

The Affordable Care Act: Implications for AIDS Service Organizations and People Living with HIV and AIDS

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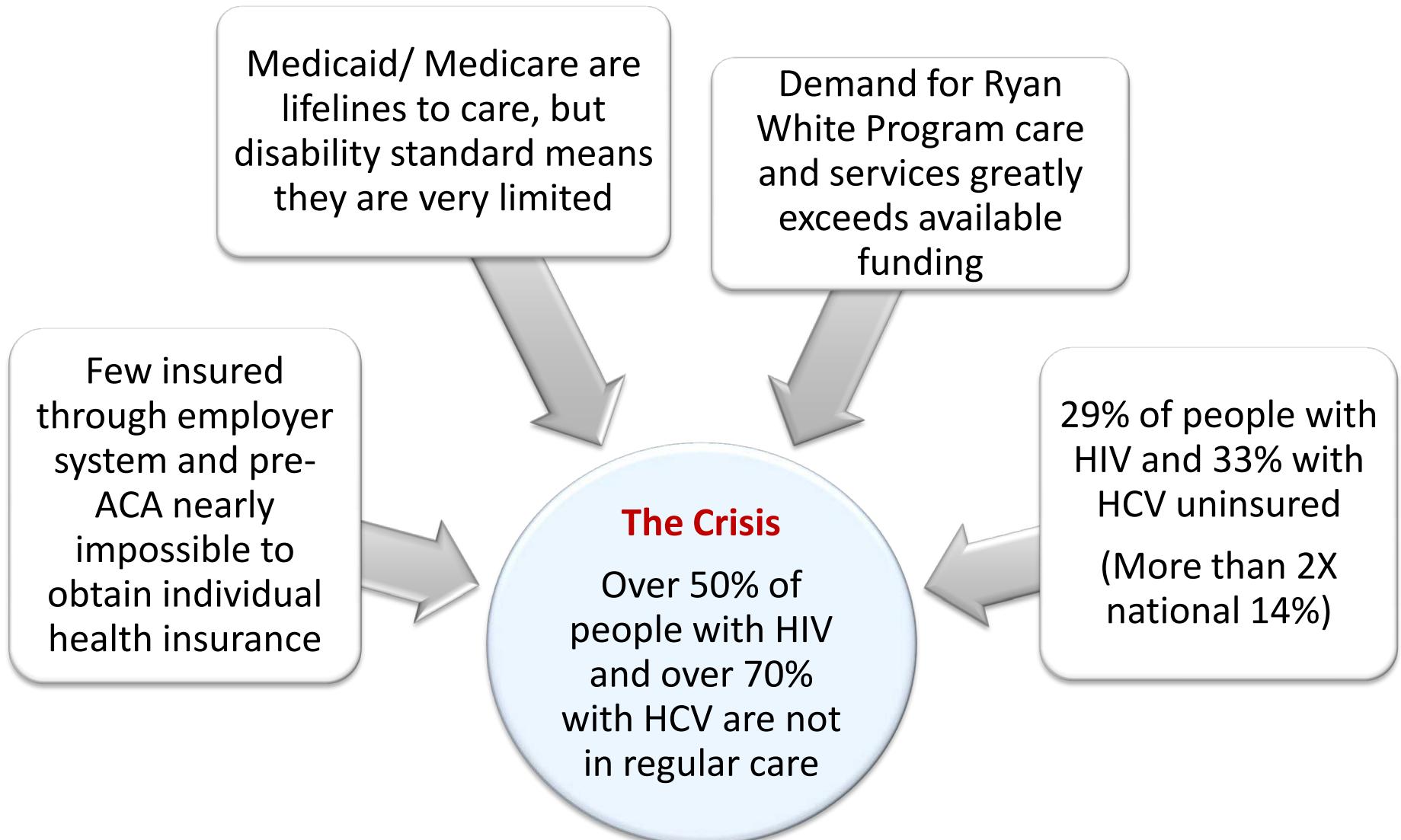
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October 30, 2014

