contracted provider network per se.<br>**Credentialing Requirement**: N/A, CCO does not pay providers directly for services rendered to members so credentialing is not necessary. All these functions are delegated to payer partners.<br>**Issuance of EOBs**: N/A, CCO does not pay claims for services rendered to eligible members.<br>**Payment Policies**: This CCO has developed a process to pay LPHAs for invoices for certain services including communicable diseases (HIV/STI/TB) that are not submitted via a standardized claims process. Appendix F<br>**CHW Policies**: This CCO delegates all decisions relative to CHWs to their subcontracted payers. |
| **Intercommunity Health Network** | **Contract Status:** Memorandums of Understanding in place with Linn, Benton, and Lincoln counties. Contract relationship with Siletz Health Clinic. |

| | |
|---|---|
| | **Credentialing Requirements:** The Public Health agencies are assumed to be preferred providers and credentialed.<br>**Issuance of EOBs:** CCO issues EOBs only if a claim is denied due to a loss of member eligibility.<br>**Payment Policies:** Most public health funding from CCO is through capacity payments or based on other special program funding like maternal health visiting and care coordination services. CCO states that Linn and Benton Public Health do not currently bill, and that Lincoln County can bill but "don't do a lot of it."<br>**CHW Policies:** Currently paying for CHW services through capacity payments to public health or Patient Centered Primary Care Homes. |
| **Jackson Care Connect** | **Contract Status:** MOU in place with Jackson County.<br>**Credentialing Requirements:** Providers are credentialed if contracted and at this time Jackson County only has an MOU and there is no credentialing.<br>**Issuance of EOBs:** CCO does not issue EOBs for OHP enrollees.<br>**Payment Policies:** The CCO states that they could and would pay a claim to the county without a contract as long as they are an enrolled Medicaid provider. The CCO reported that their county does not have the capacity to issue a claim.<br>**CHW Policies:** CHWs are not compensated directly but the payer supports CHW services through subsidized funding for provider practices and community-based organizations. |
| **PacificSource Community Solutions** | **Contract Status:** Contracts with Washington, Multnomah, Clackamas, Lane, Marion, Polk, Deschutes, Crook, and Hood River counties. They do not have contracts with Neighborhood Health or Prism Health.<br>**Credentialing Requirements:** CCO credentials all providers when possible but it depends on the type of provider.<br>**Issuance of EOBs:** CCO does not issue EOBs for OHP enrollees.<br>**Payment Policies:** All county public health agencies are set up on a fee for service schedule with a conversion factor for all covered services rendered to eligible members. Neighborhood Health and Prism Health would be paid on a non-participating or out-of-network provider fee for service basis.<br>**CHW Policies:** CHWs need to be certified and have a DMAP ID so that they can be paid incident to the ordering provider. |
| **Trillium Community Health Plan** | **Contract Status:** Lane, Clackamas, Multnomah, and Washington counties either have current contracts or are in the process of getting a contract. Neighborhood Health is contracted. and Prism Health is in process of being contracted.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** CCO does not issue EOBs for OHP enrollees.<br>**Payment Policies:** County public health agencies are paid on a fee for service basis.<br>**CHW Policies:** CHWs that are certified and have a DMAP ID are paid fee for service. |

Health Share of Oregon includes five additional delegated payers that manage their own distinct networks. Responses from those delegated payers are summarized below.

| | |
|---|---|
| **CareOregon** | **Contract Status:** Contracts in place with Clackamas, Multnomah, and Washington County plus Prism and Neighborhood Health<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** Payer does not issue EOBs for OHP enrollees.<br>**Payment Policies:** There is a variety of value-based payment arrangements and supplemental payments for EISO providers who operate as primary care providers. At a minimum, providers are paid OHP Open Card fee schedule.<br>**CHW Policies:** CHWs are not compensated directly but the payer supports CHWs through subsidized funding for provider practices and community-based organizations. |

| | |
|---|---|
| **Kaiser Permanente** | **Contract Status:** Contracts have expired with Clackamas, Multnomah, and Neighborhood Health. They are reaching out to Prism Health. They have no record of Washington County submitting claims, therefore, no contract status.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** Payer does not issue EOBs for OHP enrollees.<br>**Payment Policies:** All services will be paid on the OHP Open Card fee schedule despite expiration of contracts.<br>**CHW Policies:** N/A, this is an integrated staff model and CHWs would be employed by KP. Any CHWs funded via community benefit investments are not restricted to serving KP enrollees and KP does not direct the service model. |
| **Legacy/ PacificSource** | **Contract Status:** Contracted with Clackamas, Multnomah, Washington, Lane, Marion, Polk, Deschutes, Crook, and Hood River counties. Not contracted with Neighborhood Health or Prism Health.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** Payer does not issue EOBs for OHP enrollees.<br>**Payment Policies:** All services will be paid on the OHP Open Card fee schedule.<br>**CHW Policies:** CHWs need to be certified and have a DMAP ID and would be compensated on a FFS basis if consistent with OHP regulatory requirements. |
| **OHSU/Moda** | **Contract Status:** There are no contracts in place for Clackamas, Multnomah, and Washington county nor are there contracts with Neighborhood Health and Prism Health.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** Payer does not issue EOBs for OHP enrollees.<br>**Payment Policies:** All services will be paid on the OHP Open Card fee schedule.<br>**CHW Policies**: Unknown |
| **Providence Health Plan** | **Contract Status**: Contracts in place with Multnomah, Clackamas, and Neighborhood Health. Prism Health is not under contract but would be paid at non-par FFS rates.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** Payer does not issue EOBs for OHP enrollees.<br>**Payment Policies:** All services will be paid based on a FFS conversion factor or the OHP Open Card fee schedule if not contracted.<br>**CHW Policies:** Unknown |

### CCOs Outside of EISO Service Areas

HMA also interviewed seven CCOs operating in 23 counties that are outside of the EISO service areas. In our interviews, it was clear that those CCOs generally had very close relationships with their public health departments. All but one, Umpqua Health in Douglas County, reported having contracts or memorandums of understanding with their public health departments. Notably, Umpqua Health said they would welcome claims from the public health entity[8] and would pay them on a fee for service basis as part of the safety net without a contract and without a credentialing requirement.

Most of the seven CCOs said that they receive claims regularly from their public health partners and they generally pay them on a fee for service basis. Some counties, including Klamath, Josephine, and

[8] Douglas County decentralized public health from the county and established a 501(c)3 non-profit, Douglas Public Health Network, which operates as a consortium of businesses and organizations to provide public health services. While the county retains the public health authority, Douglas Public Health Network provides the services. Their affiliated organization, Umpqua Community Health Center (UCHC), provides immunization services, women's reproductive health, family planning and sexually transmitted disease (STD) and school-based health services

Coos, none of which operate federally qualified health centers, have entered into value-based payment arrangements with their CCO, generally full or partial risk capitation. Under this scenario, a capitation payment is when a CCO pays a per-person (i.e., "per capita') rate to the county public health department based on the number of CCO members both parties anticipate the public health entity will serve during a given time period. "Full risk" means that if the public health department serves more or fewer members than anticipated, they still receive the same agreed upon capitation payment. "Partial risk" means that they may either have to refund an amount to the CCO if they serve fewer members than expected or the CCO may have to pay them more if they serve more members than expected.

There was consistency across the interviews that they see very few claims for HIV/STI screening. Most of the public health departments in this 23-county region are billing for immunizations and family planning services. Columbia Pacific CCO reported that Clatsop County recently started billing for some services and was examining other services that could be billed. Yamhill CCO reported that they receive claims from their own county public health plus other counties such as Klamath. As with the CCOs in the EISO service areas, these CCOs reported that they credential providers who are contracted, pay for CHW covered services if the CHW has a DMAP ID, and none of them issue EOBs for OHP enrollees.

### *Commercial Insurance Interviews*

HMA conducted Zoom interviews with five commercial payers and corresponded with a sixth payer. While all reported that the services in question are covered, only PacificSource reported having contracts with any of the EISO contracted entities. Those who do not have contracts with the EISO entities reported that the claims would be processed as "out of network" or non-preferred resulting in higher out-of-pocket costs for both commercial and Medicare enrollees, or for some products, there would be no coverage at all. All six commercial payers stated that they will send EOBs to their members with commercial insurance or Medicare Advantage coverage.

Some states have recently enacted laws to provide greater privacy with respect to health information communicated by insurance such that insurers cannot specify or describe sensitive health care services in a common summary of payments form. This type of policy has not been contemplated by the State of Oregon.

