



Public Health Law

Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Health Department Billing for Immunization Services: A Menu of Suggested Provisions

Public Health Law Program
Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

In cooperation with
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention

Introduction

The cost of vaccinating children and adolescents, a service frequently provided free of charge by health departments, continues to increase as new, more expensive vaccines are added to the recommended immunization schedule.¹ For example, in 1990 it cost \$70 to vaccinate one child in the public sector from birth to age 18 for Diphtheria, tetanus, pertussis, measles, mumps, rubella and Polio. From 2000 to 2012, ten different vaccines were added to the schedule and the cost of immunizing one child from birth through age 18 went from \$370 in 2000 to \$1712 in 2012, an increase of nearly 500%.² The issue is further complicated by data from a survey by the National Association of County and City Health Officials that reported in 2011, 19% of US local health departments made cuts to immunization services.³

¹ Megan C. Lindley, Angela K. Shen, Walter A. Orenstein, Lance E. Rodewald & Guthrie S. Birkhead. *Financing the Delivery of Vaccines to Children and Adolescents: Challenges to the Current System*, PEDIATRICS, 102 SUPP. 2, S548–57 (2009), available at http://pediatrics.aappublications.org/content/124/Supplement_5/S548.long.

² Anne Schuchat. *Vaccine Management*, Presentation to the National Vaccine Advisory Committee Meeting, June, 2012 available at http://www.hhs.gov/nvpo/nvac/meetings/pastmeetings/2012/shuchat_062912.pdf

³ NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS, LOCAL HEALTH DEPARTMENT JOB LOSSES AND PROGRAM CUTS: FINDINGS FROM THE JANUARY 2012 SURVEY (May 2012), available at <http://www.naccho.org/topics/infrastructure/lhdbudget/upload/research-brief-final.pdf>.



To address the rising costs of immunization services while state operating budgets are decreasing, one strategy is to bill public and private insurance payers when immunization services are provided to an insured client. However, third party billing may only cover the cost of the vaccine and the administrative cost to store and administer the vaccine may not be reimbursable or cost effective for public health clinics. In addition, the cost burden of establishing a billing system could exceed the benefit of reimbursement for the vaccine only. To make vaccination reimbursement worth the expense of billing practices, it might be necessary to bill for vaccine delivery, administrative costs, and other services related to vaccine delivery such as counseling.⁴

Pilot programs show the potential for health departments to create a new stream of revenue by billing third parties for services to their insured clients, but some health departments report legal barriers to planning and implementing billing programs. In 2013, CDC's Public Health Law Program reviewed and analyzed potential legal and policy concerns state and local health clinics might face when considering billing insurance companies and other third-party payers for immunization services. A sample of 14 states⁵ was chosen for geographical diversity, known diversity in laws related to immunization services, and recent billing initiatives. A preliminary draft of laws was circulated at the Second Annual Immunization Stakeholder Meeting in Atlanta, Georgia, on August 26, 2013. Participants discussed the topics presented, confirmed issues of concern and provided feedback relating to the domains identified in this document and the provisions presented. This document is the product of that research.

This menu can help public health officials and their counsel when planning and implementing billing programs or requesting legislative support for new initiatives. It provides information to consider about billing-related legal issues and suggests possible approaches for addressing them. However, any legal provisions must be considered within the policy and legal frameworks of the jurisdiction.

When deciding whether to adopt any of the provisions presented in this paper, careful consideration should be given as to whether a provision should appear in statute or regulation. States may wish to adopt broad or general statutes that confer discretion to the regulatory process, which can be more expeditiously exercised to make changes or updates. Regulations must be authorized by statute (i.e., there can be a statute without a regulation, but not a regulation without an authorizing statute). Some factors that go into this decision are 1) the timeframe in which the regulation could be promulgated by the authorized agency or the statute enacted by the legislature, 2) how often changes might need to be made to the law, 3) whether the subject matter of the legal provision is technical and regular updates are likely according to advances in technology or practice, and 4) whether statutory authority exists to promulgate a regulation.

⁴ Carmella Bocchino, et al., *Vaccines and Immunization Roundtable Report, Vaccine Financing*, AHIP (2009).

⁵ Arkansas, Arizona, California, Indiana, Iowa, Louisiana, Massachusetts, Michigan, New York, Ohio, Oklahoma, Tennessee, Texas, and Washington.

Domains of Provisions

The following legal domains were explored to develop a legal landscape of the provisions that exist related to states' authority to bill and receive reimbursement for immunization services:

- General authority to bill
- Revenue streams
- Credentialing
- Contracting
- Scope of practice and billing codes
- Public health clinics as in-network providers
- Any willing provider laws and public health
- Essential community providers

Each section begins with a brief note describing the domain and types of provisions included within the section. Provisions in each section are organized under sub-headings.

General Authority to Bill

Health departments considering billing for immunization services must determine whether the department has the legal authority to bill patients or third parties and whether there are any restrictions on that legal authority. Authority to bill may be express (e.g., a state may authorize or preclude a health department to bill for services explicitly in the list of powers granted to the health department or in a separate statute) or implied (e.g., authorization to bill may be inferred from a general grant of power to the health department).

Express Authority

Several states expressly address a health department's authority to bill for services. In some states, the legislature gives the health department discretion to determine the amount to charge for services. In other states, the legislature gives discretion to determine fees but also places restrictions on whom a health department can charge, limits the amount charged for services or, in some cases, expressly denies the health department the authority to bill for services.

The state of **Washington** authorizes the departments of health and social health and services to charge fees for services provided. The amount to be charged may be up to the full cost of services or based on the individual's ability to pay.

The department of social and health services and the department of health are authorized to charge fees for services provided unless otherwise prohibited by law. The fees may be sufficient to cover the full cost of the service provided if practical or may be charged on an ability-to-pay basis if practical. This section does not supersede other statutory authority enabling the assessment of fees by the departments. Whenever the department of social and health services is authorized by law to collect total or partial reimbursement for the cost of its providing care of

or exercising custody over any person, the department shall collect the reimbursement to the extent practical. WASH. REV. CODE ANN. § 43.20B.020 (West 2013).

Oklahoma allows local health departments to seek reimbursement from insurance companies, health maintenance organizations, and other providers for health services performed.

