Delivering HIV Counseling and Testing Services to Insured Populations

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Disclaimer

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The views expressed in by the speakers and moderator do not necessarily reflect the official policies of the Department of Health and Human Services (DHHS), nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US Government.
Meet the Experts

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CIS Subcontractor
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UW Public Health Capacity Building Center/ Cardea
Four-Part Training Series

- October 28, 2014: Delivering HIV Counseling and Testing Services to Insured Populations
- November 6, 2014: Medicaid Basics for HIV Prevention Programs
- November 20, 2014: Commercial Health Insurance Basics for HIV Prevention Programs
- December 4, 2014: New Opportunities for Community-Based HIV Prevention and Care Management Services to Insured Populations
Overview of Today’s Topics

- Policy and funding landscape – why bill?
- Key considerations for providing counseling and testing services (CTS) to insured individuals
- Components of CTS preventive and diagnostic services
- Regulatory, public health, and business rationale for coverage of CTS by health plans
- Ways that State Medicaid programs pay for CTS
- Key steps in providing CTS to insured populations
- Contracting with health plans and related key agency functions
- Practical considerations for providing CTS to insured individuals
- Building support and systems to implement billing
Overview

- Funding landscape
- Patient Protection and Affordable Care Act (ACA)
- Rationale for billing and reimbursement
Funding Landscape—State Health Departments

- State budget cuts
  - 52 agencies have reported budget cuts since 2008
  - Of those states reporting cuts, the amount ranged from 1% to 7%, with an average cut of ~3%

# State Health Departments—Program Cuts

## Table 2. Number and Percentage of SHAs with Program Cuts Since July 2008 by Program Area (N=55)

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Number with Program Cuts</th>
<th>As % of the Whole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health hospitals and clinics</td>
<td>26</td>
<td>47%</td>
</tr>
<tr>
<td>HIV, AIDS, and STDs</td>
<td>25</td>
<td>45%</td>
</tr>
<tr>
<td>Disease-specific programs (ALS, Alzheimer’s, Arthritis, Asthma, Cystic Fibrosis, Epilepsy, Genetic Disorders, Hepatitis C, Infectious Diseases, Osteoporosis, Parkinson’s, PKU, Renal Diseases, Sickle Cell, Tuberculosis, Valley Fever)</td>
<td>22</td>
<td>40%</td>
</tr>
<tr>
<td>Family health and nutrition (including WIC)</td>
<td>22</td>
<td>40%</td>
</tr>
<tr>
<td>Maternal and child health programs</td>
<td>20</td>
<td>36%</td>
</tr>
<tr>
<td>Prevention programs</td>
<td>18</td>
<td>33%</td>
</tr>
<tr>
<td>Tobacco prevention and control</td>
<td>17</td>
<td>31%</td>
</tr>
<tr>
<td>Immunization</td>
<td>17</td>
<td>31%</td>
</tr>
<tr>
<td>Children with special healthcare needs</td>
<td>17</td>
<td>31%</td>
</tr>
<tr>
<td>Family planning services</td>
<td>16</td>
<td>27%</td>
</tr>
</tbody>
</table>
Funding Landscape—Local Health Departments

- Local budget cuts
  - In early 2014, 28% of LHDs reported a lower budget in the current fiscal year compared to the prior year
  - During 2012, 48% of all LHDs reduced or eliminated services in at least one program area


Funding Landscape—CBOs

- **CBO budget cuts**
  - CBOs are facing cuts in direct federal funding, as well as in health department subcontracts
  - Between 2007 and 2012, of state and local jurisdictions and territories directly funded by Division of HIV/AIDS Prevention (DHAP):
    - 43% funded fewer community-based providers
    - 40% reduced the size of awards to community-based providers


Funding Landscape

- National HIV/AIDS Strategy (NHAS)
  - Called for intensified HIV prevention efforts targeted to “communities where HIV is most heavily concentrated”

- CDC funding for HIV prevention aligned with the NHAS
  - Geographic funding distribution
  - Emphasis on High-Impact Prevention: proven, cost-effective, scalable HIV prevention interventions

Affordable Care Act

- Medicaid expansion
- Access to commercial health insurance

States’ Decisions—Medicaid Expansion

Map showing states implementing the expansion (28 states including DC), open debate (2 states), and not moving forward at this time (21 states).
The Coverage Gap

- If all states implement Medicaid expansion, eligibility would increase in 42 states for parents and in nearly every state for other adults.
- In states that do not expand Medicaid, nearly five million poor uninsured adults may fall into a “coverage gap.”