***Commercial Payer Summary***

| | |
|---|---|
| **Kaiser Permanente** | **Contract Status**: None of the EISO providers are contracted.<br>**Credentialing Requirement**: Providers are credentialed if contracted.<br>**Issuance of EOBs**: EOBs are issued for all services.<br>**Payment Policies**: Unless services are an emergency, there would be no coverage for services.<br>**CHW Policies**: N/A |
| **Moda Health** | **Contract Status:** None of the EISO providers are contracted.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** EOBs are issued for all services.<br>**Payment Policies:** Out of network benefits would apply.<br>**CHW Policies:** CHWs are not a covered provider type. |
| **PacificSource** | **Contract Status:** Contracted with Clackamas, Multnomah, Washington, Lane, Marion, Polk, Deschutes, Crook, and Hood River counties. |

| | |
|---|---|
| | **Credentialing Requirements**: Providers are credentialed if contracted.<br>**Issuance of EOBs:** EOBs are issued for all services for members with commercial insurance or Medicare.<br>**Payment Policies:** In network benefits would apply.<br>**CHW Policies:** CHWs are not a covered provider type unless affiliated with a contracted provider and billing incident to a contracted provider. |
| **Providence Health Plan** | **Contract Status:** None of the EISO providers are contracted.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** EOBs are issued for all services.<br>**Payment Policies:** Out of network benefits would apply.<br>**CHW Policies:** CHWs are not a covered provider type. |
| **Regence Blue Cross Blue Shield** | **Contract Status:** None of the EISO providers are contracted.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** EOBs are issued for all services.<br>**Payment Policies:** Out of network benefits would apply.<br>**CHW Policies:** CHWs are not a covered provider type. |
| **UnitedHealthcare** | **Contract Status:** None of the EISO providers are contracted.<br>**Credentialing Requirements:** Providers are credentialed if contracted.<br>**Issuance of EOBs:** EOBs are issued for all services.<br>**Payment Policies:** Out of network benefits would apply.<br>**CHW Policies:** CHWs are not a covered provider type. |

## Gaps and Challenges

Based on the findings from the document review and the payer interviews, HMA has identified some gaps that would need to be addressed to improve opportunities for enhanced billing and revenue collection.

### *Misinformation/Lack of Information*

Without exception, the CCOs that reported they were receiving and paying claims from their public health department partners reported that they did not receive HIV/STI claims from those agencies in any significant volume. Some said that they never receive those types of claims and a few said they could see a handful of STI claims in their system. Some of these public health departments currently billing for other services were part of the EISO program and many were not. Given that these agencies have the capabilities to submit bills for vaccines and family planning, it may be that they do not know they can bill for HIV/STI testing and services or they may be concerned about confidentiality.

This misinformation may also be leading to fewer OSPHL lab submissions that include a client's OHP eligibility information. The OSPHL asks that public health agencies include the CCO information when submitting specimens for HIV/STI testing and if the eligibility information is not submitted, the OSPHL does not check MMIS for eligibility and does not bill a Medicaid payer for the services. This is out of concern for confidentiality; however, since none of the CCOs nor the OHA Open Card issue EOBs, that concern should not be a factor.

### *Issuance of EOBs*

The Employee Retirement Income Security Act (ERISA) and the ACA both **require insurers** to communicate to policyholders about the **benefits** received and denied, commonly referred to

collectively as EOBs. Unlike commercial insurance, Medicaid does not have the same requirements to send out EOBs.

Billing and claims processing procedures widely used in private health insurance routinely, albeit inadvertently, prevent anyone insured as a dependent on someone else's policy from obtaining sensitive services confidentially. In addition, adult patients may not wish to have an EOB sent to their home for a wide variety of reasons. EOBs—which typically identify the individual who received care, the health care provider and the type of care obtained—essentially make it impossible for clients who value confidentiality including dependents, often minors and young adults, to obtain the confidential access to sexual and reproductive health care they need.

Several states have developed creative approaches to address these challenges, as well as broader confidentiality concerns—solutions that satisfy the needs of insurers, protect policyholders from unexpected financial exposure and, most importantly, facilitate access to confidential care for all covered individuals. All six commercial payers stated that they will send EOBs to their members with commercial insurance or Medicare Advantage coverage unless directed otherwise through state or federal policy.

### *Commercial Insurance Preferred Provider Networks*

One of the commercial payers, PacificSource, has preferred provider contracts with several public health agencies. The remaining payers showed little to no interest in adding EISO agencies to their network.

## Successes and Strengths

We identified several areas of significant strengths and assets that can enhance billing opportunities and increase revenue recovery from other sources.

### *Essential Health Benefits/Essential Community Providers*

As discussed in detail above, the ACA has positioned EISO services and providers for payment success through the creation of Essential Health Benefits and designation of Essential Community Providers.

### *Community Health Workers*

Oregon is a national leader in the development of a CHW workforce and deployment of an infrastructure to sustain the CHW workforce. Recognizing that the certification and registration process should be carefully considered before making CHW certification a requirement for the job, there may be an opportunity to leverage Oregon's national leadership in this space to the benefit of the EISO work.

### *OSPHL*

The OSPHL operates a robust and effective billing process that collects insurance payments for services rendered when the insurance eligibility of the patient or client is known. OSPHL also operates an effective invoicing process that collects payments from submitters such as public health agencies, safety net clinics and other providers when insurance eligibility is unknown. The billing service, Public Consulting Group, appears to perform well relative to most industry standards when reviewing balances written off as uncollectible. Note that HMA did not review the contract between OSPHL and Public

Consulting Group to determine whether the administrative costs of the billing service are within industry norms.

### *CCO Engagement*

A significant strength to the EISO programs is the fact that the CCOs are willing and able to pay for point of care services provided by public health if proper claims can be submitted. There was no hesitation in interviews or email correspondence to the contrary. It appears that a substantial number of public health agencies are already able to submit claims to CCOs and have done so for many years. Expanding the range of services billed, beyond immunizations and family planning, should be achievable through education and, perhaps, technical assistance.

## Recommendations

Through our analysis of opportunities to maximize insurance payment for HIV/STI services provided by HIV/STI Providers, we have identified several recommendations for further exploration. Our initial scope of work anticipated that the greatest areas of opportunity would lie in training HIV/STI Providers, or other public health entities, to bill for services covered by insurance. While some of our recommendations involve LPHA training opportunities, others involve proposed changes to public policy, enhanced enforcement of existing policies, and more general education about these services and how they are delivered and could be funded. Recommendations are organized by the entity that would be responsible for carrying the out.

### State/HST Program

#### *Create a Billing and Coding Guide and Training*

HMA will create a billing and coding guide and curriculum for public health agencies in the second phase of this project. This will educate HIV/STI Providers about which HIV/STI services are billable under which conditions, by which providers, and the codes associated with those services. It will also include tools, such as a "billing code cheat sheet" for common HIV/STI services.

#### *Change EISO Contract Language Regarding Billing*

The current contract language requires grantees to get permission from OHA to bill for services and specifies that revenue generated from billing must be returned to the program. This is a disincentive to bill for services. If possible, OHA should remove that language from the contracts.

#### *Counter Misinformation*

Much of the hesitancy for LPHAs to bill for services has more to do with misinformation than inability or lack of training. OHA could explore a "myth busting" campaign about the following:

- EOBs—when they go out, who sends them out (e.g., not CCOs), etc.
- HIV/STI Providers are not prohibited from billing for HIV/STI services because they receive funding from OHA to provide those services
- Public health agencies are likely already collecting enough information to look up Medicaid eligibility in MMIS, so they do not need to ask for insurance information from a number of

clients which should assuage any concerns about needing to collect more information than they currently are

- The vast majority of health plans are not allowed to require cost sharing for HIV/STI services

### *Host a Learning Collaborative*

Some HIV/STI Providers are already billing for HIV/STI services through their clinical partners, and others are billing for other public health services directly. OHA could invite these LPHAs to share their best practices with the other LPHAs and seek their input on billing code "cheat sheets" for common HIV/STI services.

## State/OHA

### *Update and Enforce CCO Contracts*

As noted above, the current CCO contracts do not include language enforcing the statute and rules that require CCOs to contract with LPHAs for certain point of care services. OHA should remedy this during the next contract amendment process and ensure that it is enforced. This could be navigated through a partnership between HST and the OHA Health Services Division.

### *Create a Learning Opportunity for Commercial Payers*

OHA has little official role in regulating commercial payers. However, commercial payers do have an interest in showing support for OHA initiatives due to political and market pressures. HST could partner with other parts of the Public Health Division and the OHA to design a learning opportunity for commercial payers to start a conversation about the value of public health services to their members and the benefit to the plans of increasing their data collection about their members' health risks and services they have received that count toward health plan quality metrics.

## Oregon State Public Health Lab

### *Check MMIS for Medicaid Coverage*

The need to ensure patient confidentiality is understandable. However, since the CCOs do not issue EOBs or any other type of communication specific to services rendered, even claims for services that are being denied, there could be more revenue collected from the CCOs simply by checking MMIS for eligibility. This could be done at the OSPHL or the billing vendor, PCG, regardless of whether a provider has indicated insurance status on the specimen. This type of eligibility inquiry is highly automated and rarely presents a labor burden.

### *Bill Commercial Payers the Maximum Allowed Amount*

The fee schedule established at OSPHL is at a level to ensure the maximum allowed amounts can be collected from the OHA fee schedule. This may not be the case for commercial payers or Medicare Advantage plans where the OSPHL fee schedule may be established at a price less than the maximum allowed amount. OSPHL should ensure they are billing commercial payers the maximum allowed amount under those contracts.

## HIV/STI Providers

### *Leverage Existing Infrastructure*

If a public health agency is already billing for other public health services, or a related FQHC is billing for clinical services, the LPHAs should leverage the billing infrastructure and best practices already in place in other parts of their agencies. For example, if a public health agency is billing CCOs for family planning or other public health services, they should use the same infrastructure to bill the CCOs for HIV/STI services.

