End HIV Oregon Toolkit:

Billing for HIV/STI Services Performed by Public Health Agencies & Their Partners

July 2021

Oregon Health Authority

END HIV

Contents

Background & Purpose of this Toolkit

With the implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, more Americans 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 be used for those persons who are uninsured or who experience other access barriers. As such, direct federal funding for these point-of-contact public health services has decreased. 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 (OSPHL) —collectively referred to as "HIV/STI Providers"—for a variety of services covered by insurance, such as 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 Public Health Division's HIV/STD/TB Section (HST) commissioned a comprehensive assessment of opportunities to maximize insurance billing for HIV/STI services and determined that the first step is to ensure that all HIV/STI providers are billing the Oregon Health Plan (OHP), either coordinated care organizations (CCOs) or the fee-for-service or "open card" program, for billable services. This toolkit will support HIV/STI Providers with implementing appropriate billing practices for the OHP-covered population receiving HIV/STI prevention and care services from public health entities.

The purposes of the toolkit are to:

- Ensure HIV/STI Providers know the rules around billing the Oregon Health Plan for HIV/STI services
- Ensure HIV/STI Providers know the ways in which OHP members' personal health information is protected
- Provide technical guidance for billing CCOs and Open Card OHP
- Provide sample communications about billing to clients receiving HIV/STI services
- Prepare for possible expansion of billing for HIV/STI services to commercial insurance

Executive Summary of the Oregon HIV/STI Billing Assessment

The Oregon Health Authority (OHA) engaged the health care consulting firm Health Management Associates (HMA) to conduct a comprehensive assessment of insurance billing opportunities for HIV/STI services performed in public health settings or by public health providers in Oregon. HMA conducted the assessment between July 2020 and April 2021, which culminated in the report: *Maximizing Insurance Payment for Covered HIV/STI Services Performed by Public Health Agencies and their Partners*.

Methods

To identify opportunities for maximizing insurance billing, HMA:

- Performed a comprehensive review of relevant federal and state regulations, as well as CCO contracts
- Engaged a certified medical coder to analyze available codes for HIV/STI services in Oregon
- Analyzed Oregon State Public Health Lab (OSPHL) data as a proxy for utilization of public health HIV/STI services
- Conducted 12 interviews with HIV/STI Providers
- Fielded a 74-question survey of 15 HIV/STI Providers
- Conducted 12 interviews with organizations representing 16 coordinated care organizations (CCOs) and follow-up correspondence.
- Conducted 6 interviews with 6 commercial insurers and follow-up correspondence.

Findings

After synthesizing information gathered from the activities above, HMA made the following major findings:

- Using OSPHL data as a proxy, 60% of HIV/STI Provider services are billed to the Oregon Health Plan (either through CCOs or fee-for-service)
- CCOs are required to pay for HIV/STI services performed by public health agencies in their service areas and required to partner with their local public health authorities
- All commercial insurers consider these services as covered benefits
- Many public health agencies are already routinely billing insurance for HIV/STI services
- Some public health agencies that are not already billing insurance for these services are billing insurance for other public health programs
- Most public health agencies have relationships with clinical partners, such as federally qualified health centers (FQHCs) and can draw upon their existing billing infrastructure to claim payment for these services
- Some HIV/STI providers are reticent to bill insurance because they are concerned about patient confidentiality or perceived administrative burden of collecting payer information

Recommendations

Based on these findings, HMA determined the most impactful steps to maximize insurance billing to HIV/STI services provided by public health agencies and their partners involve ensuring the Oregon Health Plan, through both CCOs and Open Card, are paying for these covered services. To that end, HMA developed the following recommendations, organized by entity that would be responsible for taking the recommended action.

State/HST Program

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. OHA has stated they will 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 infrastructure. See *Common Misconceptions About Billing for HIV/STI Services* in this toolkit.

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 will 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

While CCOs are required by statute to cover these services, 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.

Create a Learning Opportunity for Commercial Payers

OHA has little official role in regulating commercial payers. However, HST could partner with other parts of the Public Health Division and the OHA to design a learning opportunity for commercial payers 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

Since the CCOs do not issue explanation of benefits (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 the Medicaid Management and Information Systems (MMIS) for eligibility. 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 immunizations, family planning, or other public health services, they should use the same infrastructure to bill the CCOs for HIV/STI services.

Maximize Office Visit (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 (CHWs)

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 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 EOB. CCOs do not send EOBs to members because there is no cost sharing in OHP. HIV/STI Providers could start a policy conversation about requiring commercial insurers to suppress EOBs for sexual health services.