A city-county health department may perform any and all health-related services, within the scope of practice, as prescribed by law, by the city-county board of health, or by standards of care for medical services. When a city-county health department provides a health-related service to any person covered by an applicable health insurance plan, the city-county health department may submit a claim for said service to the appropriate insurance company, health maintenance organization or preferred provider organization. Upon receipt of the claim, said insurance company, health maintenance organization or preferred provider organization shall reimburse the city-county health department for the service provided in accordance with the standard and customary rate schedule established by the plan. All health insurance plans, doing business in Oklahoma, shall recognize the public health service delivery model utilized by the city-county health department, as an appropriate provider of services for reimbursement. OKLA. STAT. ANN. tit. 63, § 1-214(G) (West 2013).

Tennessee allows the Commissioner of Health to adopt rules that establish fees for any health service provided by the health department. The statute expressly places responsibility of paying those fees on the person receiving the health service. The statute also allows but does not require the commissioner to adopt rules to reduce or eliminate payment of fees for certain persons on the basis of their ability to pay.

The commissioner is empowered to adopt, promulgate and enforce, with the concurrence of the comptroller of the treasury and the commissioner of finance and administration, rules and regulations establishing fees and charges for any public health service, including, but not limited to, licenses, permits, or authorizations rendered pursuant to, or required by, any statute administered by the department of health. Any and all recipients of public health services shall be responsible for payment of same. The commissioner is empowered to promulgate regulations to reduce or eliminate fees for any classification or classifications of services, based upon recipients' condition or ability to pay . . . With the approval of the commissioner, district, municipal and county public health departments may establish fees and charges in excess of, or less than, fees and charges set by the commissioner. Any fee for services performed by the municipal, county or district public health departments not included on the fee schedule prepared by the commissioner shall be established by the district, municipal or county public health department. The amount of any fee established by the commissioner or by a district, municipal or county public health department under this section shall not exceed the cost of providing the service. TENN. CODE ANN. § 68-1-103 (West 2013).

Iowa allows a local health board to charge "reasonable fees" for health services provided for the protection of public health. The law does not specify who must be charged for the services. However, the health board cannot deny reasonable services to individuals because they are unable to pay.

A local board of health may provide such population-based and personal health services as may be deemed necessary for the promotion and protection of the health of the public and charge reasonable fees for personal health services. A person shall not be denied necessary services within the limits of available resources because of inability to pay the cost of such services. IOWA CODE ANN. § 137.104(2)(a) (West 2013).

Arkansas allows the department of health to establish a reimbursement system to pay for some or all costs associated with providing healthcare services, but the department of health may collect fees only from patients who are “financially able to pay,” and no clinic may deny a person a service because of inability to pay.

The Department of Health may implement a reimbursement system to recover part or all of the costs of delivering services. The system shall provide that fees shall be collected only from those patients who are financially able to pay the fee and that no one shall be denied services because of inability to pay. ARK. CODE. ANN. § 20-7-129 (West 2013).

Texas allows local governing bodies, such as the board of a public health district, to adopt ordinances and rules that establish fees for public health services. The governing bodies are restricted from charging fees to those who are unable to pay for services and may establish fee reductions for people receiving service based on their ability to pay.

The governing body of a municipality, the commissioner’s court of a county, or the administrative board of a public health district may adopt ordinances or rules to charge fees for public health services.

A municipality, county, or public health district may not deny public health services to an individual because of inability to pay for the services. A municipality, county, or public health district shall provide for the reduction or waiver of a fee for an individual who cannot pay for services in whole or in part . . .

A fee for a public health service charged in the jurisdiction of a public health district may be uniform throughout the district regardless of which governmental entity member of the district charges the fee. The fee may be set at an amount up to this highest amount charged by any governmental entity member of the district.

In this section, “public health services” means:

- Personal health promotion and maintenance services;
- Infectious disease control and prevention services;
- Environmental and consumer health programs;
- Public health education and information services;
- Laboratory services; and
- Administrative services.

TEX. HEALTH & SAFETY CODE ANN. § 121.006(b) (West 2013).

Arizona allows a county board of health to establish a reimbursement plan when the services provided are for the convenience of the patient. A health clinic cannot collect fees for services performed as a part of “preventive or curative medical care” when the “county has a legal responsibility” to the person receiving the service. Immunization services for students are the legal responsibility of the county, and the county may not charge a student, parent, guardian, or person responsible for the student any charge for immunization. Billing for vaccine administration among non-student populations, however, has been used to generate revenue sufficient to hire additional nurses and fund educational programs for child immunization.

A county board of health . . . may adopt a schedule of reasonable fees to be collected by the department for issuing or renewing licenses or permits or for other services as are authorized by law and rule of the director of the department of health services or the director of environmental quality, provided that:

- Fees for services shall not be assessed or collected for services rendered to individuals except when those services are for the convenience of the individual and not a part of the preventive or curative medical care of persons for whom the county has a legal responsibility.
- Fees for services shall not exceed the reasonable cost of providing the services required, including administrative costs.
- Any such fee or schedule shall be approved by the county board of supervisors.

ARIZ. REV. STAT. ANN. § 36-187(C)(1) (2013).

A local health department shall provide immunizations required for school attendance at no cost to the pupil’s parent, guardian or person in loco parentis. In order to receive reimbursement for the cost of immunization from the pupil’s or parent’s private health insurance coverage, the local health department may enter into a contract with a private health care insurer on its own, in conjunction with other local health departments or through a qualified intermediary. If the local health department chooses not to contract with a private health care insurer, or does not respond to the request to contract from a private health care insurer within ninety days of the request, the insurer is not required to reimburse the local health department for the immunization. If a private health care insurer declines or does not respond to a request to contract with a local health department, with a coalition of other local health departments or through a qualified intermediary within ninety days of the request to contract, the private health care insurer must reimburse the local health department at the rate paid to an in-network provider. ARIZ. REV. STAT. § 36-673(B) (2013).

Massachusetts authorizes local boards of health to charge patients who receive services for any disease dangerous to the public health, with the exception of tuberculosis. If the patient is unable to pay, the service may be charged to the municipality where the patient resides.

