

July 20, 2016

Ms. Vikki Wachino
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Center for Medicaid and Medicare Services

Re: North Carolina Medicaid and Health Choice Section 1115 Demonstration Waiver

Dear Ms. Wachino:

The Duke Health Justice Clinic and North Carolina AIDS Action Network (NCAAN) appreciate the opportunity to comment on North Carolina's Medicaid and Health Choice Section 1115 Demonstration Waiver Application.

We submitted extensive written comments during the state comment period, and have attached those comments to this letter ("State Comments"). Those comments provide important background information about the HIV/AIDS Medicaid population in North Carolina and important health care priorities. In this letter, we highlight our most important concerns.

While we applaud the State's demonstration goal of achieving the "Quadruple Aim" of improving the patient care experience, improving population health, containing per capita costs, and improving provider engagement and support, we are concerned that the demonstration application lacks detail and specifics. Much program development and planning remains, and we hope CMS will make certain that the needs of people living with HIV/AIDS and other serious illness are protected as the demonstration program evolves. We note that the State's Response to Public Comments does provide some additional detail, but many of those responses are not incorporated into the body of the waiver application. We encourage CMS to ensure that commitments made in the Response to Public Comments are maintained.

Key Concerns

Access to Medications

People living with HIV/AIDS depend on unfettered access to life-saving antiretroviral medications, as well as drugs for comorbid conditions. We are generally supportive of the State's plans with respect to prescription drugs, although the demonstration application does not set those out in detail. As we understand those plans, the State intends to require all PHPs to use a standard formulary and preferred drug list, which will be established by DHHS. Further, the State "intends to specify in PHP contracts that the PHP's utilization management requirements can be no more restrictive than the State's requirements unless the State has provided prior approval of the PHP's UM requirements."¹ We endorsed such a requirement in our State Comments and are pleased that the State plans to take this approach. However, the State's

¹ Demonstration Application, Response to Public Comments, 136.

commitments to holding PHPs to a standard formulary and utilization management requirements will be of no consequence unless the State continues to provide an expansive formulary and avoid unnecessary and burdensome utilization management techniques such as prior authorization or step therapy. We are concerned by the State’s reference to the possibility of permitting exceptions to utilization management requirements at the request of PHPs. We note that many providers expressed concern in the state public comment period about the administrative burden of dealing with multiple PHPs and their unique requirements. To reduce burden on providers, and increase access for beneficiaries, we urge that the State not permit utilization management exceptions. We ask the following with respect to drug coverage:

- Require all PHPs to use the state’s Fee for Service formulary and employ utilization management criteria that are no more restrictive than Fee for Service Medicaid, without exception.
- With respect to antiretroviral drugs, require that utilization management criteria be based on Department of Health and Human Services *Adult and Adolescent Antiretroviral Treatment Guidelines*.

Provider Access

As discussed in our State Comments, access to qualified HIV specialists is key to retaining beneficiaries in care and achieving viral suppression. In our State Comments, we asked that Ryan White providers be designated as essential providers. In its response, the State replied that North Carolina statute “prohibits DHHS from classifying physicians and other practitioners as essential providers. However, DHHS intends to include requirements specific to enrollees with HIV/AIDS in the PHP contract, including network requirements that encourage PHPs to contract with Ryan White providers.”² We appreciate the statutory requirement, but were not asking that individual Ryan White funded physicians be designated as essential providers, rather that clinics or other entities receiving Ryan White funds receive this designation. We do acknowledge the complexities of such designations, particularly when the Ryan White funds are directed to a larger entity, such as a large hospital system. We appreciate the State’s stated intention to include contract requirements specific to enrollees with HIV/AIDS, and urge the following with respect to provider access:

- Network adequacy factors should include reasonable access to HIV specialists, without referral, including out of network access if HIV specialists are not reasonably available.
- Require plans to develop uniform criteria for designating HIV specialists, and require that such specialists be identified as such in provider directories.

Quality Measures and Performance Incentives

We support the State’s intention to adopt appropriate quality measures and financial performance incentives for PHPs and providers. We urge the State to adopt quality measures for HIV particularly, as discussed in our previous comments at page 9.³

² Demonstration Application, Response to Public Comments, 141.

³ We specifically endorse NQF #2082 – Viral Load Suppression.

Enrollment/Transition to Managed Care

The transition of nearly all of North Carolina's 1.9 million beneficiaries to managed care will be a challenging undertaking. Since North Carolina is a late adopter of managed care, we can learn from the experiences of other states. In other states that have implemented managed care in recent years, such as Illinois and California, the transition has been disruptive of provider relationships, retention in care, and adherence to lifesaving medications. It is imperative that the State plan adequately for vulnerable populations such as people living with HIV/AIDS.

- Ensure that beneficiaries have adequate information to make informed decisions about enrollment, including information about formularies, providers, and plan performance.
- Include prior specialist relationships as an auto-assignment factor.
- Adopt other measures to ensure that access to providers and medications will not be disrupted in the transition to managed care.

Consumer Protections:

In our State Comments, we urged that PHPs be required to comply with consumer protections in Chapter 58. We applaud the State's response that "when not superseded by federal Medicaid managed care requirements, DHHS intends to incorporate the provider and patient protections in Chapter 58 in the PHP contract, program regulations, and/or NC Medicaid statute."

Support Services for People Living with HIV/AIDS

We have previously encouraged the State to explore additional opportunities for innovation in serving people living with HIV/AIDS, including programs to offer services or supports such as housing, enhanced case management, or other support services aimed at addressing social determinants of health. We appreciate that the State has indicated in its response to comments that "DHHS supports services for persons with HIV/AIDS and plans to include requirements specific to persons with HIV/AIDS in the PHP contract." We urge CMS to encourage the State to consider further innovations in this area, including the possibility of identifying a PHP to specialize in serving people with HIV/AIDS, similar to the demonstration's plan to designate a PHP to provide care for foster children.

Waiver Authority

We note in Section 9 of the application that the state seeks waiver authority with respect to amount, duration, and scope of services. It is not clear from the waiver application whether the State contemplates any reductions in amount, duration, or scope of services. We hope CMS will clarify whether any such reductions are planned, and if so, ensure that stakeholders have the opportunity to respond prior to approval of the waiver.

Research and Evaluation

North Carolina has historically operated a highly successful Fee for Service Medicaid program, with excellent levels of provider participation and patient access. It is now essentially recreating

its Medicaid system, placing at risk the accomplishments of many decades. Thus it is imperative that the new program be evaluated rigorously, with attention to quality measures.

Medicaid Expansion

In its application, the state has sought expenditure authority for uncompensated care costs. While we support the plight of safety net hospitals and the need for supplemental funding, we agree with CMS's principal that uncompensated care funds should not pay for costs that would otherwise be covered in a Medicaid expansion. We join the many other individuals and organizations urging North Carolina to expand Medicaid as part of its implementation of managed care. There are 5000 or more people living with HIV in North Carolina who presently have no health insurance, as well as thousands more who are at risk of HIV. In addition to the many other economic, moral, and practical reasons that North Carolina should expand Medicaid, expansion would play a critical role in achieving the goal of the National AIDS Strategy that "the United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unfettered access to high quality, life-extending care...."

Thank you for the opportunity to comment on the North Carolina Medicaid and NC Health Choice Section 1115 Demonstration Waiver Application. Please contact Allison Rice, Duke Health Justice Clinic, rice@law.duke.edu, or Lee Storrow, North Carolina AIDS Action Network, lee@ncaan.org if there are any questions.

Supporting Organizations

AIDS United, Washington, D.C.
Ballantyne Family Medicine, Charlotte, NC
Carolinas CARE Partnership, Charlotte, NC
East Carolina University Infectious Diseases, Greenville, NC
National Alliance of State and Territorial AIDS Directors, Washington, DC
Positive Wellness Alliance, Lexington, NC
Regional AIDS Interfaith Network (RAIN), Charlotte, NC
Southern AIDS Coalition, Birmingham, AL
Southern HIV/AIDS Strategy Initiative, Durham, NC
Triangle Empowerment Center, Inc., Durham, NC
Warren-Vance Community Health Center, Inc., Henderson, NC
Wellness & Education Community Action Health Network, NC
Western North Carolina AIDS Project, Asheville, NC
Women's Empowerment Team of the East, Greenville, NC

April 18, 2016

Division of Health Benefits
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: North Carolina Medicaid and NC Health Choice Draft Section 1115 Waiver Application

The Duke Health Justice Clinic and North Carolina AIDS Action Network (NCAAN) appreciate the opportunity to comment on North Carolina’s Medicaid and NC Health Choice Draft Section 1115 Waiver Application (“Draft Waiver”).

The Duke Health Justice Clinic is a project of Duke School of Law and has been providing free legal assistance to low-income people living with HIV/AIDS since 1996, as well as policy research and advocacy on issues related to HIV, including access to healthcare.

NCAAN is a state-wide advocacy organization that aims to improve the lives of people living with HIV/AIDS and affected communities through outreach, public education, policy advocacy, and community-building to increase visibility and mutual support of people living with HIV/AIDS throughout the state.

I. INTRODUCTION

A. HIV Population in North Carolina

There are over 7,000 people living with HIV in North Carolina who depend on Medicaid for healthcare.¹ If Medicaid is expanded, another 4000 – 5000 people living with HIV will be eligible for benefits.²

B. Healthcare Needs of People living with HIV

The vision of the National HIV/AIDS Strategy is that “the United States will become a place where new HIV infections are rare, and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic

¹ Kaiser State Health Facts, 2011, <http://kff.org/hiv/aids/state-indicator/enrollment-spending-on-hiv/>

² Estimate based on enrollment in AIDS Drug Assistance Program.

circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”

Medicaid has a major role to play in the achievement of these goals, by providing care and prevention services to people living with HIV as well as those who are at risk. A study led by researchers at the University of North Carolina found that when HIV patients are treated with antiretroviral medications and their HIV virus is suppressed to an undetectable level, they are 96 percent less likely to transmit HIV.³ Thus the highest goal of HIV treatment is viral suppression. To achieve that goal, efforts must be focused on the steps along the HIV care continuum: diagnosis, linkage to care, retention in care, prescription of antiretroviral therapy, and viral suppression.⁴ Medicaid policies can have a profound impact on each of these steps.

Even though suppression of HIV virus greatly reduces the chances of transmission, only 45% of people living with HIV in North Carolina were virally suppressed in 2014.⁵ Without proper healthcare, people living with HIV may not learn of their HIV status, fail to receive care, lack consistent access to antiretroviral medications, develop resistance to medications, and experience a rise in viral load that makes it easier to transmit HIV. Providing adequate healthcare to people living with HIV, including easy access to HIV specialists and antiretroviral medications, is critical to controlling the HIV epidemic, to public health, and to managing public finances.

C. The Role of HIV Specialists and Medications in Achieving Viral Suppression

i. HIV Specialists

To achieve viral suppression and optimal outcomes, people living with HIV must receive care from a provider with HIV expertise. Many HIV specialists are physicians trained in Infectious Diseases, but not all Infectious Diseases specialists have the experience to manage patients with HIV. Many providers with HIV expertise are physician’s assistants or nurse practitioners. There is no board certification for HIV medicine, but several professional organizations have identified the necessary qualifications, including the HIV Medicine Association (HIVMA), American Academy of Medicine (AAHIV), and Associations of Nurses in AIDS Care (ANAC). The AAHIV has a credentialing process for HIV physicians, nurse practitioners, physician’s assistants and pharmacists. ANAC created the HIV/AIDS Nursing Certification Board for certification of registered nurses and nurse practitioners in HIV nursing.⁶ Some state Medicaid programs, including Florida, have established additional criteria for designation as an HIV specialist.⁷

³ Myron Cohen, Ying Q Chen, Marybeth McCauley, et al. "Prevention of HIV-1 Infection With Early Antiretroviral Therapy," *New England Journal of Medicine*, 365 (6): 493–505. (August 2011), accessed at <http://www.nejm.org/doi/full/10.1056/NEJMoa1105243>, April 16, 2016.

⁴ <https://www.aids.gov/federal-resources/policies/care-continuum/>

⁵ NC Department of Health & Human Services, HIV Continuum of Care in North Carolina Reported HIV Case Data, 2014, accessed at http://epi.publichealth.nc.gov/cd/stds/figures/factsheet_HIV_continuum_of_care_2014.pdf, April 15, 2016

⁶ Joel E Gallant, Adaora A. Adimora, J Kevin Carmichael, et al., “Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers

Maintaining a strong provider relationship facilitates adherence to HIV medications. Most Medicaid beneficiaries living with HIV receive care in a clinic funded through the federal Ryan White program. Ryan White-funded clinics are found in major medical centers, such as UNC, Duke, ECU, Wake Forest Baptist, and Carolinas Health System, New Hanover Regional Medical Center, and Catawba Valley Medical Center (Fairgrove Primary Health), as well as in Federally Qualified Health Centers, such as Western North Carolina Community Health Services (Asheville), Carolinas Family Healthcare (Wilson & other eastern locations), CommWell Health (Dunn & other locations), Lincoln Community Health Center (Durham), Rural Health Group (Jackson & other locations), and CW Williams Community Health Center (Charlotte). Ryan White-funded health clinics are also found in local health departments, including in Wake and Hertford Counties, as well as in private or nonprofit practice settings, such as Rosedale Infectious Diseases (Huntersville) and Regional Center for Infectious Diseases/Cone Health (Greensboro).

Many people living with HIV travel great distances to access an HIV specialist. Often, this is because there is no HIV specialist in their local community. However many people with HIV have established relationship with HIV specialists far from their homes because they are not comfortable seeking care locally due to HIV stigma. This is especially true in rural communities, where HIV can result in ostracism and discrimination. Others travel to major medical centers because they need highly specialized care for their HIV and comorbid conditions. Maintaining these long-distance provider relationships is essential to ensure that people living with HIV remain in care and on appropriate antiretroviral treatment.

ii. HIV Medications

Once in treatment for HIV, patients must be placed on a regimen of antiretroviral medications and adhere to that regimen. Treatment guidelines developed by the National Institutes of Health are uniformly recognized and followed by HIV specialists.⁸ Treatment is highly individualized, based on many factors including the patient's strain of the virus, drug resistance, comorbidities, and side effects. Limitations on formularies and burdensome utilization management requirements create barriers to treatment and thus, viral suppression.

Coalition," *Clinical Infectious Diseases*, 2011 Dec; 53(11):1043-50; HIV Medical Association, *Identifying Providers Qualified to Manage the Longitudinal Treatment of Patients with HIV Infection and Resources to Support Quality Care*, March 2013, accessed at

http://www.hivma.org/uploadedFiles/HIVMA/Guidelines_Patient_Care/HIVMA_Standards_Practice_Guidelines/HIV_Guidelines/Guidelines_Content/Revised%20Qualified%20HIV%20Provider%20Policy%20Statement%20Approved%203%2016%2013.pdf, April 15, 2016.

⁷ Florida Agency for Healthcare Administration, Medicaid Managed Care Contract, Attachment II, Exhibit II-C, HIV/AIDS Specialty Plan, November 1, 2015, accessed at https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-C-HIV-AIDS_2015-11-01.pdf, April 15, 2016. The HIV/AIDS Specialty Plan uses the following definition: "A Practicing HIV Specialist as defined by the American Academy of HIV Medicine (AAHIVM), a Qualified HIV Physician as defined by the HIV Medicine Association (HIVMA), or a physician who, by education, training and working practices, is versed in changing evidence-based standards, new drug releases, drug interactions, management of HIV resistance, opportunistic disease complications, effective antiretroviral (ARV) treatment, and potential interaction with other comorbid condition medications for persons diagnosed with HIV or AIDS."

⁸ Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services, accessed at <http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf> April 15, 2016.

D. Importance of Support Services, Including Case Management

Having access to HIV specialists and antiretroviral medications does not alone lead to viral suppression. Support services must be provided to low income and vulnerable people living with HIV to keep them in the HIV continuum of care: diagnosis → enrollment in care → staying in care → prescription of antiretrovirals → adherence to treatment → achieving the long-term goal of viral suppression.

These supports include enhanced care management, prevention services, transportation, housing, and linkage to social services. Many of these services are offered through Ryan White-funded clinics and AIDS Services Organizations. The goal is to provide wrap around services that address the needs of the whole person and help keep the person in care and adherent to treatment. Medicaid can have a role in providing these support services. North Carolina Medicaid currently offers targeted case management. It will be important for DHB to carefully assess how this program will be handled in the managed care setting.

II. RECOMMENDATIONS FOR ENHANCING THE NORTH CAROLINA 1115 WAIVER APPLICATION

A. People living with HIV Need Access to Life-Saving HIV Medications.

We support a strong prescription drug standard that ensures that people living with HIV and other chronic conditions have access to the medications they need to stay healthy, including new therapeutic agents as they become available. We applaud the legislative requirement in S.L. 2015-245 that “all PHPs shall be required to use the same drug formulary, which shall be established by DHB...”⁹ Providing consistency in formularies across PHPs will reduce administrative burden on providers and minimize confusion among Medicaid beneficiaries. The current Medicaid formulary provides excellent access to HIV medications, and this robust formulary should be maintained. As long as the state maintains a strong fee-for-service Medicaid formulary, and applies it to managed care, the needs of people living with HIV will be served.

However, we are concerned that the requirement for a uniform formulary is not clearly stated and detailed in the Waiver draft. The draft contains only a brief mention in section 2.3.4.7 that “all PHPs will be required to use the State’s preferred drug list (PDL).” We encourage DHB to make clear in the final Waiver application that 1) all PHPs will be required to use a uniform formulary; 2) the uniform formulary will be the FFS formulary; and 3) the current FFS formulary will be maintained and strengthened.

Additionally, we urge DHB to include standardized requirements for drug utilization management. In other states, MCOs have increasingly chosen to limit access to HIV medications not only through narrowing their formularies, but also through employing

⁹ S.L. 2015-245 § 5(6)(b).

burdensome utilization management requirements such as prior authorization and step therapy that serve to discourage enrollment of individuals living with HIV and other costly conditions. These barriers to access are not appropriate for HIV patients given the complexity of prescribing, and the existence of recognized treatment guidelines. We ask DHB to require all PHPs to adhere to standard drug utilization management guidelines as a floor, as is required in other states, including Florida.¹⁰ These utilization management guidelines should be the same as those used for FFS Medicaid.¹¹

Summary of Recommendations for HIV Medications:

- We oppose barriers to accessing medication through limitations in formulary and utilization management techniques such as prior authorization or step therapy.
- DHB should maintain its FFS formulary and designate it as the required, uniform formulary for all PHPs.
- DHB should require PHPs to use, as a floor, uniform drug utilization management requirements identical FFS Medicaid requirements.