### *Maximize E&M Codes for Licensed Providers*

Licensed providers (physicians, nurses, advance practice providers) in public health agencies can bill E&M codes for certain counseling and other services rendered as part of HIV/STI diagnosis and treatment. They should ensure their licensed providers are billing these codes to their full extent.

### *Hire Certified Community Health Workers*

Many services rendered in the EISO program are covered as part of "office visits" rendered by licensed providers. There is an opportunity to expand billing for certain services with non-licensed staff members providing services in community settings who could bill for Medicaid enrollees if they are certified CHWs. This would also support OHA's goal of expanding access to CHWs to OHP members and help CCOs meet their contract requirements for providing access to CHW rendered services for their members. This could be achieved by hiring certified CHWs or supporting currently employed staff in becoming certified CHWs.

### *Advocate for Suppression of EOBs for HIV/STI Services*

One of the main barriers to insurance billing cited by HIV/STI Providers is confidentiality. LPHAs worry that clients will not seek services if information about their diagnosis will be sent to their home in the form of a bill or an explanation of benefits (EOB). As noted above, CCOs do not send EOBs to members because there is no cost sharing in the OHP. Advocates for patient confidentiality have attempted to pass laws to require state-regulated commercial insurers to suppress EOBs for certain procedures, generally related to sexual health. Oregon law requires regulated commercial payers to allow health plan members to choose to receive mail addressed to themselves, rather than the policyholder. This was an attempt to increase patient confidentiality, but it is not as effective as suppressing EOBs for certain codes or suppressing select codes and rendering provider on EOBs would be. Our understanding is that other states have successfully implemented such requirements. HIV/STI Providers could start a policy conversation about implementing such a requirement in Oregon.

## Coordinated Care Organizations

### *Develop APMs to Support Public Health Services*

As noted above, CCOs are required to partner with LPHAs to pay for certain point of care services. If CCOs were billed for every point of care public health service provided to their members by an LPHA or their partner, it would be a tiny fraction of their annual global budget. It might garner significant good will in the community and with local officials for CCOs to partner with their LPHAs and develop alternative payment models to support the public health services that are enhancing their members' health.

## Appendix A: HIV STI Partner Assessment Survey

Start of Block: HIV/STI Provider Insurance Billing Assessment Survey

Thank you for participating in the HIV/STI Provider Insurance Billing Assessment Survey. The Assessment is part of a current effort led by OHA's HST Section to develop guidance and training resources to modernize insurance billing for HIV/STI services. Your responses will help inform the development of billing and training resources that are both responsive and relevant to your agencies' needs. Based on the information you provide in the survey, our project consultant, Health Management Associates, will develop interview questions that are tailored to your agency and focus on gaining a better understanding of your current billing capacity and practices. For this project, please keep in mind we are focused on information specific to billing for HIV/STI services provided by your agency.

Please fill out the following:

- Name _____
- Title _____
- Organization _____
- Email Address _____
- Phone Number _____

## Health System and Insurer Relationships

Goal: understanding of current health plan contracts and collection of client insurance information

### Client Insurance Information

Does your organization have a standardized process for collecting insurance information from clients?

- Yes
- No

**Display This Question If: Does your organization have a standardized process for collecting insurance information from clients? = Yes**

If yes, please provide documents.

**Display This Question If: Does your organization have a standardized process for collecting insurance information from clients? = Yes**

If yes, do you use this information for billing purposes?

- ○ Yes
- ○ No
- ○ Sometimes

**Display This Question If: If yes, do you use this information for billing purposes? = Sometimes**

If sometimes, please explain:

_____

What percent of your HIV/STI clients have insurance?

- ○ Please fill in percentage _____
- ○ We do not have this data
- ○ Unsure

Have your clients expressed concern with sharing insurance information?

- ○ Yes
- ○ No

**Display This Question If: Have your clients expressed concern with sharing insurance information? = Yes**

If yes, please describe the kinds of concerns expressed:

_____

Do you provide assistance to clients for enrolling in insurance?

- ○ We provide referrals
- ○ We provide direct enrollment assistance
- ○ No

## Health Plan Contracts

Do you have contracts/MOUs with any of the following payer groups for HIV/STI services? (Please choose all that apply)

- ☐ Medicaid CCOs
- ☐ Medicaid FFS
- ☐ Medicare
- ☐ Private insurance
- ☐ We don't have contracts

**Display This Question If: Do you have contracts/MOUs with any of the following payer groups for HIV/STI services DOES NOT = We don't have contracts**

Please identify names of all Health Plans contracts in place:

_____

Do you receive reimbursement for HIV/STI services under these contracts?

- ○ Yes
- ○ No

**Display This Question If: Do you receive reimbursement for HIV/STI services under these contracts? = No**

If no, please explain:

_____

Do you bill payers even if you do not have a contract in place?

- Yes
- No
- Sometimes

Do you receive reimbursement for HIV/STI services when you don't have a contract in place?

- Yes
- No
- Sometimes

Have you had challenges obtaining contracts?

- Yes
- No

**Display This Question If: Have you had challenges obtaining contracts? = Yes**

Please describe any challenges:

_____

## Organizational and Billing Capacity

Goal: Understanding of current insurance billing capacity and practices

Does your organization have billing policies and procedures specific to HIV/STI services?

(E.g., identifies staff responsibilities and authorities for health plan billing and contracting; standards for determining costs and billing rates; processes to collect insurance information; procedures to bill various health plan types (private, CCOs, Medicare))

- ○ Yes, we have HIV/STI billing policies and procedures that are specific to these services.
- ○ Yes, we have general billing policies and procedures that encompass HIV/STI services but do not address specific expectations.
- ○ No
- ○ Unsure

**Display This Question If: Does your organization have billing policies and procedures specific to HIV/STI services? = Yes, we have HIV/STI billing policies and procedures that are specific these services.**

Please provide a copy:

**Display This Question If: Does your organization have billing policies and procedures specific to HIV/STI services? = Yes, we have general billing policies and procedures that encompass HIV/STI services but do not address specific expectations.**

Please provide a copy:

Does your organization bill through a tribal health clinic or FQHC model?

- ○ Yes
- ○ No

Does your organization bill through subcontractors for HIV/STI services?

- ○ Yes
- ○ No

Does your organization identify staff responsible for billing and contracting activities?

- ○ Yes
- ○ No

**Display This Question If: Does your organization identify staff responsible for billing and contracting activities? = Yes**

If so, please identify position and responsibilities.

_____

Does your organization credential and/or enroll providers in order to bill health plans for HIV/STI services?

- ○ Yes
- ○ No

**Display This Question If: Does your organization credential and/or enroll providers in order to bill health plans for HIV/STI services? = Yes**

Please list types of providers that are credentialed or enrolled:

_____

## Health and Equity Impacts

Goal: Uncovering any potential health equity impacts of implementing insurance billing for HIV/STI on clients, organization, and service models so that we can take steps to mitigate them.

### Client Focused

Are you concerned about any potential negative impacts billing may have on your clients?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Are you concerned about any potential negative impacts billing may have on your clients? = Yes**

If yes, please explain:

_____

Do you have concerns about disparate impacts of insurance billing on certain client populations?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Do you have concerns about disparate impacts of insurance billing on certain client populations? = Yes**

If yes, please explain:

_____

Do you have concerns that insurance billing will have negative impacts on populations disproportionately impacted by HIV/STI?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Do you have concerns that insurance billing will have negative impacts on populations disproportionately impacted by HIV/STI? = Yes**

If yes, please explain:

_____

Do you think insurance billing would: (please check one box)?

- ○ Increase disparities
- ○ Decrease disparities
- ○ Be neutral
- ○ Unsure

Please explain:

_____

Do you see ways to overcome any potential negative impacts or challenges for your clients?

- ○ Yes
- ○ No

Do you see any potential positive impacts billing may have on your clients?

- ○ Yes
- ○ No

**Display This Question If: Do you see any potential positive impacts billing may have on your clients? = Yes**

If yes, please specify:

_____

## Organization Focused

Are you concerned about any potential negative impacts billing may have on your organization?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Are you concerned about any potential negative impacts billing may have on your organization? = Yes**

If yes, please specify:

_____

Do you see ways to overcome any potential negative impacts or challenges for your organization?

- ○ Yes
- ○ No

Do you see any potential positive impacts billing may have on your organization?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Do you see any potential positive impacts billing may have on your organization? = Yes**

If yes, please specify:

_____

## Service Model Focused

Are you concerned about any potential negative impacts billing may have on your service models?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Model Focused Are you concerned about any potential negative impacts billing may have on your service models? = Yes**

If yes, please specify:

_____

Do you think that these impacts to your service model would disproportionately impact certain populations?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Do you think that these impacts to your service model would disproportionately impact certain populations? = Yes**

If yes, please specify:

_____

Do you see ways to overcome any potential negative impacts or challenges billing may have on your service models?

- ○ Yes
- ○ No

Do you see any potential positive impacts billing may have on your service models?

- ○ Yes
- ○ No
- ○ Unsure

**Display This Question If: Do you see any potential positive impacts billing may have on your service models? = Yes**

If yes, please specify:

_____

## General Attitudes

Goal: Understanding of key billing concerns and best practices/opportunities

In general, how do you feel about the idea of starting/increasing insurance billing for your current HIV/STI services?