Reasonable expenses incurred by boards of health or by the commonwealth in making the provision required by law for persons infected with smallpox or other disease dangerous to the public health, other than tuberculosis, shall be paid by such persons, or, if such person is a minor, by his parents, if he or they are able to pay; otherwise, by the town where he has a residence upon the approval of the bill by the board of health of such town or by the

department of public health of such town or by the department of public health when such person is determined to be a chronically nonresident person. MASS. GEN. LAWS ANN. 111 § 116 (West 2013).

Louisiana state law authorizes the health department to charge for immunization services and sets a schedule of fees for some childhood vaccinations, immunizations for foreign travel, yellow fever, cholera, and typhoid vaccines, and copayment fees for each visit to a local health unit when the visit is not for one of the above immunizations. A local health unit charges fees for childhood immunizations only if the patient receives other pediatric services outside of the health department. However, the statute that sets forth the schedule of fees does not apply to Title XIX recipients (Medicaid), Title XXI recipients (Children’s Health Insurance Program – CHIP), or those who can demonstrate that their “financial status [is] at or below one hundred percent of the federal poverty level.”

The department shall charge and collect a ten-dollar administrative fee in parish health units for each childhood vaccination visit by a patient whose other pediatric services are provided outside of the department's system.

The department shall charge and collect an administrative fee of twenty-five dollars in parish health units for administering international immunizations for foreign travel. In addition, the patient shall be responsible for the parish health unit's current cost of yellow fever, cholera, and typhoid vaccines.

The department shall charge and collect a clinic service copayment fee of five dollars per clinic service and five dollars per pharmacy service, not to exceed ten dollars per clinic visit, for each service performed at a parish health unit. Such fee shall not apply to visits paid for under Subsection A or B of this Section.

The provisions of this Section shall not apply to Title XIX recipients, Title XXI recipients, and those documenting financial status at or below one hundred percent of the federal poverty level.

LA. STAT. ANN. tit. 40, § 31.36 (West 2013).

Implied Authority

“Implied authority” related to billing for immunization services grants power to the health department using a more general legal authority available in the state. While the statute does not expressly provide for the health department to bill for services, authority lies in another legal mechanism of the state such as the state’s Constitution.

In **New York**, the authority for local health departments to bill for services provided comes from the New York Constitution.⁶ Health clinics rely on the constitutional provision that gives full power and authority to municipalities to regulate local administration, with some express exceptions.⁷

Revenue Streams

A health department's motivation to bill for services is often to generate income to close the gap between the actual health department cost to provide services and the statutory authority to spend tax revenue. Therefore, laws governing whether health departments can keep the revenue they generate are critical to the analysis. States may have laws that direct health department revenue to the jurisdiction's general fund or to special health funds. Health departments' ability to retain these revenues may affect their ability to cover the expenses of setting up a third-party billing system, as well as improve on the delivery of health services. For example, healthcare funds may use all revenue from public health clinics for health-related expenses. A second type of fund permits spending public health receipts on health-related spending but mandates that some funds be reverted to the general treasury. A third type of fund allows the public health department to keep revenue from specific services for specific purposes.

Oklahoma requires that all payments coming from insurance payers for services provided to their insured become a part of the general revenue of the local government collecting that revenue.

All insurance reimbursement payments collected shall become a part of the general revenue of the unit of government levying the same. OKLA. STAT. ANN. tit. 63, § 1-214G (West 2013).

In **Iowa**, all district boards of public health are required to establish a public health fund in which all fees must be placed. At the end of the year, no more than 20% of the unexpended funds collected may remain in the public health fund. The district board may distribute the other 80% to the general district fund at its discretion.

No more than twenty percent of the unexpended balance remaining in the fund at the end of each fiscal year shall be maintained in the district public health fund. IOWA CODE ANN. § 137.112(2) (West 2013).

Texas law requires any fee collected for public health services to be placed in the state treasury under the funds for public health. The funds are then reallocated to the various state and federal programs that generated the services for which the fees were billed.

The department shall deposit all money collected for fees and charges collected under Sections 12.0122(d) (lab services) and 12.032(a) (fees for public health services) 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).

⁶ Dinesh Kumar & Dean Hendrick, *State Health Department Billing for HIV/AIDS and Viral Hepatitis Services: An Analysis of Legal Issues in Five States*, NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS 5 (Feb. 2013).

⁷ MCKINNEY'S CONST. ART. 9, § 2 (West 2013).

Arizona law requires the county’s treasurer to establish a health department fund. Any revenue received by the health department must be credited in the health department fund., and those funds may be expended only for the purposes of the local health department.

The treasurer of the county shall, upon organization of the department, establish a health department fund to which shall be credited any monies appropriated from a general county or city fund or funds, any revenue received by the department and any monies received from state, federal or other grants or donations for local health purposes. Any monies credited to such funds shall be expended only for the purposes of the local health department and claims or demands against the funds shall be allowed only if certified by the director of the department or the president of the local board of health or any other member of the board designated by the president for such purpose. ARIZ. REV. STAT. § 36-187(B) (West 2013).

Indiana requires that any fee collected by a local health department remain in the health fund of that department. The health department is allowed to charge only for the cost of services provided.

The board of each local health department may . . . establish and collect fees for specific services. . . . However, fees may not exceed the cost of services provided. The fees shall be accounted for and transferred to the health fund of the taxing jurisdiction. IND. CODE ANN. § 16-20-1-27 (West 2013).

Allowing assessment of fees by municipalities, **New York** does not require collected revenue to be placed in a specific fund. Instead, the revenues are to be used to “enhance or expand” public health services as much as possible.

Each municipality shall establish a schedule of fees for public health services provided by the municipality and shall make every reasonable effort to collect such fees. . . . To the extent possible revenues generated shall be used to enhance or expand public health services. . . . Each municipality shall periodically report to the department fees and revenue actually collected.

. . . .

Third party coverage or indemnification. For any public health service for which coverage or indemnification from a third party is available, the municipality must seek such coverage or indemnification and report any associated revenue to the department in its state aid application.

N.Y. PUB. HEALTH LAW § 606 (McKinney)

Tennessee requires any fee for services that a municipal, county, or district health department collects to cover the cost of providing the service be retained by that health department.