B. People living with HIV Need Easy Access to Qualified HIV Specialists and Continuity of Existing Provider Relationships

i. Essential Providers (S.L. 2015-245 § 5(13))

We support the legislative requirement in SL 2015-245 § 5(13) that Essential Providers be designated to ensure that safety net and rural health community providers are included in PHP networks. This requirement will support the availability of critical services that may not be available from other providers. We also endorse the adoption of an Essential Provider policy that requires PHPs to make at least a good faith effort to contract with all Essential Providers in their region, as discussed in the Legislative Report.¹² Such a policy is

¹⁰ Florida requires the following: “In no instance may the limitations or exclusions imposed by the Managed Care Plan be more stringent than those specified in the Handbooks, the applicable federal waivers, and Medicaid fee schedules except that, pursuant to s. 409.973(2), F.S., the Managed Care Plan may customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional MMA services as specified in the MMA Exhibit.” Florida Agency for Health Care Administration, Medicaid Managed Care Contract, Attachment II, Core Contract Provisions, November 1, 2015, 87, accessed at http://www.fdhc.state.fl.us/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit II-A-Managed Medical Assistance MMA Program 2015-11-01.pdf, April 18, 2016.

¹¹ We encourage DHB to maintain its current FFS utilization management requirements and preferred drug list. As discussed above, HIV drugs should be exempt from prior authorization and other restrictive utilization management requirements. Prescribing of HIV medications is highly individualized and physicians follow detailed guidelines developed by the NIH, *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*, <http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf>

¹² *Legislative Report*, 28-29

in force in some states, including Minnesota and Colorado.¹³ The final Waiver application should be further fleshed out to include this requirement.¹⁴

We note that the list of Essential Providers in the Waiver draft is currently limited to Federal Qualified Health Centers (FQHCs), Rural health centers, free clinics, and local health departments. The Legislative Report accompanying the Waiver draft indicates that DHB may identify additional Essential Providers. We ask that the list of Essential Providers be expanded to include Ryan White-funded clinics. Including Ryan White-funded clinics is consistent with the goal to “maintain and enhance the current safety net infrastructure” expressed in the Waiver draft.¹⁵ A vast majority of Medicaid beneficiaries with HIV receive care from Ryan White-funded clinics. Ryan White providers offer expert HIV care management as well as comprehensive care and services such as case management, which facilitate and support successful treatment of HIV. Ryan White providers created the original Medical Home model, so they are experienced in providing holistic care in a cost effective structure.

Many organizations already designated Essential Providers receive Ryan White funding and offer HIV specialty services. However, some Ryan White-funded clinics operate in organizations that do not fall under the proposed Essential Providers designation, including non-FQHC clinics and academic medical centers. We urge DHB to expand the list and add Ryan White-funded clinics to the list of Essential Providers.

Designating Ryan White-funded clinics as Essential Providers would align Medicaid plans with Qualified Health Plans in the Federally Facilitated Marketplace, which include Ryan White-funded clinics as “Essential Community Providers.”¹⁶

ii. Network Adequacy

The Waiver draft provides little concrete detail about network adequacy standards. We understand that DHB is awaiting the release of the federal managed care regulations, which will provide direction on the development of network adequacy standards. We hope that DHB will quickly review those rules when they are released and provide more detail about network adequacy standards in the final Waiver application. We encourage DHB to include robust time, distance, and patient to provider ratios that promote access to providers. We also support a requirement that people living with HIV be permitted to go out of network if the PHP has not contracted with a provider with HIV expertise.

¹³ See Minnesota Department of Health. *Essential Community Providers*. Accessed at: <http://www.health.state.mn.us/divs/hpsc/mcs/ecpmain.html>, April 15, 2016; Colorado Department of Health Care Policy and Financing. *Provider Bulletin*, accessed at: https://www.colorado.gov/pacific/sites/default/files/Bulletin_0110_B1000274_0.pdf, April 15, 2016.

¹⁴ Waiver draft section 2.3.4.5 provides the only reference to essential providers and provides no detail on requirements or standards for contracting with essential providers.

¹⁵ Waiver draft section 2.3.4.5.

¹⁶ Centers for Medicare and Medicaid Services, *2015 Letter to Issuers in the Federally-facilitated Marketplaces*, p. 22, table 2.1, March 2014. Accessed at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf>, April 15, 2016.

We also encourage DHB to detail how it intends to measure compliance to the access standards. States have used a combination of evaluation methods, including relying on self-reports from MCOs, external quality reviews, and direct tests conducted by the states themselves. A report by the Office of Inspector General concluded that the procedures for evaluation were weak.¹⁷ We urge DHB to develop strong measures to measure compliance with access standards.

iii. Access to HIV Specialists:

Direct Access to Specialists Without Referral: To ensure adequate access to care, an adequate number of HIV specialists located throughout the state must be available to people living with HIV who are enrolled in Medicaid. Including Ryan White-funded clinics as Essential Providers as discussed above, will facilitate the inclusion of HIV specialists. To further ensure access, beneficiaries should have direct access to HIV specialists without the need for a referral by a primary care physician. This is in keeping with the standard practice of MCOs in other states such as California.¹⁸ Texas requires “[t]he MCO [be] 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 services and HIV diagnosis services without prior authorization or referral by a PCP.”¹⁹

Maintenance of Existing Provider Relationships: Additionally, it is essential that existing provider relationships be maintained, including where a beneficiary currently receives services from a specialist at a distant location. As noted above, many people living with HIV choose to seek HIV care outside their local communities because of stigma or specialized medical needs. Such beneficiaries who currently travel a distance to receive HIV specialist care at facilities such as UNC Healthcare, Wake Forest Baptist, Duke, Carolinas Health System, and ECU/Brody should be able to maintain these relationships, even if plans available in their local communities may not include these providers.

Identification of HIV Specialists: Finally, it is of no benefit for a provider to be included in a network unless PHPs afford sufficient transparency, including complete, accurate, and accessible provider directories that identify HIV specialists. This can be difficult because there is no board certification in HIV medicine. However, as discussed above, there are resources DHB can use to set standards for HIV specialists that can be used by PHPs,

¹⁷ Office of Inspector General, *State Standards for Access to Care in Medicaid Managed Care*, September 2014, OEI-02-11-00320, accessed at <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>, April 15, 2016.

¹⁸ California Code – Section 1374.16. accessed at <http://codes.lp.findlaw.com/cacode/HSC/1/d2/2.2/5/s1374.16>, accessed 6/30/15.

¹⁹ Texas Health & Human Services Commission, Office of General Counsel (OGC), *Texas Health & Human Services Commission Uniform Managed Care Terms & Conditions*, v. 2.16. § 8.2.2.5. accessed at <http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf>, April 11, 2016.

including guidelines from the HIV Medicine Association²⁰, the American Academy of HIV Medicine²¹, and HIV specialist definitions in HIV/AIDS Specialty Plans.²²

Provider Discrimination: Provider discrimination protections are critical to people living with HIV and others with high cost conditions that require specialty care and expensive treatments. Narrow provider networks that exclude HIV specialists are an increasingly popular strategy employed by some health plans to discourage enrollment by individuals with HIV and other high cost conditions. It is critical to state and enforce provider discrimination protections to ensure HIV providers and others serving costly patients are not excluded because of the patient population that they serve.

Federal regulations prohibit discrimination against providers that serve high-risk populations or that specialize in conditions that require costly treatment, such as HIV/AIDS.²³ In the Legislative Report, DHB states the intention to include nondiscrimination language in PHP contracts, and we urge DHB to specifically address discrimination protections in the final Waiver application.

Summary of Recommendations for HIV Providers and Relationships:

- DHB should align with federal QHP standards and include Ryan White-funded clinics as Essential Providers.
- The Waiver application should include the requirement for a “good faith effort” effort to contract with Essential Providers.
- DHB should set clear network adequacy standards, evaluate MCO compliance by directly querying the MCO, and build in performance measures for access to care.
- Network adequacy factors should include reasonable access to HIV specialists.
- Plans should be required to cover out of network HIV specialists to maintain existing provider relationships, particularly if the needed expertise is inaccessible under the network adequacy standard.
- DHB should develop uniform criteria for designating HIV specialists, and require that such specialists be identified as such in provider directories.
- DHB should adopt protections to prohibit PHPs from provider exclusion measures that discriminate against people living with HIV to control costs.

²⁰ HIV Medical Association, *Identifying Providers Qualified to Manage the Longitudinal Treatment of Patients with HIV Infection and Resources to Support Quality Care*, March 2013, accessed at http://www.hivma.org/uploadedFiles/HIVMA/Guidelines_Patient_Care/HIVMA_Standards_Practice_Guidelines/HIV_Guidelines/Guidelines_Content/Revised%20Qualified%20HIV%20Provider%20Policy%20Statement%20Approved%203%2016%2013.pdf, April 15, 2016.

²¹ AAHIV *Credentialing*, accessed at <http://www.aahivm.org/about>, April 18, 2016.

²² Florida Agency for Healthcare Administration, Medicaid Managed Care Contract, Attachment II, Exhibit II-C, HIV/AIDS Specialty Plan, November 1, 2015, accessed at https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2015-11-01/Exhibit_II-C-HIV-AIDS_2015-11-01.pdf, April 15, 2016.

²³ 42 CFR § 438.214(c).

C. Adoption of HIV-Specific Quality Measures and Performance Incentives Will Promote HIV Viral Suppression

i. Quality Measures

We support the proposal to identify performance measures for managed care plans. Monitoring for effective management of HIV is critical to promoting improved individual health outcomes, the public health, and cost containment. As North Carolina develops its approach to quality measures in a changing health care landscape, we urge DHB to take into account existing, nationally-endorsed quality measure sets and other federal health care quality improvement initiatives that include HIV-specific quality and outcome measures. Recently the Centers for Medicare & Medicaid Services and America's Health Insurance Plans (AHIP) as part of their Core Quality Measures Collaborative, released a consensus set of core quality measures. The guiding principles used by the Collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost.²⁴ The Core Measures including measures for HIV.²⁵ DHB should incorporate appropriate HIV quality measures, including NQF #2082 - Viral Load Suppression, which is included in this consensus set.

In determining specific HIV measures to be used in North Carolina's Medicaid program, the Division of Health Benefits should consult with experts at the North Carolina Department of Public Health HIV/STD Prevention and Care Branch, the North Carolina AIDS Education and Training Center, and other recognized experts in HIV treatment.

ii. Performance Incentives

We also support DHB's intention to tie performance on quality measures to PHP payments, using payment rewards and sanctions.²⁶ We hope such plans will be addressed more fully in the final waiver application. We encourage DHB to look at the success of performance incentives for HIV/AIDS quality measures in Louisiana's Medicaid managed care program, Bayou Health. This program includes eight incentive-based performance measures, including the HRSA HIV/AIDS Bureau viral load suppression core measure.²⁷ As a direct result of including these incentive-based performance measures, Louisiana has achieved a viral suppression rate of 50 percent among all people living with HIV — 20 percent higher than the national average.²⁸

²⁴ The consensus set includes measures developed by The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) HIV/AIDS Bureau in its Revised Performance Measure Portfolio, including Core Performance Measures. These core performance measures include viral load suppression, prescribed antiretroviral therapy, medical visits frequency, gap in medical visits, and PCP prophylaxis.

²⁵ Centers for Medicare & Medicaid Services, Core Quality Measures Collaborative, *HIV/Hep C Core Measures*, accessed at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/HIV-Hep-C-Core-Measures.pdf>, April 18, 2016.

²⁶ *Legislative Report*, 24.

²⁷ IPRO, *Quality Companion Guide Managed Care Organizations* 58, February 2015, accessed at http://dhh.louisiana.gov/assets/docs/BayouHealth/CompanionGuides/LA_QCG_MCO.pdf, April 18, 2016.

²⁸ Health Management Associates & National Alliance of State & Territorial AIDS Directors, *Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies*, 7–8, [hereinafter NASTAD, Financing

iii. **Consumer Transparency**

In addition to identifying and monitoring quality measures, it is essential that information about plan performance on quality measures be made easily available to Medicaid beneficiaries in accessible language and formats.

Summary of Recommendations for HIV Quality and Performance Measures:

- DHB should adopt quality measures for HIV, based upon the Core Quality Measures Collaborative, including at a minimum, HIV Viral Load Suppression, NQF #2082.²⁹
- We strongly support and applaud the plan to set payments to PHPs according to the plans' performance on quality measures.
- DHB should adopt measures to ensure transparency to consumers in formulary, providers, services, and quality, so that consumers can have information needed to choose the best plan for their medical needs.

D. Enrollment Procedures Should Avoid Service Disruptions That Have Occurred in Other States Transitioning to Managed Care

People living with HIV have important relationships with their HIV specialists, and it is critical that the enrollment process does not interrupt these relationships. In other states that have implemented managed care in recent years, such as Illinois and California, the transition has been challenging for people living with HIV, and has resulted in disruption of provider relationships, raising the potential for dropping out of care or losing access to medications.³⁰

Medicaid applicants and beneficiaries must have sufficient information and support to make informed choices prior to enrollment. We support DHB adopting a model consistent with the Beneficiary Support System outlined in Section 438.71 of the proposed Medicaid managed care rule.³¹ CMS's Beneficiary Support System requires additional personalized assistance to beneficiaries living with chronic, complex conditions and empower them to make informed choices about which plan is appropriate. This type of support should include information about the services not covered or not fully covered by Medicaid that may be available through Ryan White providers and AIDS Drug Assistance Program.

Active enrollment is essential to ensuring that beneficiaries are enrolling into plans that cover their provider network and care and treatment needs. Prior to enrolling in a plan, beneficiaries must have access to clear and detailed plan information, including scope of coverage (including formulary information), provider networks, and availability of care

HIV Prevention], accessed at <https://www.nastad.org/sites/default/files/NASTAD-HIV-Prevention-Financing-Final.pdf> April 28, 2016.

²⁹ A copy of the Core Measures are attached.

³⁰ Michael D. Dalzell, HIV: A Fragile Population Enters Managed Care, *Managed Care*, December 2013, accessed at <http://www.managedcaremag.com/archives/2013/12/hiv-fragile-population-enters-managed-care>, April 18, 2016.

³¹ 80 Fed. Reg. 31272.

coordination services. This information must include any utilization management or other coverage limits imposed on services, as well as PHP performance on quality measures. As discussed above, transparency is key, especially with respect to prescription drugs and identification of HIV specialists.

While active enrollment is optimal, many beneficiaries will fail to enroll in a PHP on their own. Thus careful attention must be paid to the auto-assignment process. We support the proposed protections regarding auto-assignment into plans, particularly the requirement that the state seek to preserve existing provider beneficiary relationships. The Legislative Report indicates that DHB plans to consider as one factor in auto-assignment the beneficiary's *primary* care provider. We ask that for people with serious chronic diseases such as HIV/AIDS, the auto-assignment factors also include the beneficiary's *specialist provider*. Medicaid beneficiaries with HIV in a number of states, including California and Illinois, experienced disruptions in care due to auto-assignments to managed care plans that did not contract with their current HIV specialist and/or plans that lacked providers with HIV expertise. In California, there were complaints that people living with HIV were auto-assigned to a pediatric clinic that had no HIV specialist.

We strongly support a “warm hand-off” model for the transition to managed care, under which people with chronic diseases such as HIV/AIDS who must change providers have the option to stay with their current HIV providers until they are able to form a new relationship with experienced HIV providers in their new PHP.

Summary of Recommendations for HIV Enrollment Procedures:

- Beneficiaries must have the information they need to make an informed decision about enrollment, including information about formularies, providers, and plan performance.
- DHB should include prior specialist relationships as an auto-assignment factor.
- We strongly support a “warm hand-off” model for the transition to managed care.

E. DHB Should Continue to Explore Opportunities for Innovation in the Reform Plan

We encourage DHB to explore additional opportunities for innovation in serving HIV positive Medicaid beneficiaries in North Carolina. We urge the state to use the flexibility provided under the 1115 Waiver to explore programs to offer services or supports that may otherwise not be covered under fee-for-service Medicaid that would improve outcomes. DHB should permit and encourage PHPs to provide additional support services, such as housing supports, enhanced case management, and other support services aimed at addressing social determinants of health. For example, unstable housing is a major barrier to successful HIV care. A recent CMS Informational Bulletin discussed the housing-related

activities that are permissible through Medicaid.³² Innovations related to support services for HIV could contribute greatly to the achievement of viral suppression, by helping to keep people living with HIV in care and on their medications. Other states, such as Wisconsin, have developed HIV Medical Homes, building on the Ryan White medical home model, and the Medicaid Health Home initiative.³³

Many other states have used 1115 Waivers to test innovative programs and models to provide suitable care to people living with HIV. For example, by leveraging financing through a statewide Delivery System Reform Incentive Payment Program (DSRIP) Medicaid 1115 Waiver, the City of Houston developed a program to link newly HIV diagnosed and out-of-care HIV patients to care and treatment.³⁴ In Rhode Island, the state provides targeted case management services as covered services as part of its Medicaid managed care contracts. Individuals “at risk” of HIV infection, including men who have sex with men and active substance users, receive targeted case management services.³⁵ These individuals receive assessment and referrals to relevant services like behavioral health services, HIV testing, and housing.³⁶ New York and Florida have created Special Needs Plans (SNPs) to provide HIV-specific care to people living with HIV who rely on Medicaid.³⁷ In North Carolina, a Special Needs Plan or an HIV focus within a standard PHP could support HIV care and the goal of viral suppression.

Summary of Recommendations for Innovative Strategies:

- DHB can make use of the flexibility built into the Waiver process to offer support services to enhance treatment success for people living with HIV.
- We urge the Division of Health Benefits to engage with the HIV community, including major HIV providers as well as the Department of Public Health HIV/STD Prevention and Care Program to explore ways in which Medicaid innovation can contribute to the fight against HIV/AIDS in North Carolina.

F. The HIV Community Should be Part of a Robust Stakeholder Involvement Process

We are disappointed that HIV/AIDS providers, advocacy groups, and beneficiaries were not involved in development of the draft Waiver. While we applaud DHB for engaging with various stakeholders, we strongly support a participatory model in which all stakeholders are brought together at the table to have a voice in the entire process of Medicaid reform. We also urge DHB to create a mechanism that enables stakeholders, including consumers,

³² Vikki Wachino, CMCS Informational Bulletin, *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*, June 26, 2015, accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>, April 18, 2016.

