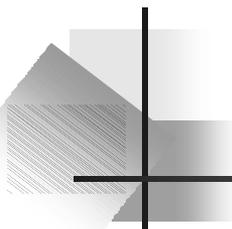


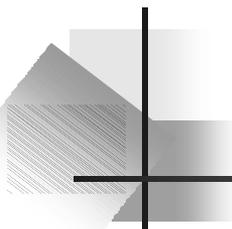
Determination of Covered Entity Status

Who Am I?



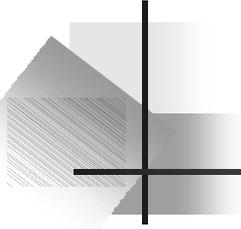
Covered Entity Status

- Determining covered entity status under HIPAA is the first step in knowing:
 - Whether HIPAA applies to you
 - How HIPAA applies to you
- Covered Entity status is determined by function, not by title
 - It's what you do, not what you call it



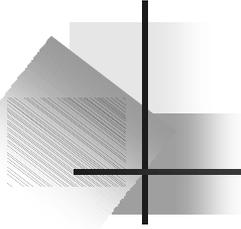
Who Must Implement HIPAA?

- **Health plans** – Any group or individual plan that pays or provides cost of medical care. Named plans include Medicaid, SCHIP, CHAMPUS, Indian Health Services, employee benefit plans, health insurance issuers, HMOs, etc.
- **Health-care providers** who use computers/ telephones to transmit health information. (Case Management, physician or nurse services, home health services, chemical dependency services, assessment services, immunizations, functional or habilitation services).
- **Health Care Clearinghouses** - Includes billing services, re-pricing companies, and any other entities that process information received from another entity.



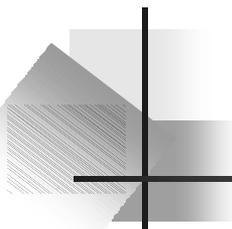
First Steps

- List all organizational functions (not just major ones)
- If there are multiple departments/programs, list the functions of each one
- Identify all funding sources, including government funding (Medicaid funding may have particular implications)
- Identify any grant funding
- Is any grant funding passed on to others as grants?



HIPAA Providers

- Health care provider functions
 - Many programs provide “health care” including care, services, or assessment with respect to the physical or mental condition of an individual
 - Examples: case management, casework services, assessments, counseling, etc.
- Not all providers are covered
 - Only providers who transmit health information electronically are covered entities



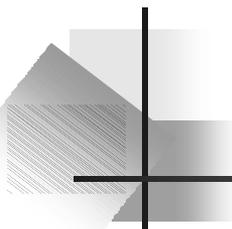
Health Care Provider

Does your program furnish, bill, or get paid for health care, or provide medical or health services and transmit any health information in electronic form in connection with a covered transaction?

“Health care” means care, services or supplies related to the health of an individual, including, but not limited to: preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affect the structure or function of the body; and sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

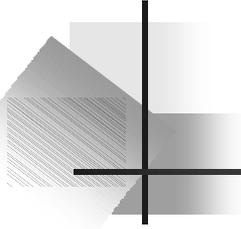
Yes. Your program *is* performing HIPAA provider functions.

No. Your program *is not* performing HIPAA provider functions.



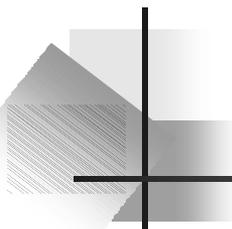
Covered Transactions

- Billing (claims) transactions most likely
- Eligibility information
- Electronic check stub (Remittance Advice)
- Claims status
- Authorization
- Typical examples
 - Medicaid or Medicare
 - State programs
 - Via Internet, modem, State or Federal systems



HIPAA Health Plans

- Named plans under HIPAA include:
 - Medicaid and Medicaid waiver program
 - Named plans cannot utilize exceptions
- Functional plan- any program that pays for medical care
 - Not all government health plans may be covered
 - May meet exception if primary purpose is not health care
 - May meet exception if funding provided through grants



Counties--Health Care Plan

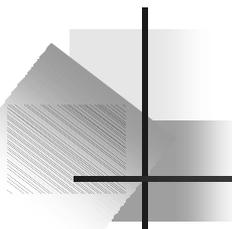
Does your program provide or pay the cost of medical care?

You provide Medical care when you PAY for:

- **Diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body**
- **Transportation primarily for/essential to medical care**
- **Insurance covering medical care**

Yes. Your program performs HIPAA Health Plan functions.

No. Your program may still perform HIPAA Health Plan functions.