Coordinated Care Organizations

Develop Alternate Payment Models (APMs) to Support Public Health Services

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.

Common Misconceptions About Billing for HIV/STI Services

As local public health authorities consider increasing their insurance billing practices for HIV and STI services, it is important to ensure we are all operating on the same facts and actively countering existing misinformation that can pose a challenge to securing buy-in from staff, community partners, and consumers. Below are four myths that deserve special attention as they can result in real barriers to insurance billing if not corrected.

Myth 1: Insurance billing requires collecting too much client information and won't work with our low barrier model or in the field.

FALSE! The best part of busting this myth is that you are already collecting everything you need to bill Medicaid. All you need to do is get someone's first and last name and their date of birth and you have sufficient information to search the Medicaid Management Information systems (MMIS) to see if they are enrolled in OHP. You do not need a copy of their insurance card.

Myth 2: If we start to bill insurance, we will have to start collecting copays or our patients will get a bill.

FALSE! Focusing on billing for people enrolled in OHP (Medicaid) helps to alleviate this concern because OHP does not participate in cost sharing which means there is no payment required from the patient. This means there are no copays to collect and members do not receive bills for their services.

Myth 3: If we bill insurance, our members may get an Explanation of Benefits (EOB) sent to their house and then their confidentiality will be jeopardized.

FALSE! While this may be a valid concern when billing private insurance, we are focused on billing for people enrolled in OHP (Medicaid), and Medicaid does not have the same requirements to send out EOBs like commercial insurance. Bottom line, people on OHP will not get an EOB sent to their home.

Myth 4: We aren't allowed to bill since we receive state funds for HIV/STI Services.

FALSE! State funds are really intended to cover those individuals that don't have insurance or where there is no other funding source available. If someone is enrolled in OHP (Medicaid), HIV/STI Services can be billed for and CCOs are required to pay for covered services to their members.

Oregon Health Plan Billing Guide for HIV/STI Services

Section I – Introduction

This guide is designed to support local public health agencies, health clinics, and other organizations to increase insurance billing for human immunodeficiency virus and sexually transmitted infection (HIV/STI) services covered by Medicaid, thereby supporting the public health infrastructure. By reducing the burden on public health funding to pay for services that are covered by other payment sources, we can continue to pursue the mission of public health: *the fulfillment of society's interest in assuring the conditions in which people can be healthy.*

With that in mind, we have developed a guide for billing Coordinated Care Organizations (CCOs) and the Oregon Healthy Authority (OHA) for HIV/STI services delivered by public health departments and their partner organizations.

DISCLAIMER

This guide was prepared as a service to the public and is only intended to be a general summary. It is not intended to take the place of either the written law or regulations and is not a substitute for legal advice. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents and to consult with their own legal counsel or other experts for guidance specific to their individual circumstances. Specific coding and payer guidelines should be reviewed prior to the submission of claims for reimbursement. Use of this guide does not guarantee that claims have been formatted or submitted properly or that claims will be reimbursed as billing coding requirements and insurance policies and coverage may change from time-to-time.

Background

There are a number of relevant federal and state regulations, as well as CCO contract requirements, that create a supportive environment for billing insurance plans for the costs of HIV/STI services.

For example, the passage of the Affordable Care Act (ACA) ensures coverage of medically necessary HIV/STI services and in Oregon routine HIV/STI testing. States must also cover pre-exposure prophylaxis (PrEP), the drug used to prevent HIV among those at increased risk, and associated labs and medical visits. Oregon has requirements in statute, rule, and CCO contracts that require CCOs to have agreements in place with publicly funded providers and pay for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. For additional information, including regulatory citations, please see *Regulations Governing Medicaid/Oregon Health Plan/CCO Coverage of HIV/STI Services* in this toolkit.

Based on the federal, state, and CCO contract guidance, public health and other providers who are working with populations at higher vulnerability for HIV/STI or people living with HIV/AIDS (PLWHA) are rightfully able to be paid by the CCOs and the OHA for services

delivered to people on OHP. This includes people who are assigned to a CCO as well as people who are on "Open Card."

Confidentiality

The Oregon Health Authority (OHA) recognizes that billing insurance companies for HIV/STI services is complicated and requires attention to personal privacy and confidentiality issues. Most insurance companies are required to issue Explanations of Benefits (EOBs) for covered services. These EOBs list the services that were provided and may include diagnosis information. An EOB sent to a client's home could be opened by somebody other than the client resulting in their privacy being violated.