³³ http://www.arcw.org/whats-new/about_the_arcw_medical_home/index.php

³⁴ NASTAD, *Financing HIV Prevention*, at 20–23.

³⁵ *Ibid* at 12.

³⁶ *Ibid* at 13.

³⁷ New York State HIV Special Needs Plan Model Member Handbook 22 (2014), accessed at http://www.health.ny.gov/diseases/aids/general/resources/snps/docs/hiv_snp_model_member_handbook.pdf, April 18, 2016

to be part of Medicaid oversight on an ongoing basis. Such stakeholder groups have been created in other states implementing managed care, such as Texas.³⁸ DHB should create an advisory committee that has broad representation and real voice.

Summary of Recommendations for Stakeholder Engagement:

- We urge DHB to engage in an open, public process for stakeholder involvement both during the process of planning for managed care and afterward.

G. Consumer Protections in Chapter 58 of the General Statutes Should be Adopted or Serve as a Model for Managed Care

The Waiver draft and Legislative Report both recommend that managed care organizations be exempt from the insurance provisions in Chapter 58 of the North Carolina General Statutes. However, Chapter 58 includes many excellent consumer protections that DHB should adopt for Medicaid managed care. Relevant consumer protections contained in Section 58 include:

- No penalty for using out-of-network providers when in-network providers cannot meet health needs of the insured.³⁹
- Extended or standing referrals to specialists for beneficiaries with chronic degenerative, disabling, or life-threatening disease or conditions.⁴⁰
- Clearly stated rights of appeal for: utilization review,⁴¹ insurer grievance procedures,⁴² notice of right to external review,⁴³ and exhaustion of the internal grievance process.⁴⁴
- Clear definition of the term ‘medical necessity.’⁴⁵
- Clearly defined information that must be provided to beneficiaries by the PHPs about:
 - The details of their health coverage plan
 - Procedures used for reviewing claims
 - Reasons for denial of coverage
 - Specifics about the drug formulary
 - Criteria for determining whether treatments are considered experimental⁴⁶
- Provider protections against retaliation for appealing denials.⁴⁷
- Access to information about the utilization review procedures.⁴⁸

³⁸ See, for example, Texas State Medicaid Managed Care Advisory Committee, https://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/smmcac.shtml;

³⁹ N.C.G.S. § 58-3-200(d).

⁴⁰ N.C.G.S. § 58-3-223.

⁴¹ N.C.G.S. § 58-50-61

⁴² N.C.G.S. § 58-50-62

⁴³ N.C.G.S. § 58-50-77.

⁴⁴ N.C.G.S. § 58-50-79.

⁴⁵ N.C.G.S. §§ 58-50-61(12), and 58-3-200(b).

⁴⁶ N.C.G.S. § 58-3-191.

⁴⁷ N.C.G.S. § 58-50-62.

⁴⁸ N.C.G.S. §§ 58-50-61(e)(3), and 58-50-61(m).

H. The Reform Process Should Be An Opportunity to Establish New Collaborations Between Medicaid and Public Health

Currently, North Carolina Medicaid and the Department of Public Health, including the HIV/STD Prevention and Care Branch, operate in silos that result in lost opportunities for improving HIV prevention and care. The Medicaid reform process presents an opportunity for new collaborations between these departments to address issues such as best practices, data sharing, quality measures, and prevention. As an example of the potential in this collaboration we point to Louisiana's partnership between public health and Bayou Care.

As part of this partnership, Louisiana's public health and Medicaid divisions signed a data sharing agreement "that allows them to share Medicaid claims and eligibility data and public health data and statistics for the administration and evaluation of the Medicaid program and public health services."⁴⁹ The divisions also hold monthly meetings. Thanks in part to this collaborative relationship, Louisiana included viral load suppression rates in its quality measures, which has also encouraged managed care organizations to work directly with Louisiana's public health division and include its STD/HIV program resources into their case and disease management programs.⁵⁰ As a result of this collaboration, Louisiana has achieved a viral load suppression rate of 50%, which is higher than the national average. Also, Louisiana MCOs are developing a direct working relationship with the state's public health department and STD/HIV Program and are incorporating public health resources into their case and disease management programs and referring members to them.

Medicaid can also support public health by ensuring that preventive care is widely available, and by monitoring PHP performance in delivering preventive care. In 2013, the U.S. Preventive Services Task Force (USPSTF) assigned an "A" grade to HIV testing for all adults age 15-65 regardless of risk, as well as for others at risk and all pregnant women. We urge the DHB to require PHPs to provide for coverage of preventive services with a USPSTF grade of "A" or "B" and monitor performance this area. Ensuring that Medicaid beneficiaries receive appropriate preventive care will contribute to the fight against HIV/AIDS.⁵¹

Summary of Recommendations for Medicaid/Public Health Collaboration:

- DHB should engage with the Department of Public Health to explore potential collaborations between DHB, PHPs and DPH in the areas of data sharing, quality measures, support services, and prevention.
- DHB should require PHPs to cover preventive services with an "A" or "B" grade, and measure performance in this area.

⁴⁹ NASTAD, *Financing HIV Prevention*, at 6.

⁵⁰ *Id.*

⁵¹ NASTAD, *Financing HIV Prevention*.

I. Medicaid Reform Presents an Opportunity to Close the Coverage Gap on North Carolina's Terms.

Medicaid expansion is crucial to North Carolina's transition to managed care. There are 5,000 or more people living with HIV in North Carolina who presently have no health coverage, as well as thousands more who are at risk of HIV. We join the many voices urging that expansion of Medicaid be incorporated into North Carolina's 1115 Waiver.

On behalf of the organizations listed below, we thank you for the opportunity to offer comments to this draft waiver and for your commitment to implementing Medicaid in ways that ensure access to prevention, care, and treatment for people living with HIV and other chronic conditions. Please contact Allison Rice (rice@law.duke.edu) or Lee Storrow (lee@ncaan.org) if we can be of assistance.

Respectfully Submitted,



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Supporting Organizations

AIDS United, Washington, D.C.
Ballantyne Family Medicine, Charlotte
Carolinas CARE Partnership, Charlotte
East Carolina University Infectious Diseases, Greenville
National Alliance of State and Territorial AIDS Directors, Washington, DC
Positive Wellness Alliance, Lexington
Regional AIDS Interfaith Network (RAIN), Charlotte
Southern AIDS Coalition, Birmingham, AL
Southern HIV/AIDS Strategy Initiative, Durham
Triangle Empowerment Center, Inc., Durham
Warren-Vance Community Health Center, Inc., Henderson
Wellness & Education Community Action Health Network
Western North Carolina AIDS Project, Asheville
Women's Empowerment Team of the East, Greenville



Identifying Providers Qualified to Manage the Longitudinal Treatment of Patients with HIV Infection and Resources to Support Quality HIV Care

Revised: March 2013

This document was developed to help health systems and third-party payers identify physicians who are best qualified to manage the care of HIV-infected patients and to compile clinical tools, standards and resources to promote high quality HIV care. The suggested standards are intended for medical providers managing the care of HIV-infected patients in an out-patient or clinic setting.

The criteria recommended below are based on a large body of evidence that indicates that, regardless of a physician’s specialty training, the two best predictors of high quality, cost effective HIV care are patient management experience and ongoing professional development through HIV-related continuing medical education.

Qualified HIV Physician Criteria

Category	Criteria
Patient Management	Management of at least 25 HIV-infected patients in the preceding 36 months.
Continuing Medical Education	At least 40 hours of HIV-related continuing medical education ¹ in the preceding 36 months, earning a minimum of 10 hours per year.
Board Certification Or Significant Clinical Experience	Board certification or equivalent in one or more medical specialties or subspecialties recognized by the American Board of Medical Specialties or the American Osteopathic Association is preferred. Significant clinical and professional experience in HIV medicine, defined as a minimum of at least five years, should be considered in the absence of board certification.

Infectious Diseases Physicians

Many HIV physicians are trained in infectious diseases (ID), but not all ID physicians continue to provide HIV care after training. Recently trained or recertified ID physicians should be considered qualified HIV physicians within 36 months of completing certification or recertification. However, ID physicians continuing to provide longitudinal care for HIV-infected patients should meet the criteria above

¹Completion of HIV-related Maintenance of Certification modules and the HIV Practice Improvement Module is encouraged as part of professional development for physicians who focus on HIV medicine.

beginning 36 months after certification or recertification to continue to be considered a qualified HIV physician.

Non-physician providers

Patient management experience and HIV-related continuing education also should be used to identify qualified nurse practitioners, physician assistants and nurse midwives who provide HIV primary care.

Other Considerations

<p>Areas of Lower HIV Prevalence *</p> <p>*Such as 6.8 cases per 100,000 or less</p> <p>Prevalence Rates available at: http://gis.cdc.gov/GRASP/NCHHSTPAtlas/main.html</p>	<p>The criteria above should NOT be used to exclude physicians from providing HIV care in areas with limited HIV workforce capacity. In communities or geographic areas where no physicians meet the criteria, medical providers are encouraged to develop a consultative relationship with a qualified adult or pediatric HIV/ID physician.</p>
<p>Pediatric/Adolescent Patient Management</p>	<p>The success of interventions to prevent perinatal HIV transmission has dramatically reduced the number of pediatric HIV cases in the U.S. However, managing pediatric and adolescent patients with HIV also requires appropriate expertise. In areas of low prevalence, less experienced physicians are encouraged to develop a consultative relationship as described above.</p>

Resources for Identifying HIV Medical Providers

- The Ryan White Program funds clinical sites to provide comprehensive HIV care in communities across the country. A directory of Ryan White-funded programs is available from the Health Resources and Services Administration website at <http://hab.hrsa.gov/>.
- The National HIV/AIDS Clinical Consultation Center supports a warmline for HIV providers available at 1-800-933-3413 or <http://www.nccc.ucsf.edu>.
- HIVMA maintains an online directory of members accepting new patients available at www.hivma.org. HIVMA does not credential or certify HIV medical providers.

HIV-related Standards of Care and Resources

- Federal HIV treatment guidelines on a range of topics, including antiretroviral treatment and the prevention and treatment of opportunistic infections are available at <http://aidsinfo.nih.gov/guidelines>.
- HIVMA guidelines on primary care and chronic kidney disease are available at www.hivma.org.
- HIV-related quality measures have been approved by the National Quality Forum (http://www.qualityforum.org/Measures_List.aspx) and included in Medicare’s Physician Quality Reporting System and Electronic Health Record Meaningful Use programs as well as the Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults. Email info@hivma.org for additional information.

- A highly effective model for delivering HIV care has been developed by the Ryan White Program, the Department of Veterans Affairs and others. The model is detailed in *Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition* (available online at www.hivma.org or by emailing info@hivma.org).

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Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition

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Human immunodeficiency virus (HIV) antiretroviral agents and effective HIV care management transformed HIV disease from a death sentence to a chronic condition for many in the United States. A comprehensive HIV care model was developed to meet the complex needs of HIV patients, with support from the Ryan White program, the Veterans Administration, and others. This paper identifies the essential components of an effective HIV care model. As access to health care expands under the National HIV/AIDS Strategy and the Patient Protection and Affordable Care Act, it will be critical to build upon the HIV care model to realize positive health outcomes for people with HIV infection.

THE EVOLUTION OF HIV CARE

Antiretroviral therapy and expert human immunodeficiency virus (HIV) care management transformed HIV disease from a death sentence to a chronic condition for many in the United States, as evidenced by the near-normal life spans expected for most HIV patients today [1]. The complexity of treatment and management of this multiorgan system disease requires coordination among many providers in outpatient and inpatient settings. The comprehensive HIV care model

was developed to address the challenges providers face in meeting the complex medical and psychosocial needs of many HIV-infected patients [2]. The model has been critical to the success of HIV treatment in dramatically reducing HIV morbidity and mortality rates by as much as 80% [3]. In the HIV Prevention Trials Network 052 study, antiretroviral therapy was associated with a 96% reduction in sexual transmission to HIV-negative partners and with improved health outcomes for the HIV-infected patient. In light of these results, we anticipate an even greater emphasis on identifying and linking people with HIV to care, which will require greater system capacity and increased emphasis on effective HIV care models [4].

The Ryan White program is one example of an effective HIV care model. Created by the US Congress in 1990 to help communities respond to the HIV epidemic, the program grants HIV clinics the flexibility to develop systems of care that are responsive to the needs of local patient populations [5]. The program is the third largest funder of HIV care in the United States, after Medicare

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and Medicaid, and provides grants to states, high-impact cities, and clinical programs [6]. It has supported the development of centers of excellence in HIV care across the United States.

The president's National HIV/AIDS Strategy (NHAS) sets a framework for leveraging federal and private resources to reduce HIV incidence, increase access to care, improve health outcomes, and reduce HIV-related disparities [7]. The Patient Protection and Affordable Care Act (ACA) together with the NHAS provides an unprecedented opportunity to improve access to HIV care and develop more sustainable funding streams that can be used to expand access to the effective HIV care model developed by the Ryan White program [8, 9]. To do so will require Medicaid, Medicare, and private insurers to adopt delivery systems and risk-adjusted payment mechanisms that support access to effective HIV care. This paper outlines the essential components of an effective HIV care model (Figure). It will be critical to build on this effective model for chronic disease management to promote positive health outcomes for people with HIV infection, particularly those with more intense medical and social service needs, as they gain health insurance coverage under the ACA.

GOALS OF HIV CARE

Effective HIV care leads to earlier and greater engagement in care, effective viral control, improved immune status, near-normal life expectancy, enhanced quality of life, and prevention of HIV transmission [4, 10]. These goals can be achieved through

increased HIV testing within communities, efficient linkage to HIV primary continuity care and specialty care, access to HIV medications, medication adherence support, efforts to retain patients in care, and social services that address the unmet psychosocial needs of HIV-infected patients [11, 12]. However, if these essential aspects of effective care are fragmented, that is, not integrated, patients receive either incomplete care or no care at all. The NHAS estimates that 35% of patients newly diagnosed with HIV are not linked to HIV care within 3 months of diagnosis, which is recommended by the Centers for Disease Control and Prevention. However, higher levels of linkage are found in integrated care systems [7, 13]. Previous reports estimated that between 30% and 50% of HIV patients are not in ongoing care and do not have reliable access to HIV treatment. Ryan White clinical programs report that 73% of patients are in continuous care, defined as at least 2 visits, 3 months apart, within 1 year [7, 14–16]. Stigma and health disparities also lead to inconsistent care [1, 17]. Delayed entry into care and cycling in and out of care can lead to poor clinical outcomes, development of drug-resistant virus, and transmission of HIV to others [18].

As the goals of HIV care suggest, integrated medical care for HIV-infected patients is essential. In general, this has been achieved through the “medical home” model. In this model, access to primary and specialty care is coordinated and monitored by the HIV primary care team, as are psychosocial and social services for patients based on their needs. HIV providers have subscribed to this model of care since the early 1990s, with

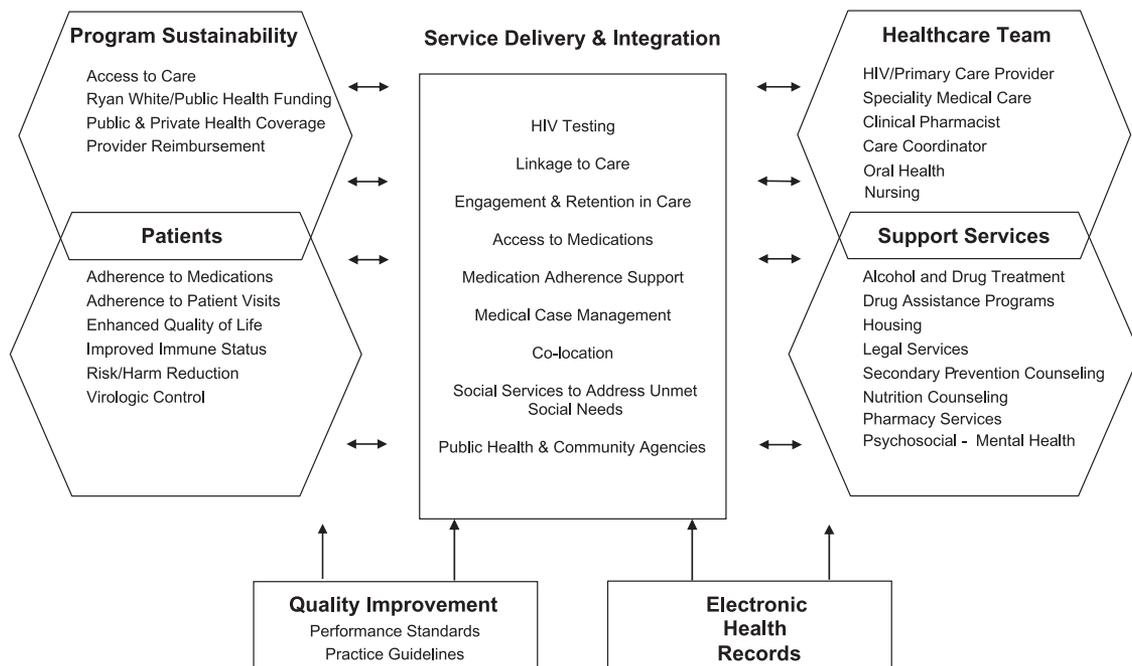


Figure. Essential components of HIV care. Abbreviation: HIV, human immunodeficiency virus.

Ryan White Part C clinics, Veterans Administration (VA), and other health care systems as strong examples [19–21]. The high rates of care and treatment adherence required for ongoing suppression of HIV are best supported within this type of integrated service delivery environments, such as Ryan White–funded clinics and the VA [22]. This is particularly true for patients with 2 or more co-occurring conditions.

The extent and type of care integration vary according to the complexity and needs of a clinic’s HIV patient population. The simplest category of collaborative services is coordinated care that is delivered in different settings but with information sharing among the programs. Colocated (services delivered at one location, with data sharing) and integrated (merged medical and behavioral health care components, including mental health and substance use treatment in one treatment plan) medical services are used for patients with complex needs to prevent barriers or gaps in service delivery. Electronic health records (EHRs) that can be shared by the entire care team, specialists, and others who provide the patient’s care are a key component of the integrated care model.

