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State Health Department Billing for HIV/AIDS and Viral Hepatitis Services: An Analysis of Legal Issues in Five States

Prepared for the
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Executive Summary

The health care landscape is changing, and health departments are preparing to adapt to and innovate with these changes to ensure that they are able to continue to provide access to vital HIV/AIDS and viral hepatitis prevention, care, and, treatment for underserved populations.¹ As the Affordable Care Act (ACA) is implemented, more people will have access to Medicaid and the private insurance market, and new benefits requirements will mean greater coverage of HIV/AIDS and viral hepatitis services. In this environment, the capacity to bill public and private insurance for certain HIV/AIDS and viral hepatitis services may help ease the strain on health department budgets by providing another revenue source for these services.

There are a range of technical, operational, and policy issues to consider as health departments assess whether and how to expand their (and their contracted providers') capacity to bill third parties for services. In support of state health departments and their efforts to increase billing capacity, the National Alliance of State and Territorial AIDS Directors (NASTAD) has partnered with the Harrison Institute for Public Law at Georgetown University Law Center to focus on one specific set of identified challenges: legal and regulatory hurdles to health department billing and reimbursement. To get a sense of the legal and regulatory landscape with regard to health department billing, the laws and regulations of five jurisdictions were analyzed: Massachusetts, Minnesota, New York, Texas, and Washington. Three areas were explored:

- 1) the authority for state health departments and their contracted providers to bill for services;
- 2) the ability to receive reimbursement for those billed services; and
- 3) privacy and confidentiality requirements to ensure that information is properly shared between the health department, providers and payers.

While there is a great deal of state-by-state variability with regard to the legal and regulatory landscape for health department billing, several lessons emerged from the analysis that are applicable to state health departments nationwide:

¹ Note that this report refers to “health departments” as the state agency with programmatic responsibility for providing HIV/AIDS and viral hepatitis services. In some states, such as Minnesota, there are separate agencies responsible for administering public programs that may not bill (e.g., Department of Health) and working with providers for billing purposes (e.g., Minnesota Department of Human Services). Distinctions among the five states are provided in the specific case study.

- No laws in the surveyed states explicitly bar health departments from billing public and private insurers for their services, but this could be an issue in other jurisdictions.
- Many state health departments do not provide direct HIV/AIDS and viral hepatitis services, but instead contract these services to a variety of entities, including community-based organizations, clinics and hospitals. Therefore, as contracted providers increasingly bill third parties for services rather than rely on the health department's categorical funding, health departments may be free to use these funds for services not covered by third-party payers.
- The review finds that contracting will play a major role in health departments and billing for HIV/AIDS and viral hepatitis services. Contracts between the health department and providers may determine the extent to which the health department can require a detailed accounting of revenue generation for services provided. In addition, contracts between the providers and insurers regarding coverage policy can vary widely among and within states.
- The extent to which privacy laws could be a barrier to successful billing for HIV services will vary among states. States with restrictive laws and regulations around the sharing of HIV information, for instance, will need to negotiate these laws to ensure that health departments and contracted providers can bill for services while still recognizing privacy rights.
- States vary in how their laws treat the flow of reimbursement from payers to providers and health departments as well as the accounting requirements for contracted providers. Where the health department is billing for services provided, some states ensure that funds go back to the individual health department program, whereas in some states monies are put back into a general fund. Some states also require detailed accounting from contracted providers with regard to revenue generated through third-party billing.

Introduction

A. Background

State and local health departments are vital players in HIV and viral hepatitis prevention and access to care, directly providing or contracting with community-based organizations, area clinics and hospitals to provide a range of HIV/AIDS and viral hepatitis services² including prevention education, testing, treatment, and disease management. Recipients of these services have historically been disproportionately uninsured or underinsured.³ Many state health departments have traditionally used federal categorical funding, in particular through the Ryan White Program and Centers for Disease Control and Prevention (CDC), as well as state funding to provide a range of HIV/AIDS and viral hepatitis prevention, care, and treatment services.⁴

However, health departments are facing changes that will impact their HIV/AIDS and viral hepatitis activities. The passage of the Affordable Care Act (ACA) – which includes a significant expansion of Medicaid as well as increased access to private insurance through elimination of pre-existing condition exclusions and other insurance reforms – means that more health department clients who were formerly uninsured will be eligible for Medicaid or private insurance in 2014. The benefits mandates included in the ACA also mean that more services – including many of the HIV/AIDS and viral hepatitis services performed by health departments and their contracted providers – will be covered by public and private insurance. In addition, as state governments labor to balance budgets across all programs, HIV/AIDS and viral hepatitis programs are under continued budgetary strain year to year. These realities have prompted state health department officials to investigate the feasibility of expanding their capacity for billing Medicaid and other third-party payers (e.g., private insurers) for HIV/AIDS and viral hepatitis services.

Through a survey of its members, the National Alliance of State and Territorial AIDS Directors (NASTAD) identified several sets of challenges requiring further analysis in order for

² For the purposes of this report, the focus is on chronic adult Hepatitis B and C.

³ National Coalition of STD Directors, *Setting the Stage: Policy and Funding Landscape Impacting Third-Party Billing for STD Services*, September 2012, at 4 (noting that as many as 85 percent of patients participating in state and local STD and HIV programs are below 150 percent of the federal poverty line (FPL)).

⁴ Note that health departments vary considerably in how their federal categorical funding for HIV and viral hepatitis services is allocated. For example, some states like New York are able to cover a large number of people living with HIV through its expanded Medicaid program and use federal grants to complete a continuum of services, while other states with more limited Medicaid programs utilize federal funding to provide a greater proportion of medical services.

states to bill third parties successfully for HIV/AIDS and viral hepatitis services. This paper focuses on one specific set of identified challenges: legal and regulatory hurdles to health department billing and reimbursement.