However, CCOs and the Oregon Health Authority *do not send* EOBs to enrollees covered by the OHP, so there are not the same privacy and confidentiality issues as there are with other insurance companies or Medicare Advantage plans. This is one reason why this toolkit is focused on HIV/STI billing for people on OHP. *See the section on Common Misinformation in this toolkit for more information.*

HIV/STI Services Eligible for OHP Billing

Many of the HIV/STI services provided to people on OHP are already being billed through an "office visit" by a physician, nurse practitioner, or physician's assistant at a public health clinic or a federally qualified health center. This billing guide does not address those services because HIV/STI Providers are already billing for those services fairly consistently. There are also services that can be billed by other provider types such as Community Health Workers (CHWs) or Licensed Clinical Social Workers (LCSW). There are also some services provided to these populations that are not covered by OHP regardless of the type of provider or the place that the service is rendered, an example would be contact tracing. Those services will need continued support through grants, public health funding, or other funding.

In Oregon, there is also no balance billing, copays, coinsurance, or deductibles for clients enrolled in OHP. This means that individuals who receive HIV/STI services will not receive surprise bills for those services nor are there any copays to collect at time of service delivery

The following are examples of services that are covered benefits for people on OHP, but HIV/STI Providers might not currently be billing:

- **Education Information and Referral** -- Providing education to a patient on the nature of their infections can be delivered by a certified Community Health Worker if prescribed by a licensed physician or nurse practitioner.
- **Testing and Diagnosis (Specimen Collection) –** Specimen collection for HIV/STI testing required to confirm a diagnosis, if collected under a standing order by a licensed provider, can be collected by anybody trained to draw the specimen.

- **Counseling** – Counseling patient about reducing their risk for acquiring or transmitting infection to others can be provided by a LCSW, QMHP, or LPC under Health Behavior Assessment and Intervention benefits.
- **Monitoring** – Nurses can conduct patient follow up services for recommended re-testing per CDC and OHA guidance under a Chronic Care Case Management benefit.

Oregon state public health laboratory (OSPHL)

HIV/STI testing specimens submitted to the OSPHL may also be eligible for insurance reimbursement. However, the OSPHL does not provide in-person services with clients, so it must rely on organizations submitting specimens to provide insurance information when possible, by clearly noting OHP coverage on the lab order request form. The OSPHL can bill for testing and services for people on OHP. Promoting a culture that receives payment for covered services helps to ensure that our public health system is truly the payer of last resort.

Section II – Billing 101

Billing for services provided to people on OHP clients can feel like a daunting task. The following sections are designed to inform and support the transition to billing.

Contracting and Credentialing

Many CCOs already hold contracts or memorandums of understanding with their local public health agency to pay for required point of care services. These CCOs will typically credential licensed or certified providers who are delivering services directly to clients. Credentialing is a standardized process that involves verification of licenses, copies of medical degrees, information on malpractice insurance, work history, and other information. This can be a time-consuming process that requires a keen attention to detail and follow up to complete the process. If a CCO has not contracted with and credentialed a provider, they may pay less for the services rendered.

Other CCOs view LPHAs as part of the safety net and will pay for point of care services without a contract or credentialing verification.

If you are working with a FQHC or other type of physical health clinic, they will likely have an administrative infrastructure for contracting and credentialing their providers.

When in doubt, contact your local CCO for information on their contracting and credentialing process.

Types of Eligible Providers

A variety of agencies in Oregon offer HIV/STI services. They are organized in different ways and face distinct opportunities and challenges for billing. These providers include:

- **Local Public Health Agencies**. There are 32 LPHAs across Oregon, many already have experience billing for services from public insurers like OHP, in addition to grant funding. However, some LPHAs can also face unique challenges in staffing with

licensed providers and adopting technology to support billing, such as electronic health records (EHRs).

- **HIV Early Intervention Services & Outreach** providers. Among the LPHAs, there are six with OHA contracts to provide HIV Early Intervention Services & Outreach (EISO) in 13 counties and in partnership with the Confederated Tribes of Siletz Indians.
- The **Oregon State Public Health Lab**. The OSPHL does not provide in-person services with clients, so it must rely on organizations that submit specimens to provide insurance information that it can use to bill for their services.
- Other **Community-Based Organizations**. Community-based organizations provide specific health care services to a largely uninsured or underinsured population. These agencies rely heavily on grant funding and, as a result, may be prime candidates to partner with other entities that have greater volumes of billable services and more billing experience to draw upon. They may also include Ryan White programs, which are funded through the Ryan White HIV/AIDS Treatment Extension Act of 2009 (originally passed in 1990).
- **Federally Qualified Health Centers, Rural Health Clinics, Other Medical Practices**. These providers are adept at billing for the wide range of services they deliver. With Electronic Health Records and robust "practice management" systems, they are well positioned to bill OHP whenever possible.