Lower levels of integration can be sufficient for the care of some HIV patients. Critical system components for all levels of integration include established relationships with providers and ongoing communication between the HIV primary care team or the HIV expert and other specialty, primary care, mental, and social service providers. Effective HIV programs allow for a tailored approach for a service population and an individualized approach for patients, using a variety of methods to meet a broad range of needs.

ELEMENTS OF CARE DELIVERY

Care Team

The HIV care team includes an HIV expert who manages or comanages the patient’s HIV primary continuity care needs and identifies subspecialty care needs. A care coordinator, who may be a qualified nurse, case manager, or another member of the care team, is responsible for maintaining communication and coordination with other providers as well as identifying and coordinating access to services such as psychosocial support, reproductive and gynecologic services, alcohol or drug treatment, drug assistance programs, prevention counseling, and other services required to meet basic needs. Medication management is a critical component of primary HIV care, and ideally a clinical pharmacist with HIV expertise is included on the team to identify drug interactions, support patient adherence and medication management, and oversee medication profiles for patients who see multiple medical providers [23–26].

A range of other specialists also participate on the HIV care team to treat the comorbidities common among HIV patients, such as hepatitis B and C, HIV-related and nonrelated

malignancies, heart disease, metabolic disorders, serious mental illnesses, and substance use disorders, and to meet needs of unique populations, such as women requiring obstetric-gynecological care [27–32]. Subspecialists ideally have an ongoing relationship with the HIV care team and have the appropriate level of comfort and expertise with HIV disease. Mental health and substance use treatment services, including psychiatric care and psychotherapy, are particularly important given that as many as 50% of HIV patients also have a psychiatric diagnosis and/or a substance use disorder [33]. Dental and oral health care is recognized as an important component of comprehensive HIV care, and access to oral health providers with HIV experience is preferred [34].

HIV Medical Provider Expertise

Patients with HIV disease who are managed by clinicians with greater HIV experience and expertise have better health outcomes and receive more appropriate and cost-effective care, regardless of the clinician’s specialty training [35–38]. HIV disease does not fall under the purview of any one medical specialty—physicians trained in internal medicine, family medicine, and other medical subspecialties join infectious disease specialists as HIV experts. Although many HIV experts are infectious disease physicians, not all infectious disease physicians are HIV experts. Ongoing patient management and continuing education are required for HIV expertise, regardless of specialty training.

The primary care and specialty boards do not recognize an HIV specialty designation. The HIV Medicine Association (HIVMA) developed guidance in 2002, updated in 2010, to assist third-party payers, health systems, and institutions in identifying HIV physicians who are qualified to provide HIV care. HIVMA recommends a combination of patient management experience and continuing medical education to identify qualified HIV physicians. (HIVMA recommends that HIV physicians have managed a minimum of 25 patients with HIV during the previous 36 months and have completed a minimum of 40 hours of category 1 HIV-related continuing medical education during the same period. HIVMA also recommends that infectious disease physicians certified or recertified within the previous 12 months be considered qualified HIV physicians. In the 36 months immediately following certification, newly certified infectious diseases fellows should be managing a minimum of 25 patients with HIV and earning a minimum of 10 hours of category 1 HIV-related continuing medical education per year.) The American Academy of HIV Medicine (AAHIVM) has a credentialing process for HIV physicians, nurse practitioners, physician’s assistants, and pharmacists. The Association of Nurses in AIDS Care created the HIV/AIDS Nursing Certification Board for certification of registered nurses and nurse practitioners in HIV nursing [39]. Some states, including

California, have adopted the HIVMA and AAHIVM recommendations for identifying HIV experts, while other states, including Arizona, have developed their own definition using similar criteria [40, 41].

Caseloads and appointment times vary greatly according to provider expertise, disease severity, and comorbidities. Clinic staffing levels and available resources also affect the number of patients that providers can effectively manage. Evolving productivity standards that support quality care by HIV clinicians should reflect the complexity and intensity of HIV care and allow adequate time to monitor and manage the patient's HIV treatment and primary care needs and provide oversight of comorbidity management.

Access to an HIV Expert

The specialized expertise required of HIV clinicians contributes to a growing shortage of HIV medical providers and necessitates models for managing HIV care that can be adapted to the resources available in a community [42]. Under the Ryan White care model, HIV-infected patients typically have a medical provider who manages their HIV and primary care or an on-site medical team that includes an HIV expert who comanages patients with a primary care provider.

For healthier patients with less intensive medical and social service needs, a comanagement model in which a primary care provider has an ongoing consultative relationship with an HIV expert is also effective, particularly when the provider relationship is established at the time of the patient's HIV diagnosis. In this model, the patient has a primary care provider who consults with the HIV expert. The HIV expert manages the patient's HIV treatment through regular visits, typically at intervals of 3 to 6 months.

In settings with a dearth of HIV experts, a primary care provider may manage the ongoing care of the patient, with the HIV expert serving as an ongoing consultant via teleconference or telemedicine [43].

Regardless of the role of the HIV expert, the patient and medical provider relationship has proven to be central to effective primary care and chronic disease management [44, 45]. An ongoing and consistent relationship between patient and provider establishes open communication and trust. HIV patients who trust their medical providers have better medication adherence rates and are more likely to accept treatment recommendations [46–48].

Quality Improvement

Quality improvement is an integral component of the HIV care model and a requirement of Ryan White funding [34]. Other integrated health systems have identified the value of such efforts [13, 49]. Programs collect quality and outcomes measures and utilize the data to evaluate and monitor clinical processes and

Table 1. HIV Prevention and Treatment Guidelines and Recommendations

Federal HIV-related guidelines and recommendations, including date of implementation ^a
Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents—10 January 2011
Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection—16 August 2010
Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States—24 May 2010
MMWR: Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis—30 September 2005
MMWR: Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States—21 January 2005
Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents—10 April 2009
MMWR: Guidelines for the Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children—4 September 2009
Incorporating HIV Prevention Into the Medical Care of Persons Living With HIV—18 July 2003
MMWR: Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings—22 September 2006
Guidelines Developed by the HIV Medicine Association of the Infectious Diseases Society of America ^b
Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2009 Update by the HIV Medicine Association of the Infectious Diseases Society of America ^c
Guidelines for the Management of Chronic Kidney Disease in HIV-Infected Patients: Recommendations of the HIV Medicine Association of the Infectious Diseases Society of America ^d
Guidelines for the Evaluation and Management of Dyslipidemia in Human Immunodeficiency Virus (HIV)-Infected Adults Receiving Antiretroviral Therapy ^e
Guidelines Developed by the International Antiviral Society-USA ^f Antiretroviral Treatment of Adult HIV Infection ^g

Abbreviations: HIV, human immunodeficiency virus; MMWR, Morbidity and Mortality Weekly Report.

^a Available at <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx>.

^b Available at <http://www.hivma.org>.

^c Clinical Infectious Diseases 2009; 49:651–81.

^d Clinical Infectious Diseases 2005; 40:1559–85.

^e Clinical Infectious Diseases 2003; 37:613–27.

^f Available at <http://www.iasusa.org/guidelines/>.

^g JAMA 2010; 304:321–33.

patient outcomes and to effectively manage limited program resources. Prevention, care, and treatment guidelines developed by the US Department of Health and Human Services and professional associations inform the scope and content of HIV provider practices (Table 1). Corresponding quality measures are employed to evaluate provider and practice adherence to standards of HIV care. Evaluations utilizing these measures are performed by the practice itself (internal quality management) and by funding agencies (external quality assurance) to ensure

Table 2. HIV Quality Measures for Adults With an HIV Diagnosis

Measure	Recommended national measure (HIVMA/HRSA/NCQA) ^a	2011 Medicare PQRS number ^b	NQF number ^c	HHS-proposed initial core set of health quality measures for Medicaid-eligible adults	HRSA/HAB HIV core clinical performance measures ^d
Retention in care	✓	...	0403	✓	✓
CD4 cell count	✓	159	0404	...	✓
Gonorrhea/chlamydia screening	✓	205	0409	...	✓
Syphilis screening	✓	208	0410	...	✓
Injection drug use screening	✓	207	0415	...	Substance use screening
High-risk sex screening	✓	206	0413	...	HIV risk counseling
Tuberculosis screening	✓	...	0408	...	✓
Hepatitis B screening	✓	...	0411	...	✓
Hepatitis C screening	✓	...	0414	...	✓
Influenza immunization	✓	...	0522	...	✓
Pneumococcal immunization	✓	...	0525	...	✓
Hepatitis B vaccination order	✓	...	0412	...	✓
Hepatitis B vaccination completed	✓
PCP prophylaxis	✓	160	0405	...	✓
Adolescents/adults prescribed ART	✓	161	0406	...	✓
Achieving maximal viral control (system level)	✓
Achieving maximal viral control (provider level)	✓	162	0407

Abbreviations: ART, antiretroviral therapy; HAB, HIV/AIDS Bureau; HHS, US Department of Health and Human Services; HIV, human immunodeficiency virus; HIVMA, HIV Medicine Association; HRSA, Health Resources and Services Administration; NCQA, National Committee for Quality Assurance; NQF, National Quality Forum; PCP, *Pneumocystis pneumonia*; PQRS, Physician Quality Reporting System.

^a Horberg et al, Development of National and Multiagency HIV Care Quality Measures, CID 2010; 51:732–38.

^b Measure included and assigned a number in CMS' 2011 Physician Quality Reporting System Individual Quality Measures, http://www.cms.gov/PQRI/15_MeasuresCodes.asp.

^c National Quality Forum—endorsed standards can be accessed at: http://www.qualityforum.org/Measures_List.aspx.

^d Health Resources and Services Administration. HIV/AIDS Bureau. HIV Performance Measures, <http://hab.hrsa.gov/deliverhivaidscore/habperformmeasures.html>.

that patients are offered a uniform standard of care, regardless of location. This is particularly important in areas where HIV expertise may be lacking. In these areas, quality measurement can support workforce development by enhancing HIV knowledge and expertise among willing but inexperienced providers.

Rapid advances in HIV medicine make quality management and clinical practice tools, such as practice guidelines, critical to supporting and evaluating implementation of the latest standards of care. HIV-related quality measures developed by a consortium with the National Committee for Quality Assurance have been endorsed by the National Quality Forum and incorporated into Medicare's Physician Quality Reporting System (PQRS) [50]. Adoption of uniform measures across federal programs and by private insurers is important when evaluating and improving HIV care outcomes, regardless of insurance status or funding source (Table 2).

The HIVQual program developed by the New York AIDS Institute and the HIV/AIDS Bureau has assisted Ryan White–funded clinics with building sophisticated quality management systems. Participating programs use quality improvement and performance measures to improve their delivery of HIV care [51].

The PQRS, developed by the Centers for Medicare and Medicaid Services (CMS), provides incentive payments to providers for reporting on certain HIV-related quality measures. Reporting of HIV measures is currently limited to registries; this creates administrative barriers to participation for some programs, limiting the potential for the PQRS to improve HIV care [52].

Electronic Health Records

EHRs are a key component of effective integrated care and medical home models. Although HIV programs are at varying levels of EHR implementation, HIV care programs, including many funded by the Ryan White program, have been leaders in using EHRs and/or electronic data collection to support quality improvement programs and to meet data reporting requirements. Many commercial products can meet these needs, and some health care systems and clinics have developed their own (examples include the VA and the University of Alabama at Birmingham [UAB] 1917 Clinic). A majority of Ryan White–funded medical programs utilize CAREWare, software developed by the HIV/AIDS Bureau in 2000 that is used to monitor clinical and supportive care (<http://hab.hrsa.gov/careware/>).

The Medicare and Medicaid EHR Incentive Programs provide financial incentives for providers to adopt and use EHRs and require providers to report on CMS-identified quality measures. HIV-specific measures were not included in stage 1 of the clinical quality measures. The addition of HIV measures during the next phase will be important to improve the delivery of care, align HIV program expectations across federal agencies, and monitor progress toward the goals of the NHAS [53].

Sustainability

Financial viability is a component of effective HIV care delivery and is important to supporting access to expert HIV providers and programs. The financial operating requirements for the delivery of effective HIV care are complex, with many programs relying on institutional support to cover salaries, administrative infrastructure, rent, and other operating costs. However, in the current environment, models of care with costs that exceed benefits to the institutions are no longer sustainable.

Effective payment systems and methodologies are grounded in the cost of care, adjusted according to disease severity, and take into account nonclinical costs associated with chronic disease management, such as care coordination, quality monitoring and evaluation, and EHR adoption. With a few exceptions, most state Medicaid programs fall short in supporting complex, comprehensive HIV care. The new Medicaid health home benefit, for which HIV disease is identified as an eligible condition, provides an important opportunity for states to support this level of care [54]. The movement toward health home or medical home care provides an opportunity to transform the delivery of chronic care if supported through innovative and reasonable provider payment mechanisms.

Fee-for-Service

The Medicaid and Medicare programs cover 40% and 20%, respectively, of people with HIV in care [6]. The inadequacy of payment rates under both programs contributes to health-related disparities in access and outcomes [55–57]. Medicaid rates average 66% of Medicare payment rates for primary care services, yet even Medicare rates fall short of supporting the true cost of care. In a study conducted by the 1917 Clinic at UAB, Medicare payments for physician services for patients with HIV disease averaged \$359 per year, with a range of \$285 to \$533 per patient per year, depending on disease severity [58]. The annual payment covers 18% of the \$1959 in per-patient medical provider costs incurred by the UAB 1917 Clinic for managing the patient's primary and HIV care needs (James Raper, DSN, CRNP, JD, personal communication, January 2011).

Managed Care Capitation Rates

Under managed care, adequate monthly capitation rates are grounded in the cost of care and are risk-adjusted according to disease severity to ensure that quality and outcomes are not compromised due to cost [59]. A few states have developed

Table 3. Maryland Medicaid Monthly Capitation Rates, 1 January 2011–31 December 2011

	City of Baltimore	Rest of state
Disabled persons with AIDS	\$3030.41	\$2135.18
Disabled persons with HIV	\$1609.69	\$1609.69
Families and children with HIV	\$612.79	\$612.79

Source: Maryland Office of the Secretary of State. COMAR (codification number 10.09.65.19). Available at: <http://www.dsd.state.md.us/comar/>.

Abbreviation: HIV, human immunodeficiency virus.

payment mechanisms under Medicaid managed care to support HIV care. For example, the Maryland Medicaid program pays special capitation rates for Medicaid beneficiaries with HIV and AIDS that are adjusted for geography and hepatitis C status. Services with unpredictable costs are excluded and paid on a fee-for-service basis, including HIV antiretroviral agents, viral load, and HIV drug resistance testing (Table 3). In 2003, the New York State Department of Health's AIDS Institute established 3 managed care plans, referred to as HIV Special Needs Plans (SNPs), in New York City for Medicaid beneficiaries with HIV disease [60]. SNPs are paid capitation rates that exclude all pharmaceuticals, including antiretroviral medications; the rates are based on the enrollee's age and receipt of supplemental security income (Table 4). Beginning in October 2011, New York state plans to incorporate pharmaceuticals and other services previously paid on a fee-for-service basis into the managed care benefit package for HIV SNPs and other Medicaid managed care plans and to adjust the capitation rates accordingly.

Public Health Funding

Appropriated by the federal government with contributions from state governments, Ryan White funding has allowed for the development of a robust system of care for people with HIV who are uninsured (nearly 30% of those diagnosed and living with HIV) or underinsured and at serious risk for going untreated in the absence of Ryan White-funded services [61]. Given the inadequacies of third-party coverage and payments, Ryan White

Table 4. New York HIV Medicaid Managed Care Monthly Capitation Rates, March 2010–April 2011^a

Medicaid Eligibility Category	Monthly Capitation Rate
TANF adult	\$1136.37
TANF child ^b	\$672.82
SSI adult	\$1746.59
SSI child ^b	\$936.90

Source: New York State Department of Health AIDS Institute, August 2011. Abbreviations: HIV, human immunodeficiency virus; SSI, supplemental security income; TANF, temporary assistance for needy families.

^a These rates will be adjusted in October 2011 to reflect costs for services such as pharmaceuticals that were previously paid on a fee-for-service basis because these services will be incorporated into the managed care benefit package.

^b Under 21 years of age.

funding will remain vital to ensuring access to HIV care and treatment for individuals who remain uninsured or are underinsured under the ACA.

CONCLUSION

The HIV care model that incorporates the best aspects of the medical home model and contributes to our remarkable success in treating HIV disease should be promoted and enhanced with national health care reform. Further evaluation of this HIV care model and its impact on patient outcomes and cost effectiveness is warranted to inform the development of financing and delivery systems that improve HIV care and care for other complex, chronic conditions. The ACA, steered by the NHAS, offers great promise for turning the tide of the HIV epidemic if it builds on the remarkable delivery and care programs developed by the Ryan White program and other HIV providers. However, Medicaid and Medicare payment reform for complex care management along with continuation of the public health funding available through the Ryan White program will be critical to maintaining the HIV care model. This reform and continued funding will also make it possible to improve outcomes for people with HIV and prevent HIV infection through effective HIV care. Weakening of this model, with fragmentation of care or a decline in essential services, will not only result in adverse consequences for HIV-infected patients but will also increase preexisting disparities in health outcomes and HIV transmission within at-risk communities, ultimately increasing the burden of disease and the cost of HIV care.

Notes

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**Consensus Core Set: HIV / Hep C Core Measures
Version 1.0**

Table 1. HIV Measures				
NQF #	Measure	Measure Steward	Level of Analysis	Consensus Agreement / Notes
0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	NCQA	Clinician	Consensus reached for inclusion in core set.
0409	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis	NCQA	Clinician	Consensus reached for inclusion in core set.
2082	HIV viral load suppression	HRSA - HIV/AIDS Bureau	Clinician	Consensus reached for inclusion in core set.
2079	HIV medical visit frequency	HRSA - HIV/AIDS Bureau	Clinician	Consensus reached for inclusion in core set.
0579	Annual cervical cancer screening or follow-up in high-risk women	Resolution Health, Inc.	Clinician	Consensus reached for inclusion in core set. <i>Note:</i> This measure may require updating if better scientific evidence becomes available.
N/A PQRS #P22	HIV Screening of STI patients: Percentage of patients diagnosed with an acute STI who were tested for HIV.	CDC	Clinician	Consensus reached for inclusion in core set.