B. Purpose

As part of its broader strategy to explore the challenges to third-party billing, NASTAD partnered with the Harrison Institute for Public Law at Georgetown University Law Center (the “Harrison Institute”) to analyze legal and regulatory hurdles to billing. In some states and localities, laws and regulations exist that may affect a health department’s authority to bill for HIV/AIDS and viral hepatitis services. Even if health departments themselves do not directly provide most HIV/AIDS services – as was the case in the five states analyzed in this report – knowing the relevant legal and regulatory challenges is vital because they impact the contracted providers that health departments rely on to serve their clients.

The purpose of this report is to provide NASTAD’s members with an overview of the laws related to third-party billing for HIV/AIDS and viral hepatitis services in five states: Massachusetts, Minnesota, New York, Texas, and Washington. By identifying common legal and regulatory themes, this report aims to help health departments as they consider increasing their billing and revenue generation capacity. NASTAD selected these five states as candidates for further study because health department officials have been contemplating third-party billing to some extent in these states, and the legal and regulatory schemes of these jurisdictions provide a useful cross-section for analysis.

II. Synthesis of Findings Across States

A. Authority to Bill

Important Billing Authority Questions for State Health Departments to Consider:

- Does the health department have the authority to bill for services?
- Can the department require its contractors to bill for services?
- Are there any state laws that restrict the ability of the department to bill?

The first issue related to a health department's ability to bill is whether it has the legal authority under statute or regulations to bill for HIV/AIDS and viral hepatitis services. This includes whether the health department has the authority to bill directly or through its contracted providers. Also related to the health's department ability to bill is whether laws exist requiring the department to provide free services or services regardless of an individual's insurance status or ability to pay.

1. State and local authority to bill

Fig. 2. Example Law: Texas Statute on Authority to Bill

The board by rule may charge fees to a person who receives public health services from the department. TEX. HEALTH AND SAFETY CODE ANN. § 12.032(a)

State health departments are responsible for various public health functions at the state level such as disease prevention and surveillance, overall planning, coordination, and fiscal management of public health services.⁵ In many states, the state health department provides these functions through local health departments or community-based organizations by funding programs and services. While state health departments have the authority to manage HIV/AIDS and viral hepatitis programs and services, the authority to bill third-party payers directly or through contractors varies by state law.

Of the states surveyed, Massachusetts⁶ and Texas⁷ have granted the state health department explicit authority to bill for services provided, while New York has provided implicit authority (see **Fig. 2** for an example from Texas).⁸ Explicit authority means that there is specific

⁵ See NASTAD, *The Role of Health Departments in Administering Federal HIV/AIDS Programs*, April 2007, http://www.nastad.org/Docs/highlight/200759_Role%20of%20States.pdf.

⁶ MASS. GEN. LAWS ANN. ch. 111 § 116 (West 2012).

⁷ TEX. HEALTH AND SAFETY CODE ANN. § 12.032(A) (West 2012).

⁸ N.Y. CONST. art. IX, § 2, cl. c.

language authorizing billing whereas implicit authority means that billing would be allowed under broad authorizing language. Minnesota and Washington do not have statutes that would enable billing, but also have no provisions that would prevent the state from billing. Three of the five states – Texas,⁹ Massachusetts¹⁰ and Washington¹¹ – also grant explicit authority to local health departments to bill for services, while Minnesota and New York provide implicit authority.

2. *Requiring contractors to bill*

Many health departments do not provide services directly, but rather contract with public and private partners to provide testing and treatment for HIV/AIDS and viral hepatitis services. While these contractors can usually bill for services voluntarily, some states have provisions that allow the health department to compel the contractors to bill for services when possible. Texas law specifically allows the state to require contractors to bill for services,¹² while Massachusetts

has promulgated regulations that require STD clinics to seek payment (in full or in part) from patients and their insurers before requesting reimbursement from the department (see **Fig. 3**).¹³ Minnesota, New York and Washington do not have specific provisions that would either allow them

**Fig. 3. Example Law:
Massachusetts Regulation on Clinics Billing Insurers**

If any patient, contact or suspect can pay any part of the clinic's established fee or has insurance that can do so, he or she shall be required to do so, and the total amount so collected from such patients, contacts and suspects shall be deducted from the clinic bill submitted to the Department. 105 MASS. CODE REGS. 345.400(B).

to or prevent them from requiring contractors to bill.

Even with billing requirements for contractors, states (and insurers themselves) may have specific credentialing requirements that providers must meet in order to be eligible to participate in public and private insurance and be reimbursed for provision of services. Credentialing refers to the process of regulating providers that want to practice in a state and may encompass licensing and requirements for training and continuing education. In addition, health insurers, managed care organizations, and other health care entities (like hospitals) may have additional

⁹ TEX. HEALTH AND SAFETY CODE ANN. § 121.006(A) (West 2012).

¹⁰ MASS. GEN. LAWS ANN. ch. 111 § 116(West 2012).

¹¹ WA. REV. CODE ANN. § 70.05.060 (West 2012).

¹² TEX. HEALTH AND SAFETY CODE ANN. § 12.032(b) (West 2012).

¹³ 105 MASS. CODE REGS. 345.400(B).

credentialing requirements to participate in their network or organization.¹⁴ This report did not encompass credentialing, but health departments should be aware of the various credentialing requirements that their contracted providers must possess in order to bill third parties.