Oppose Strong Support

0 1 2 3 4 5 6 7 8 9 10

| | |
|---|---|
| Sliding Scale () |  |

What concerns you about starting/increasing insurance billing for your current HIV/STI services? Once you have identified a concern, please drag and drop it into the box on the right, starting with your top priority. Please hover over "Please identify a concern" in order to enable the Drag feature.

| Concerns, by Top Priority |
|---|
| _____ Please identify a concern: |
| _____ Please identify a concern: |
| _____ Please identify a concern: |
| _____ Please identify a concern: |

What opportunities or benefits from starting/increasing insurance billing for your current HIV/STI services do you see?

_____

What kind of support does your agency need to start/increase insurance billing for HIV/STI services?

_____

Fill in the blank, "If we could just do _____, I would be fully supportive of billing insurance for our HIV/STI services."

_____

# Service Models

Goal: Understanding of current HIV/STI services provided and models of care

## Education, Information and Referral

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) |
|---|---|---|---|
| **STI/HIV:** Provide education to patient on the nature of their infection. | | | |
| **STI/HIV:** Refer patient for additional prevention services, if needed (e.g., alcohol and drug treatment, HIV PrEP, PEP access, etc.). | | | |
| **STI/HIV:** Refer patient to other services, if needed (e.g., mental health/behavioral health, other social services.) | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **STI/HIV:** Provide education to patient on the nature of their infection. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV:** Refer patient for additional prevention services, if needed (e.g., alcohol and drug treatment, HIV PrEP, PEP access, etc.). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV:** Refer patient to other services, if needed (e.g., mental health/behavioral health, other social services.) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Screening/Evaluation

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) |
|---|---|---|---|
| **STI/HIV:** Offer screen for additional STIs and HIV | | | |
| **STI/HIV:** Offer vaccinations for Hepatitis A&B if not previously received by patient | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **STI/HIV:** Offer screen for additional STIs and HIV | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV:** Offer vaccinations for Hepatitis A&B if not previously received by patient | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Testing and Diagnosis

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) | Where do you send your specimens? (private lab, OSPHL, in-house, combination of above, other) **(not applicable for Rapid HIV Test)** |
|---|---|---|---|---|
| **HIV Test:** Rapid HIV Test | | | | |
| **HIV Test:** Blood Draw | | | | |
| **STI Test:** Syphilis | | | | |
| **STI Test:** Gonorrhea | | | | |
| **STI Test:** Chlamydia | | | | |
| **STI/HIV Test:** Other (please describe) | | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **HIV Test:** Rapid HIV Test | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **HIV Test:** Blood Draw | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI Test:** Syphilis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI Test:** Gonorrhea | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI Test:** Chlamydia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV Test:** Other (please describe) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Treatment

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) |
|---|---|---|---|
| **STI:** Treat patient for STI if not already treated or link them to medical care and treatment. | | | |
| **STI:** Treat partners found to be positive for STI or link them to medical care and treatment. | | | |
| **HIV:** Link individual to HIV medical care and treatment or HIV pre-exposure prophylaxis. | | | |
| **HIV:** Treat partners found to be positive for HIV or link them to medical care and treatment. | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **STI:** Treat patient for STI if not already treated or link them to medical care and treatment. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI:** Treat partners found to be positive for STI or link them to medical care and treatment. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **HIV:** Link individual to HIV medical care and treatment or HIV pre-exposure prophylaxis. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **HIV:** Treat partners found to be positive for HIV or link them to medical care and treatment. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Counseling

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) |
|---|---|---|---|
| **STI/HIV:** Counsel patient about reducing their risk for acquiring or transmitting infection to others. | | | |
| **STI/HIV:** Counsel partner about reducing their risk for acquiring HIV infection and other types of STIs. Refer them for additional prevention services, if needed. | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **STI/HIV:** Counsel patient about reducing their risk for acquiring or transmitting infection to others. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV:** Counsel partner about reducing their risk for acquiring HIV infection and other types of STIs. Refer them for additional prevention services, if needed. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Case Investigation and Partner Services

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) |
|---|---|---|---|
| **STI/HIV:** Conduct interview with patient to elicit information about their sexual partners to conduct confidential partner notification. | | | |
| **STI/HIV:** Notify partners of their exposure. | | | |
| **STI/HIV:** Offer partners STI/HIV testing. | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **STI/HIV:** Conduct interview with patient to elicit information about their sexual partners to conduct confidential partner notification. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV:** Notify partners of their exposure. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **STI/HIV:** Offer partners STI/HIV testing. | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Monitoring

Please fill out the following table:

| | In what setting is the service provided? (clinic based, field-based, other) | How many services were provided in the last 12 months? **(For CBOs only)** | Do you bill for these services? (Y/N) |
|---|---|---|---|
| **STI:** Patient follow up for recommended re-testing per CDC and OHA guidance | | | |
| **HIV:** Patient follow up for recommended re-testing per CDC and OHA guidance | | | |

What types of providers deliver the service? Please choose all that apply.

| | MD | DO | ND | NP | RN | CHW | QMHP | LCSW | Lay-person | Other |
|---|---|---|---|---|---|---|---|---|---|---|
| **STI:** Patient follow up for recommended re-testing per CDC and OHA guidance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **HIV:** Patient follow up for recommended re-testing per CDC and OHA guidance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Thank you for completing the HIV/STI Providers Insurance Billing Assessment Survey. Health Management Associates will review your responses and schedule a follow up interview to better understand your agency's current insurance billing capacities and any further input you would like to provide. If you have any questions, please contact **Michael Anderson-Nathe, HMA Principal, at MAndersonnathe@healthmanagement.com.**

End of Block: HIV/STI Provider Insurance Billing Assessment Survey

# Appendix B: HIV STI Partner Assessment Survey and Interview Participants

## Survey Respondents

1. Cascade AIDS Project
2. Clackamas County
3. Crook County
4. Deschutes County
5. HIV Alliance
6. Jackson County
7. Lane County
8. Lincoln County
9. Linn County
10. Marion County
11. Multnomah County
12. Neighborhood Health Center
13. Planned Parenthood of Southwestern Oregon
14. Washington County
15. Unknown

## Interviewees

1. Benton County
2. Cascade AIDS Project
3. Clackamas County
4. Deschutes County
5. HIV Alliance
6. Jackson County
7. Lincoln County
8. Linn County
9. Marion County
10. Multnomah County
11. Neighborhood Health Center
12. Washington County

## Appendix C: HIV/STI Coding Analysis

# Service Category: Education, Information and Referral

**Activity Definition:** Provide education to patient on the nature of their infection.

**Applies to STD & HIV**

**Questions / Assumptions:**

1. Patient has an established STD/HIV Diagnosis.
2. The specific activity is provision of education on the nature of the STD/HIV infection (as opposed to providing education on how to reduce risk of getting the infection).
3. The term "Counseling" in a CPT name/definition may involve / include "patient education" on the nature of the STD/HIV infection.

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • CPT 98960-98962: Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum:<br>  ○ CPT 98960: face-to-face with the patient … each 30 minutes; individual patient,<br>  ○ CPT 98961: 2-4 patients,<br>  ○ CPT 98962: 5-8 patients. | • CPT 98960-98962 must be prescribed by a physician or eligible QHP (e.g., APRN, PAs), and are provided by a qualified, nonphysician health care professionals, if approved by State regulation (e.g., Certified CHWs).<br>• If a state Medicaid program has opted to expand their coverage of preventive services and received permission from CMS these codes could be used by CHWs or other non-licensed professionals. [iii] | • 98960-98962 are not paid by Medicare; and are not currently listed on the Oregon Medicaid Fee Schedule. These codes are payable by many non-governmental payers and/or other state Medicaid programs.<br>• Note – these codes may be used to report Telehealth services during COVID crisis by some payers. [iv] If used for Telehealth, codes may require modifier 95. |
| • For counseling and education provided by a physician or other qualified health professional (QHP) [v] to an individual, see appropriate E/M medical visit / preventive visit and counseling codes, including: [vi]<br>  ○ Office / Other OP (99202-99215) [vii]<br>  ○ Preventive Medicine (99381-99397)<br>  ○ Counseling Risk Factor Reduction and Behavior Change Intervention (99401-99404; 99411-99412)<br>  ○ CPT 99078 Educational services by a Physician or other QHP, group setting | • For Medicare, E/M Services must be provided by Physicians and eligible QHPs. [viii]<br>• State scope of practice laws and regulations define the roles and responsibilities for health professionals' licenses. Other nonphysician providers may / may not be permitted to bill E/M codes.<br>• Per CPT, 99078 may be reported by a Physician or other qualified health care professional qualified by education, training, licensure/regulation. | • Medicare, Medicaid, and other Payers cover E/M services if services are separate and distinct from other billable services provided during the same encounter.<br>• E/M code may require Modifier 25 if other separate / distinct billable services are provided during the same encounter. |
| • Patient education, not otherwise classified, non-physician provider, [ix] | • See Scope of Practice State scope of practice laws and regulations for specific provider types. | • Blue Cross/Blue Shield and other commercial payers develop S codes to report drugs, services, and supplies. |

| | | |
|---|---|---|
| ○ HCPCS S9445 - individual, per session<br>○ HCPCS S9445 – group, per session | • See individual Payer coverage manuals. | • These codes may not be used to bill services paid under any Medicare payment system. Medicare does not reimburse for services under S codes.<br>• S codes are not listed on the Oregon Medicaid Fee Schedule. |

## Service Category: Education, Information and Referral (Continued)

### Activity Definition:

1. Refer patient for additional prevention services, if needed (e.g., alcohol and drug treatment, HIV PrEP, PEP access, etc.)
2. Refer patient to other services, if needed (e.g., mental health/behavioral health, other social services).