Additional Impact of ACA

- Coverage of preventive services
- Expansion of dependent coverage
- Essential community providers
- Continued importance of safety net providers

Impact—Billing & Reimbursement

- Close budget gaps
- Offset the cost of providing free services to patients without health insurance
- Free up resources to fund efforts not covered by other funding streams
Concerns About Billing

- Public health has always been free
- Billing might turn away those most in need
- It is not worth all the work
Cardea adapted the Transtheoretical Model of behavior change, or Stages of Change, developed by Drs. Prochaska and DiClemente, to identify benchmarks of organizational capacity building for revenue cycle management.
Participant Poll

Where would you stage your organization/program on the RCM continuum? (select all that apply)

A. Precontemplation (Not billing / not really thinking about billing)
B. Contemplation (Interested, unclear how to proceed)
C. Preparation (Developing systems)
D. Action (Charging patient fees, billing Medicaid and/or commercial insurance)
E. Improvement & Maintenance
Counseling and Testing Service Components

- Test Kits
- Venipuncture
- Lab procedure
- Counseling
Key Considerations About CTS

- Insurers consider HIV CTS to be preventive and diagnostic services
  - **PREVENTIVE SERVICES**
    - Part of services undertaken in pre-exposure prophylaxis (PrEP)
    - CTS should trigger HIV education and behavioral health interventions including counseling to prevent primary and secondary HIV infections
    - Identifies HIV+ pregnant women to also initiate treatment to avoid perinatal infection
  - **DIAGNOSTIC SERVICES**
    - CTS determines if an individual is HIV positive (+) and should begin treatment
    - Identifies individuals in the acute HIV infection phase to initiate treatment and secondary prevention services
- Licensing of new HIV testing technology and related CDC policy recommendations have outpaced insurers’ coverage of some CTS
Making the Case for Coverage of CTS by Health Plans

Why should health plans pay for CTS?

- **Regulatory rationale:**
  - Meet federal ACA, Medicaid, and Medicare requirements
  - Meet health insurance performance and quality standards (e.g., Healthcare Effectiveness Data and Information Set or HEDIS measures and CMS Initial Core Set of Measures for Medicaid-Eligible Adults)

- **Public health rationale:** Promote local, state, and federal efforts to reduce
  - Rates of new HIV infections in the US
  - Reduce community viral load
  - Improve clinical outcomes among HIV positive (+) beneficiaries
Making the Case for Coverage of CTS by Health Plans

- Why should health plans pay for CTS?
- Business case: Lower the long-term cost of HIV+ beneficiaries to health plans by providing
  - High impact prevention (HIP) to HIV negative (-) individuals
  - Early identification of HIV+ individuals
  - Rapid linkage and sustained retention
  - Avoidance of expensive inpatient stays and ER visits
  - Reduction of new HIV+ individuals, including newborns, via secondary prevention
The Department of Human Services (DSS) US Preventive Services Task Force (USPSTF) recommended an “A” grade for clinicians screening for HIV infection in

- Adolescents and adults ages 15 to 65 years
- Younger adolescents and older adults who are at increased risk
- All pregnant women, including those who present in labor who are untested and whose HIV status is unknown

“A” grades are assigned services recommended be offered by clinicians because "there is high certainty that the net benefit is substantial”

ACA Marketplace Qualified Health Plans (QHPs) and many other plans must provide services assigned an “A” grade without beneficiary charge

The ACA requires most other commercial individual and group health plans to cover Grade “A” services without cost sharing
CTS as Preventive Services

- “Traditional” Medicaid programs must cover “medically necessary” lab services
  - Including HIV screening for adults
  - States can voluntarily cover routine testing (regardless of “medical necessity”)
  - The ACA offers financial incentives to States to cover Grade “A” and “B” services by increasing the federal match payment by 1%

- “Expanded” State Medicaid programs include that have expanded Medicaid eligibility to individuals below 138% of the Federal Poverty Level (FPL)
  - ACA requires expansion states to cover routine HIV testing without cost sharing