3. Free STD testing and care laws

In order to encourage testing and treatment for sexually transmitted diseases (STDs) like HIV/AIDS, some states have laws requiring free STD care. These laws can sometimes form a barrier to billing if the state defines “free” as applying to both the patient and the insurer. Of the five states we

Fig. 4. Example Law: New York Statute on Free STD Care

It shall be the responsibility of each board of health of a health district to provide adequate facilities for the free diagnosis and treatment of persons living within its jurisdiction who are suspected of being infected or are infected with a sexually transmissible disease. N.Y. PUB. HEALTH LAW § 2304 (McKinney 2012).

studied, only New York has a statute that requires that the health department provide STD care free of charge (see **Fig. 4**).¹⁵ However, New York’s law permits the Commissioner of Health to define “sexually transmitted diseases” for the purposes of the statute,¹⁶ and New York’s definition does not include HIV or viral hepatitis.¹⁷ Therefore, New York’s law does not create a barrier to billing for HIV/AIDS or viral hepatitis services. With regard to billing for other STD services, legal interpretation of these types of laws has allowed health departments to bill for these services as long as the patient is not ultimately responsible for any charges.¹⁸

In addition, some state Medicaid provider manuals (including in Texas¹⁹) cite a Medicaid “free care” policy – which would prohibit providers from billing Medicaid for services that it offers to those not enrolled in Medicaid for free. Though the “free care” policy does not exist in

¹⁴ Matthew Haddad, Continuous Credentials Monitoring: Building a Solid Compliance Infrastructure, 11 No. 4 J. Health Care Compliance 39 (July-August 2009).

¹⁵ N.Y. PUB. HEALTH LAW § 2304 (McKinney 2012).

¹⁶ N.Y. PUB. HEALTH LAW § 2304 (McKinney 2012).

¹⁷ *Sexually Transmitted Diseases Reporting and Treatment Requirements*, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.health.ny.gov/regulations/recently_adopted/docs/2011-07-06_sexually_transmitted_disease_reporting_and_treatment_requirements.pdf.

¹⁸ National Coalition of STD Directors, *Setting the Stage: Policy and Funding Landscape Impacting Third-Party Billing for STD Services*, September 2012, at 12-13.

¹⁹ See e.g., Texas Medicaid and Healthcare Partnership, Texas Medicaid Provider Enrollment Application (2010), available at <http://www.mhmrharris.org/RFP/ECI-CRS/Consumer%20Related%20Services%20ECI%20RFP%20%20Texas%20Medicaid%20Provider%20Enrollment%20Application%202008%20FY2010.pdf>.

federal statute or regulation (and judicial decisions with regard to the application of this policy in the realm of school-based services have called into question its validity²⁰), state policy and practices may require providers to set up sliding fee schedules for all patients, presenting a barrier to increasing billing capacity in jurisdictions with a disproportionate share of low-income and uninsured populations.

4. “Without regard to payment” provisions

Several federal laws require certain providers to provide services regardless of a patient’s ability to pay.²¹ In addition, states often have their own laws requiring access to STD testing or treatment. These laws are less restrictive than provisions that require the health department to provide care for free, but can still impact the ability of the department to seek reimbursement. Of the states examined, only Texas explicitly prohibits its health department from denying services due to an individual’s inability to pay.²² However, most clinics have policies to accept patients regardless of ability to pay; for example, Red Door Services in Minnesota has a sliding pay scale but also will not refuse a patient who cannot pay.²³ In addition, federal requirements for certain health care entities receiving federal funding require provision of services without regard for the ability to pay.²⁴ For example, “federally-qualified health centers” or FQHCs must provide care regardless of an individual’s ability to pay as part of being a FQHC and receiving federal funds.²⁵ The Ryan White Program has a similar statutory requirement for grantees.²⁶ The existence of these laws should not preclude a health department or its contracted providers from billing; however “without regard to payment” laws ensure that those without insurance cannot be turned away from certain public health services.

²⁰ Department of Health and Human Services, Departmental Appeals Board, Oklahoma Health Care Authority, Docket No. A-03-79 (June 14, 2004), available at <http://www.hhs.gov/dab/decisions/dab1924.htm>.

²¹ See e.g., 42 USC § 300ff-27(7)(B), requiring agencies responsible for administering Ryan White grants to provide HIV services without regard to a patient’s ability to pay.

²² TEX. HEALTH AND SAFETY CODE ANN. § 12.032(c) (West 2012).

²³ National Coalition of STD Directors, *Setting the Stage: Policy and Funding Landscape Impacting Third-Party Billing for STD Services*, September 2012, at 35.

²⁴ Note that health centers receiving grants under Section 330 of the Public Health Services Act must provide care regardless of the ability to pay. These centers provide care to medically underserved populations or areas. See 42 U.S.C. §§ 254(b) & 1396 (1)(2)B; 42 C.F.R. § 51c.102 (e).

²⁵ 42 U.S.C. §§ 254(b) & 1396 (1)(2)B; 42 C.F.R. § 51c.102 (e).

²⁶ 42 U.S.C. § 300ff-27(b)(7)(B)(i).

B. Ability to Receive Reimbursement

Important Reimbursement Questions for State Health Departments to Consider:

- What happens to funds generated by third-party billing?
- Does the health department or its contractors meet the requirements to receive Medicaid reimbursement?
- Are there any laws that require private insurers to cover specific providers or services?

The second topic related to a health department's legal ability to bill is whether or not the department has the ability to receive reimbursement for the services it provides directly or through its contractors. This section covers sub-issues related to the ability to receive reimbursement from Medicaid and private insurers, and whether the health department or its contractors can bill unpaid amounts directly to a patient. It also includes discussion of whether or not reimbursement amounts for HIV/AIDS or viral hepatitis services are able to go back into those specific programs, rather than into a general fund. Lastly, this section summarizes the extent to which Medicaid and private insurers cover HIV/AIDS and viral hepatitis testing and treatment.