### Applies to STD & HIV

### Questions / Assumptions:

1. Patient may or may not have an established STD/HIV Diagnosis.
2. The specific activity is to “Refer” patient for additional prevention services or other services, if needed, as opposed to providing such other services.

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • There are no CPT/HCPCS codes specifically defined as "patient referrals".<br>• Referrals are included as an element of E/M medical visit / preventive visit and counseling codes.<br>• A referral to another provider may require a written order by a physician / QHP. Referral without an order may impact coverage. | • For Medicare, E/M Services must be provided by Physicians and eligible QHPs.<br>• State scope of practice laws and regulations define the roles and responsibilities for health professionals’ licenses. Other nonphysician providers may / may not be permitted to bill E/M codes. | • Medicare, Medicaid, and other Payers cover certain E/M services, including CPT 99202-99215). [vii] E/M codes may require Modifier 25 if other separate / distinct billable services are provided during the same encounter.<br>• 99381-99397 / 99401-99404 are not paid Medicare; however, these codes are listed in the Oregon Medicaid Fee Schedule and are typically paid by commercial insurers. |

## Service Category: Screening / Evaluation

### Activity Definition:

1. Offer screening for additional STDs and HIV.
2. Offer vaccinations for Hepatitis A&B if not previously received by patient.

### Applies to STD & HIV

### Questions:

1. Assume the billable activity is “to offer" screening for STDs/HIV and "to order / administer" vaccinations for Hepatitis A&B
2. For “ordering and/or providing” screening laboratory tests for STDs/HIV See next section “Testing”

### Assumptions:

1. Patient may or may not have an established STD/HIV Diagnosis
2. Assume that all patients will be offered appropriate screening during any encounter since under the ACA, all non-grandfathered private health plans must provide coverage for a range of preventive services, including screening target and at-risk populations for HIV and STDs.

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • There are no CPT/HCPCS codes specifically defined as "To offer screening" or "To offer Vaccinations”.<br>• To order screening laboratory test / vaccination would be a component of an E/M medical visit / preventive visit, or counseling session.<br>  ○ For a listing of CPT/HCPCS codes for HIV/STD Screening Lab tests, see Appendix 1 - Lab codes.<br>• For a listing of CPT codes for vaccines recommended by the CDC for people with HIV, CPT codes for HAV immunization, and CPT codes for vaccine administration, See Appendix 2 Immunizations. | • For Medicare, E/M Services must be provided by Physicians and eligible QHPs.<br>  ○ 99381–99397 are generally utilized by primary care providers and some specialty clinics (e.g., OB/GYN). STD clinics might not be credentialed to provide these services. Check with the clinic’s contracted payers to verify eligibility to use CPT preventive medicine codes.<br>• State scope of practice laws and regulations define the roles and responsibilities for health professionals’ licenses. Other nonphysician providers may / may not be permitted to bill E/M codes.<br>• Vaccinations can be administered by physicians and QHPs, as well as by RNs. It is possible that LPNs also can administer vaccines. Pharmacists can immunize people aged 7 years or older with all ACIP recommended vaccines in accordance with posted pharmacy protocols. With a valid prescription, pharmacists may administer vaccine to a patient of any age. | • Medicare, Medicaid, and other Payers cover certain E/M services, including CPT 99202-99215).[vii] E/M code may require Modifier 25 if other separate / distinct billable services are provided during the same encounter.<br>• Preventive Medicine Services (99381-99397 / 99401-99404) are not paid Medicare; however, these codes are listed in the Oregon Medicaid Fee Schedule and are typically paid by commercial insurers.<br>• Screening laboratory tests for HIV and STDs are payable by Medicare, Medicaid, and other Payers with physician/QHP order.<br>• Medicare Part B covers the hepatitis B vaccine if patient is at medium or high risk for hepatitis B. [x]<br>• Medicare Part D covers most vaccines and immunizations when ordered by a physician. [xi]<br>• All Health Insurance Marketplace plans, and most other private insurance plans must cover certain vaccines (including Hepatitis A & B) without charging a copayment or coinsurance when provided by an in-network provider. [xii] |

## Service Category: Testing & Diagnosis*

*Rapid (Preliminary Positives) vs Delayed vs Blood Draw – Understand nuances in service delivery

**Activity Definition:** Provide STD and HIV testing as well as any additional testing required to confirm a diagnosis

### Assumptions:

1. The specific activity is to "provide HIV/STD testing required to confirm a diagnosis" implies Patient does not already have an established diagnosis for the HIV/STD to be tested, but Patient may have other confirmed STD/HIV diagnoses.
2. Testing to confirm a diagnosis does not include laboratory tests to monitor an established condition (e.g., viral load).

### Applies to STD & HIV

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • Common STD Screening Codes include:[xiii]<br>  ○ Chlamydia<br>  ▪ 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810<br>  ▪ 87800 (combined chlamydia/gonorrhea test)<br>  ○ Gonorrhea: 87590, 87591, 87850<br>  ○ Syphilis: 86592, 86593, 86780<br>  ○ Hepatitis B (hepatitis B surface antigen):<br>  ▪ G0499: HBV screening for asymptomatic, nonpregnant adolescents & adults at high risk<br>  ▪ 86704: Hep B core antibody (HBcAb); total<br>  ▪ 86706: Hepatitis B surface antibody (HBeAb)<br>  ▪ 87340: Hepatitis B surface antigen (HBsAg)<br>  ▪ 87341: Hepatitis B surface antigen (HBsAg) neutralization<br>• HIV (Antibody Detection) [xiv]<br>  ○ 86701, 86702, 86703<br>  ○ For Medicare – G0432, G0433, G0435<br>• For a more complete listing of CPT/HCPCS codes for HIV/STD Screening Lab tests, see Appendix 1 - Lab codes. | • Screening:<br>  ○ The FDA has approved several rapid HIV tests and STD tests as waived tests under CLIA. CLIA-waived tests can be performed by nonmedical staff who have been trained to perform the test using manufacturer's instructions. [xv]<br>• Clinical Laboratories that are accredited by an approved accreditation organization under the Clinical Laboratory Improvement Amendments (CLIA).<br>• With a CLIA Certificate of Waiver, Point of Care Testing (POCT) can be performed by non-laboratory trained individuals such as nurses, physicians, nursing assistants, and anesthesia assistants, among others.[xvi] | • Medicare, Medicaid, and other Payers pay for medically necessary laboratory tests that have been ordered and performed at an approved laboratory by qualified personnel.<br>• Modifiers 33, 92, QW may be appropriate; See Appendix 9 for full definitions of these modifiers. |

## Service Category: Treatment (Medical)

### Activity Definition:

1. Link individual to HIV medical care and treatment or HIV pre-exposure prophylaxis.
2. Treat patient for STD if not already treated or link them to medical care and treatment.
3. Treat partners found to be positive for an STD or link them to medical care and treatment.

### Assumptions:

1. A patient with a confirmed HIV diagnosis may require referral to and treatment by a primary care physician and/or infectious disease specialist.
2. Partner is seen as New Patient for billing purposes.
3. Assume "treatment" may involve E/M services, minor procedures, and/or prescribing /administering appropriate medications:
   a. Chlamydia may be treatable immediately upon diagnosis by the HIV/STD Clinic using oral medications.
   b. Gonorrhea may be treatable immediately upon diagnosis by the HIV/STD Clinic using oral / injectable medications. Disseminated gonococcal infection (DGI) may require referral to another providers.
   c. Syphilis medication, dosage, and length of treatment depend on the stage and clinical manifestations of the disease and may require referral to another provider.
   d. Pregnancy may complicate STD/HIV treatment and require referral to another provider.

### Applies to STD & HIV

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • E/M codes would be reported for management / treatment of STDs and/or HIV.<br>• There are no CPT/HCPCS codes specifically defined as "patient referrals". Referral / linkage to HIV Medical Care is an element of E/M, preventive visit, and counseling codes.<br>• CPT codes 96372 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular).<br>• Drug HCPCS Codes (See Appendix 6).<br>• Surgical Procedure Codes (see Appendix 7 – STD Procedures). | • E/M Codes - Physician, PA or APRN. If surgical procedure(s) or injection(s) are performed on the same day as the E/M and E/M is separate and distinct, append Modifier -25 (*Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).*<br>• SQ/IM Injections - Physician, PA, APRN or by nonphysician personnel incident to a physician service, as permitted by applicable Oregon Scope of Practice guidance.<br>• Surgical Procedure Codes - Physician, PA or APRN, as permitted by applicable Oregon Scope of Practice guidance. | • Medicare, Medicaid, and other Payers pay for medically necessary E/M services, surgical procedures, injections, and some drugs that have been ordered and provided by qualified personnel.<br>• Modifiers 25; See Appendix 9 for full definition of this modifier. |

## Service Category: Counseling

### Applies to STD & HIV

### Activity Definition:

1. Counsel patient about reducing their risk for acquiring or transmitting infection to others.
2. Counsel partner(s) about reducing their risk for acquiring HIV infection and other types of STDs. Refer them for additional prevention services, if needed.