Table 2. Hepatitis C Measures				
NQF #	Measure	Measure Steward	Level of Analysis	Notes
N/A	PQRS #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	AGA	Clinician	General consensus reached for inclusion in core set. <i>Note:</i> This measure may require updating if better scientific evidence becomes available.
N/A	PQRS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	AMA-PCPI	Clinician	Consensus reached for inclusion in core set.

**Consensus Core Set: HIV / Hep C Core Measures
Version 1.0**

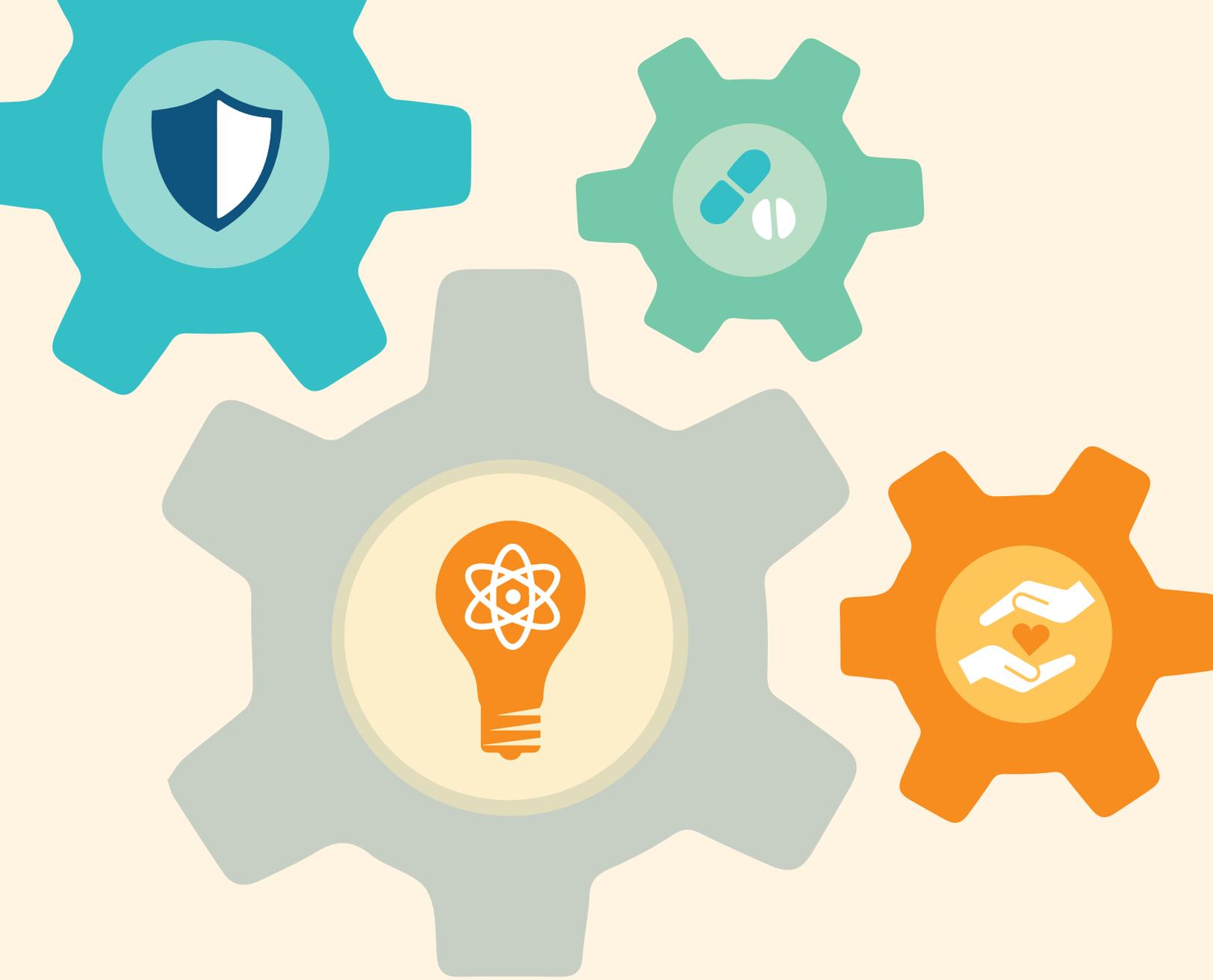
Table 3. Gap Areas for Future HIV/Hepatitis C Measure Development

HIV

- HIV RNA Level (revise NQF #0404 CD4 Cell Count or Percentage Performed to assess HIV RNA Level which is now recognized as the key metric)
- #0413 HIV/AIDS: Screening for High Risk Sexual Behaviors (NCQA) had endorsement removed in 2013
- #0573 HIV Screening: Members at High Risk of HIV (Health Benchmarks - IMS Health) had endorsement removed in 2014
- P23 - HIV: Ever Screened for HIV: Percentage of persons 15-65 ever screened for HIV. Reconsider upon release of additional testing data likely in summer or fall of 2016. Less than 100% performance expected.
- Updated medical visit frequency measurement with virtual visits (#2079)
- Follow up for patients diagnosed with HIV and with low viral load

Hepatitis C

- #0393 Hepatitis C: Testing for Chronic Hepatitis C - Confirmation of Hepatitis C Viremia
- Testing of viral load 12 weeks post-end of treatment (AGA currently revising this measure)



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*A report prepared by Health Management Associates and the
National Alliance of State and Territorial AIDS Directors*



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Introduction & Background



The Centers for Disease Control and Prevention (CDC) estimates that, despite ongoing prevention efforts, 50,000 Americans become infected with HIV annually. Nearly 1.2 million individuals are living with HIV in the United States. Continued growth in the population living with HIV will lead to more infections unless prevention, care and treatment efforts are maintained and intensified.*

In July 2010, the Obama Administration released the National HIV/AIDS Strategy (NHAS) to identify priority activities to address the domestic HIV epidemic. In July 2015, the White House released an updated five-year strategy that includes an emphasis on prevention and the following strategy goals, each tied to measurable outcomes:

- Reduce new infections,
- Increase access to care and improve health outcomes for people with HIV,
- Reduce HIV-related health disparities and health inequities,
- Achieve a more coordinated national response to the HIV epidemic.

Funding for prevention, care and treatment services directed towards individuals living with or at risk of acquiring HIV comes from an array of public and private insurance and public health programs. This array of services and programs is undergoing a decidedly complex evolution, as the Affordable Care Act (ACA) expands Medicaid and other insurance coverage options; health care financing and delivery systems are re-designed to emphasize quality and population health; and public health prevention and safety net roles adapt to these developments.

The purpose of this report is to identify emerging opportunities to strengthen and enhance efforts to prevent HIV infection and improve HIV care by forging collaborations between public insurance and public health programs. State health departments are uniquely positioned to develop and lead partnerships with their state Medicaid counterparts.

*Centers for Disease Control and Prevention (CDC), HIV in the United States, available at <http://www.cdc.gov/hiv/statistics/overview/atagance.html>

COVERAGE AND FINANCING OF HIV CARE AND PREVENTION

The CDC is the federal agency with primary responsibility for HIV prevention. The CDC supports state and local HIV prevention programs, including health departments and community-based organizations, through funding and technical assistance, surveillance activities, and targeted research efforts. In 2012, the CDC introduced a new “high-impact prevention” approach designed to prioritize proven, cost-effective interventions, including:

- HIV testing
- Behavioral HIV risk reduction interventions (primarily for people living HIV and their partners)
- STD screening and treatment
- Biomedical interventions, particularly pre-exposure prophylaxis (or, PrEP)
- Linkage, reengagement and retention in HIV medical care and treatment
- Partner services
- Condom distribution

In addition, because “treatment as prevention” — ensuring that people living with HIV are virally suppressed and far less likely to transmit the virus — is an effective HIV prevention strategy, the lines between care and prevention have blurred. The close alignment of HIV prevention and care services, particularly around the importance of linkage to and retention in care and treatment, makes new partnerships with health care providers, systems, and payers even more timely and relevant.

Public health and safety net programs supported through the CDC and Ryan White HIV/AIDS Program have been and continue to be essential to responding to the epidemic. However, given the resource constraints on these programs coupled with the ACA’s insurance expansion

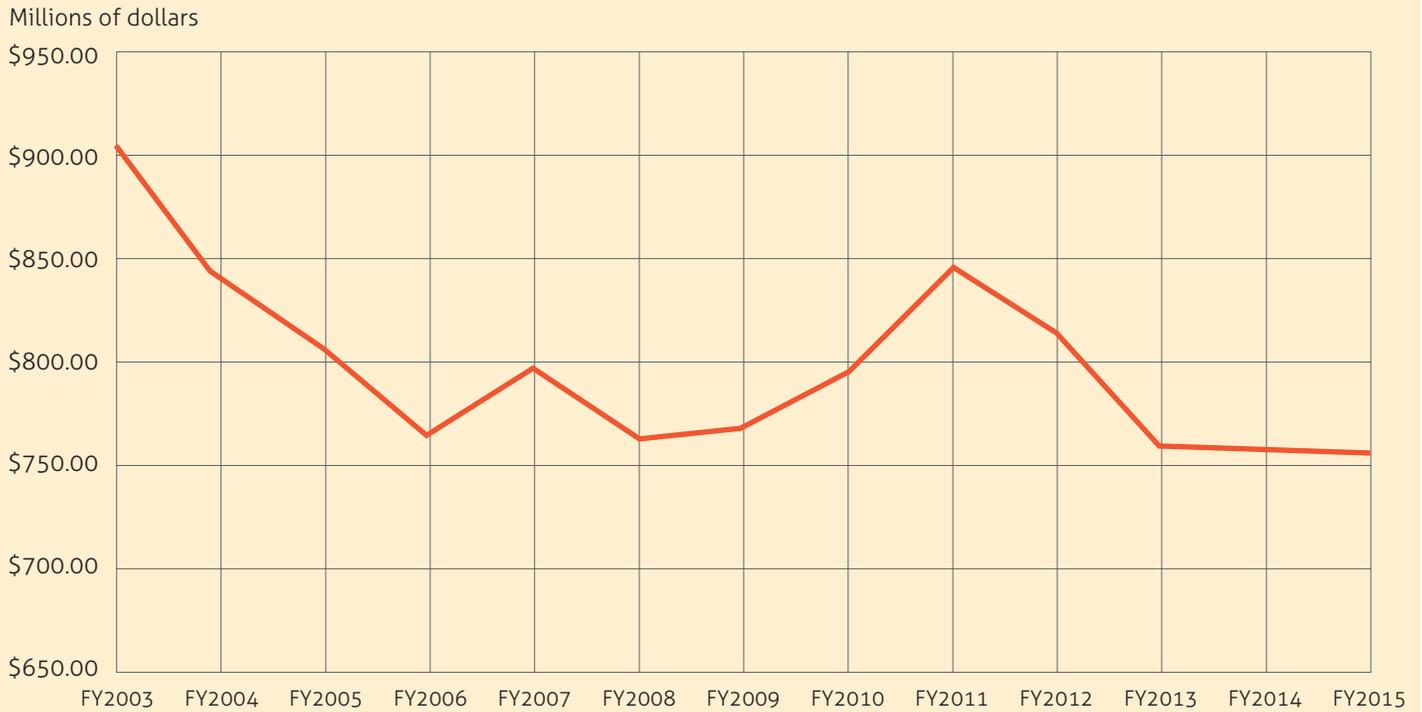
and federal investments in community health centers and primary care, public health programs are looking to health care systems, providers, and payers as new partners in HIV care and prevention efforts. Even before the ACA, Medicaid was the largest payer of HIV care in the United States.¹ Although Medicaid enrollees with HIV represent less than 1% of the overall Medicaid population, they account for a significant share — 47% — of people with HIV in regular care.² Generally speaking, Medicaid coverage for people living with HIV is fairly comprehensive and is a critical source of care and services, including antiretroviral therapy. However, as more people living with and at risk for HIV become eligible for Medicaid through the ACA, HIV programs are assessing how Medicaid delivers and finances preventive services for vulnerable populations. This is true not only for the U.S. Preventive Services Task Force (USPSTF) A and B rated services, which Medicaid expansion benefits must include, but also for the linkage and coordination services that are so important in both HIV prevention and care efforts.³

In order to meet the updated HIV prevention goals established in the NHAS, the strategy update calls for public health and health care officials across levels of government and advocates to maximize the opportunities afforded by health care reform. In addition, as **Figure 1** shows, dedicated HIV prevention funding to CDC, when adjusted for inflation, has decreased since FY2003 by approximately \$150 million in 2015 dollars.

HEALTH CARE DELIVERY SYSTEM REFORMS

Spurred by the recognition that traditional fee-for-service reimbursement incentives are inadequately designed to support patient outcomes population health, the broader health

Figure 1: HIV Prevention Funding Adjusted for Inflation



care system is undergoing significant changes. These changes can be generally characterized by:

- A greater focus on quality measurement and improvement
- An emphasis on the crucial role of primary and preventive care
- Care delivery philosophies that emphasize integration of care across settings and providers
- An acceleration of initiatives to restructure provider payment methodologies to incentivize quality and value over volume
- A shift to Medicaid managed care

These reforms are forcing new interactions between public health and Medicaid programs.⁴ With greater emphasis on preventative care in health insurance and in evolving delivery system reforms, there are new opportunities for Medicaid

and other payers to cover new services aimed at coordinating care, linking people to appropriate services, and keeping people healthy. This dynamic presents a range of opportunities, some of which are described in this report. At the same time, it creates complexities in grant management for prevention services providers and a need for those same providers to understand the mechanics of health insurance.

THIS REPORT

The National Alliance of State & Territorial AIDS Directors (NASTAD) represents the nation's chief state health agency staff administering HIV/AIDS and viral hepatitis health care, prevention, education and support service programs. Given the growing importance of collaboration between Medicaid and public health programs, NASTAD contracted with Health Management Associates

(HMA) to develop a paper to highlight best practices in financing HIV prevention and care services and to identify ongoing challenges. HMA is a national consulting firm specializing in state Medicaid programs, health care system financing, program evaluation and delivery system reform. This report was funded, in part, through a cooperative agreement awarded to NASTAD by the CDC.*

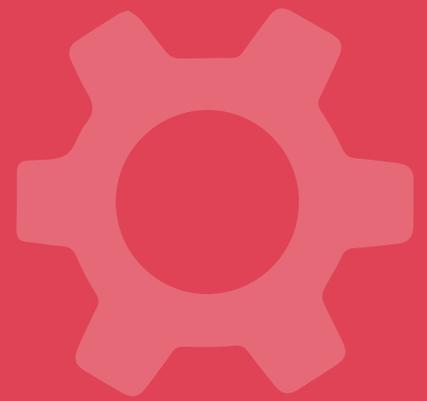
HMA conducted research on national trends and state-specific activities for the purpose of

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identifying initiatives that represent innovative approaches to HIV treatment and prevention and that exhibit an important connection between public health officials and Medicaid agencies. Four case studies emerged from this research and are presented in the first section of this report. To develop each case study, HMA conducted interviews with the state AIDS Director, representatives of the state Medicaid agency, and other providers or health plans involved with the initiative.

HMA and NASTAD also identified a set of notable trends in financing HIV prevention and treatment, which are addressed in the second section of this report. Based on the report's findings, the final section includes considerations for state public health departments.

Case Studies



LOUISIANA

Using Medicaid Quality Incentive Payments to Improve Services and Outcomes Across the HIV Care Continuum



OVERVIEW

In recent years, the Louisiana Department of Health and Hospitals' (DHH) Office of Public Health (OPH) STD/HIV Program has successfully implemented innovative programs to improve access to and the utilization of HIV prevention and treatment services. These programs include the Louisiana Public Health Information Exchange (LaPHIE), a bi-directional, electronic information exchange between OPH's HIV surveillance systems and participating health care providers that allows providers to support retention in care for patients with HIV. Another program of the OPH is LA Links, a Care and Prevention in the U.S. (CAPUS) funded initiative which uses regionally located care coordinators to help connect people with HIV care and treatment. Through these and other programs, Louisiana has achieved a viral suppression rate of 50 percent among all people living with HIV — 20 percent higher than the national average of 30 percent.

Most recently, the OPH's STD/HIV Program has demonstrated its commitment to improving the health and well-being of people living with HIV by partnering with the Bureau of Health Services Financing (the state's Medicaid program) to leverage the flexibility of its Medicaid managed care program — Bayou Health — to increase access to and use of HIV care and treatment. Through this combined effort, beginning in 2016, the state's Medicaid managed care plans will be held accountable for helping their members living with HIV to achieve and maintain viral suppression. The new Bayou Health contracts include eight incentive-based performance measures, including one HIV-related measure, HRSA's HIV viral load suppression measure.⁵

Inclusion of this performance measure should lead not only to improved access and use of HIV treatment, including anti-retroviral therapy, but also increased use of other HIV prevention services. While the Managed Care Organizations

Bayou Health managed care plans will be held accountable for helping their members living with HIV to achieve and maintain viral suppression.

The new Bayou Health contracts include HRSA's HIV viral load suppression measure.

(MCOs) are not yet paying for a wide array of HIV prevention services, such as linkage to care services, inclusion of this measure has led the MCOs to think about HIV care and treatment differently. For the first time, the MCOs are developing a direct working relationship with the OPH's STD/HIV Program and learning about its programs and providers. As a result, the MCOs are incorporating these resources into their case and disease management programs and referring members to them, as well as exploring ways to leverage the LA Links program.

While this initiative is in the early phases of implementation, and much remains to be done, the successes and lessons learned from Louisiana's innovative use of Medicaid managed care to improve the health and well-being of people living with HIV provide a valuable model for other states.

PROCESS AND ENGAGEMENT

In 2013, the Department of Health and Hospitals — the agency that administers both the OPH and the Bureau of Health Services Financing (Medicaid) — experienced a change in leadership that facilitated greater interaction and data sharing between OPH and the state Medicaid program. Under the new leadership, OPH and Medicaid signed a data sharing agreement in 2014 that allows them to share Medicaid claims and eligibility data and public health data and statistics for the administration and evaluation of the Medicaid program and public health services. Prior to this, the two agencies did not regularly share data. Only a few programs had negotiated individual data sharing agreements for limited data sets. The new data sharing agreement took about six months to negotiate and put in place.