1. *Flow of reimbursement funds*

Whether or not a health department can retain reimbursement for public health services such as HIV/AIDS or viral hepatitis testing or treatment in their respective programs varies depending on state law. Some states may specify that a health department place any

Fig. 5. Example Law: Texas Statute on Flow of Reimbursement

The department shall deposit all money collected for fees and charges collected under Sections 12.0122(d) and 12.032(a) in the state treasury to the credit of the Texas Department of Health public health services fee fund. TEX. HEALTH AND SAFETY CODE ANN. § 12.035(a) (West 2012).

revenue generated through third-party billing into a general fund or into a specified program fund. More likely, however, states are silent as to the issue of the flow of reimbursement funds. States also differ as to accounting requirements for contractors with regard to revenue generated through third-party billing. For instance, New York's health department required contractors to account for revenue generated through third-party billing for services to the health department.²⁷

²⁷ Telephone Interview with New York State Department of Health Staff (Dec. 7, 2012).

In contrast, the Texas health department is required to place any funds it generates from third-party billing in a public health services fund,²⁸ and has authority to impose requirements for how contractors dispose of third-party reimbursement (e.g., requiring contractors to use any fees collected in accordance with their contract requirements) (see **Fig. 5**).²⁹ Occupying something of a middle ground, Washington does not specify how reimbursement funds are handled at the state level, but does require that local departments deposit any revenues generated by health services in a separate district health fund.³⁰ For services directly provided by the Massachusetts health department, the health department could receive reimbursement funds, but would have to deposit such funds in the state's general account.³¹ Additionally, many cities and towns have local ordinances that may affect where revenue generated by local health departments must flow. For instance, some local ordinances require placement of revenue generated by the local health department into the local or county general fund.

2. *Eligibility for Medicaid reimbursement*

To bill Medicaid for services, providers must be qualified Medicaid providers, a process that varies by state and requires appropriate credentialing.³² If the provider is approved, it then enters into a provider agreement with the state. While there is no federal application, providers must submit a National Provider Identifier (an identification code assigned by the federal government) to the state agency as part of the provider agreement.³³ Qualified Medicaid providers are eligible to be reimbursed for HIV/AIDS and viral hepatitis testing and treatment as long as those services are covered under the state's Medicaid plan.³⁴ Three of the five states discussed here – Washington,³⁵ Massachusetts³⁶ and Minnesota³⁷ – have expansive definitions of

²⁸ TEX. HEALTH AND SAFETY CODE ANN. § 12.035(a) (West 2012).

²⁹ TEX. HEALTH AND SAFETY CODE ANN. § 12.032(b) (West 2012).

³⁰ WA. REV. CODE ANN. § 70.05.060 (West 2012).

³¹ Telephone Interview with Massachusetts Department of Public Health TB Program staff (Jan. 7, 2013).

³² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 6401.

³³ 77 FED. REG. 25,285 (Apr. 27, 2012)

³⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 6401.

³⁵ WA. REV. CODE ANN § 74.09.520 (West 2012).

³⁶ MASS. GEN. LAWS ANN. ch. 118E § 8(f) (West 2012).

³⁷ MINN. STAT. ANN. § 256B.03 (West 2012).

qualified Medicaid providers that allow their health departments to qualify as Medicaid providers as long as they undergo the appropriate credentialing. New York and Texas specifically define what types of providers qualify for Medicaid, and therefore neither permit nor disqualify the state and local health departments from Medicaid eligibility.

3. *“Any willing provider” provisions under private insurance*

Many states have passed “any willing provider” (AWP) legislation that requires private health insurers and health plans, such as managed care organizations, to accept any licensed provider into their network as long as the provider is willing to accept the terms and conditions of the contract.³⁸ The purpose of AWP laws are to allow beneficiaries to receive care from any qualified provider willing to accept an insurer or health plan’s conditions of participation. These laws also prohibit insurers and health plans from discriminating against any qualified providers wanting to join their networks. AWP laws can affect the ability of departments and contractors to be reimbursed for services because they may simplify the process of negotiating with insurers. This is particularly significant for smaller providers that may not have the capacity to negotiate individual contracts for reimbursement with multiple health plans. Several states limit their AWP laws to pharmacies, while others apply only to specific provider groups, such as chiropractors and clinical labs. A few states have enacted statutes with a broader scope applying to all licensed providers of health care. Three of the five states surveyed – Minnesota, New York, and Washington – do not have “any willing provider” provisions. The Texas AWP law applies only to pharmacies, and requires that insurers allow any pharmacy that agrees to the insurer’s conditions to participate.³⁹ Massachusetts has two AWP laws; the first also requires that insurers compensate any pharmacy that agrees to their conditions,⁴⁰ while the second requires medical service corporations (a particular type of nonprofit insurer under Massachusetts laws) to permit any type of provider that agrees to their conditions to participate.⁴¹

4. *“Balance billing” provisions*

“Balance billing” refers to the practice of billing patients directly for the amount that an insurer refuses to pay either because the service is not covered or the cost of the service exceeds

³⁸ Thomson Reuters/West, *50 State Statutory Survey: Insurance: Health, Any Willing Provider Laws*, 0110 SURVEYS 23 (Dec. 2011).

³⁹ TEX. INSUR. CODE ANN. § 21.52B(a)(2) (West 2012).

⁴⁰ MASS. GEN. LAWS ANN. ch. 176D § 3B (West 2012).

⁴¹ *Id.*

the negotiated rate between the provider and the insurer. Some states have passed provisions prohibiting providers from billing patients the difference between the provider cost and negotiated rate since a provider has agreed to accept the payment from an insurer. Balance billing laws affect whether the health department's contracted providers can bill the patient for services in addition to the reimbursement received by insurers. While permitting balance billing might increase revenues, public health programs generally serve low-income individuals who have limited access to care. A health department may not want such clients to bear costs, especially if it may cause a barrier to testing and treatment. Thus, laws against balance billing would serve as a protection against costs to clients. All five states surveyed prohibit balance billing in at least some circumstances. Minnesota,⁴² Washington,⁴³ Massachusetts⁴⁴ and New York⁴⁵ prohibit balance billing of Medicaid patients. In addition, Massachusetts prohibits balance billing of patients covered by "medical service corporations," (a particular type of nonprofit insurer under Massachusetts laws)⁴⁶ while New York⁴⁷ and Washington's⁴⁸ balance billing laws also apply to health maintenance organizations (HMOs). Texas prohibits balance billing for any type of insurance coverage, but has exceptions for out-of-network providers and services that a health plan does not cover.⁴⁹ The New York legislature is currently considering a bill that requires all providers to inform patients, in writing, of the cost of services prior to treatment.⁵⁰

⁴² *Provider Requirements*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008921#P29_868.