### Assumptions:

1. Patient may/ may not have an established STD/HIV Diagnosis.
2. Partner may/ may not have an established STD/HIV Diagnosis.
3. The specific activity is provision of counseling on risk reduction related to STD/HIV infections.
4. Partner is seen as New Patient for billing purposes.

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • Office / Other Outpatient E/M services (e.g., CPT codes 99202-99215, etc.) may include preventive counseling on risk reduction related to STI/HIV. [vii]<br>• Preventive Medicine Counseling codes (CPT codes 99401–99404) can be used for preventive STI/HIV counseling when there are no reported symptoms of infection and only guidance, advice, and recommendations are provided.<br>• Preventive Medicine codes (99381-99397) may involve counseling services.<br>• HCPCS G0445 High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes.<br>• Health Behavior Assessment and Intervention (HBAI) codes (96156-96171) are to report assisting patients to overcome emotional / social barriers to their physical disease management and self-management of chronic disease. These codes address a wide range of physical health issues, including HIV. | • For Medicare, E/M Services must be provided by Physicians and eligible QHPs.<br>○ 99381–99397 are generally utilized by primary care providers and some specialty clinics (e.g., OB/GYN). STD clinics might not be credentialed to provide these services. Check with the clinic's contracted payers to verify eligibility to use CPT preventive medicine codes.<br>• For G0445, CMS requires that the patient must be referred by a primary care provider to be eligible to receive this service, according to Medicare. Physicians, advanced practice nurses and physician assistants may provide the service. The service must be performed in a primary care setting. [xvii]<br>• HBAI codes are not used for mental health services. They apply to services that address psychological, behavioral, emotional, cognitive, and interpersonal factors in the treatment / management of patients with physical health problems.<br>○ For Medicare, the required provider type is a Clinical Psychologist.<br>○ Most MA Plans allow a credentialed LCSW to serve as the supervising clinician providing oversight of HBAI services. | • Preventive Medicine Services (99381-99397 / 99401-99404) are not paid Medicare; however, these codes are listed in the Oregon Medicaid Fee Schedule and are typically paid by commercial insurers.<br>• CMS covers counseling to prevent STI in certain circumstances. The code is G0445. G0445 is not listed on the Oregon Medicaid Fee Schedule. Contact other payers for coverage.<br>• HBAI codes (96156-96171) covered by Medicare and HBAI codes (96156-96171) are listed on the Oregon Medicaid Fee Schedule<br>○ Do not report HBAI codes with 90832-90899 on the same date per CCIs. |

| | | |
|---|---|---|
| | ○ When a NP or Physician provides HBAI and oversight, the service is billed under the E&M coding requirements. | |

## Service Category: Case Investigation and Partner Services

1. Conduct interview with patient to elicit information about their sexual partners to conduct confidential partner notification.
2. Notify partner(s) of their exposure.
3. Offer partners STD/HIV testing.

### Assumptions:[xviii]

1. In Oregon, HIV test results may be disclosed to:
   a. The tested individual,
   b. The health care provider or licensed health care facility or person ordering the test,
   c. Anyone the tested individual authorizes to receive the results.
2. The OHA Public Health Division or LPHA may inform people if they have had a substantial exposure to HIV.
3. The OHA Public Health Division or LPHA may disclose the identity of an individual with an HIV-positive test to a health care provider to aid treatment.

### Applies to STD & HIV

| HCPCS code(s) defined as / including Activity | Who can provide this service? | Are these codes reimbursable? |
|---|---|---|
| • There are no CPT/HCPCS codes specifically defined as “Interview STD / HIV patient about partners” or “Partner Notification”. Eliciting information about their sexual partners for notification with patient approval could be included as an element of E/M medical visit / preventive medicine and counseling codes and / or Case Mgt / Care Mgt codes.<br>• There are no CPT/HCPCS codes specifically defined as "To offer STD/HIV testing" This would be included as an element of E/M medical visit / preventive medicine and counseling codes.<br>• See Appendix 1 for a listing of HCPC codes for laboratory tests to monitor a diagnosis of STD / HIV.<br>• See Appendix 5 for potential Case Mgt / Care Mgt HCPCS Codes (e.g., G2076). | • For Medicare, E/M Services must be provided by Physicians and eligible QHPs.<br>• 99381–99397 are generally utilized by primary care providers and some specialty clinics (e.g., OB/GYN). STD clinics might not be credentialed to provide these services. Check with the clinic’s contracted payers to verify eligibility to use CPT preventive medicine codes.<br>• State scope of practice laws and regulations define the roles and responsibilities for health professionals’ licenses. Other nonphysician providers may / may not be permitted to bill Case Management / Care Management codes. | • Medicare, Medicaid, and other Payers cover certain E/M services, including CPT 99202-99215).[vii] E/M code may require Modifier 25 if other separate / distinct billable services are provided during the same encounter.<br>• Preventive Medicine Services (99381-99397 / 99401-99404) are not paid Medicare; however, these codes are listed in the Oregon Medicaid Fee Schedule and are typically paid by commercial insurers.<br>• Chronic Care Management CPT Codes (99487-99491) are covered by Medicare and listed on the Oregon Medicaid Fee Schedule.<br>• Case Management HCPCS Codes (T1016-1017, T2022-T2023) are not payable by Medicare and are not listed on the Oregon Medicaid Pee Schedule. |

| **Service Category: Monitoring** | | |
|---|---|---|
| **Activity Definition:** Patient follow up for recommended re-testing per CDC and OHA guidance | | |
| **Assumptions**: Monitoring may involve Evaluation and Management Services, Case / Care management services, as well as laboratory testing to monitor disease status | | |
| **Applies to STD & HIV** | | |
| **HCPCS code(s) defined as / including Activity** | **Who can provide this service?** | **Are these codes reimbursable?** |
| • Monitoring patient health status is a core element of E/M services (99202-99215) and Chronic Care Management E/M Codes (99487-99491).[vii]<br>• Ongoing laboratory testing is essential for HIV patients.<br>• Periodic STD Screening for at risk patients is appropriate.<br>• See Appendix 1 for a listing of HCPC codes for laboratory tests to monitor a diagnosis of STD / HIV. | • For Medicare, E/M Services must be provided by Physicians and eligible QHPs.<br>• State scope of practice laws and regulations define the roles and responsibilities for health professionals' licenses. Other nonphysician providers may / may not be permitted to bill Case Management / Care Management codes.<br>• Clinical Laboratories that are accredited by an approved accreditation organization under the Clinical Laboratory Improvement Amendments (CLIA).<br>• With a CLIA Certificate of Waiver, Point of Care Testing (POCT) can be performed by non-laboratory trained individuals such as nurses, physicians, nursing assistants, and anesthesia assistants, among others. | • Medicare, Medicaid, and other Payers cover certain E/M services, including CPT 99202-99215). [vii] E/M code may require Modifier 25 if other separate / distinct billable services are provided during the same encounter.<br>• Medicare, Medicaid, and other Payers pay for medically necessary laboratory tests that have been ordered and performed at an approved laboratory by qualified personnel.<br>• Modifiers 33, 92, QW may be appropriate; See Appendix 9 for full definitions of these modifiers. |

| Service Category: Targeted Case Management | | |
|---|---|---|
| **Activity Definition:** Provide ongoing HIV case management services to assist person in adhering to HIV treatment | | |
| **Applies to HIV** | | |
| **HCPCS code(s) defined as / including Activity** | **Who can provide this service?** | **Are these codes reimbursable?** |
| • T1016 Case management, each 15 minutes.<br>• T1017 Targeted case management, each 15 minutes.<br>• T1023 Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.<br>• T2022 Case management, per month.<br>• T2023 Targeted case management; per month.<br>• G9012 Other specified case management services not elsewhere classified. | • The Oregon HIV Medical Case Management Program addresses the needs of persons with HIV disease by funding case management and support services that support access to and retention in medical care. [xix]<br>○ The *county-based* model of case management services is provided by local health departments in Hood River, Tillamook, Polk, and Deschutes counties.<br>○ The *regional*-based model of case management is provided by community-based service organizations HIV Alliance and Eastern Oregon Center for Independent Living (EOCIL).<br>https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/cmstdrds.aspx | • Case Management HCPCS Codes (T1016-1017, T2022-T2023) are not payable by Medicare and are not listed on the Oregon Medicaid Pee Schedule.<br>Note:<br>• Washington State uses T1023 for initial intake/assessment for HIV Case Mgt and T2022 for monthly CM. Modifier is required for billing HIV Case Management:[xx]<br>○ Full Month T2022 -U8<br>○ HIV Case Management Partial Month T2022 -U9<br>• NC uses G9012 for billing HIV Case Mgt [xxi]<br>• For a Fee for Service Model for Targeted HIV Case Management, see: https://targethiv.org/sites/default/files/rw2012/A21.pptx |

## Endnotes

[iii] See *BILLING CODING GUIDE FOR HIV PREVENTION: PrEP, SCREENING, and LINKAGE SERVICES,* NASTAD p 16: https://www.nastad.org/resource/billing-coding-guide-hiv-prevention

[iv] See *Telehealth Services Covered by Medicare and Included in CPT Code Set*; ma-assn.org/system/files/2020-05/telehealth-services-covered-by-Medicare-and-included-in-CPT-code-set.pdf

[v] In 2013, the American Medical Association (AMA) established a definition for a qualified healthcare professional (QHP), in terms of which providers may report medical services: "*A physician or other qualified health care professional' is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service*." QHPs, depending on state scope of practice, licensing, and the Centers for Medicare & Medicaid Services' (CMS), or other payers' guidelines, include Nurse practitioner (NP), Certified nurse specialist (CNS), Physician assistant (PA), Certified nurse mid-wife (CNM), Certified registered nurse anesthetist (CRNA), Clinical social worker (CSW), Physical therapist (PT)

[vi] See American Medical Association CPT 2020 Profession Edition: Education and Training for Patient Self-Management, pp 746-747

[vii] AMA elected to delete 99201, effective Jan. 1, 2021, making the lowest office-based E&M service 99202.