All fees received for the performance of services shall be retained by the district, municipal or county health department rendering the service, subject to the prior approval of the commissioner. Any fees received by the state department of health, and any fees not retained by the district, municipal or county health department, shall be deposited with the state treasurer in accordance with the provisions set forth in § 9-2-127. Any fees retained by district, municipal or county public health departments are to be applied toward the cost of providing or

expanding the service or evaluating and processing the license, permit or other authorization, and the district, municipal or county department shall provide an accounting to the state of all such fees retained by that department, in such manner as shall be determined by the commissioner. TENN. CODE ANN. § 68-1-103 (West).

Credentialing

Before a health department can begin to bill and receive reimbursement from either a public or private insurance payer for immunization (or other) services, the health department's medical staff must be credentialed as participating providers based on the payer's accepted standards or an accepted standard within the state. Healthcare credentialing is "the process of verifying education, training, and proven skills of healthcare practitioners."⁸ All healthcare providers must be evaluated through a credentialing process in order to successfully bill third-party payers, with limited exception.⁹

Credentialing is increasingly difficult when different insurance companies require different information and use varying procedures to gather information from a provider. Therefore, many states have mandated a consistent credentialing procedure, or "universal credentialing," and may use their own standardized form, while others have adopted standardized forms from other sources.¹⁰ Other states have given insurance companies leeway in determining what information is necessary to ensure quality providers. "Partially standardized credentialing" usually requires the provider to give basic information to an agency that the insurer must use, but does not prevent the insurer from requesting additional information. Some states are silent on the form of credentialing and leave the determination of necessary information to the individual insurer.

Universal Credentialing

Two models of universal credentialing were found in the sample states. One model requires insurance companies to use credentialing information provided by a standard form from the Council for Affordable Quality Healthcare (CAQH). The other universal credentialing model allows the state to create a unique standardized form for all credentialing.

CAQH Forms

Indiana requires all providers and insurers whose policies cover basic healthcare services to use the CAQH form. The law also provides a timeframe in which insurers must notify providers of any deficiencies in the credentialing application and provides that the insurer must notify the provider on a monthly basis of the application's status.

The department of insurance shall prescribe the credentialing application form used by the [CAQH] in electronic or paper format, which must be used by a provider who applies for

⁸ *What Is Healthcare Credentialing*, NAT. CREDENTIALING SOLUTIONS (last visited Oct. 3, 2014), <http://healthcarecredentialing.com>.

⁹ COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE, INITIATIVES (2014), http://www.caqh.org/about_initiatives.php.

¹⁰ Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, New Jersey, New Mexico, Ohio, Rhode Island, Tennessee, Vermont, and the District of Columbia all use a form created by the non-profit, CAQH. Texas and Oklahoma have created their own standard forms.

credentialing by an insurer and an insurer that performs credentialing activities. IND. CODE ANN. § 27-8-11-7(2) (West 2013).

Ohio requires insurers to accept the CAQH form when credentialing physicians, but the department of insurance requires a separate, standardized form “for all other providers.” The Ohio statute’s only guidelines for the standardized credentialing form for non-physician providers is that it be “as simple, straightforward, and easy to use as possible,” in consideration of other forms widely used in the state previously. Insurers are expressly prohibited from requiring information outside the standardized credentialing forms, but the insurers are not prohibited from limiting the scope of a provider’s services.

[T]he State Board of Health shall promulgate rules necessary to develop a uniform application which shall be used in the credentialing process of health care providers. The State Department of Health shall develop such application form for: Initial privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification; and credentialing or reappointment in a hospital, managed care organization, or other entity requiring credentials verification. OKLA. STAT. ANN. tit. 63, § 1-106(2) (West 2013).

Unique Standardized Forms

Texas requires the commissioner of health and human services to create a standardized credentialing form, taking into consideration any application widely used in the state previously.

The commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, a health maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials. TEX. INS. CODE § 1452.052 (West 2013).

Partial Standardized Credentialing

Many states use a middle path for standardized credentialing wherein providers disclose certain information on a standardized form. Insurers use the form to obtain baseline information but have the opportunity to gather additional information before certifying a provider.

Oklahoma requires the state board of health to develop a uniform credentialing application. Oklahoma expressly permits any insurer requiring credentials verification to require information beyond what is asked for in the uniform application.

[T]he State Board of Health shall promulgate rules necessary to develop a uniform application which shall be used in the credentialing process of health care providers. The State Department of Health shall develop such application form for: Initial privileges or membership in a hospital, managed care organization, or other entity requiring credentials verification; and recredentialing or reappointment in a hospital, managed care organization, or other entity requiring credentials verification. Any entity requiring credentials verification may require supplemental information. OKLA. STAT. ANN. tit. 63, § 1 106.2 (West 2013).

Washington has a standardized electronic process to collect provider data, but the state also permits the credentialing party to clarify information and use information from other sources to complement the state-provided data.

By December 31, 2010, the lead organization shall: Develop a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processes that . . . [s]erves as the sole source of credentialing information required by hospitals and payors from providers for data elements included in the electronic process, except this shall not prohibit: (i) A hospital, payor, or other credentialing entity subject to the requirements of this section from seeking clarification of information obtained through use of the uniform electronic process, if such clarification is reasonably necessary to complete the credentialing process; or (ii) A hospital, payor, other credentialing entity, or a university from using information not provided by the uniform process for the purpose of credentialing, admitting privileges, or faculty appointment of providers, including peer review and coordinated quality improvement information, that is obtained from sources other than the provider. WASH. REV. CODE ANN. § 48.165.035(1) (West 2013).

Arkansas has a standardized system that uses a credentialing database that meets a defined set of minimum standards. If credentialing entities use this system, they may not collect duplicate information but may supplement the information and consult the National Practitioner Data Bank.

Subject only to the exceptions recognized in subdivisions (f)(1) and (2) of this section, a credentialing organization shall be precluded hereby from seeking credentialing information from the physician or from sources other than the board if: (A) The same credentialing information is available from the board; and (B) At the time the credentialing information is requested, the board: (i) Holds certification by the National Committee for Quality Assurance as a certified credentials verification organization;(ii) Demonstrates compliance with the principles for credentials verification organizations set forth by the Joint Commission on the Accreditation of Healthcare Organizations;(iii) Documents compliance with Department of Health rules and regulations applicable to credentialing; and (iv) Maintains evidence of compliance with the standards referenced in subdivisions (e)(2)(B)(i)-(iii) of this section; and (C) The board charges fees that comply with subdivision (d)(7) of this section.” ARK. CODE ANN. § 17-95-107(e)(2) (West 2013).