⁴³ The balance billing provision also applies to state operated programs. WASH. ADMIN. CODE § 388-539-0300.

⁴⁴ MASS. GEN. LAWS ANN. ch. 112 § 2 (West 2012).

⁴⁵ *General Billing Policy*, N.Y. MEDICAID PRACTICE MANUAL.

⁴⁶ MASS. GEN. LAWS ANN. ch 176B § 7 (West 2012).

⁴⁷ N.Y. COMP. CODES R. & REGS. tit. 10, § 98. *See also Opinion*, N.Y. OFFICE OF GENERAL COUNSEL (Apr. 13, 2009).

⁴⁸ WA. REV. CODE ANN. § 70.47.230 (West 2012).

⁴⁹ 1 TEX. ADMIN. CODE ANN. § 370.453 (West 2012).

⁵⁰ N.Y. Bill No. A3518 (introduced Jan. 28, 2013), *available at* http://assembly.state.ny.us/leg/?default_fld=&bn=A03518&term=2013&Summary=Y&Memo=Y&Text=Y.

5. Coverage under Medicaid and private insurance

The ability of a health department or its contracted providers to bill for services hinges on whether the third-party payer covers that service. This section summarizes whether HIV/AIDS and viral hepatitis services are covered under Medicaid and private insurance.

i. Medicaid

Medicaid provides a significant amount of HIV/AIDS and viral hepatitis care and treatment and, because of provisions in the ACA, the scope of relevant services (and the populations covered by Medicaid) will greatly expand in 2014. Along with a significant increase in access to vital prevention, care, and treatment services for the many uninsured people living with or at risk for HIV and viral hepatitis, the ACA's Medicaid reforms also provide an unprecedented opportunity for health departments and their contracted providers to leverage Medicaid reimbursement in new ways. Although the federal government mandates certain benefits in Medicaid, there is some variation between states. For example, some states cover routine HIV testing, while others only provide coverage for "medically necessary" testing – usually individuals who have heightened risks.⁵¹

The United States Preventive Services Task Force (USPSTF) – and independent panel of experts that makes recommendations for clinical preventive services – has recently issued a draft recommendation giving an A rating for routine HIV screening.⁵² Because the ACA requires Medicaid coverage for newly eligible beneficiaries (those ineligible under current Medicaid law but who will be moving into the program in 2014) to include USPSTF A or B recommended services, if the USPSTF recommendation for HIV screening is adopted, this service will be covered for the Medicaid expansion population. Similarly, if the USPSTF draft recommendation for hepatitis C screening for those at increased risk is adopted, this service will also be required for newly eligible Medicaid beneficiaries in 2014. Effective January 2013, the ACA also provides a one percentage point increase in federal matching payments (FMAP) for state Medicaid programs that offer their traditional Medicaid beneficiaries services with a USPSTF A or B rating. All five states examined in this report cover HIV treatment and routine HIV

⁵¹ Kaiser Family Foundation, *State Medicaid Coverage of Routine HIV Screening Fact Sheet*, March 2012, available at <http://www.kff.org/hiv/aids/8286.cfm>.

⁵² United States Preventive Services Task Force *Draft Recommendation* November 2012, available at <http://www.uspreventiveservicestaskforce.org/uspstf13/hiv/hivdraftrec.htm>.

screening through their Medicaid programs.⁵³ In addition, Medicaid could cover a range of other HIV and viral hepatitis services, including prescription drug coverage, chronic disease management and case management, and substance use disorder services. The scope of coverage for these services and the rate at which they are reimbursed will vary by state.

ii. Private insurance

In addition to Medicaid, some states have laws mandating coverage of certain benefits by private insurers. For instance, a Massachusetts insurance mandate requires residents to possess insurance that covers both preventive care and prescription drugs.⁵⁴ Washington, New York and Minnesota do not require private insurers to cover HIV treatment or testing. In addition the scope of this coverage varies based upon the individual insurance plans. Furthermore, beginning in 2014 the ACA will require private insurers in individual and small group markets to cover certain “essential health benefits,” including prescription drugs, laboratory services and preventive services.⁵⁵ New benefits requirements will also require every plan to cover preventive services with a USPSTF A or B rating. This means that if the USPSTF draft recommendations for routine HIV screening and hepatitis C screening for those at increased risk are accepted, these services will be required in private insurance coverage. The scope of coverage for other HIV services – for instance case management – will vary depending on the plan. Coupled with provisions that bar discriminatory insurance practices (e.g., pre-existing condition exclusions) and provisions that make private insurance more affordable, these benefits requirements mean that there will be greater opportunities for health departments and their contractors to bill private insurance for services.

⁵³ Kaiser Family Foundation, *State Medicaid Coverage of Routine HIV Screening Fact Sheet*, March 2012; Telephone Interview with Texas Department of State Health Services Staff (Dec. 20, 2012).

⁵⁴ 956 MASS. CODE REGS. 5.03.

⁵⁵ 42 U.S.C.A. § 18022 (West 2012); 42 U.S.C.A. § 300gg-6 (West 2012).

C. Privacy and Confidentiality Requirements

Important Privacy/Confidentiality Questions for State Health Departments to Consider:

- What federal HIPAA requirements must be met in order to share information for billing and reimbursement purposes?
- What state laws exist particular to protect HIV/AIDS information privacy?
- What steps does your state take to ensure that Explanation of Benefits forms sent by insurers do not lead to inadvertent confidentiality breaches?