[viii] According to the Centers for Medicare and Medicaid Services (CMS), E/M services are medical in nature and therefore may not be furnished by psychologists or social workers. See https://www.apaservices.org/practice/advocacy/medical/acknowledge-services

[ix] See HCPCS Codes, 2020 Healthcare Common Procedure Coding System https://hcpcs.codes/s-codes/

[x] See https://www.medicareinteractive.org/get-answers/medicare-covered-services/preventive-services/hepatitis-b-shots

[xi] See https://www.medicareinteractive.org/get-answers/medicare-prescription-drug-coverage-part-d/medicare-part-d-costs/part-d-covered-vaccinations

[xii] See https://www.cdc.gov/vaccines/adults/pay-for-vaccines.html

[xiii] See NGS **Preventive Services Guide, SCREENING FOR SEXUALLY TRANSMITTED INFECTIONS AND HIBC TO PREVENT STIS;** https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/Manuals/preventive%20services%20guide/screening%20for%20sexually%20transmitted%20infections%20and%20hibc%20to%20prevent%20stis%20-%20preventive%20services%20guide/!ut/p/z0/vY8_b8JADMW_ijtkRD4oqsQY0f8UCYmh4ZbquJjgNnHCnZPSb98r6tCljGx-z9b7PaPFAq24gSun3Iqrk97Ym7dp_nQ3Hs_NwtwvpiZf384eJ_ns2qwMrknwGe35o5QyCcv5skLbOd2PWHYtFl2ggUR5IlgUBvYUoeq5JCyiD0TCUsGuDWl77F1df4EGJ7FhVSohZZD_aRnBSQl73nrQFn5DlSpHGMEZBm74_XCwOVrfitJRsZAqNlSyd4FOnqjQZ2b-2Cfd9ds6qRM8M42T1C4N_7Iyc4F_uo-H19VLfvUNuVAWeA!!/

[xiv] See *BILLING CODING GUIDE FOR HIV PREVENTION: PrEP, SCREENING, and LINKAGE SERVICES,* NASTAD p 8: https://www.nastad.org/sites/default/files/BillingCodingGuide_v4_Final_2016.pdf

[xv] See https://www.cdc.gov/hiv/testing/nonclinical/clia.html#:~:text=The%20Food%20and%20Drug%20Administration,test%20systems%20have%20been%20waived.

[xvi] See https://www.cdc.gov/labquality/docs/waived-tests/self-assessment-checklist-good-testing-practices.pdf

[xvii] See https://codingintel.com/counseling-prevention-sexually-transmitted-a2/

[xviii] See HIV Rules and Statutes: A Guide for Oregon HIV Service Providers and Advocates, see: https://www.oregon.gov/oha/PH/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/Documents/HIVLaws.pdf

[xix] See https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/Pages/cmstdrds.aspx.

[xx] see https://www.hca.wa.gov/assets/billers-and-providers/HIV-bi-20180101.pdf

[xxi] see https://medicaid.ncdhhs.gov/providers/programs-services/care-management/hiv-case-management

OREGON PUBLIC HEALTH DIVISION
HIV/STD/STB Section
Kate Brown, Governor

Date

Name, Title
Address
CCO Name
City, State ZIP

Dear Name:

With the implementation of the Patient Protection and Affordable Care Act (ACA), more individuals gained access to insurance. The plan was, and is, that the individual's insurance would cover the cost of prevention and care services provided by public health agencies, so direct federal funding for these services, such as HIV/STI prevention and care services, would no longer be needed. As such, direct federal funding for these point-of-contact public health services has declined. According to the Oregon Health Insurance Survey, nearly 94% of Oregonians are insured. Thus, it is appropriate that those insurance plans cover services for their enrollees rather than using limited public health funds.

At this time, OHA still provides financial resources to local public health, community-based organizations, and the Oregon State Public Health Lab for a variety of covered services – including prevention, screening, diagnosis, case management, and treatment services—to maintain individuals in medical care. As federal funding for these services continues to decline, this is unsustainable for the public health system.

Further, coordinated care organizations (CCOs) are required to contract with public health entities for these services. In OHA's most recent CCO procurement, the selection criteria included the requirements contained in ORS 414.153 and OAR 410-141-3705(7)(a-b) to have cooperative agreements with publicly funded programs, such as public health entities. As a contracted CCO, NAME, is also required to contract with publicly funded providers, unless cause can be demonstrated to OHA's satisfaction why such an agreement is not feasible, for authorization of payment for point of contact services in the following categories:

(a) Immunizations
(b) Sexually transmitted diseases; and
(c) Other communicable diseases.

This requirement can be found in OAR 410-147-0080(6).

In order to achieve a sustainable future for Oregon's public health system, we are working on understanding and implementing appropriate billing practices for the insured population receiving HIV and STI prevention and care services from public health entities. To that end, the Oregon

Health Authority has retained Health Management Associates (HMA) to conduct an assessment of insurance billing policies and payment requirements for the prevention and treatment of people with HIV/STI diagnoses, or those at risk for contracting them.

The purposes of the billing assessment are to:

- Understand insurance payment policies and other cost saving opportunities for services currently funded by OHA's Public Health Program
- Develop guidance and recommendations to modernize billing for HIV and STD prevention and care services, and
- Ensure the CCOs' HEDIS data has the highest level of integrity by accurately reflecting the services members are receiving.

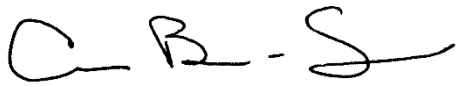
NAME will also benefit from collecting this information about your members' health status and current treatment arrangements. Some of these members have complex health conditions that could benefit from the many innovative programs NAME offers their members that improve health outcomes.

HMA is looking for information regarding the billing requirements and payment policies for NAME's members that are receiving services through the public health system. To that end, HMA's Janet Meyer (copied) would like to either schedule an interview with you or review your relevant policies and procedures.

Attached is an outline of the types of information HMA seeks for the billing assessment. Please let Janet know at your earliest convenience who she can work with at NAME to further this work. She can be reached at janetmeyer@healthmanagement.com or 503-449-3698.

Thank you for your assistance.

Best,



Annick Benson-Scott

HIV/STD/TB Section Manager

Oregon Health Authority

Public Health Division

Cc: Government Affairs Staff

Lori Coyner - Medicaid Director and/or

Veronica Guerra – OHA Quality Assurance and Contract Oversight Manager
Dave Inbody - CCO Operations Manager
Cara Biddlecom – Deputy Public Health and Policy and Partnerships Director

Attachment: Services Coding Framework

October 28, 2020

Payer Letter

Dear Name:

With the implementation of the Patient Protection and Affordable Care Act (ACA), more individuals gained access to insurance. The plan was, and is, that the individual's insurance would cover the cost of prevention and care services provided by public health agencies, so direct federal funding for these services, such as HIV/STI prevention and care services, would no longer be needed. As such, direct federal funding for these point-of-contact public health services has declined. According to the Oregon Health Insurance Survey, nearly 94% of Oregonians are insured. Thus, it is appropriate that those insurance plans cover services for their enrollees rather than using limited public health funds.

At this time, OHA still provides financial resources to local public health, community-based organizations, and the Oregon State Public Health Lab for a variety of covered services – including prevention, screening, diagnosis, case management, and treatment services—to maintain individuals in medical care. As federal funding for these services continues to decline, this is unsustainable for the public health system.

In order to achieve a sustainable future for Oregon's public health system, we are working on understanding and implementing appropriate billing practices for the insured population receiving HIV and STI prevention and care services from public health entities. To that end, the Oregon Health Authority has retained Health Management Associates (HMA) to conduct an assessment of insurance billing policies and payment requirements for the prevention and treatment of people with HIV/STI diagnoses, or those at risk for contracting them.