Credentialing organizations that utilize the credentialing information system offered by the board shall not attempt to collect duplicate information from individual physicians or originating sources, but nothing in this section shall prevent any credentialing organization from collecting or inquiring about any data not available from or through the board, nor from reporting to or inquiring of the National Practitioner Data Bank. ARK. CODE ANN. § 17-95-107(f)(1) (West 2013).

No Standardized Credentialing

Of the states reviewed, two have no standardized credentialing processes. These states allow insurance companies to establish and determine the credentialing standards of practitioners.

Iowa allows a work group composed of health insurance carriers, consumer advocates, healthcare providers, and others to put in place any rules to improve the credentialing process.

The commissioner shall annually convene a work group composed of the consumer advocate, health insurance carriers, health care providers, small employers that purchase health insurance under chapter 513B, and individual consumers in the state for the purpose of considering ways to reduce the cost of providing health insurance coverage and health care services, including . . . improvements to provider credentialing procedures. IOWA CODE ANN. § 505.8(18) (West 2013).

New York allows “appropriately qualified health care professionals” to help develop qualification requirements of the insurance provider on an individual basis.

The plan shall consult with appropriately qualified health care professionals in developing its qualification requirements.” N.Y. PUB. HEALTH L. § 4406-d(1)(a) (2013).

Contracting

Contracting with third-party payers for services at an agreed-upon rate is one of the most difficult challenges in building a successful reimbursement system.¹¹ States can use laws to make contracting more efficient or to encourage insurers to contract with public health clinics.

To aid public health clinics, some states provide funds for personnel whose sole role is establishing contracts. To encourage insurers to contract with public health clinics, some states have centralized billing programs, whereas others simply require insurers to reimburse public health clinics for specific services even when there is no contract. Those laws make it easier and more attractive for insurers to contract with public health clinics.

An example exists in **Arizona** where a coalition of state and local health department provider organizations, other interests groups, and the Arizona Partnership for Immunization (TAPI) have a coordinate a state-wide billing program.¹² The centralization of the billing program has helped the state acquire contracts with insurance payers.¹³ TAPI was instrumental in promoting and passing state legislation to encourage providers to contract with health clinics. Until that legislation passed, health clinics had difficulty contracting with private health plans, despite local health departments being expressly authorized to contract with insurers for reimbursement for immunization services.¹⁴ The bill requires insurance payers to recognize public health departments as in-network providers.¹⁵

In **California**, the statewide budget allows for additional local health departments to receive assistance for establishing and maintaining a billing system in the initial stages of implementation.¹⁶ In Kern County, California, a grant from the Centers for Disease Control and Prevention helped expand the county’s billing program. The result was revenue 10 times the amount collected in the past.

¹¹ CENTERS FOR DISEASE CONTROL & PREVENTION, IMMUNIZATIONS BILLABLES PROJECT: BILLING PROJECT SUCCESS STORIES, KERN COUNTY (Sept. 24, 2013), <http://www.cdc.gov/vaccines/programs/billables-project/success-stories.html>.

¹² IMMUNIZATIONS BILLABLES PROJECT: BILLING PROJECT SUCCESS STORIES, ARIZONA.

¹³ *Id.*

¹⁴ ARIZ. REV. STAT. § 36-673(B) (2013).

¹⁵ IMMUNIZATIONS BILLABLES PROJECT: BILLING PROJECT SUCCESS STORIES, ARIZONA.

¹⁶ *Id.*, KERN COUNTY.

New York does not require insurance plans to contract with individual providers, and insurance plans are not required to reimburse medical providers outside their networks for service to insurance plan members.¹⁷ The state does require, however, certain terms in any contract between providers and insurers if the insurer does decide to contract with a provider, including the method of payment calculation and the amount of time in which payment must be made.¹⁸ Additionally, the New York State Department of Health Medicaid Managed Care Plan contract clause requires insurance carriers to reimburse local public health agencies for immunization and other specific public health services, even when there is no contract with the specific provider.¹⁹

Scope of Practice and Billing Codes

When health departments bill third-party payers, they typically require accurate completion of a claim form that provides information about the patient's demographics, services provided, and type of provider responsible for the services (e.g., physician, nurse, or therapist). The claim form conveys this information as diagnostic codes and procedure codes. Third-party payers rely on the existing system of diagnosis and procedure codes to administratively and financially reimburse for services. Proper use of the diagnosis and procedural codes, as well as accurate coding, is essential for claims submitted to third-party payers.

The healthcare services coding system is regulated by the Centers for Medicare and Medicaid Services and is recognized under the Health Insurance Portability and Accountability Act. The Current Procedural Terminology (CPT) coding system is maintained and copyrighted by the American Medical Association and revised each year in October. The CPT codes describe the medical, surgical, and diagnostic services provided.

The International Statistical Classification of Diseases (ICD) coding system describes the diagnosis or disorder and is maintained by the National Center for Health Statistics of the US Public Health Service. Currently, the ICD coding system uses the ninth revised edition (ICD-9), which has been in existence since 1977 and documents just over 14,000 diagnoses and 400 procedures. The tenth revised edition (ICD-10) will be released in October 2015 and will use more than 68,000 diagnostic codes and 87,000 procedure codes.

Together, third-party payers use the code systems to identify covered procedures in coordination with the identified patient diagnosis. While scope of practice is clearly a state statutory issue, third-party payers look for consistency between scope of practice and an anticipated level of care based on the available codes. The release of ICD-10 and its exponential expansion of diagnosis and procedural codes

¹⁷ NEW YORK STATE DEPARTMENT OF HEALTH, BUREAU OF IMMUNIZATION OFFICE OF PUBLIC HEALTH PRACTICE, ELEMENTS FOR SUCCESSFUL BILLING PRACTICE AT NEW YORK STATE'S LOCAL HEALTH DEPARTMENTS (June 2012), [http://www.naccho.org/toolbox/toolbox/Billing_Toolkit_\(1\)_State_Toolkits_-_NY_Elements_for_Successful_Immunization_Billing_Practice_1.pdf](http://www.naccho.org/toolbox/toolbox/Billing_Toolkit_(1)_State_Toolkits_-_NY_Elements_for_Successful_Immunization_Billing_Practice_1.pdf).