Health care privacy is an important legal issue affecting every stakeholder in the health care system that accesses information about a patient’s treatment, including providers, health departments, and third-party payers. Moving to third-party reimbursement for HIV/AIDS and viral hepatitis services may require health departments to produce documentation of diagnoses and provided services through insurance claims, explanation of benefits, and other forms. The legal privacy protections required for such documentation may be of concern to public health providers and be a potential barrier to billing for services.

The federal Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of individuals’ health information across all disease areas, but includes exceptions for HIPAA-covered entities that need to share health information electronically in order to carry out health care operations.⁵⁶ Examples of HIPAA-covered entities include health care providers, insurance companies, and billing clearinghouses.⁵⁷ Under HIPAA, health care providers may share protected health information with insurers to obtain payment for their services. Likewise, insurers are able to share information in order to obtain premiums and reimburse providers for covered health care services.⁵⁸ Health departments may have concerns around billing third-party payers for HIV/AIDS and viral hepatitis services because of HIPAA requirements; however, the HIPAA exception for billing and payment, clearly allows health departments to share information with payers for billing purposes.

In addition, the HIPAA “security rule” requires HIPAA-covered entities to maintain appropriate technical and physical safeguards in order to protect the health information they

⁵⁶ 45 C.F.R. § 164.502(a)(1)(ii).

⁵⁷ 45 C.F.R. § 160.103.

⁵⁸ 45 C.F.R. § 164.502(a)(1).

possess.⁵⁹ These safeguards include taking reasonable steps to ensure that only authorized personnel have access to electronic personal health information.⁶⁰ If health departments become HIPAA-covered entities by entering into third-party billing arrangements, they should be aware of HIPAA security requirements to protect their patients' data.

At the state level, HIV/AIDS (and to some extent viral hepatitis) testing and services may require a higher standard of privacy and confidentiality due to their communicable and stigmatized status. The unique nature of HIV/AIDS leads to specific privacy considerations, discussed in more detail below.

1. *General confidentiality of HIV/AIDS testing*

Many states have a general state law mirroring the federal HIPAA privacy rule that establishes a basic privacy of individually identifiable health information. In these cases, an explicit exception exists to allow insurance companies to obtain personal health information from providers for the purposes of reimbursement – as is true with HIPAA. These “state HIPAA” laws generally apply to information obtained in the course of treating all disease areas, including HIV/AIDS and viral hepatitis. For the five states studied in this report, Minnesota, Massachusetts, and Texas have “state HIPAA” laws that broadly guarantee privacy of protected health information for all diseases.⁶¹

New York, Washington, Texas, and Massachusetts have specific laws related to the confidentiality of HIV/AIDS information, driven by the heightened need to keep such information private and prevent discrimination. The state laws have slight variations in how they treat HIV/AIDS information. New York and Washington have HIPAA-like laws specifically for HIV/AIDS, protecting any HIV/AIDS information related to testing or treatment, except for certain exceptions, including billing.⁶² Texas law provides that HIV test results are confidential, but is silent as to whether the *existence* of a test is confidential.⁶³ Presumably, existence of a test is covered under Texas's general “state HIPAA” confidentiality statute. It appears that Minnesota does not have laws specifically related to the confidentiality of HIV/AIDS

⁵⁹ 45 C.F.R. § 164.306(a).

⁶⁰ 45 C.F.R. § 164.306(a).

⁶¹ See, e.g., MINN. STAT. ANN. § 144.651 (West 2012); WA. REV. CODE ANN. § 70.24.105 (West 2012); MASS. GEN. LAWS ANN. ch 111§ 70E (West 2012).

⁶² N.Y. PUB. HEALTH LAW § 2782 (McKinney 2012).

⁶³ TEX. HEALTH AND SAFETY CODE ANN. § 81.103(a) (West 2012).

information, and relies on the blanket protection provided by its “state HIPAA” law.⁶⁴ Massachusetts regulations create heightened protections for this type of information, including prohibiting the health department from releasing information on HIV status collected through the state reporting system to any part of the state or federal government.⁶⁵ Therefore, while Massachusetts likely creates the strongest protections of HIV/AIDS information out of the five states, these rules may create additional hurdles to providers being able to bill for services provided.

2. Duty to obtain informed consent

Obtaining informed consent is a vital step in the process of providing HIV/AIDS treatment and ultimately impacts the ability to be reimbursed. States vary in their consent requirements with some requiring providers to obtain separate consent for HIV testing. Other states consider testing to be part of a general consent to medical treatment and do not require specific consent for an HIV test. States also differ on whether an individual must provide consent in writing. Knowing what consent requirements exist can ensure health departments take steps to obtain consent and retain any applicable documentation required for billing third parties. All five states in this report have specific requirements in place to obtain informed consent for testing for HIV/AIDS.⁶⁶

3. Additional privacy duties regarding minors

Some states have specific laws on the extent to which minors can consent to HIV/AIDS testing and treatment (the age at which a person may consent for any medical treatment varies by state). Privacy concerns for minors may impact billing and reimbursement in instances where minors are covered by a parent’s insurance plan and do not want information about services received being disclosed to their parents (this is also a major concern with Explanation of Benefits forms, explained further below). Generating a paper trail may be a deterrent to minors seeking care.

⁶⁴ MINN. STAT. ANN. § 144.651 (West 2012).

⁶⁵ MASS. GEN. LAWS ANN. ch. 112 § 12F (West 2012).

⁶⁶ See, e.g., MINN. STAT. ANN. § 144.7407 (West 2012); 10 NYCRR § 63.3; WASH. ADMIN. CODE § 246-100-207 (1); MASS. GEN. LAWS ANN. ch 111 § 70F (West 2012); TEX. HEALTH AND SAFETY CODE ANN. § 81.105(a) (West 2012).