- Medicare *may allow* coverage of Grade “A” and “B” preventive services
  - The ACA removes cost-sharing for those preventive services
  - Medicare covers HIV screening for pregnant women and individuals at increased risk, and may also cover routine screening for beneficiaries 15-65 years of age
## Making the Case to Insurers for CTS: Return on Investment

Example from the CMS Innovation Center-funded Prevention at Home Project in Washington DC for Medicaid Beneficiaries

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Net</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention Model</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Clients</td>
<td>4,000</td>
<td>7,804</td>
<td>11,423</td>
<td>23,227</td>
</tr>
<tr>
<td>Net Savings</td>
<td>-$204,116</td>
<td>$241,616</td>
<td>$947,923</td>
<td>$985,423</td>
</tr>
<tr>
<td>Savings PMPM</td>
<td>-$51</td>
<td>$31</td>
<td>$83</td>
<td>$42</td>
</tr>
<tr>
<td><strong>Care Model for HIV+ Clients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Clients</td>
<td>3,284</td>
<td>3,284</td>
<td>3,284</td>
<td>9,852</td>
</tr>
<tr>
<td>Net Savings</td>
<td>$14.2 M</td>
<td>$13.0 M</td>
<td>$133.0 M</td>
<td>$40.3 M</td>
</tr>
<tr>
<td>Savings PMPM</td>
<td>$4,334</td>
<td>$3,972</td>
<td>$3,966</td>
<td>$4,091</td>
</tr>
<tr>
<td>Total Net Savings</td>
<td>$14.0 M</td>
<td>$13.3 M</td>
<td>$14.0 M</td>
<td>$41.3 M</td>
</tr>
</tbody>
</table>
How Medicaid Pays for CTS

- CTS are funded by
  - Fee for service (FFS) covered services (medical, inpatient, ER, lab tests ordered by a clinician)
  - Managed care organization (MCO) contracts
  - Waivers and demonstrations
  - State Plan Amendments (SPAs) to cover preventive services (e.g., counseling)
  - CMS Innovation Center funds State Medicaid programs and community providers to test new service delivery and payment models: http://innovation.cms.gov/
### Examples of Medicaid Model Managed Care CTS Contract Language

**District of Columbia:** Covered Services for Medicaid Enrollees Ages 21 and Older: HIV/AIDS screening, testing, and counseling. Contractor shall provide an organized health education program including but not limited to the importance and availability of testing for HIV/AIDS and the services available for treatment of HIV/AIDS.

**New Jersey:** Contractor shall address the HIV/AIDS prevention needs of uninfected enrollees, as well as the special needs of HIV+ enrollees by establishing methods for promoting HIV prevention to all enrollees in the Contractor’s plan, methods for accommodating self-referral and early treatment, methods for education about HIV/AIDS risk reduction, and a process for HIV/AIDS testing and counseling.

**Texas:** The MCO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The MCO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The MCO must allow Members access to STD and HIV diagnosis services without prior authorization or referral by a PCP.
Waivers and Demonstrations

- **Section 1115 Research and Demonstration Projects:** States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.

- **Section 1915(b) Managed Care Waivers:** States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.

- **Section 1915(c) Home and Community-Based Services Waivers:** States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.

- **Concurrent Section 1914(b) and 1915(c) Waivers:** States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all Federal requirements for both programs are met.
New Opportunities for Medicaid Payment for Counseling as Part of CTS

- CMS published a final rule effective in January 2014
- **Before the rule change:** preventive services could only be provided by a physician or other licensed practitioner (OLPs) of the healing arts to be paid by Medicaid
- **After the rule change:** other practitioners, not just physicians and OLPs, can be paid to provide preventive services *recommended* by a physician or OLP
- Assigns authority to State Medicaid Programs to
  - Define practitioner qualifications
  - Ensure appropriate services are provided by qualified practitioners
  - Define the preventive services to be provided
  - Design the reimbursement methods
- *Does not define the type of personnel to be covered*
New Opportunities for Medicaid Payment for Counseling as Part of CTS

- State Medicaid Programs can voluntarily
  - Expand the types of practitioners to furnish preventive services
  - Increase beneficiaries’ access to preventive services not currently covered

- State Medicaid Programs must submit a SPA to CMS for review and approval to make changes in eligibility, coverage, or reimbursement

- CMS must approve SPAs before a Medicaid program can implement their proposed changes

- Proposed and approved SPAs are posted on the CMS website
How Can We Find Out About Medicaid Preventive Services Efforts in Our State?