Health Care Plan Exceptions

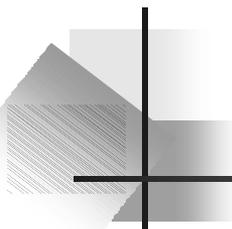
Does your program's function(s) meet one or more of the three Health Plan function exceptions?

a. Does your program pay for excepted benefits?

Medical care is secondary or incidental to other insurance benefits: coverage only for accident, or disability insurance, liability insurance including general and automobile, workers compensation

b. Is your government-funded program's principal purpose other than providing, or paying the cost of, health care?

c. Is your government-funded program's principal activity the direct provision of health care to persons or making of grants to fund direct provision of health care to persons?



Health Care Plan Exceptions

Does your program's function(s) meet one or more of the three Health Plan function exceptions?

Yes to (a). That portion of your program that provides or pays for excepted benefits is excluded from the Health Plan definition

Yes to (b) or (c). Your program is excluded from the Health Plan definition, though you may be a health care provider.

No to all. Your program is not excluded as a Health Plan by these exclusions.

County Covered Entity Status - Overall

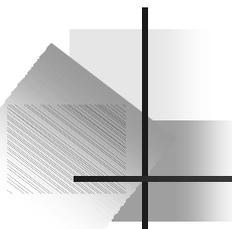
- The “covered entity” is the “legal entity”
- “...where a public program meets the definition of “health plan” the government agency that administers the program is the covered entity.” *Federal Register*, Vol. 65, p. 82578
- Generally, the county government as a whole is the legal entity
- County departments also determine covered entity by department as part of the county’s covered component

County Covered Entity Status - Programmatic

- Which county programs meet the covered entity definition?
- **Decision Point**: At what level will the agency/department test for the government funded program exception: Department, Division, Unit, Program...?
- To the extent that the substance abuse program is part of a larger organizational level, it may be included or excluded as a health plan
- Ultimate decision is at the departmental or county level

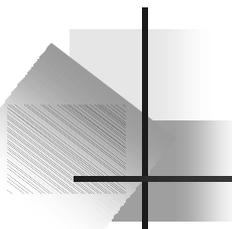
Covered Provider Requirements

- Providers are not required under HIPAA to conduct any transactions electronically
- However, many payers may require any transactions submitted to them be electronic (and therefore in the standard)
- Any standard transactions (most commonly, claims) that are conducted electronically must use the HIPAA standard transactions format and content



Health Plan Requirements

- Health plans are required to have the capability to conduct all standard transactions they use electronically
- All standard transactions conducted by health plans must use the HIPAA standard format and content
- Health plans can continue to accept paper transactions, but operating two systems can be costly



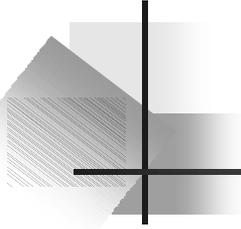
Counties--Clearinghouse

Does your program currently receive health care transactions (regardless of media) from health care providers or other entities, translate the data from one format into another format and forward the processed transaction?

Examples include any of the following: billing service, repricing company, community health management information system, or community health information system, and “value-added” networks and switches

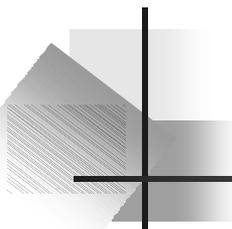
Yes. Your program performs HIPAA Health Care Clearinghouse functions.

No. Your program does not perform HIPAA Health Care Clearinghouse functions.



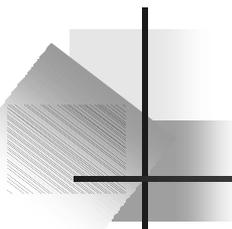
Clearinghouse Requirements

- Clearinghouses are required to have the capability to conduct in electronic form all standard transactions their business partners use
- All standard transactions conducted by clearinghouses must use the HIPAA standard format and content
- Clearinghouses must be able to accept and translate transactions in, from and to both the HIPAA standard and the business partner's format



Counties and Providers

- Business Associates
 - If Counties are acting as clearinghouses for their providers, they are business associates of their providers
 - Providers must have a BA agreement with the County
 - BA agreement requires privacy and security assurances
- Trading Partners
 - If Counties are not acting as business associates, then the Counties and providers are trading partners
 - Trading partner agreements are not required under HIPAA; expectation is that such agreements already exist
 - Trading partner agreements set out the rules of doing business between the parties



Multi-Function Status

- A covered entity that performs multiple covered functions that would make the entity any combination of a plan, provider, or clearinghouse must:
 - Comply with the standards as applicable to each type of entity for that entity's functions performed, and
 - Use or disclose PHI only for the purposes related to the function being performed, *e.g., either health plan or provider, but not both*