In all of the reviewed states, a minor may consent to HIV/AIDS and viral hepatitis treatment without parental consent.⁶⁷ Only Massachusetts and Washington specifically address the reimbursement ramifications of obtaining HIV/AIDS care without parental consent; both laws specify that the parents or guardians shall not be liable for the cost of treatment when there is no parental consent.⁶⁸ Additionally, insurers in Washington cannot require minors to obtain parental or a covered person's authorization to receive health services.⁶⁹

4. *Anonymous testing provisions*

Anonymous testing laws allow and may encourage people to be tested for HIV without fear that their identity is inadvertently revealed or linked to an HIV test. From a billing and reimbursement standpoint, the presence of laws requiring or encouraging anonymous testing may complicate the process of accurately billing for services rendered and being paid by third parties for those services. Therefore, these provisions could be a hindrance to third-party billing.

The five states vary on the extent to which they incorporate anonymous testing requirements into their laws. Massachusetts and Minnesota laws do not require providers to offer or perform anonymous testing. Washington allows for anonymous testing, but appears to leave it up to the provider's discretion to offer it or not.⁷⁰ New York and Texas go farther in requiring that providers at least offer an anonymous test so that the patient is aware that the anonymity option exists.⁷¹ In New York, only a limited number of clinics in the state actually perform anonymous testing. Therefore, if a patient wants anonymous testing, but the place of service does not offer such testing, a provider must provide the name and address of the anonymous testing sites.⁷²

5. *"Explanation of benefits"*

All insurers are generally required to send their main policyholders an "Explanation of Benefits" (EOBs), a form explaining what services the policyholder received and what the

⁶⁷ See, e.g., MINN. STAT. ANN. § 144.343 (West 2012); N.Y. PUB. HEALTH LAW § 2780 (McKinney 2012); WA. REV. CODE ANN. § 70.24.110 (West 2012); 109 MASS. CODE REGS. 11.09(1)(b) & (1)(q); TEX. FAM. CODE ANN. § 32.003(a)(3) (West 2012).

⁶⁸ WA. REV. CODE ANN. § 70.24.110 (West 2012); MASS. GEN. LAWS ANN. ch. 112 § 12F (West 2012).

⁶⁹ WASH. ADMIN. CODE § 284-04-510 (3)(a).

⁷⁰ WASH. ADMIN. CODE § 246-100-207 (4).

⁷¹ N.Y. PUB. HEALTH LAW § 2781(4) (McKinney 2012); TEX. HEALTH AND SAFETY CODE ANN. § 85.088(a)(2) (West 2012).

⁷² N.Y. COMP. CODES R. & REGS. tit. 14, § 309.4.

insurer will cover. This practice could lead to inadvertent confidentiality breaches if a minor dependent, spouse or other household member who received HIV/AIDS or viral hepatitis services does not want the main policyholder, to know of the treatment. States have discretion to formulate laws that go beyond general HIPAA protection for a wide range of legal issues, including EOBs. EOBs may potentially hinder individuals such as minors, spouses, and partners

from receiving HIV/AIDS or viral hepatitis testing or treatment when they are not the main policyholder.

The five states in this report have sought, through different policies, to balance the importance of requiring EOBs for the sake of health plan transparency with the privacy right of dependents who do not want to reveal their HIV/AIDS information to parents or other main policyholders. Massachusetts

Fig. 6. Example Law: New York Statute on Explanation of Benefits

(a) Every insurer ... is required to provide the insured or subscriber form with an explanation of benefits form in response to filing of any claim

...

(c) Except on demand by the insured or subscriber, insurers... shall not be required to provide an EOB form in any case where ... full reimbursement for the claim, other than a co-payment, is paid by the insurer directly to the participating facility or provider.

NY INSUR. LAW § 3234

requires an EOB only when insurance coverage is denied,⁷³ while New York requires an EOB only when the patient owes money to the provider (see **Fig. 6**).⁷⁴

Texas requires that insurers provide an EOB,⁷⁵ but encourages insurers to use billing codes based on the symptoms presented, rather than the treatment provided. Minnesota's requirement differs in that it only requires group purchasers to provide an EOB to providers when a claim is adjudicated. In cases of adjudication, the group purchaser must also follow up with a document to policyholders.⁷⁶ Washington allows patients to request that information regarding STD services not be disclosed, in which case an insurer would be prohibited from sending an explanation of benefits.⁷⁷ However, when charges are processed through a large billing clearinghouse, there have been instances when these requests have been lost.

⁷³ MASS. GEN. LAWS ANN. ch.176D § 3(n) (West 2012).

⁷⁴ NY INSUR. LAW § 3234(c) (McKinney 2012).

⁷⁵ TEX. ADMIN. CODE ANN. § 21.203 (West 2012).

⁷⁶ MINN. STAT. ANN. § 62J.581 (West 2012).

⁷⁷ WASH. ADMIN. CODE § 284-04-510 (2).

III. Conclusion

Based on the review of the laws and informative interviews with staff at each state health department, several conclusions can be drawn:

- No laws in the surveyed states explicitly bar health departments from billing public and private insurers for their services, but this could be an issue in other jurisdictions.
- Many state health departments do not provide direct HIV/AIDS and viral hepatitis services, but instead contract these services to a variety of entities, including community-based organizations, clinics and hospitals. Therefore, as contracted providers increasingly bill third parties for services rather than rely on the health department's categorical funding, health departments may be free to use these funds for services not covered by third-party payers.
- The review finds that contracting will play a major role in health departments and billing for HIV/AIDS and viral hepatitis services. Contracts between the health department and providers may determine the extent to which the health department can require a detailed accounting of revenue generation for services provided. In addition, contracts between the providers and insurers regarding coverage policy can vary widely among and within states.
- The extent to which privacy laws could be a barrier to successful billing for HIV services will vary among states. States with restrictive laws and regulations around the sharing of HIV information, for instance, will need to negotiate these laws to ensure that health departments and contracted providers can bill for services while still recognizing privacy rights.
- States vary in how their laws treat the flow of reimbursement from payers to providers and health departments as well as the accounting requirements for contracted providers. Where the health department is billing for services provided, some states ensure that funds go back to the individual health department program, whereas in some states monies are put back into a general fund. Some states also require detailed accounting from contracted providers with regard to revenue generated through third-party billing.