The purposes of the billing assessment are to:

- Understand insurance payment policies and other cost saving opportunities for services currently funded by OHA's Public Health Program
- Develop guidance and recommendations to modernize billing for HIV and STD prevention and care services, and
- Ensure the CCOs' HEDIS data has the highest level of integrity by accurately reflecting the services members are receiving.

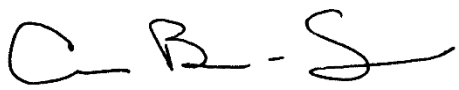
NAME will also benefit from collecting this information about your members' health status and current treatment arrangements. Some of these members have complex health conditions that could benefit from the many innovative programs your CCO offers their members that improve health outcomes.

HMA is looking for information regarding the billing requirements and payment policies for NAME's members that are receiving services through the public health system. To that end, HMA's Janet Meyer (copied) would like to either schedule an interview with you or review your relevant policies and procedures.

Attached is an outline of the types of information HMA seeks for the billing assessment. Please let Janet know at your earliest convenience who she can work with at Advanced Health to further this work. She can be reached at janetmeyer@healthmanagement.com or 503-449-3698.

Thank you for your assistance.

Best,



Annick Benson-Scott

HIV/STD/TB Section Manager

Oregon Health Authority

Public Health Division

Cc: Government Affairs Staff

Dave Inbody - CCO Operations Manager

Cara Biddlecom – Deputy Public Health and Policy and Partnerships Director

Janet Meyer – Principal, Health Management Associates

Attachment: Services Coding Framework

# Oregon Medicaid Fee-for-Service reimbursement for Community Health Workers

The Oregon Health Authority (OHA) encourages Community Health Workers (CHWs) to become eligible to support clients enrolled in the Oregon Health Plan (OHP).

This fact sheet explains how CHWs can qualify to serve OHP clients – and be reimbursed for services – through the following process.

## Step 1: Become a certified and registered Community Health Worker (CHW).

Services you provide as a CHW can be paid for by the Oregon Health Plan – if you are certified and registered as a Traditional Health Worker (THW).

- **What is a Traditional Health Worker?** Traditional Health Workers (THWs) is the Oregon umbrella term for five categories and sub categories of workers: Community Health Workers (CHWs), Peer Support Specialists (PSS) (e.g., addictions and mental health family and youth), Peer Wellness Specialists (PWS) (e.g., addictions and mental health family and youth), Personal Health Navigators (PHN) (also known as Patient Health Navigator), and Doulas. THWs in Oregon are integrated and embedded in various organizational settings which includes behavioral health agencies, county health departments, federally qualified health centers, tribal health centers, government agencies, primary care clinics, hospitals, rural health clinics and community-based organizations. THWs provide critical services that include outreach and case management, mobilizing patients, making community and cultural connections, coordinating care, assisting in system navigation, and providing health promotion and providing coaching and support.

- **What is a Community Health Worker?** CHWs are a type of THW. CHWs have expertise or experience in public health; work in an urban or rural community; and to the extent practicable, share ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves. A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Please see Community Health Worker Scope of Practice.

- **You must be a certified CHW provider to be eligible for OHP payment.** To learn more about CHW training, certification and registration, visit the OHA Office of Equity and Inclusion's Traditional Health Worker Program.
- How To Become a Certified Traditional Health Worker
- OEI Traditional Health Worker Registry
- Traditional Health Worker Resources, Policies, and Laws
- THW-Approved Training Programs and Continuing Education

## Step 2: Become an Oregon Medicaid provider.

Once you are registered with the Traditional Health Worker Registry, your next step is to obtain a unique National Provider Identifier (NPI) and enroll as an Oregon Medicaid provider:

- **To obtain an NPI**: Apply on the National Plan and Provider Enumeration System website. For reference, the taxonomy code for CHW is 172V00000X.
- **To enroll as an Oregon Medicaid provider**: complete form OHP 3113. Enter provider type 13, specialty code 601. Include your NPI and a copy of your OEI certification. To learn more, visit the OHP provider enrollment page.

## Learn more about Oregon Medicaid reimbursement for CHWs

### Oregon Administrative Rule

The requirements for Community Health Workers in terms of Certification and Provider Registry Enrollment; Certification Curriculum Standards; Training; Standards of Professional Conduct are addressed in OAR Chapter 410, Division 180.

### Medicaid State Plan

- General Information
  https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/State-Plans.aspx
- Relevant Information: Other Practitioner Services/Non-licensed practitioners (page 376)
  https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid%20State%20Plan.pdf
- Relevant Excerpt

  CHW "must be supervised by existing licensed practitioners and perform services for them within the licensed practitioner's scope of practice. Licensed health providers are responsible for the work that they order, delegate or supervise when health care professionals work under their supervision. The state assures that only the Licensed Health Care Professional will bill for services. For purposes of this State Plan a Licensed Health Care Professional (LHCP) includes Physicians*, Certified Nurse Practitioners, Physician Assistants, Dentists, Dental hygienists with an Expanded Practice Permit, Ph.D. Psychologists, PsyD Psychologists, LCSW Social Workers and Licensed Professional Counselors. (*covered in the state plan under physician services)". . . a) Community Health Worker services are provided under the supervision of LHCP; . . . The state assures that only the Licensed Health Care Professional will bill for services."

### Fee Schedule Information

Medical/Dental Fee Schedule and Behavioral Fee Schedule
https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx

- Note: For providers reimbursed at an encounter rate methodology (such as FQHCs, RHCs, and tribal/urban Indian health programs), these codes may be reimbursable under the applicable encounter rate rather than under fee schedule pricing.

### Billing Information

Community Health Workers will be enrolled as "non-payable rendering provider". CHWs must work and bill "under the supervision of a licensed provider". When the CHW is the rendering provider, OHA will allow the code to pay. The billing provider must be a clinic or supervising medical provider.

**Billable Codes for CHW services covered by Oregon Medicaid.**

Instructions for billing OHA are on the OHP Billing Tips page.

| Service | Description |
|---|---|
| 97535 | Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes |
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. |
| 99401 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes |
| 99402 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes |
| 99403 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes |
| 99404 | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes |
| 99406 | Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes |
| 99407 | Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes |
| 99408 | Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes |
| 99409 | Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes |
| 99600 | Unlisted home visit service or procedure |
| G0176 | Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more) |

| | |
|---|---|
| G0177 | Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more) |
| H0032 | Mental health service plan development by nonphysician |
| H0033 | Oral medication administration, direct observation |
| H0048 | Alcohol and/or other drug testing: collection and handling only, specimens other than blood |
| H2014 | Skills training and development, per 15 minutes |
| H2016 | Comprehensive community support services, per diem |
| H2032 | Activity therapy, per 15 minutes |
| 98960 | Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient |
| 98961 | (see 98960); for 2-4 patients |
| 98962 | (see 98960); for 5-8 patients |

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# Appendix F: Health Share of Oregon Public Health Payment Process

Health Share of Oregon

## MEMORANDUM

**TO:** Janet Meyer

**FROM:** Alyssa Craigie

**DATE:** April 16, 2021

**SUBJECT:** Public Health Billing

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Health Share of Oregon holds Services Agreements with each of the region's Local Public Health Departments for the provision of:

(a) Immunizations;
(b) Sexually transmitted diseases (STI); and
(c) Other communicable diseases, including COVID-19.

Health Share's agreement addresses the CCO's contractual obligations to pay local public health authorities (LPHAs) for screening and treatment of active and latent tuberculosis (TB) for Health Share members as well as direct point-of-contact routine services provided to Health Share members by LPHAs for STIs and COVID-19 screenings.

Operationally, Health Share pays the three LPHAs through a combination of tiered monthly case rates for latent and active tuberculous (TB) case management and fee-for-service rates for STI, TB, or COVID-19 screenings for Health Share members. The services included in the monthly case rates include, directly observed therapy, sputum collection, home and community visits and services associated with ensuring compliance of treatment plan and medication adherence. The services can be provided by, but are not limited to, Community Health Workers, Disease Intervention Specialists, Licensed Practical Nurses, Registered Nurses, and Physicians.

In order to receive reimbursement, the LPHAs submit monthly invoices for services including: screening for TB, treatment for active or latent TB, immunizations for communicable diseases, STI screening (including screening for HIV and HCV), and COVID-19 screening. The invoices are submitted in Excel format and include the following elements:

- Member Name
- Member Medicaid ID #
- ICD-10 Diagnosis Code
- Service provided (screening, Tier 1 case management or Tier 2 case management)
- Disposition (if providing Tier 1 or 2 case management), such as active treatment, suspended treatment, completed treatment

Costs covered by state grants to support public health activities, point of care lab test costs, and services provided and billed under any of Contractor's existing contracts are all excluded.

Health Share does not contract directly with Providers for the provision of these services, nor does the CCO credential the Providers offering services under this agreement. Health Share does retain the ability to audit any Provider with respect to its performance under the Services Agreement and with respect to compliance issues, including Provider's compliance programs. The Provider is required to address compliance issues through education, counseling or corrective action plans. Providers can also bill Health Share's subcontracted partners directly for these services as part of their provider network or as non-par providers for those plans that allow it.

Health Share does not produce or submit EOBs under this agreement.

Let me know if you have any questions related to this information or need anything additional.

Alyssa Craigie
Director, Health System Integration