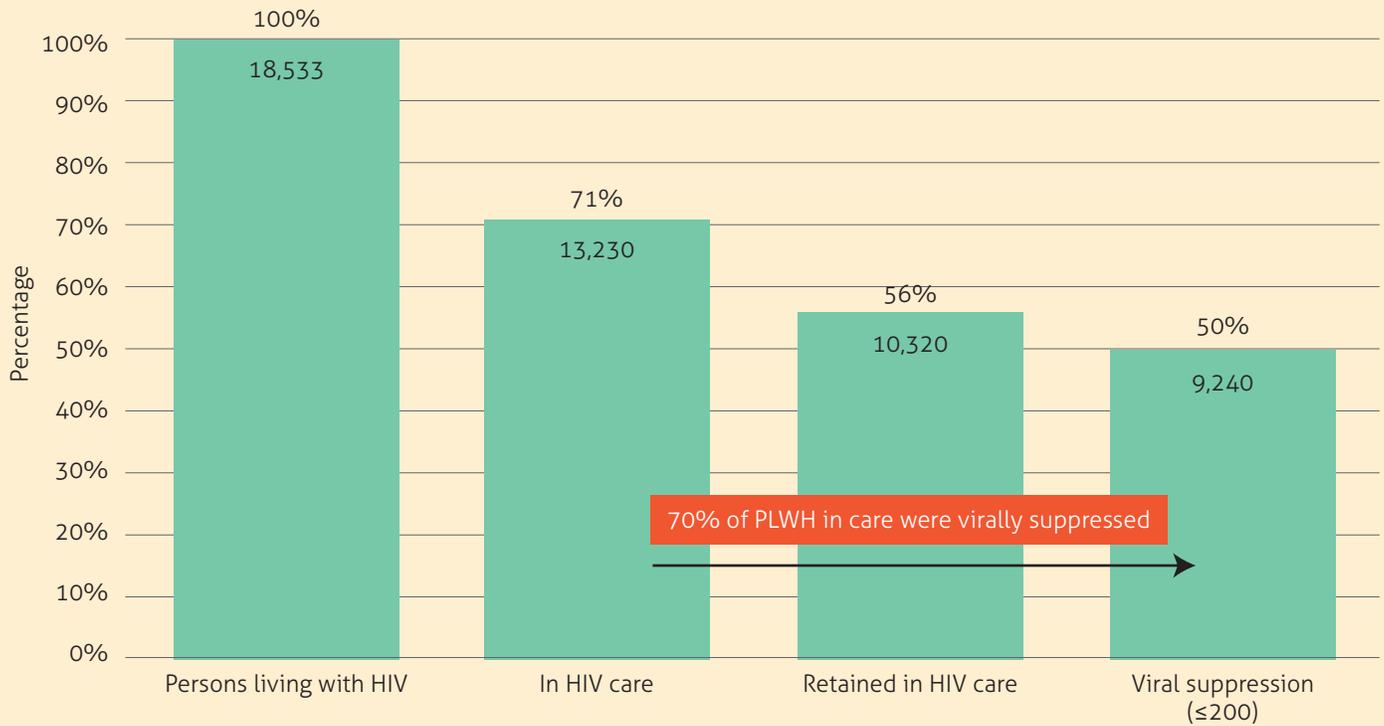
Additionally, OPH and the state Medicaid program began having monthly meetings to discuss joint

projects. Staff members from the OPH STD/HIV Program are actively involved in these monthly meetings. This timing coincided with the beginning of the state Medicaid program's re-procurement process for Bayou Health — Louisiana's Medicaid managed care program. As part of this process, the state Medicaid program evaluated the existing quality measures, as well as potentially new quality measures. Given the high HIV prevalence in the state, Medicaid asked OPH whether the HIV viral suppression measure should be included in the MCO contract.

OPH supported inclusion of the viral suppression measure and, using its comprehensive HIV surveillance and continuum of care data, was able to support inclusion of the viral load suppression measure in the Bayou Health contract. (See **Figure 2**: HIV Continuum of Care, Louisiana 2014.) In addition to the data, strong leadership and a champion in the state Medicaid agency were integral to ultimate inclusion of the viral load measure as a value-based performance measure in the MCO contract. Quality improvement in Medicaid is a primary objective of the state Medicaid program, and both the OPH Assistant Secretary and Deputy Assistant Secretary supported inclusion of the HIV viral load measure in the MCO contracts.

The state Medicaid program has developed a strong, engaged relationship with the MCOs in the state, with quarterly business meetings and weekly "touch base" meetings with MCO Executive Directors, the state Medicaid Director and Bayou Health Director. However, OPH has not previously had the opportunity to develop similar relationships with the MCOs. As a result of this new initiative, OPH is now engaging with the MCOs through data sharing, as well as educating them about public health programs for people living with HIV, such as the LA Links program. The goal is to develop relationships between the LA Links program and the MCOs. The exact nature of

Figure 2: HIV Continuum of Care and Viral Suppression Rate, Louisiana 2014



Adapted from Public Health in the Era of Health Reform: Developing an HIV Performance Measure with Managed Care Organizations in Louisiana, presented July 20, 2015

these relationships is yet to be determined, but this is an important development in the area of HIV prevention.

While the OPH and state Medicaid staff have actively collaborated in the development of this initiative from the beginning, the MCOs were not involved early in the process. In retrospect, all parties agree that had the MCOs been involved sooner, some of the obstacles encountered could have been prevented. For example, OPH and Medicaid could have learned early that the MCOs do not have the data necessary to calculate the performance measure. Because the plans did not have the necessary data and ability to calculate performance on the quality measure, the accountability component of the quality

measure has been delayed until 2016 when the ability to calculate performance on it has been achieved.

QUALITY MEASURE

The Bayou Health HIV viral suppression measure is based on the HRSA HIV/AIDS Bureau Performance Measure, National Quality Forum measure #2082 and is also included in the 2015 Core Set of Adult Health Care Quality Measures for Medicaid. It measures the percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load of less than 200 copies/mL at last HIV viral load test during the measurement year. The Louisiana Medicaid program selected this measure because it is endorsed by the

National Quality Forum (NQF), supported by HHS, and is an outcome-focused measure.

As part of the Core Set of Adult Health Care Quality Measures for Medicaid — which are optional for states — states choose whether to measure and submit the results of these measures to CMS. However, CMS has developed a variety of tools to help states implement collection and reporting of these quality measures, including a Technical Specifications and Resource Manual.⁶ Having access to these kinds of resources can be very important. MCOs are used to collecting and reporting on the National Committee for Quality Assurance (NCQA) approved Healthcare

CMS has developed a variety of tools to help states implement collection and reporting of these quality measures.

Effectiveness Data and Information Set (HEDIS), one of the most widely used sets of health care performance measure in the United States. These quality measures have very detailed technical

specifications and are designed for MCOs. One of the MCOs interviewed for this study noted the use of this non-HEDIS measure as a point of concern, because, in their opinion, it lacks the detailed, stringent technical specifications that HEDIS measures have. However, the state Medicaid program sees this as a “growing pain” and that with time, support, and experience, the MCOs will become comfortable with the measure.

The Louisiana Medicaid program noted that a valuable lesson learned in this process is the important role that piloting the measure could have played to identify obstacles so that solutions could be developed before full implementation. Additionally, the Medicaid program contracts with the University of Louisiana — Monroe, to calculate and validate

the viral suppression measure using data provided by OPH and Medicaid and the measure specifications. This has proved very important because the MCOs were not able to calculate the measure results. Medicaid stressed the importance of having an external entity that can calculate and validate the measure results.

Louisiana’s Medicaid program set the baseline at 51.34% and the performance improvement target at 54.34%. The first year, 2015, is a reporting year, but beginning in 2016, MCOs will be held accountable for meeting or exceeding the established target. Currently, all of the MCOs in Louisiana are exceeding the target. When setting the target, Medicaid wanted to set something that was achievable. It is likely that the initial target was set too low and will need to be revised to continue incentivizing performance improvement among MCOs. A revision of the performance target will require a contract amendment, which may come as soon as 2016.

DATA SHARING

One of the most valuable lessons learned to date is that timely, reliable, and complete data are critical — but ensuring their availability may require some ingenuity. As a result of the highly collaborative process to implement the viral suppression measure, OPH and Louisiana’s Medicaid program have gained a better understanding for the limitations of the data that MCOs have available through claims submitted by providers. For example, while MCOs may receive a claim for a viral load test, the MCO does not necessarily have the results of the test. This means that the MCO cannot determine whether a member meets the measure standard for viral suppression (i.e., viral load less than 200 copies/mL). Additionally, the MCO may not be able to determine which of its members are living with HIV since the MCO may not have received a claim for HIV care.

While OPH and Louisiana’s Medicaid program have a fairly broad data sharing agreement in place, determining which agency shares what data with whom has sometimes proven challenging to operationalize. After a year and a half of discussions, OPH and Medicaid have settled on the following approach:

1. Medicaid provides OPH with information about all Bayou Health members who have had a HIV related claim in a set period of time.
2. OPH compares that information to its surveillance data to confirm whether the individual has been diagnosed with HIV; if so, it provides Medicaid individual level information about whether the person is virally suppressed.
3. Medicaid then shares that information with the MCOs via a secure network.

To determine which Medicaid enrollees have been diagnosed with HIV and what their viral loads are, OPH ran a series of data analyses. In July 2014, OPH conducted an initial match between Medicaid claims data and HIV surveillance data. A second match was conducted in January 2015, which included the MCO name and a field “Did recipient have an HIV-related claim in 2014?” In July 2015, a third match was conducted that included a larger set of Medicaid records (1,430,774 enrollees). In the July 2015 data match, OPH identified people living with HIV who were enrolled in Medicaid and found not only matches involving people who had a Medicaid claim for HIV care, but also 2,674 people who did not have a claim for HIV care. Among this latter group, surveillance data indicated that 409 were not virally suppressed and 1,108 had no viral load results. If not for the data shared by OPH, MCOs would have been unaware of those 1,517 members’ HIV care needs. Indeed, the data analysis conducted by

OPH also found that as many as 3,487 Medicaid enrollees living with HIV could benefit from linkage to care services. (See **Figure 3**: Results of Medicaid and HIV Data Match, July 2015.)

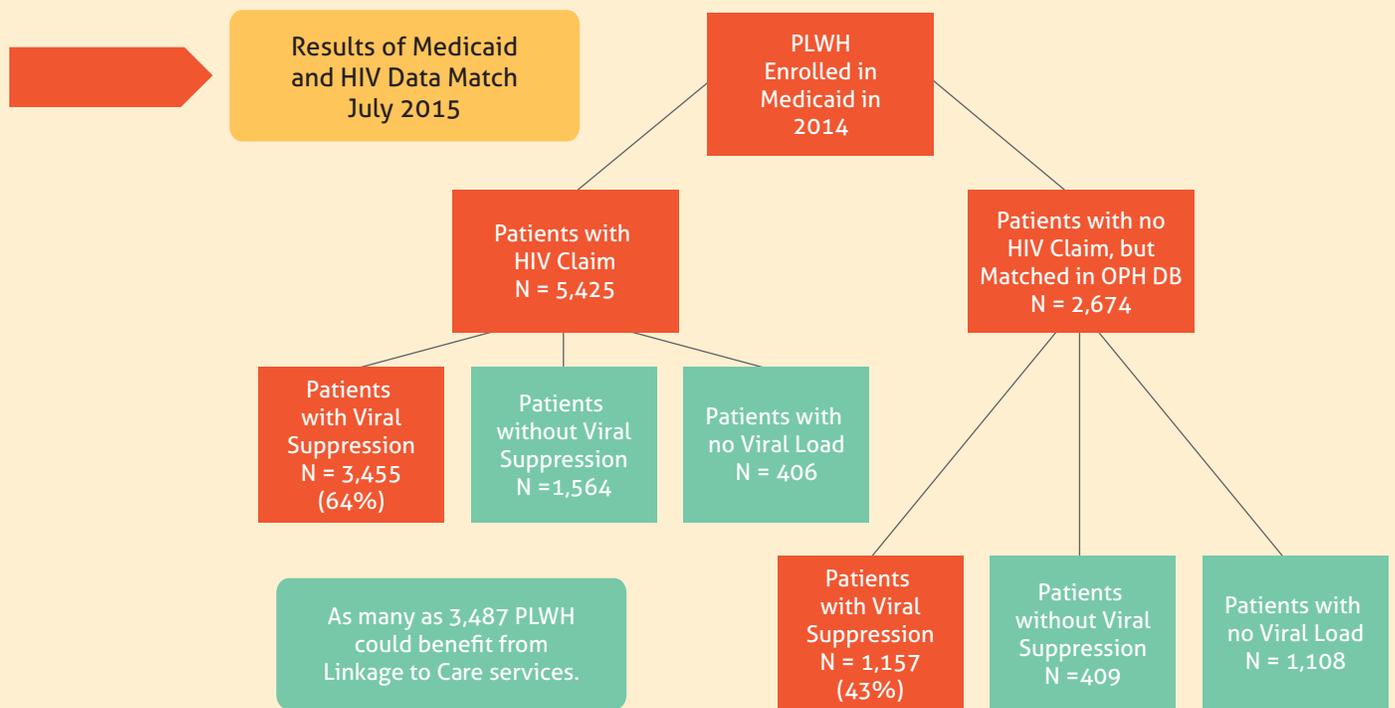
This type of data sharing is important and to have the intended results, it must be performed regularly. Originally, OPH intended to share information with MCOs annually. MCOs requested this data be shared more frequently so that they can act on it in a timely manner. The MCOs prefer monthly data sharing, but no less frequently than quarterly. OPH and the state Medicaid program were responsive to the MCOs’ request and OPH will share these data quarterly.

While OPH and Louisiana’s Medicaid program have a fairly broad data sharing agreement in place, determining which agency shares what data with whom has sometimes proven challenging to operationalize

MEDICAL CARE AND SUPPORT SERVICE PROVIDERS

Each of the five MCOs in Louisiana has disease management or case management programs that provide services to their enrolled members living with HIV. However, these programs differ from the Ryan White-or CAPUS-funded linkage to care services, such as LA Links, in several respects. For example, none of the MCOs have care managers dedicated to providing care management to people living with HIV. Additionally, the programs often rely on telephone and mailings for outreach and engagement. While the programs often include a health risk assessment and some care planning, including referral to services, they do not provide the same comprehensive, in-person care management that Ryan White programs or LA Links provide. Further, not every member who is living with HIV may be enrolled in one of these

Figure 3: Results of Medicaid and OPH HIV Data Match, July 2015



Unpublished data provided by the Department of Health and Hospitals (DHH) Office of Public Health (OPH) STD/HIV Program, September 28, 2015.

programs. For example, the care management program for one of the MCOs interviewed for this project includes the top five percent of members most in need regardless of their HIV status.

However, introduction of the HIV viral suppression measure as a value-based performance measure in the MCO contract has spurred additional activities by the MCOs. These include educating in-network providers and MCO staff about HIV testing, care, and treatment; putting greater focus on meaningfully engaging members who are living with HIV in disease or case management; engaging community-based services and programs for people living with HIV; and providing incentive payments to providers to encourage HIV testing and treatment engagement.

One of the five Bayou Health MCOs, for example, has begun to use its regionally located Clinical Practice Consultants (CPCs) to work with

providers whose patients have a HIV viral load greater than 200 copies. The Quality Department for that MCO uses the data provided by OPH to identify members who have not obtained viral suppression and their provider of record. The Quality Department then supplies the CPCs with the list of providers whose patients have not achieved viral suppression. The CPCs works with the provider to identify potential reasons why his/her patient(s) have not achieved viral suppression and helps the provider identify additional local resources that may be able to help his/her patients, such as linkage to care services. This same MCO has begun to explore with OPH how it can better leverage OPH HIV programs, including the LA Links program. The MCO hopes to better understand the services LA Links provides and how the LA Links program and the MCO's care management program can work together to provide comprehensive services to members while avoiding duplication of effort.

However, it is important to note that it is not the MCOs' intention, at this time, to pay for the provision of those services. The MCO hopes to identify community resources to which its care managers can refer members to receive community-based services.

FINANCING

All of the MCOs are risk-bearing and are paid a monthly capitation rate, from which the state withholds two percent. In order to receive the withheld amount, MCOs must meet or exceed the performance targets set for the eight value-based performance measures, including the HIV viral load suppression measure. MCOs that achieve the target for the HIV viral suppression measure will receive \$250,000 of the withheld amount. MCOs that do not meet the target will not receive that portion of the withheld amount.

MCO REIMBURSEMENT OF HIV PREVENTION SERVICES

Both the state Medicaid program and OPH hope that the HIV quality measure will result in greater focus on Medicaid members living

with and at risk for HIV, as well as a closer collaboration between Medicaid, OPH, and the MCOs. However, the MCOs are largely focused on realizing performance improvements through better delivery and use of the care and support services they are contractually required to provide, as these services are included in the rates that are paid to the MCOs by the state. If an MCO elects to contract with new providers for additional HIV prevention services, such as linkage to care services, it must pay for these services out of its current rate. As a result, MCOs may be interested in helping their members better leverage publicly supported, community-based prevention services, but they are not currently considering contracting for and paying community-based providers for the provision of these services.

When asked if they would consider doing so, MCOs did indicate that if a business and value proposition case is made, it is something they would consider. Nonetheless, it is more likely that if Louisiana wishes to have the MCOs pay for such services, it will need to require that as part of the contract and incorporate it into the MCOs' rate structure.



Lessons Learned

- Quality measurement is technical work and implementing new quality measures requires careful thought to capture necessary data, validate information, and calculate measures.
- Emphasizing performance on a quality measure can lead MCOs to investigate how to coordinate with public health resources and encourage the development of practice-level interventions designed to improve performance.
- Collaboration between MCOs and the state health department to understand available data and data-sharing protocols is crucial and is a specific way to introduce public health agencies and MCOs to the ways that data sharing can be useful to support care delivery improvements.

RHODE ISLAND

Reimagining Medicaid Case Management to Include High-Risk HIV Negative Individuals



Building off of the success of TCM coverage for people living with HIV, the state health department began conversations with the state Medicaid program and Medicaid MCOs to explore a similar set of services for HIV negative individuals.

OVERVIEW

Targeted case management (TCM) is an established service option under federal Medicaid law. In Medicaid terms, TCM is an optional service, and the process of gaining approval for federal matching funds for the service involves the submission of a state plan amendment⁷ that defines a “target group,” explains the services to be delivered and the qualifications required of providers, and outlines how the services will be reimbursed. In Rhode Island, HIV-related TCM services were originally delivered through the fee-for-service system, but as the state has shifted to greater reliance on a managed care model for delivering Medicaid services, TCM services have been brought “in plan” as covered services in the MCO contracts. Specifically, when Rhode Island expanded its Medicaid program in 2014, the state used the contract negotiation process as an opportunity to extend TCM to its new coverage population. Incorporating TCM coverage for the Medicaid expansion population into the MCOs for people living with HIV allowed Rhode Island to leverage the expertise and capacity of existing HIV providers to ensure continuity and coordination between the state Medicaid program and the Ryan White HIV/AIDS program, and to maximize federal funding.