- Visit the CMS Medicaid website and use the search engine to find out about the Medicaid State Plan, SPAs, and waivers in your state
  - Check out the Medicaid Moving Forward box and select your state: [http://www.medicaid.gov/](http://www.medicaid.gov/)

- Check out the American Public Health Associations Community Health Worker Section website: [http://www.apha.org/membergroups/sections/aphasections/chw/](http://www.apha.org/membergroups/sections/aphasections/chw/)

- The Association of State and Territorial Health Officials (ASTHO) website posts up to date information about newly emerging State Medicaid CHW activities: [http://www.astho.org/Community-Health-Workers/?terms=community+health+worker](http://www.astho.org/Community-Health-Workers/?terms=community+health+worker)
Keys Steps in Providing CTS to Insured Patients

**CONTRACTING**
- Join FFS Network or Negotiate Contract
- Credential Staff
- Establish Patient Health Record System
- Create Billing & Accounting Systems
- Design Policies & Procedures
- Train Staff

**PRE-VISIT**
- Register Patients
- Schedule Patients
- E-Verify Patient Eligibility
- Process Prior Authorization Docs
- Point of Service Patient $ Collections

**DURING VISIT**
- Provide & Document Covered Services
- Code Services Claims in Processing System

**POST-VISIT**
- Generate e-Claims
- Review Remittance Notices
- Research / Resubmit Rejected Claims
- Process Accounts Receivable
- Performance/ QM Monitoring & Reporting
CTS Scenario 1 - Limits CBOs from Health Plan Participation
CTS Scenario 2- Promotes CBO Health Plan Participation

CBO POC Testing, Linkage, Retention

- MCOs
- HIV Clinics
- Community Health Centers
- Substance Abuse Tx Programs
- Mental Health Tx Programs
- Private Medical Practices
- Hospital Outpatient Clinics ERs
- Public Health Departments
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does my agency get started?</td>
<td>Check out resources on the HealthHIV website, including a contracting guide for HIV prevention providers. Also the HIVMA contracting guide for healthcare providers. Stay tune for resources on the ETR and Cardea CBA webpages</td>
</tr>
<tr>
<td>Which QHPs and Medicaid MCOs operate in my state?</td>
<td>See the AAHIVMA website to get a list of QHPs plans and Medicaid MCOs in your state.</td>
</tr>
<tr>
<td>How can my agency participate in a health plan?</td>
<td>Join their provider network. See the AAHIVMA website for joining QHP and Medicaid MCO networks.</td>
</tr>
<tr>
<td>What are the right codes to use to bill health plans for CTS?</td>
<td>Code structures vary by your organization type and the CTS your agency provides. Check with the insurer. See the State of Hawaii coding guide for an overview of codes.</td>
</tr>
<tr>
<td>What type of HIV tests are covered by Medicaid FFS?</td>
<td>Check out your Medicaid program’s provider webpage, including provider handbooks. If unclear, contact the Medicaid lab expert.</td>
</tr>
<tr>
<td>What types of personnel can provide CTS covered by a health plan?</td>
<td>CTS personnel credentialing requirements vary based on the types of services for which your agency contracts with a plan. Ask about personnel credentialing requirements during your contract negotiations.</td>
</tr>
<tr>
<td>How much will Medicaid FFS pay for HIV CTS?</td>
<td>Check out your Medicaid program’s fee schedule.</td>
</tr>
<tr>
<td>How can I get a copy of my Medicaid program’s MCO model contract?</td>
<td>Search on your State Medicaid website for “model contract” or the managed care webpage. Call the Medicaid director’s office.</td>
</tr>
</tbody>
</table>
Cardea adapted the Transtheoretical Model of behavior change, or Stages of Change, developed by Drs. Prochaska and DiClemente, to identify benchmarks of organizational capacity building for revenue cycle management.
Increasing Staff Buy-in

Successful billing implementation requires both specific people to drive the change forward and the support of the rest of the staff.

Engage staff input in planning & implementation... Why?