¹⁸ See DEPARTMENT OF FINANCIAL SERVICES, HEALTH CARE PROVIDER RIGHTS (last visited Oct. 2, 2014), <http://www.dfs.ny.gov/insurance/hprovrght.htm>.

¹⁹ *Id.*; NEW YORK STATE DEPARTMENT OF HEALTH, MEDICAID MANAGED CARE/FAMILY HEALTH PLUS/HIV SPECIAL NEEDS PLAN MODEL CONTRACT (Aug. 1, 2011), http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

will likely be a defining moment in health care and may enable health departments to alter practices to bill third-party payers for services provided. The Department of Health and Human Services will not release ICD-10 until October 2015; therefore, further discussion related to CPT and ICD codes are outside the scope of this paper.

Clinics often rely on nurses and other providers, such as medical assistants to provide services. Every state establishes a code of scope of practice for health providers, including doctors, nurses, and other providers. “Scope of practice” refers to the defined boundaries within which a licensed practitioner may practice within his or her field.²⁰ A state defines the scope of practice for each practitioner in statute or regulation. Because the legal definition of scope of practice determines what different practitioners can and cannot do and consequently can and cannot get paid for, there are often underlying tensions between interests groups when a state sets or changes a scope of practice.²¹

Nurse Protocols

Nursing initially was considered “the performance of certain functions under the supervision of a physician.”²² Eventually, states permitted nurses to broaden their practice from a complementary role to an active practice role. Nurses are often permitted to diagnose medical issues and provide treatment within their scope of practice.²³ Although nurses are granted a wider practice role, nursing practice acts place limitations on nurses to ensure that a physician’s knowledge and abilities are available when needed.²⁴ These acts often require nurses to work under a physician’s supervision or under a written protocol between the nurse and a physician. Nursing practice acts often limit which types of nurses can perform certain procedures and whether on-site supervision is necessary to perform the action. They can also limit the number of nurses a doctor can supervise when he or she is not on site. Nursing practice acts often have special exceptions or allowances for public health providers.²⁵ However, relatively few states permit registered nurses to perform medical procedures independently without on-site supervision.²⁶

California permits nurse practitioners to prescribe medication under protocols when a doctor is available by phone, but registered nurses may only administer medication when given an order for a specific patient.²⁷

²⁰ *Id.*

²¹ *Id.* at 8.

²² Elizabeth Harrison Hadley, *Nurses and Prescriptive Authority: A Legal and Economic Analysis*, 15 AM. J.L. & MED. 245, 250 (1989) (describing initial mandatory licensing laws for nurses).

²³ *See id.* at 258 (describing amendments to Connecticut’s Nursing Practice Act that broadened definition of nursing to include diagnosing medical problems and providing care under direction of doctor).

²⁴ *Id.* at 259.

²⁵ American Medical Association (AMA), *AMA Scope of Practice Data Series: Nurse Practitioners*, Chicago, Ill. (October 2009); *see also* Tracy Yee, Elynn R. Boukus, Dori Cross & Divya R. Samuel, *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, NATIONAL INSTITUTE FOR HEALTHCARE REFORM (Feb. 2013), www.nihcr.org/PCP-Workforce-NPs.

²⁶ *See* Barton Associates, *Interactive Nurse Practitioner Scope of Practice Law Guide* (last visited Nov. 18, 2013), <http://www.bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/>.

²⁷ *Compare* CAL. BUS. & PROF. CODE §§ 2725.1 & 2836.1 (West 2013).

Washington allows registered nurses to practice under the “general direction” of a physician.²⁸

Oklahoma permits registered nurses to provide services under protocols when working in a public health setting.²⁹

New York limits registered nurses to providing certain services under protocols from a nurse practitioner or a doctor, most of which relate to public health.³⁰

States also differ as to whether registered nurses or nurse practitioners must be supervised on site. Many laws are vague on the standard of supervision required; some allow practice under the general guidance of the physician or allow the written protocol itself to set the standard of supervision.³¹

Under **California** and **New York** laws, nurse practitioners may practice under protocols when the supervising physician is available by phone.³²

Ohio allows nurse anesthetists to administer anesthesia under supervision from a physician or dentist, but the anesthesia must be administered in the “immediate presence” of the physician.

Physician Assistant and Medical Assistant Protocols

In public health clinics, care is often provided by medical assistants, physician assistants, and specially trained public health workers. These professionals allow clinics to provide comparable primary care for a much lower price. State laws often grant special exceptions that permit alternative providers to work in public health facilities. However, this may impede the clinic’s ability to bill for services if their protocols do not match state requirements.

Physician assistants

A physician assistant is “a person [who is] not a physician nor [a] person holding a medical doctor or equivalent degree who is qualified by academic and practical training to provide certain patient service under the supervision, control, responsibility, and direction of a licensed physician.”³³ The definition might suggest that a physician assistant must work in the same facility as the supervising physician, but most state laws permit a physician assistant to work when a physician is not present.

California and **Ohio** require a physician to be present when a physician assistant provides services within his or her practice.³⁴

²⁸ WASH. REV. CODE ANN. § 18.79.260(2) (West 2013).

²⁹ OKLA. STAT. ANN. tit. 63, § 1-290.2 (West 2013).

³⁰ See N.Y. EDUC. L. § 6909(4) & (5); N.Y. COMP. CODES & REGS. ch. 8, § 64.7 (2013).

³¹ See, e.g., WASH. REV. CODE ANN. § 18.79.260(2) (West 2013); ARK. CODE ANN. § 17-87-310 (West 2013).

³² CAL. BUS. & PROF. CODE § 2725.1(A) (West 2013); N.Y. EDUC. L. § 6909(4) (McKinney 2013).

³³ Chris L. Gore, Commentary, *A Physician’s Liability for Mistakes of a Physician Assistant*, 15 J. LEG. MED. 125, 126 (2000).