Health departments face a changing health care landscape, one in which more clients will be eligible for insurance through ACA coverage expansion and more HIV/AIDS and viral hepatitis services will be covered as new benefits mandates go into effect. At the same time, federal and state funding for HIV/AIDS and viral hepatitis continues to be constrained. As such, the capacity for billing third parties will become even more important as a strategy for health departments and their contractors to navigate a new health care landscape. Having third-party billing capacity as a revenue source can ease the strain on health department budgets, and allow health departments to use and allocate categorical funding more strategically for other priority services which are not reimbursable or for services for uninsured individuals. Though there are a range of issues associated with the billing and revenue arena, the legal and regulatory authorities and barriers discussed above are one important piece that health departments and their contracted providers must confront as they increase their billing capacity.

Fig. 7 below is a visual representation of the summary of state laws above.

Fig. 7 State Laws Related to Health Departments and Third-Party Billing

Legal Issue	MA	MN	NY	TX	WA
Authority to Bill					
State and local authority to bill	Yes	--**	Yes	Yes	--
State authority to require contractors to bill	Yes ^a	--	--	Yes	--
Free STD care requirement	No	No	Yes ^b	No	No
Without regard to payment ^c	--	--	--	Yes	-- ^d
Ability for Reimbursement					
Flow of reimbursement to health department	No	--	No ^e	Yes	-- ^f
Ability for Medicaid reimbursement	Yes	Yes	--	--	Yes
Any willing provider	Yes ^g	No	No	Yes ^h	No
Balance billing prohibition	Yes ⁱ	Yes ^j	Yes ^k	Yes ^l	Yes ^m
Medicaid coverage for routine HIV testing	Yes	Yes	Yes	Yes	Yes
Private insurance coverage for HIV testing	Yes ⁿ	No	No	Yes	No
Privacy and Confidentiality					
Confidentiality of HIV testing	Yes ^o	Yes ^p	Yes ^q	Yes ^r	Yes ^s
Duty to obtain informed consent for HIV testing	Yes	Yes	Yes	Yes	Yes
Minors and informed consent	Yes ^t	Yes	Yes	Yes	Yes ^u
Anonymous testing offered or required	No	No	Yes ^v	Yes ^w	Yes ^x
Explanation of benefits	Yes ^y		Yes ^z	Yes ^{aa}	Yes ^{bb}

*** No specific provision found.

^a Massachusetts requires STD clinics to seek payment from patients and their insurers before billing the state.

^b Note that New York does not include HIV/AIDS and viral hepatitis services as part of the list of covered STDs for which free care is required.

^c Note that this section only represents state laws or regulations. At the local level, local health departments and their contractors may have policies that provide testing and treatment regardless of the ability to pay.

^d Washington's policy, as posted on the Department of Health website, provides HIV testing regardless of the ability to pay.

^e New York uses a managed care model for its Medicaid and state programs where health plans and providers negotiate rates and fees.

^f In Washington, local health departments are required by statute to establish district health funds and place revenue received for health services into that fund.

^g Massachusetts has two AWP laws; the first also requires that insurers compensate any pharmacy that agrees to their conditions; the second requires medical service corporations (but not other types of providers, like managed care organizations) to permit any type of provider that agrees to their conditions to participate

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- ^h Texas law applies only to pharmacies.
- ⁱ Massachusetts prohibits balance billing of Medicaid patients and patients covered by medical service corporations.
- ^j Minnesota only prohibits balance billing in Medicaid.
- ^k New York prohibits balance billing in Medicaid and health maintenance organizations (HMOs).
- ^l Texas prohibits balance billing for out-of-network providers and services that a health plan does not cover.
- ^m Washington prohibits balance billing in Medicaid and state-operated programs.
- ⁿ Massachusetts requires residents to possess insurance that covers both preventative care and prescription plans although does not regulate plans specifically to cover HIV/AIDS or viral hepatitis services.
- ^o Massachusetts' HIV confidentiality provisions do not contain an exception for payment processing and claims.
- ^p Minnesota does not have specific HIV/AIDS confidentiality provisions, only a "state HIPAA" law.
- ^q New York has specific HIV/AIDS provisions with an exception for payment processing and claims.
- ^r Texas has laws similar to HIPAA and provides that HIV results are confidential, but is silent as to whether the existence of an HIV test is confidential.
- ^s Washington has specific HIV/AIDS provisions with an exception for payment processing and claims.
- ^t Massachusetts specifically states that parents are not liable for the cost of treatment when there is no parental consent.
- ^u Washington also states that parents are not liable for the cost of treatment absent parental consent. Insurers in Washington also cannot require minors to obtain consent to receive health services.
- ^v New York requires providers to offer an anonymous test, and provide information on where anonymous tests are offered.
- ^w Texas also requires providers to offer an anonymous test
- ^x Washington law allows providers to determine whether or not offer an anonymous HIV test.
- ^y In Massachusetts, EOBS are only required when a service is denied.
- ^z New York only requires an EOB when there is a balance due.
- ^{aa} Texas requires an EOB, but encourages its insurers to use billing codes based on symptoms presented rather than treatment provided.
- ^{bb} In Washington, an individual can request that personal information related to STD treatment, including HIV/AIDS, not be disclosed in EOB.