- Increased staff buy-in and commitment to goals
- Opportunity to manage resistance (team and individual)
- More complete data to inform change – staff are experts in their role
Increasing Staff Buy-in

Engage staff input in planning & implementation... \textbf{How?}

- Communicate why change is necessary and potential impacts; answer for staff:
  - Why is this necessary?
  - What is happening?
  - How will it affect me and my work?
  - What’s in it for me?

- Include all levels of staff, and map new roles & responsibilities, articulating connections across roles
# Systems Changes

| Business Model | • Business model to support fiscal health & sustainability  
|                | • May include billing, partnerships, both |
| Staffing       |                                            |
| Systems/Data Collection |                                        |
| Policies & Procedures |                                        |
Business Model

- The services you provide have value...but how much?
  - Cost analysis / fee setting
  - What billable services do we provide?
- Internal capacity vs. external partnerships
# Systems Changes

| **Business Model** | • Business model to support fiscal health & sustainability  
| | • May include billing, partnerships, both  
| **Staffing** | • Changing the business model will change people’s jobs  
| | • The staff you have and the staff you need  
| **Systems/Data Collection** |  
| **Policies & Procedures** |  

Staffing

- What types of staff are providing CTS?
- Limitations on billing for services provided by non-clinicians (although some opportunities)
- Strategic decisions will increase your “billable” services
# Systems Changes

| Business Model | • Business model to support fiscal health & sustainability  
|                | • May include billing, partnerships, both |
| Staffing       | • Changing the business model will change people’s jobs  
|                | • The staff you have and the staff you need |
| Systems/Data Collection | • Improving systems for collecting and storing client info  
|                | • Electronic (EHR, PMS) or paper systems |
| Policies & Procedures |
Systems for Data Collection

Patient demographic and insurance information
- May need to add fields to registration forms
- Even if not billing, start collecting patient insurance info now

Patient medical information
- Document all visits, procedures and diagnoses thoroughly
- Code all procedures and diagnoses for billing

Electronic vs. paper systems
## Systems Changes

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Business Model**        | • Business model to support fiscal health & sustainability  
|                           | • May include billing, partnerships, both |
| **Staffing**              | • Changing the business model will change people’s jobs  
|                           | • The staff you have and the staff you need |
| **Systems/Data Collection**| • Improving systems for collecting and storing client info  
|                           | • EHR, PMS, or paper documentation |
| **Policies & Procedures** | • Adopting new policies & procedures to institute changes  
|                           | • Staff training & support |
Policies & Procedures

- Good business practice, particularly with extensive program requirements and complex systems
- Sustainability through staff turnover
- Support consistent client messaging
CBA for Health Departments

University of Washington Public Health Capacity Building Center provides capacity building assistance (CBA) to state, local, tribal and territorial health departments in the areas of:

- HIV testing
- Prevention with HIV-positive persons, with an emphasis on Data to Care
- Organizational development & management, including billing

Contact:
Becca Hutcheson
UW Public Health Capacity Building Center
(206) 897-5814, hutchbec@uw.edu
CBA for CBOs

Request CBA from CIS!

CIS Focus Areas
- Prevention with Positives
- Prevention with Negatives
- Organizational Development (including HIV financing)
- HIV testing

Directly CDC Funded
If you are a CBO that receives direct funding from the CDC you can request capacity building assistance using the CBA Request Information System (CRIS)

Indirectly or Not CDC Funded
If you are a CBO that is not CDC funded or indirectly funded you can ask the health department in your jurisdiction to submit a CBA request on their behalf

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You can find the webinar on the CIS Website!
http://www.etr.org/CIS
Resources

- American Academy of HIV Medicine: Source for ACA QHPs and Medicaid MCOs in US: [http://www.aahivm.org/frmHomeDetails.aspx?nId=NTg=](http://www.aahivm.org/frmHomeDetails.aspx?nId=NTg=)
- HealthHIV: HIV Prevention and Wrap Around Service Provider Contracting Guide: [https://www.google.com/#q=healthhiv](https://www.google.com/#q=healthhiv)
- US Prevention Services Task Force: [http://www.uspreventiveservicestaskforce.org/Page/Name/home](http://www.uspreventiveservicestaskforce.org/Page/Name/home)