³⁴ See CAL. BUS. & PROF. CODE § 3502(b) (McKinney 2013); OHIO ADMIN. CODE § 4730-1-02(A)(2) (2013).

Most state laws merely require that the physician is available by telephone and provide other means for ensuring that the physician monitors the physician's assistant.³⁵

Indiana permits off-site supervision so long as the physician is available to see the patient within 24 hours and the physician is a reasonable travel distance from the physician assistant.³⁶

Oklahoma permits off-site supervision by a physician but requires physician assistants to be approved by a licensed physician in order to work at remote sites, including federal qualified health centers and rural health centers.³⁷

Medical assistants

Medical assistants are licensed healthcare workers who “complete administrative and clinical tasks in the offices of physicians, podiatrists, chiropractors, and other health practitioners.”³⁸ Some states regulate the tasks that can be done by medical assistants.

Arizona permits medical assistants to take samples and give injections under direct supervision of doctors, physician assistants, or nurse practitioners.³⁹

Washington permits certified medical assistants, who are licensed by the state, to perform basic medical tasks without direct supervision.⁴⁰

Legislative Initiatives

Some states have considered expanding the role of practitioners in delivering services that accompany vaccinations, such as permitting nurse practitioners to bill for counseling without a physician present.⁴¹ An argument against this change comes from groups such as the American Medical Association, who argue that seeing a nurse practitioner rather than a primary care physician without physician oversight can put the patient at risk.⁴² Proponents argue that nurse practitioners are educated to perform these services and already do as a part of physician-led teams.⁴³

Massachusetts has enacted legislation that requires all insurers to consider nurse practitioners as qualified primary care providers if they are acting within the scope of practice.⁴⁴

³⁵ See IND. CODE ANN. § 25-27.5-2-14 (2013).

³⁶ *Id.*

³⁷ See OKLA. STAT. ANN. tit. 59, § 519.6 (2013).

³⁸ Bureau of Labor Statistics, *Occupational Outlook Handbook: Medical Assistants*, U.S. DEP'T OF LABOR (Jan. 8, 2014), available at <http://www.bls.gov/ooh/Healthcare/Medical-assistants.htm>.

³⁹ ARIZ. REV. STAT. ANN. § 32-1456(A) (West 2013).

⁴⁰ See WASH. REV. CODE ANN. § 18.360.050 (West 2013).

⁴¹ See Tracy Yee, Ellyn R. Boukus, Dori Cross & Divya R. Samuel, *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, NATIONAL INSTITUTE FOR HEALTHCARE REFORM (Feb. 2013), <http://www.nihcr.org/PCP-Workforce-NPs>.

⁴² *See id.*

⁴³ *See id.*

⁴⁴ THE COMMONWEALTH OF MASSACHUSETTS, General Laws, Section 3: Qualification of Nurse Practitioner as Primary Care Provider (2014), <http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176R/Section3>.

Michigan introduced a bill to expand the role of nurse practitioners in delivery primary care but it was not passed as introduced in the House during the 2011 session.⁴⁵

Public Health Clinics as In-Network Providers and Any Willing Provider Laws and Public Health

One way to facilitate billing by public health clinics is to require insurance companies to treat such clinics as in-network providers. Similarly, “any willing provider” laws provide a unique opportunity for states to integrate service providers into the existing third-party reimbursement system. “Any willing provider laws require that insurers, managed care organizations, and other health plans give all physicians (and sometimes other providers) membership on their preferred provider lists if those physicians are willing to meet the terms and conditions for membership and if they offer the type of medical services that the insurers or managed care organizations offer their subscribers.”⁴⁶

Many states have passed some form of any willing provider laws. Such laws are generally limited in two ways. First, any willing provider laws usually apply to a limited subset of medical providers.⁴⁷ Second, they always require the provider to agree to the insurance company’s terms.⁴⁸ Analysis of our sample shows that any willing provider laws can be used to mandate coverage of care provided by public health clinics but are generally used to ensure coverage of specific specialties.

In-Network Provider

Oklahoma requires insurance companies to compensate city-county health departments on a “standard and customary rate schedule established by the plan.”

When a city-county health department provides a health-related service to any person covered by an applicable health insurance plan, the city-county health department may submit a claim for said service to the appropriate insurance company, health maintenance organization or preferred provider organization. . . . All health insurance plans, doing business in Oklahoma, shall recognize the public health service delivery model utilized by the city-county health department, as an appropriate provider of services for reimbursement. OKLA. STAT. ANN. tit. 63, § 1-214(G) (West 2013).

Any Willing Provider

Indiana’s any willing provider law potentially applies to some public health practitioners, as it ensures access to groups of professionals, including physicians, dentists, and psychologists.

Notwithstanding any provision of any individual or group policy of accident and health insurance, or any provision of a policy, contract, plan, or agreement for hospital or medical service or indemnity, wherever such policy, contract, plan, or agreement provides for

⁴⁵ Michigan House Bill 4774 at <http://legislature.mi.gov/doc.aspx?2011-HB-4774> (2011).

⁴⁶ Larry J. Pittman, “Any Willing Provider” Laws and ERISA’s Saving Clause: A New Solution for an Old Problem, 64 TENN. L. REV. 409, 427–8 (1997).

⁴⁷ Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation & Policymaking*, 16 STAN. L & POL’Y REV. 233, 261 (2005).

⁴⁸ See, e.g., IND. CODE ANN. § 27-8-11-3(c) (West 2013) (“No hospital, physician, pharmacist, or other provider . . . willing to meet the terms and conditions of agreements . . . may be denied the right to enter into an agreement.”).

reimbursement for any service which is in the lawful scope of practice of a duly licensed dentist, health service provider in psychology, podiatrist, osteopath, optometrist, or chiropractor, the person entitled to benefits or the person performing services under the policy, contract, plan, or agreement shall be entitled to reimbursement on an equal basis for such service, whether the service is performed by a physician, dentist, health service provider in psychology, podiatrist, osteopath, optometrist, or chiropractor duly licensed under the laws of this state.” IND. CODE ANN. § 27-8-6-1 (West 2013).

Arkansas’s any willing provider law is the most expansive. It explicitly includes community mental health clinics and rural health clinics.