System Requirements

Building or buying the technology to support a billing system is time consuming and expensive and should be viewed as an option of last resort. Most of the partner providers delivering HIV/STI services for people on OHP already have some degree of access to a billing system. This is most likely directly through an existing system, through a partner clinic, or by arranging for access to a billing system already functioning in your community.

The opportunity lies in expanding the number of services being billed and helping to ensure that services provided to all people on OHP are being billed appropriately. If there is an interest in learning more about billing for these services, there are many useful tools and information available on the STD-TAC website.

Coding and Documentation

Coding for HIV/STI services is an essential practice for programs that are preparing for billing third party payers. Beginning to properly code for services is a critical step in improving revenue cycle management and developing sustainable systems.

Coding is the process of transforming services, diagnoses, and supplies into alphanumeric codes. Without the coding and related documentation, insurers assume the service never occurred.

- **ICD-10 Codes** describe the diagnosis – the "why"

- **CPT Codes** describe the service or treatment performed, such as Evaluation and Management (E&M, also known as "office visits") – the "what"
- **Modifiers** describe any exception to the CPT Code, and for example, can be used to describe additional services that were performed that are unrelated to the original procedure – "the additional info"
- **HCPCS Codes** – often pronounced "hick picks", these codes describe items and services that are nonphysician-based services such as ambulance services, durable medical equipment, prosthetics, orthotics, drugs, and supplies – the "what else"

A comprehensive guide to coding for HIV/STI services can be found at Building Sustainability for HIV, STD, and Related Services: A Coding Guide for Programs and Providers compiled by the University of Washington Public Health Capacity Building Center, in the toolkit.

Section III – Services Eligible for Insurance Billing

While many of the HIV/STI services are already being billed to CCOs or OHP Fee-for-Service when they are provided by clinicians in health care settings, such as FQHCs that partner with LPHAs, there are other services that are not being billed and others that cannot be billed because they are not covered by OHP. Following is a list of services as described by HST Section and their related OHP billing requirements by type of provider.

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[1], 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

[1] E/M stands for "evaluation and management," (often called "office visit") and denote CPT codes that fall into this category of common services.

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
Testing & Diagnosis*	Provide STD and HIV testing as well as any additional testing required to confirm a diagnosis	Payable to Reference Lab Payable to Clinician collecting specimen: 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.	See OSPHL Fee Schedule $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	Counsel patient about reducing their risk for acquiring or transmitting	G0445[2] 96156 - 96159[3i]	G0445 must be provided by physician, NP, or PA	$19.28 (G0445) Assessment $68.96

[2] 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

[3] 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.

patient in their own right)	infection to others.		HBAI can be provided by a QMHP, LCSW, or LPC	Intervention $47.15/$16.64 Group Intervention $6.96/$3.27
	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 96156 - 96171	G0445 must be provided by physician, NP, or PA HBAI can be provided by a QMHP, LCSW, or LPC	$19.28 (G0445) Assessment $68.96 Intervention $47.15/$16.64 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	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): 99487 - 99491	Must be billed under: Physician, Nurse Practitioners, Physician Assistant, Nurse	Complex $63.22 Add'l 30 Min $30.62 Chronic 20 min $31.48 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

In summary, there are several opportunities for increasing payments from CCOs for services currently being paid by Public Health. First, we want to ensure that all eligible services delivered within "office visits" are included in the claim submission. Second, we hope to maximize billing for OHP clients for testing and diagnosis services at the OSPHL. Finally, the following services are currently eligible for insurance coverage but may not be currently billed for OHP clients to the extent possible:

- Patient education
- Testing and diagnosis
- Counseling
- Monitoring

Regulations Governing Medicaid/Oregon Health Plan/CCO Coverage of HIV/STI Services

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. The law also expanded the Medicaid program to cover more people with low incomes and 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 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. In 2021, 75% of the contracted LPHA's and their partners are recognized as ECPs.

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 10 essential health benefits—EHBs—with no annual or lifetime dollar limit.

Many of the EHBs are especially important for people living with HIV (PLWH) 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.
- 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.

State Regulations

Payment for services provided by local public health departments as it relates to CCOs are 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.

In addition, the 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.

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 checked during the procurement and readiness process.)