Building off of the success of TCM coverage for people living with HIV, the state health department began conversations with the state Medicaid program and Medicaid MCOs to explore a similar set of services for HIV-negative individuals. Beginning in January of 2016, the state will build on this structure to include case management services for individuals who are deemed to be at risk of HIV infection, based on defined behaviors or characteristics. The new “at risk” population eligible for case management services is defined as people with any of the following:

- Men who have sex with men (MSM)
- Active substance users and/or those individuals with documented mental illness
- Persons living with hepatitis B or C
- Persons with a documented history of sexually transmitted diseases (STDs)
- People recently released from prison or juvenile detention (TCM services may be delivered within one year post-release)
- Sex workers
- Transgender individuals

- Bisexual men and women
- Adolescents engaging in unprotected sex
- Persons who engage in unprotected sex with HIV+ or high risk individuals

Each person eligible for targeted case management is assessed to determine the severity of need. For people at risk for HIV, TCM services include an intake process, assessments and re-assessments, care planning, and referrals to relevant services, including behavioral health services, medical visits, housing, HIV Testing, STI testing, and vaccinations.

PROCESS AND ENGAGEMENT

The Rhode Island Executive Office of Health and Human Services (EOHHS) is a state umbrella agency that oversees social, public health and human services, and Medicaid. In fact, the HIV Provision of Care and Special Populations Unit, which manages the Ryan White Part B program, resides within the Medicaid Division, and the Principle Investigator for the Ryan White Part B grant reports directly to the State Medicaid Director. This structure has created a channel through which state Ryan White leadership can provide direct policymaking input on how the Medicaid expansion would be implemented.

One challenge with investigating Medicaid coverage options for TCM was funding constraints. The Department of Health, which had been financing case management services, reduced its expenditures for HIV case management, in part, because of a general expectation that, since Rhode Island was expanding its Medicaid program, fewer individuals would be entirely reliant on publicly funded case management services.

The state engaged its two Medicaid MCOs in advance of the implementation of the ACA's Medicaid expansion, with discussion originally focused on the planned contract amendment that

would include TCM services for people living with HIV as MCO-covered services. The state expanded those discussions to include TCM services for HIV negative individuals.

NETWORK PROVIDERS, CLAIMS, AND REPORTING

Under the fee-for-service TCM program, the target group was defined, in part, as individuals "receiving case management services from providers who are licensed by the Department of Health and provide service under contract to the Department of Health." In effect, approved Ryan White providers were able to bill the Medicaid program for fee for service (FFS) enrollees. The new MCO contract requires MCOs to develop a network of HIV-related TCM providers. In order to streamline the development process, the state provided the MCOs with a list of existing Ryan White providers and also communicated its expectation that all of those Ryan White providers should become MCO network providers. About half of the existing providers also offered other medical services and were already enrolled providers in each MCO's network. The MCOs also developed contracts directly with all Ryan White TCM providers that were not already included in their networks.

Under the MCO contracts, MCOs negotiate rates independently with the provider agencies. Those negotiations were initially informed by the established state TCM rate and by information from local providers about their costs. In both health plans, the services are billed on a unit basis, in 15-minute increments. Both plans conveyed that billing processes were new but did not result in significant disruption or issues for Ryan White providers. In advance of the

The new MCO contract requires MCOs to develop a network of HIV-related TCM providers.

implementation of the new coverage, plans provided technical support to providers — either one-on-one training or visits to provider sites.

The state health department also played a role in encouraging the development of infrastructure and capacity at the provider level to manage and monitor HIV clinical and supportive care. This has been important to the MCO expansion of TCM because the state has set expectations of significant quality reporting for the MCOs. Beginning this year, and over the coming years, the state is collecting a set of performance measures associated with the service, including patient participation measures, patient process measures, quality of care measures, and patient outcome measures. These measures are required reporting elements under the MCO contracts and represent an interest on the state's part to be able to analyze over time the population receiving services and identify outcome variables. While the detail included in these reporting requirements has caused initial concern on the part of the MCOs, the state has worked with the MCOs to help them understand that they should be able to gather the data from their network because providers are obligated, as Ryan White HIV/AIDS Program providers, to have the reporting capacity.

Just as important, there are challenges related to the advocacy-based culture of some community-based provider organizations and their perceptions of Medicaid and managed care as bureaucratic or finance-focused entities. Technical assistance and support at the provider level is necessary — and one state interviewee suggested that such support needs to address not only staff practices and provider operations, but also governance and organizational culture. This general point may take on greater importance as the state moves toward TCM for HIV negative (at risk) individuals — when the state anticipates that the pool of participating providers could expand given the expanded potential client base.

COMBINING MEDICAID CASE MANAGEMENT AND PREVENTION SERVICES

As prevention services are prioritized for both individuals with HIV or at risk individuals, the operation of case management can support prevention but must be structured carefully to comply with federal and state rules. Indeed, the regulatory structure of the TCM program reflects the challenges of distinguishing between traditional case management services and prevention services. Because of the importance of demonstrating compliance with Medicaid rules, covered services in Rhode Island are documented as traditional case management services, including intake screening, assessment and re-assessment, and care plan development. The state's provider manual explicitly states that "Case management provides access to services but does not include the actual provision of the needed services."

Nevertheless, the case management program is designed to support the provision of high-impact prevention services. For example, the state's collection of performance measures requires that case management providers report viral suppression trends for HIV positive individuals, and case managers need to be aware through the assessment and care planning process of any risk factors and ongoing need for medical or behavioral services. Moreover, once the program is expanded to high-risk HIV negative individuals, case management providers will be required to refer such individuals for HIV testing and STD testing and help link consumers to those services.

COMBINING PUBLIC HEALTH AND MANAGED CARE APPROACHES

In interviews, both state officials and health plan representatives identified important cultural and operational differences between the state's publicly funded HIV care and prevention programs and Medicaid managed care. From the

state’s perspective, it was important for the health plans to engage meaningfully with the community of TCM providers. As the state AIDS Director stated, health plans should be encouraged to move away from acting as a traditional “payer” to engaging with community providers as a “player.”

By contrast, from the health plan perspective, the state’s regulatory and contract management approach to the TCM service failed to adequately recognize necessary differences in the organization and operation of case management available through managed care plans and those offered by stand-alone, disease specific programs. The health plans were universally impressed with the infrastructure and organization of the existing Ryan White program in Rhode Island, but they felt that some program elements—like reporting and monitoring requirements— were ill-suited to (and therefore, should not be applied to service provided within) a managed care context. As one plan representative stated, the state has to “make a transition from being a program [operator] to being an overseer.”

For practical reasons — namely, that the state already had an established TCM service for individuals with HIV — the services initially

brought into managed care were traditional HIV case management services. Looking ahead, the state is planning to expand the target group entitled to the services to those at risk of HIV infection. The point emphasized repeatedly by state officials is that their strategy has been to start small and build toward broader engagement between community-based providers and the established Medicaid delivery systems.

Indeed, as the state has begun discussions about expanding TCM through the MCOs to include individuals who are HIV-negative but are demonstrably at risk of HIV infection, it has found that MCO care managers have expressed an interest in being involved in the development process. The state intends to work with the MCOs to determine how best to identify at-risk members and to support providers as they plan for this new service model focused on case management to prevent HIV infection.

As the state AIDS Director stated, health plans should be encouraged to move away from acting as a traditional “payer” to engaging with community providers as a “player.”



Lessons Learned

- Coordination between plan-based care managers and community-based care management and prevention providers can provide mutual benefits and improve integration of care.
- Starting with a smaller managed care initiative provides a way for MCOs and providers to develop relationships and mutual respect, paving the way for broader and more comprehensive initiatives.
- Medicaid coverage for HIV care-related services, such as TCM, can provide a foundation for MCO engagement with public health programs and providers and open the door to opportunities for coverage of other HIV prevention services.

CHICAGO

Making the Case for Inclusion of Community-Based Organizations in Medicaid Managed Care Payment and Delivery Systems



AFC is working to establish new partnerships in care and prevention, built on their 30 years of serving the community with prevention, care, housing and advocacy.

OVERVIEW

In the post-ACA environment, expanded insurance coverage and experimentation with new delivery and payment models have produced significant new revenue-generating opportunities for HIV prevention and care services. In particular, new emphasis in Medicaid on population health and care coordination for people with complex conditions has created opportunities for services provided by non-clinical community-based organizations.

The AIDS Foundation of Chicago (AFC) has secured two contracts directly with Medicaid MCOs to date, and an additional four contracts are under discussion. While a majority of the work being conducted is focused on PLWH and those at risk, AFC services under contract reflect AFC parlaying its experience serving those populations to stretch beyond an established HIV-specific service track record. Prior to engaging with health plans for contracting services, AFC's funding mix consisted of grants from the public (federal, state and local governments) and private sectors, as well as donations from foundations and community supporters.

Health plan contracting with CBOs can address needs and provide benefits to both sides, but unless the state Medicaid office actively encourages MCOs to contract with community providers, the onus is generally on the CBO to initiate dialogue and propose partnership opportunities. This case study leverages AFC's experience working with Aetna Better Health of Illinois to illustrate how CBOs can articulate *and demonstrate* their potential value as part of a managed care network.

INTERNAL ASSESSMENT, POSITIONING AND VALUE-PROPOSITION

AFC conducted extensive preparation to market a range of services to MCOs, including those based on its expertise in linking and re-engaging back into care hard to reach health plan members, by developing a business case focused on supporting the MCO to achieve high-quality, cost-effective care.

A premise put forward by AFC for the services marketed to MCOs is that established, well-governed CBOs such as AFC know the communities,

populations, navigation pathways for treatment and care and the cultural contexts in which clients live their lives. Accordingly, AFC explicitly built its business case around data from key outcome indicators that demonstrated its track record of service delivery to hard-to-reach populations. In the interviews conducted for this report, senior MCO administrators repeatedly cited AFC's solid reputation and track record as two key factors in deciding whether to pursue a partnership with AFC.

CATALOGUE OF SERVICES AND CROSSWALK

Before engaging MCOs, AFC conducted an internal assessment of the "actual" cost of providing each unit of service. This analysis proved essential in the initial determination of whether the agency should pursue this line of work, and subsequently provided important benchmarks throughout the initial negotiating process. AFC then assessed its existing service mix and developed service packages to highlight key functions aimed at addressing emerging MCO and population health needs. The result of this effort, branded "CommunityLinks," is a suite of service packages—including those that address prevention, linkage and treatment—that can be marketed and sold to health plans. The catalogue became a marketing tool around which AFC constructed a business case demonstrating it could perform at the level that the MCO expected of a business partner.⁸

While AFC thus markets services across the HIV prevention and care continuum, this case study focuses on the "Reach and Engage" service package, which is described in greater detail below.

REACH & ENGAGE

Description: Our Mobile Engagement Team is designed to find and engage health insurance members to inform them

about health plan benefits and provide a brief health assessment.

Targeted members: "Unable to locate" health insurance plan members.

Benefits: By rapidly connecting and re-engaging those who are not yet connected with their primary care provider or have fallen out of care, members will be able to begin accessing services and appropriate treatment on a timely basis.

ESTABLISHING CONTACTS, BUILDING RELATIONSHIPS AND NEGOTIATING

With their services catalogued and business case for pitching partnerships honed, AFC established a logo, web page and phone line specifically for CommunityLinks. AFC then began reaching out to health plan contacts as broadly as possible. Outreach to health plans was prioritized based on corporate reputation, relationships and responsiveness. The approach was undertaken as a long-term relationship-building effort and AFC was mindful not to overwhelm the health plans with information and proposals. Initial targets for engagement included the health plan CEO, the executive responsible for Medicaid plans, or the company's government affairs representative. Beyond these systematic, strategic steps, AFC reported casting as wide a net as possible for business development contacts, including a cold call approach: "at a certain point we just picked up the phone and started dialing," when a health plan was not responsive and other approaches had failed.

Our Mobile Engagement Team is designed to find and engage health insurance members.

Once initial contact was established and as a precursor to discussing the service details, AFC and the plan established a Business Associate Agreement, which includes HIPAA provisions, in order to share information. Despite having packaged its services in a manner expected to align with what health plans would need to fulfill demands and requirements on them, significant additional discussion and customization was typically necessary to set contract terms and reimbursement methods.

To further attract interest from health plans unaccustomed to working with CBOs, AFC approached MCOs with the idea of starting small and then growing contract volume and services over time after AFC had fine-tuned its operations and demonstrated its value as a partner. Both of the MCOs with which AFC originally contracted were receptive to this idea, and initial contracts were executed for a one-year term, with a six-month re-evaluation built into the contract. In terms of authorized caseloads for the network, both contracts limit caseloads to fewer than 100 members. By starting small, AFC is able to essentially pilot a new payment and delivery model. However, for statewide policy and coverage reforms that ensure that all Medicaid MCOs are inclusive of HIV services and providers, a broader approach that addresses state MCO contracts and includes the state health department and state Medicaid program may be necessary.

REIMBURSEMENT AND CONTRACTING STRUCTURES

AFC proposed to operate on a monthly flat rate payment basis, which provides set revenue and allows for simplicity in administration of billing and payments. However, AFC has had to adapt to the unique preferences of its partner health plans. Currently, one contract is reimbursed at a flat monthly rate for services provided and the other

is a per-member per-month (PMPM) structure, based on the preference of the health plan. Furthermore, interviews with MCO executives suggest that they are increasingly favoring payment and partnership models that shift more of the risk to providers, including community-based entities like AFC. One executive noted that this is consistent with the health care system's evolution towards reimbursement structures that favor payment for performance.

AFC embarked on this initiative despite some uncertainty as to whether the payments it secured from MCOs would ultimately cover both the large upfront investment costs associated with developing its new business lines and the ongoing costs associated with providing high quality, often intensive services. In part, AFC was able to take this risk because it was well-capitalized: it secured special private and grant funding to support the transitional work, and it had a solid foundation of categorical HIV care and prevention funding. This stability has allowed AFC to be innovative and creative in designing service suites specifically tailored to the unique needs associated with new service populations.

AETNA AND REACH & ENGAGE

In March 2015, AFC finalized a contract with Aetna and began providing its Reach & Engage services to members that the health plan had been unable to locate. AFC maintains a monthly minimum case load of 83 health plan members, which the health plan identifies by holding internal interdisciplinary staff discussions, as well as reviewing claims data and Aetna case manager referrals. In assigning AFC's case load, the health plan takes into consideration factors such as whether the member is at high risk for HIV acquisition, whether the member is HIV-positive and out of care and whether the health plan has been able to "reach" the member, but not able to "engage" that individual.

AFC uses various data sources — including publicly available information (e.g., Cook County Jail and the Illinois Department of Corrections) and the agency’s internal housing database — to locate members for engagement. In addition, Aetna has been fine tuning a system whereby claims data for Emergency Department utilization and pharmacy usage would trigger immediate notifications to provide additional information on hard to reach members. Once a client is successfully contacted, AFC conducts Aetna’s

required state risk assessments and provides the client with information about the health plan’s benefits. As part of their services to health plan members, AFC offers HIV and HCV screening to every health plan member contacted, where appropriate. To date, this screening has occurred in people’s homes during a face-to-face reach and engage visit. AFC provides linkage to HIV medical care for individuals with a reactive test and re-engagement services for previously diagnosed clients who are out-of-care.

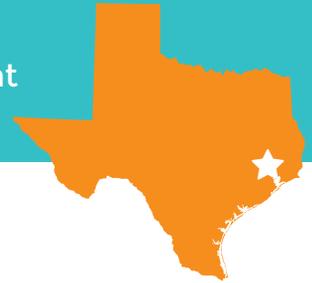


Lessons Learned

- CBOs interested in establishing new relationships with health plans must be prepared to articulate a value proposition; this may include evaluating the cost to the CBO of providing each service unit; establishing the CBO’s capacity to deliver services as contracted; and demonstrating to the MCO that the service will result in cost savings and better health outcomes.
- Contracts should be as specific as possible about all terms; however, they should also offer sufficient flexibility to allow fine-tuning as the relationship and the specific service categories evolve.
- Even partnerships grounded in a well-developed business case and support from leadership and staff on both sides will require patience and flexibility, as program requirements evolve and as the partners identify and strive to overcome technical and programmatic barriers.
- By partnering with state HIV programs and other state agencies in these contracting processes, providers and state health programs can maximize opportunities to ensure the long-term sustainability of pilot projects like this and foster state-wide approaches.

HOUSTON

Leveraging Medicaid Delivery System Reform Incentive Payment (DSRIP) Projects to Improve HIV Linkage and Reengagement



The City of Houston is using Medicaid 1115 waiver DSRIP funding to support patient navigators to link newly HIV diagnosed and out-of-care patients to care and treatment.

OVERVIEW

The City of Houston's Department of Health and Human Services Bureau of HIV/STD & Viral Hepatitis Prevention leadership has leveraged new financing opportunities through a statewide Delivery System Reform Incentive Payment Program (DSRIP) Medicaid 1115 waiver. Specifically, the DSRIP process in Texas has opened up a substantial new source of funds to support expansion of the Department's use of patient navigators to link newly HIV diagnosed and HIV diagnosed out-of-care patients to care and treatment with DSRIP funds.

Section 1115 waivers are approved by CMS and are vehicles that states can use to test new ways to deliver and pay for health care services in Medicaid. For example, Section 1115 waivers may be used by states to evaluate policy approaches such as expanding eligibility or services or using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Across the country, DSRIP waivers have been designed to support state delivery system reform goals to improve integration and coordination of Medicaid services. Typically a Section 1115 DSRIP waiver articulates state-specific goals and sets specific milestones that are measurable improvements in quality and overall population health.⁹

Eligible providers and the process for applying for funding may differ substantially across DSRIP states. While some states have been fairly prescriptive about eligibility for funding, the process for designing programs, and the metrics providers are permitted to select, Texas set up a regional system in which providers had flexibility to choose specific projects and select the metrics for delivery system reform. Specifically, Texas divided itself into geographic regions, known as Regional Healthcare Partnerships (RHPs), under which all applicants for DSRIP-funded services are organized. Each RHP is led by an anchor organization, generally the organization with the strongest leadership capacity and experience with safety net services in the area, and all public and private hospitals and non-hospital providers in a given region are eligible to participate. RHP #3 covers the entire Houston metropolitan area and is led by Harris Health Systems (HHS), which takes responsibility for coordinating the 25 other providers, overseeing the several hundred

waiver-funded projects currently underway, and providing a single point of contact for interaction with the state.