A health care insurer shall not . . . [p]rohibit or limit a health care provider that is qualified under § 23-99-203(d)⁴⁹ and is willing to accept the health benefit plan's operating terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards, from the opportunity to participate in that plan. ARK. CODE ANN. § 23-99-204(a)(3) (West 2013).

Essential Community Providers

The Affordable Care Act (ACA) mandates that any qualified health provider (QHP) who operates within the Health Insurance Marketplace must have a sufficient number of, and appropriate geographic distribution of essential community providers to ensure reasonable and timely access to low-income, medically underserved individuals in the QHP’s service area.⁵⁰ The federal government has set a threshold definition of “essential community provider” that will apply in federally operated exchanges for states that have declined to operate a health benefit exchange.⁵¹ This definition describes the minimum standards for what insurance on the health benefit exchanges must offer; however, states may use a wider definition of “essential community provider so long as services provided exceed requirements set forth in the ACA.”⁵² This section discusses the federal definition of “essential community provider” and gives examples of state definitions.

Federal Definition

“Essential community providers are providers that serve predominately low-income, medically underserved individuals.”⁵³ This includes federally qualified health centers, patient navigator programs, family planning projects, AIDS detection services, and Indian health clinics, as well as 501(c)(3) nonprofit organizations providing substantially similar services without receiving federal funding.⁵⁴ The statutory definition is not exclusive though,⁵⁵ suggesting that states have discretion to widen the scope of

⁴⁹ *Id.* § 23-99-203(d) (defines by profession who may be a licensed provider in Arkansas)

⁵⁰ *See* 42 U.S.C. § 18042 (2012) and C.F.R. § 156.235.

⁵¹ *See* 42 U.S.C. § 18041(c)(1) (granting Secretary of HHS authority to run exchange in state where it is determined that there will be no exchange by January 1, 2014).

⁵² George Washington Q&A on Essential Community Providers 3, GEORGE WASHINGTON UNIV. SCHOOL OF PUBLIC HEALTH & PUBLIC SERVICES, DEPARTMENT OF HEALTH POLICY (May 13, 2013), available at <http://www.healthreformgps.org/wp-content/uploads/ECP-FAQ-5-14.pdf>.

⁵³ *See* 45 C.F.R. § 156.325 (2012) (using the same reference statutes as 42 U.S.C. § 18031).

⁵⁴ *See* 42 U.S.C. § 18031(c)(1)(C) (2012) (referencing 42 U.S.C. §§ 256b(a)(4) & 1396r-8(c)(1)(D)(i)(IV) (2012)).

⁵⁵ *See id.* (stating that plans must include providers “such as” those listed in statutes cited above).

essential community providers. This definition will apply by default in states that have chosen not to establish health insurance exchanges.

The federal definition of essential community provider will also be used in states that have established borrowing federal definitions for the health benefit exchange or have not defined the term differently.

California has incorporated the federal definition of “essential community provider” in regulation.

Essential Community Providers: Providers that serve predominantly low-income, medically underserved individuals, as defined in 45 C.F.R. 156.235. 10 CAL. CODE REG. § 6410 (2013).

Arkansas has not defined “essential community provider” but has incorporated federal standards to determine qualified health plans, and these plans must meet federal standards for covering essential community providers.

“Qualified health plan” means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the [Affordable Care Act]. ARK. CODE ANN. § 23-61-802(6) (West 2013).

States with Alternative Definitions

A few states have enacted alternative definitions of essential community providers. While some of these definitions will impact certain public health clinics, they focus mostly on general primary care providers rather than specialty clinics.

Washington mandates that tribal clinics and urban Indian clinics be included as essential community providers but does not provide a base definition for essential community provider.

The board shall certify a plan as a qualified health plan to be offered through the exchange if the plan is determined by the Board to include tribal clinics and urban Indian clinics as essential community providers in the plan’s provider network consistent with federal law. WASH. REV. CODE ANN. § 43.71.065(1)(c) (West 2013).

Iowa defines essential community providers but gives wide discretion to the health commissioner to determine who should be considered an essential community provider.

“Essential community providers” means those publicly funded health care providing organizations which the director deems to be vital to a local health care delivery system to ensure that all vulnerable populations in Iowa have assured access to health care. IOWA ADMIN. CODE r. 641-202.1 (2013).

California regulations incorporate the federal definition of essential community provider, but additional guidance from the California Health Benefit Exchange includes school-based health centers as essential community providers.⁵⁶

Although it is outside the scope of our research, **Minnesota** has defined “essential community provider” and outlined minimum standards for being considered an essential community provider; therefore, we have included Minnesota’s law.

The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following: (1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and (2) a commitment to serve low-income and underserved populations by meeting the following requirements: (i) has nonprofit status in accordance with chapter 317A; (ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3)1; (iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and (iv) does not restrict access or services because of a client's financial limitation; (3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal government, an Indian health service unit, or a community health board as defined in chapter 145A; (4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions; (5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, “sole community hospital” means a rural hospital that: (i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services; (ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and (iii) consists of 40 or fewer licensed beds; or (6) a birth center licensed under section 144.615. MINN. STAT. ANN. § 62Q.19(1) (West 2013).

Conclusion

It is necessary to address the widening gap between health department costs and tax-generated funds available to provide public health services. With an increasing number of patients who use the health department for services who are fully insured to receive the services, state and local health departments should understand the practice environment and their own jurisdictional requirements to successfully bill insurance companies for services provided. While this paper explores various issues for

⁵⁶ California Health Benefit Exchange, 2012–2013 Initial Qualified Health Plan Solicitation to Health Issuers and Invitation to Respond (Nov. 14, 2012), *available at* http://www.healthexchange.ca.gov/Solicitations/Documents/V_HBEX_QHPSolicitation_11-14-12.pdf.

consideration, this area of legal practice is evolving and we will continue to see changes in the coming decades.

Disclaimer

The information contained in this document does not constitute legal advice and does not represent the views of the Centers for Disease Control and Prevention or the Department of Health and Human Services. Use of any provision herein should be contemplated only in conjunction with advice from legal counsel. Provisions may need to be modified, supplemented, or replaced to ensure appropriate citation to or compliance with relevant laws or to otherwise address the needs or requirements of a specific jurisdiction.

Published January 15, 2015.