Communicating with Patients/Clients

Some HIV/STI Providers expressed concern about raising the issue of billing CCOs or Open Card for HIV/STI services with their patients or clients. Below are key messages public health agencies and their partners can communicate to their patients or clients when raising the issue of billing insurance.

We can look up your insurer with the information you already gave us

If you have the Oregon Health Plan (OHP), we will be able to look up your CCO using just the information you already gave us, like your name and birthdate. You don't even have to look for your member ID card.

There is no cost sharing for OHP members

It looks like you are an Oregon Health Plan member. That means that we can bill your insurance for this service, and you will not receive a bill today or ever.

OHP will not send private information in the mail

Because there is cost sharing for OHP members, CCOs and Open Card do not send bills, "explanation of benefits," or other letters that say what kind of service you had today.

CCOs get paid to cover these services

Taxes pay for CCOs to cover HIV/STI services you received from us whether we bill them or not. They will cover the services, but they can only pay us if we bill them.

More people without health insurance can get these services if we bill when we can

If we bill CCOs and OHP Open Card for these services, then we can use our public health resources to provide HIV/STI services to more people who don't have insurance.

Commercial Insurance EOB Suppression Issue Brief

Issue

HIV/STI service providers are concerned that if they bill commercial insurance for services, their patients' confidentiality may be at risk because the insurer might send an explanation of benefits (EOB) or a bill to the member's home.

Background

Advocates have previously raised the issue of confidentiality of health services in the Oregon legislature. Historically, the issue primarily involved adolescents who are seeking health care services they may wish to be private from the policy holder. Advocates often cite sexual health services or behavioral health services as those an adolescent may wish to keep confidential.

Advocates suggested EOB suppression as a solution, but insurers indicated it would be administratively burdensome to adjust their systems to suppress EOBs for only certain services. As a compromise, the Oregon Legislature passed a law that makes it so that patients can request that mail be addressed to them, rather than the policyholder. Unfortunately, this can still result in other household members receiving personal health information that does not pertain to them.

Context

Other states have passed laws that require insurers to suppress EOBs for specific services, and insurers have changed their processes to comply. According to the Guttmacher Institute, Massachusetts, New York, Washington, and Wisconsin all have policies related to EOB protections for dependents. Guttmacher further states that Washington's law prohibits insurers from disclosing "private health information, including through an EOB, without minor's authorization."

According to the Association of State and Territorial Health Officials (ASTHO), New York and Wisconsin do not require plans to send EOBs when there is no balance for the cost of the service. Since many HIV/STI services are categorized as "Grade A" by the US Preventative Services Task Force (USPSTF), they must be provided without cost sharing by many commercial plans under the Affordable Care Act. Thus, many HIV/STI services would qualify for EOB suppression by virtue of not having cost sharing.

Options

To address the confidentiality of HIV/STI services, Oregon could consider:

Option A: Encouraging voluntary adoption of EOB suppression for services for dependents over age 15 (age of medical consent in Oregon), zero balance services for all members, or specific services that are likely to be sensitive, such as sexual health services. This is likely easier to achieve than changing public policy. It would require establishing some kind of collaborative discussion or workgroup among health plans with the goal of agreeing to voluntary confidentiality measures.

Option B: Requiring EOB suppression without express permission for services for dependents over age 15. Any policy change is going to be more challenging than a voluntary agreement. However, a policy change would be more impactful and enforceable. This particular approach can be difficult because if there are charges for the health care services received by the dependent, the insurer needs to be able to provide an explanation of what the plan is covering and what it is not.

Option C: Requiring EOB suppression for zero balance services. This will require a public policy change. It may be the least administratively burdensome option for insurers, though insurers have reasons for sending zero-balance EOBs, such as tracking fraud, waste, and abuse. Also, some individuals may wish to receive EOBs for some zero-balance services. For example, some services are provided at no cost when performed in-network as an incentive to use the preferred provider network; this would produce zero-balance EOBs. Insurers may need to design their systems around preserving the option to display these services on EOBs. To achieve the goal of protecting confidentiality, the State would also need to prohibit cost sharing for HIV/STI services, thus ensuring they are zero-balance services.

Option D: Requiring EOB suppression for specific services, such as sexual health services. This would also require a public policy change. This would be the most precise of the EOB suppression options for purposes of HIV/STI services confidentiality.

Recommendation

Of the options above, Oregon could consider a hybrid of putting together a collaborative of health plans with the intent of either agreeing to voluntary guidelines or choosing a strategy, such as one of the EOB suppression options outlined above, to ensure member confidentiality when receiving HIV/STI services.