While DSRIP implementation varies broadly, on a national level, the point of DSRIP funding is to provide a source of funding to permit planning and implementation of projects that further the state's delivery system reform goals.¹⁰

Houston has had an HIV linkage program since the early 2000s; prior to DSRIP, the city had primarily relied on Ryan White HIV/AIDS Program funding, and, more recently, additional funds from private sources. Houston had applied for, but did not receive CDC PS 12-1201 Category C funding for a re-engagement data-to-care project. With the advent of the DSRIP waiver, the city's Department of Health was able to incorporate some of the activities that were not funded under Category C into its DSRIP linkage project. In addition, the city has not only been able to plug gaps created by reductions in traditional funding streams, but also to incrementally expand the overall capacity of the operation. In fact, DSRIP funds have helped put the department on track to double the number of people served through its linkage programs. The target population is Medicaid recipients, living with HIV as well those with syphilis infection (the syphilis-related focus was added as a result of a state Medicaid program requirement to identify additional related objectives to HIV linkage from a list of approved objectives), with an ultimate goal of increasing the number of people stable in care with viral suppression beyond the short-term intervention.

To apply for funding under the Texas DSRIP waiver, which began in 2012, RHPs were required to conduct a comprehensive community health needs assessment. In Houston, this assessment identified high rates of HIV and inadequate access to HIV treatment and services, as well as lack of patient navigation and information

programs. The member organizations then developed and proposed projects for funding that each fall under any or all of the four categories established by CMS for this funding program: Category I, Infrastructure Development; Category II, Program Innovation and Design; Category III, Quality Improvement; or Category IV, Population Health Improvement.

The first two years of funding were planning years. The third through fifth year of funding are program operation years. Each year has specific outcome measures for the categories under which they proposed and are measuring the progress and impact of work. For receipt of DSRIP payment — which is a set amount of funding rather than service-based — certain milestones need to be met. For example, a certain number of clients served under the waiver must have a dual diagnosis of syphilis with evidence of treatment for satisfaction of metrics selected under the program's Category III milestones. Payments are made three months after submission directly to the Houston Health Department.

For the linkage program, the approved total of milestone payments the second year for all Category I and II goals was \$2,061,713. Houston accomplished 100% of its milestone goals and therefore was paid in full following completion and satisfactory reporting. Category III milestones, which were also accomplished, totaled \$108,511. An important component of the program is that the DSRIP funds are reimbursed only after the work has been done and successfully documented and reported. Therefore from an operational standpoint, the agency must make a large investment in

To apply for funding, RHPs needed to conduct a comprehensive community health needs assessment.

floating the costs of the program. This pressure is particularly high for Category I and II milestone payments, which are “all or nothing,” in the sense that their payments can only be received when full achievement is achieved. Category III milestones, by contrast, can be paid out in quartiles for partial achievement. If milestones had not been achieved, they can be moved forward into the following year for future accomplishment and payment.

THE SERVICE LINKAGE PROGRAM IN HOUSTON

The service linkage program in Houston uses data from multiple sources to identify: newly HIV diagnosed patients; HIV-diagnosed out of care patients; and HIV-diagnosed patients in care who need additional supportive services to achieve medical stabilization and treatment adherence. The sources of client referral include reported cases through city surveillance data, local clinic primary care sites, disease intervention staff, and less frequently, local CBOs and self-referrals. Once an intake is conducted by linkage staff, the interviewer is allowed three days to complete all documents and then a 180 day period begins, during which time it is the goal of the program staff to get the client in care and linked to other relevant services. Success requires extensive knowledge of community resources and advocacy by the program staff on behalf of the client to connect them to available (separately funded) support services and medical care. Often an appointment for medical intake can take 90 days and the linkage staff are required to be tenacious champions to accomplish their goals. Discharge occurs when the client is stable in care, or at the end of the 180 day period, whichever comes first.

The department created its own data system for tracking DSRIP-funded program clients, as there are multiple sources of data and unique tracking and reporting requirements. They also use this

independently maintained system to generate all of their internal monthly reports and biannual reports to the state. Multiple sources provide data used to operate the services of the program, such as the Centralized Patient Care Data Management System (CPCDMS), which is operated by Harris County and used to track Ryan White clients; the Sexually Transmitted Diseases Management Information System (STDMIS) operated by the state; the city health department’s surveillance database; and an internal access database the department created to capture and track other information not housed elsewhere. Importantly, use of the CPCDMS to track DSRIP clients (although they are of course not reimbursable through Ryan White/AIDS Program funds) required a special agreement with the city’s Ryan White Program. This arrangement, which was implemented during the DSRIP planning years, has proven to be critical for the program to be compliant with data use and funding restrictions.

A BROADER FRAMEWORK OF GOALS, AND SPECIFIC DSRIP MILESTONES AND PAYMENTS

The Houston health department has effectively “braided” multiple funding sources (including those available through the Ryan White and DSRIP programs) to better support its linkage to care activities. This has allowed the Department to create a framework of short, intermediate and long-term goals, combined with quantifiable objectives, which would not have been possible with any single funding stream. In that larger framework, outcomes include:

Short-term: Improved capacity for service delivery, caseload optimization, and increased number of referrals.

Intermediate-term: Enhanced capacity to prevent spread of HIV/AIDS; increased ongoing access to medical care among people living with HIV; increased ongoing access to non-medical services among

people living with HIV; reduction in people living with HIV who use ED, urgent care and/or hospital services; and decreased morbidity among people living with HIV.

Long-term: Appropriate utilization of ED among people living with HIV; improved quality of life among people living with HIV; and reduction of health disparities.

Although the specificity of the milestones and data capture requirements have proven challenging (see above), the DSRIP program complements the Department's overall framework by requiring very specific clinical and process measures. The program's category-specific milestones for the two remaining years of the program, which are broken down into specific milestones and metrics for each year, are as follows:

- **Category I or II Expected Patient Benefits:** Increase number of primary care physician

referrals for indigent or Medicaid patients without a medical home who use the ED, urgent care, and/or hospital services by 5% over the baseline (baseline of 275 patients) in Y4 and by 10% over baseline in Y5.

- **Category III Expected Outcome:** Reduce by 5% each the number of ED visits among program participants in HIV Linkage Program and number of patients from specific zip codes over baseline in Y4 and by 10% over baseline in Y5.

Now in its fourth year of operation, the program has a strong track record of accomplishing its milestones and significantly expanding linkage resources for its HIV out-of-care population. Houston has been paid a total of \$4,696,814 through the end of year three of the project. The Department characterizes the initiative as a challenging one from an operational and managerial perspective, but also one that has resulted in meaningful program expansion.



Lessons Learned

- Designing appropriate metrics for a milestone-based reimbursement program requires great attention and flexibility to adjust according to external state and federal frameworks and priorities. Even with two years of planning preparation it was extremely challenging to get this program fully up and running.
- The reimbursement process for DSRIP, which requires an organization to "float" operating costs is a compelling reason for an organization to carefully consider their capacity prior to delving into DSRIP as a new funding opportunity.
- Service providers and program managers should be as involved and vocal as possible in goal setting, in discussion of specific program metrics, and in assessing what will be required to collect data.
- For a program that is bound by a period of time for linkage services, ongoing training and workforce development efforts are needed to ensure consumer retention in care after the required time allotted to service linkage workers has expired.

Notable Trends in Financing HIV Prevention



In addition to the approaches featured in the case studies, there are other innovative payment and delivery system reforms that present opportunities for public health departments and providers to partner with Medicaid to increase access to HIV prevention services. The table below describes some of these emerging opportunities in detail.

Medicaid Delivery System and Payment Reforms: Notable Trends				
Payment and Delivery Model	States Implementing the Reform	Approval Process	Provider Reimbursement Mechanism	Federal Guidance/ Resources
Medicaid Health Home	As of May 2015, 19 states have approved SPAs with a total of 26 approved unique Health Home models. Of these, four states (AL, WA, WI, NY) expressly include people living with HIV or AIDS in the target population.	Medicaid agency in the state must obtain a Medicaid State Plan Amendment (SPA). As part of the SPA process, states must consult with the Substance Abuse and Mental Health Services Agency (SAMHSA) to assure that Health Homes meet the needs of people with behavioral health needs — a priority population for Health Home services.	States have flexibility in determining the way in which providers are reimbursed for providing Health Home services. Examples include: Wisconsin: Monthly Case Rate, Rhode Island: Weekly, bundled rate per enrollee, Iowa: Per Member Per Month patient management fee	CMS Medicaid Health Home Resource Page

Medicaid Delivery System and Payment Reforms: Notable Trends

Payment and Delivery Model	States Implementing the Reform	Approval Process	Provider Reimbursement Mechanism	Federal Guidance/ Resources
Community Health Workers	A number of states are implementing models using Community Health Workers to expand access to preventive services. Some states, such as New Mexico and Oregon, mandate use of CHWs.	There are several ways to allow peers or CHWs to provide Medicaid services, including through a State Plan Amendment expanding the types of providers who may provide preventive services. States may file a State Plan Amendment that describes what services will be covered; who will provide them and any required education, training, experience, credentialing or registration of these providers; the state's process for qualifying providers; and the reimbursement methodology.	Reimbursement for CHW services varies by program. In some cases, MCOs are hiring CHWs directly and paying them a salary. In others, MCOs or state agencies are contracting with community-based organizations, in which case reimbursement is often a per-member per-month payment.	Center for Medicaid and CHIP Services Informational Bulletin Medicaid Reimbursement for Community-Based Prevention
Delivery System Reform Incentive Plan (DSRIP)	As of June 2015, six states have implemented or are implementing DSRIP as part of a comprehensive 1115 waiver program. Other states, such as Alabama, Illinois, and New Hampshire are developing DSRIP waivers.	Included as part of a broader Section 1115 Medicaid waiver. States must apply for and obtain approval for the 1115 waiver program.	Performance-based incentive programs; not grant programs. DSRIP funding allocation methodology varies by state, but in all cases providers must meet certain process and/or outcome measures before receiving any DSRIP funding.	Using Medicaid Supplemental Payments to Drive Delivery System Reform An Overview of Delivery System Reform Incentive Payment Waivers
State Innovation Model (SIM)	As of November 2015, over half of states representing 61 percent of the U.S. population (38 total SIM awardees, including 34 states, three territories and the District of Columbia) are working toward comprehensive state-based innovation in health system transformation.	CMMI has issued two rounds of funding for SIM. To be awarded funds, states had to submit a letter of intent to apply, along with a formal application. CMMI selected and awarded Model Design and Model Test grants.	States are pursuing broad system reform through SIM, with a focus on community, public, and whole-person health. Many SIMs include some form of value based payment, such as shared savings or risk-based payment methods, for providers.	State Innovation Models Initiative: General Information State Innovation Models Initiative: Round Two The State Innovation Models (SIM) Program: An Overview

Considerations for State Health Departments



State Health Departments should consider working with their Medicaid counter-parts to include HIV-specific quality requirements in MCO contracts.

State Medicaid agencies can use program monitoring authority and different incentive arrangements to encourage MCOs to focus on HIV prevention and quality of care. States are required under federal Medicaid managed care regulations to implement a minimum number of performance improvement projects (PIPs) each year. Some states also impose additional PIP requirements. Public health agencies or departments can work with their Medicaid counterparts to incorporate HIV-prevention focused PIPs in the Medicaid managed care contracts, or can follow Louisiana's lead and include quality measures that focus on HIV care and treatment. Quality improvement efforts can be further encouraged by linking performance to payments to the MCOs.

State Health Departments should consider establishing relationships with Medicaid Managed Care Organizations (MCOs).

Medicaid MCOs have the ability to provide value-added benefits to members, as well as to contract with non-traditional providers, such as non-clinical community-based organizations. State public health agencies or departments can help foster direct connections between community-based organizations that provide care and services to people with HIV and MCOs. The goal is to include HIV prevention care and services to support health plan enrollees. Forging this connection between MCOs and CBOs can happen because a state has required it (as in Rhode Island), because a state has put in place a specific contract requirement that encourages it (as in Louisiana), or because a provider and health plan determined that the partnership could have mutual benefits (as in Illinois). In all cases, it is worthwhile to first construct the business case for why an MCO program or company should focus on HIV services and/or providers. Whether directed at state Medicaid decision makers or at the MCO itself, this business case should illustrate how the HIV programs can help the MCO achieve one or more of its contract requirements, improve health outcomes for its members, and/or contain costs by reducing unnecessary utilization.



States should consider exploring ways to establish mechanisms to support community providers in developing MCO relationships.

Comprehensive networks of providers are a significant value to MCOs, particularly those with strong ties to disproportionately impacted communities. However, community-based non-clinical providers may face capacity and infrastructure challenges in developing relationships with MCOs and implementing financing arrangements that allow for reimbursement for prevention services. State health department and Medicaid programs can help by encouraging MCOs to work directly with community-based providers, and by providing “translation services”: helping MCOs and CBOs better understand and appreciate the state or federal requirements under which each operates.



All parties should acknowledge differences of “culture and capacity” between public health organizations and health plans and work together to identify opportunities that leverage the unique strengths of both sets of stakeholders.

When establishing ongoing initiatives that involve MCOs and CBOs, it is important to recognize that these participants in the health system have evolved separately, with different orientations toward state agencies and different financial incentives. Creating new initiatives to align incentives can encourage collaboration, but the fact remains that CBOs operate in an advocacy-based culture and MCOs operate in a business-driven insurance-based culture. Moreover, these entities will have very different capacities and orientations to data collection and systems.

Experience has shown that working together on data issues is both essential to operationalize a partnership, and can help to illuminate that both public health systems and MCOs have data that can strengthen collaboration.



State public health and state Medicaid agencies should consider working together to eliminate barriers to community-based collaboration.

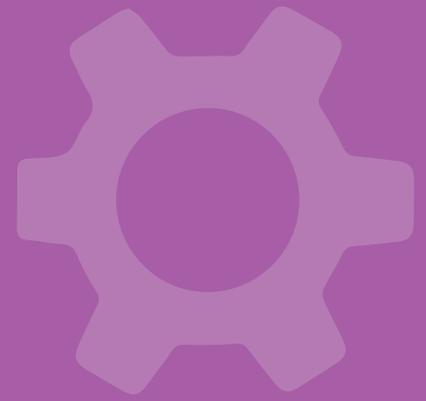
Issues of data access and Ryan White “payer of last resort” standards can be complex barriers for health plans and individual service providers to resolve, and the state health department can provide leadership and facilitate dialogue to move collaborations forward. Regardless of the specific operational context, issues of identifying eligibility and monitoring service provision cross multiple funding streams will remain important both to appropriately manage resources and to create methods to monitor progress and track clinical outcomes.



New Medicaid demonstration projects present HIV care and prevention programs with opportunities to fund public health programs and services not typically covered by Medicaid.

A central element of the Texas DSRIP program and of DSRIP nationally is achievement of quantifiable goals, so the design of DSRIP-funded programs across the country may offer opportunities to assess the challenges and possibilities of identifying specific clinical or process measures that capture how well an HIV linkage or prevention program is working. The establishment of these types of measures holds promise for creating ways to assess how public health and Medicaid programs are supporting public health.

Conclusion



This paper offers a snapshot of how states are working to bridge public health and Medicaid in ways that improve HIV services and to finance HIV prevention efforts. Much of this promising work is in its infancy, however the programs and trends described here help to provide a set of potential options to engender more collaboration across state agencies and with providers.

This report describes strategies to reform the delivery of health care that, in different ways and using different mechanisms, all emphasize the importance of care coordination, prevention and the need to address barriers to healthy lifestyles. Taken together, these new innovations represent a critique of the current health care delivery system, which is generally not adequately designed to emphasize or finance preventive services. Whether creating new incentives for managed care companies, designing specific initiatives through a state DSRIP program, experimenting with Medicaid health homes, or exploring new uses for community health workers, Medicaid programs and state public health agencies represent opportunities to collaborate on efforts to reform health care delivery so that it prioritizes proven HIV prevention strategies.

Notes



¹Assessing the Impact of the Affordable Care Act on Health Insurance Coverage for People with HIV, Kaiser Family Foundation, Publication #8535, January 2014, available at <http://kff.org/hivaids/issue-brief/assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage-of-people-with-hiv/>

²Medicaid and HIV: A National Analysis, Kaiser Family Foundation, Publication #8218, October 2011, available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8218.pdf>

³In April 2013, the USPTF gave routine HIV screening of all adolescents and adults, ages 15 to 65, an “A” rating. As a result, individuals eligible for Medicaid expansion coverage (and most individuals covered through private insurance) now receive HIV screening without any cost sharing. Coupled with USPSTF grades for STD screening and counseling and viral hepatitis screening, these coverage requirements present new opportunities for Medicaid to deliver and pay for prevention services.

⁴See generally The Critical Role of Public Health Departments in Health Care Delivery System Reform, Health Management Associates Accountable Care Institute, April 2014, available at <https://www.healthmanagement.com/assets/Publications/The-Critical-Role-of-Public-Health-Departments-in-Health-Care-Delivery-System-Reform.pdf>

⁵U.S. Department of Health and Human Services, Health Resources and Services Administration, *HIV Viral Load Suppression*, November 2013, available at <http://hab.hrsa.gov/deliverhivaidscares/coremeasures.pdf>.

⁶Centers for Medicare and Medicaid Services, *Adult Health Care Quality Measures*, available at <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html>

⁷A Medicaid State Plan is a continually evolving agreement between a state and the Federal government describing how that state administers its Medicaid program. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state, to assure the state that its program activities will be federally reimbursable and to assure the federal government that federal rules will be complied with. When a state is planning to make a change to its program policies or operational approach, it proposes a state plan amendment to CMS for review and approval.

⁸AIDS Foundation of Chicago, Community Links, available at <http://www.aidschicago.org/page/our-work/community-links>

⁹An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers, Kaiser Commission on Medicaid and the Uninsured, Oct. 2014 Issue Brief, available at <http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>

¹⁰Ibid.

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