Where we Were: The Pre-ACA Status Quo = Access to HIV Care Crisis

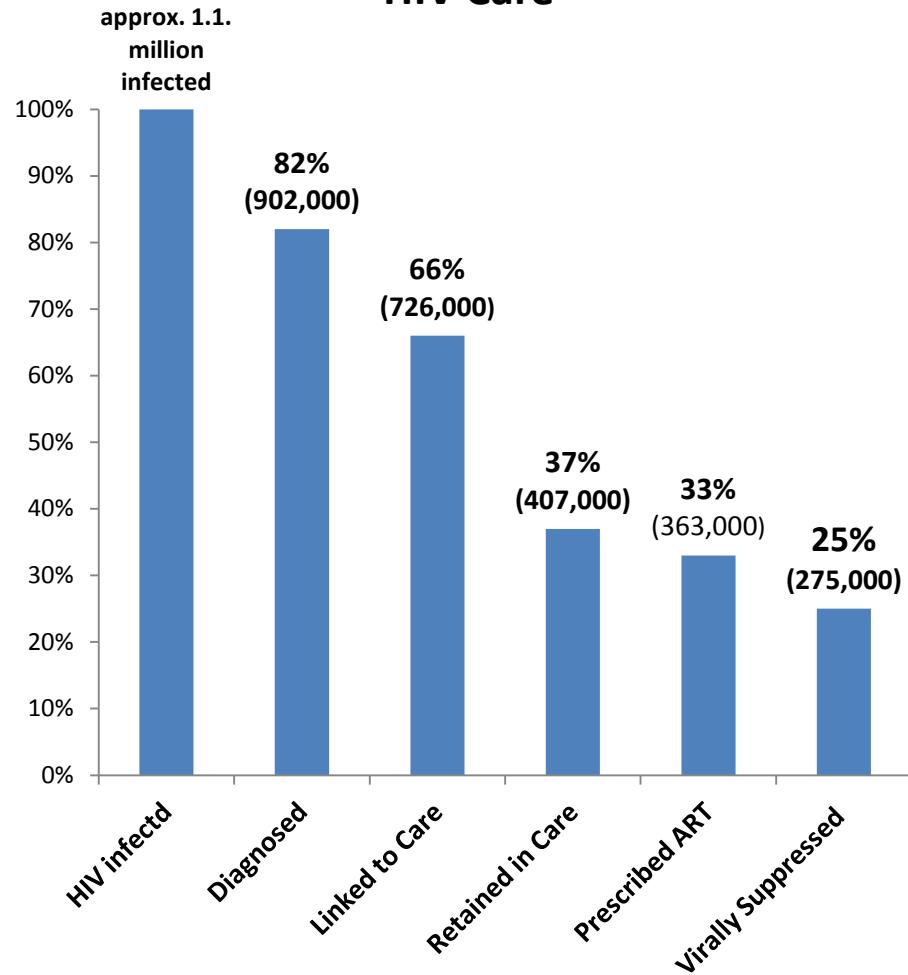


ACA Implementation Must Address Engagement and Retention in Quality Health Care

National HIV/AIDS Strategy calls for:

- Increasing HIV screening and improve linkages to care
- Increasing retention in care rates
- Closing the gap between those who need antiretrovirals (ARVs) and those who are on ARVs
- Providing needed care and support services to increase treatment adherence and number of persons with undetectable viral load rates

Engagement in Selected Stages of HIV Care



Where We Are Going: ACA Reforms Private Insurance

- Cannot be denied insurance because of pre-existing health condition, even if you don't currently have coverage
- Health plans cannot drop people from coverage when they get sick
- No lifetime limits on coverage
- No annual limits on coverage
- Allows young adults to stay on their parents' health care plan until age 26

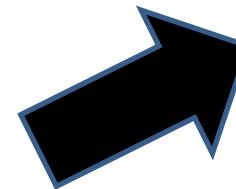
ACA Promotes Access to Subsidized Private Insurance through Marketplaces (AKA “Exchanges”)

- Consumer-friendly Marketplaces to purchase insurance
- Marketplaces must include patient-centered outreach and navigation programs to assist consumers in finding the right coverage – “No wrong door”
- Plans can't charge higher premium based on health status or gender
- Plans must include Essential Health Benefits
- Plans must include essential community providers, including Ryan White providers
- Federal subsidies with income between 100-400% FPL
 - (Up to ~\$44K for an individual/~\$92K for family of four)

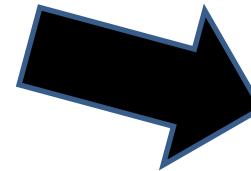
Essential Health Benefits Package Addresses Many HIV Health Care Needs

ACA Essential Health Benefits

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity/newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services



**For All Newly Eligible
Medicaid
Beneficiaries**



**For Most New
Individual and
Small Group
Private Insurance
Beneficiaries**

Ryan White Core Services vs. ACA EHB

Ryan White Core Services

- ✓ Ambulatory and outpatient care
- ✓ AIDS pharmaceutical assistance
- ✓ Mental health services
- ✓ Substance abuse outpatient care
 - Case management
 - Treatment adherence services
 - Home health care
 - Medical nutrition therapy
 - Hospice services
 - Home and community-based services
 - Oral health care (not an EHB)

Red = covered by both ACA and RWP

Black = covered by ACA only

Blue = covered by RWP only

ACA Essential Health Benefits

- ✓ Ambulatory patient services
- ✓ Mental health and substance use disorder services, including behavioral health treatment
- ✓ Prescription drugs
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Rehabilitative and habilitative care
 - Laboratory services
 - Preventive and wellness services
 - Chronic disease management
 - Pediatric services (oral and vision care)

ACA Increases Access to Medicare Drug Coverage & Preventive Services

- ADAP as TrOOP
- Free preventive services
- Part D “donut hole” phased-out by 2020
- 50% discount on all brand-name prescription drugs for those in the donut hole

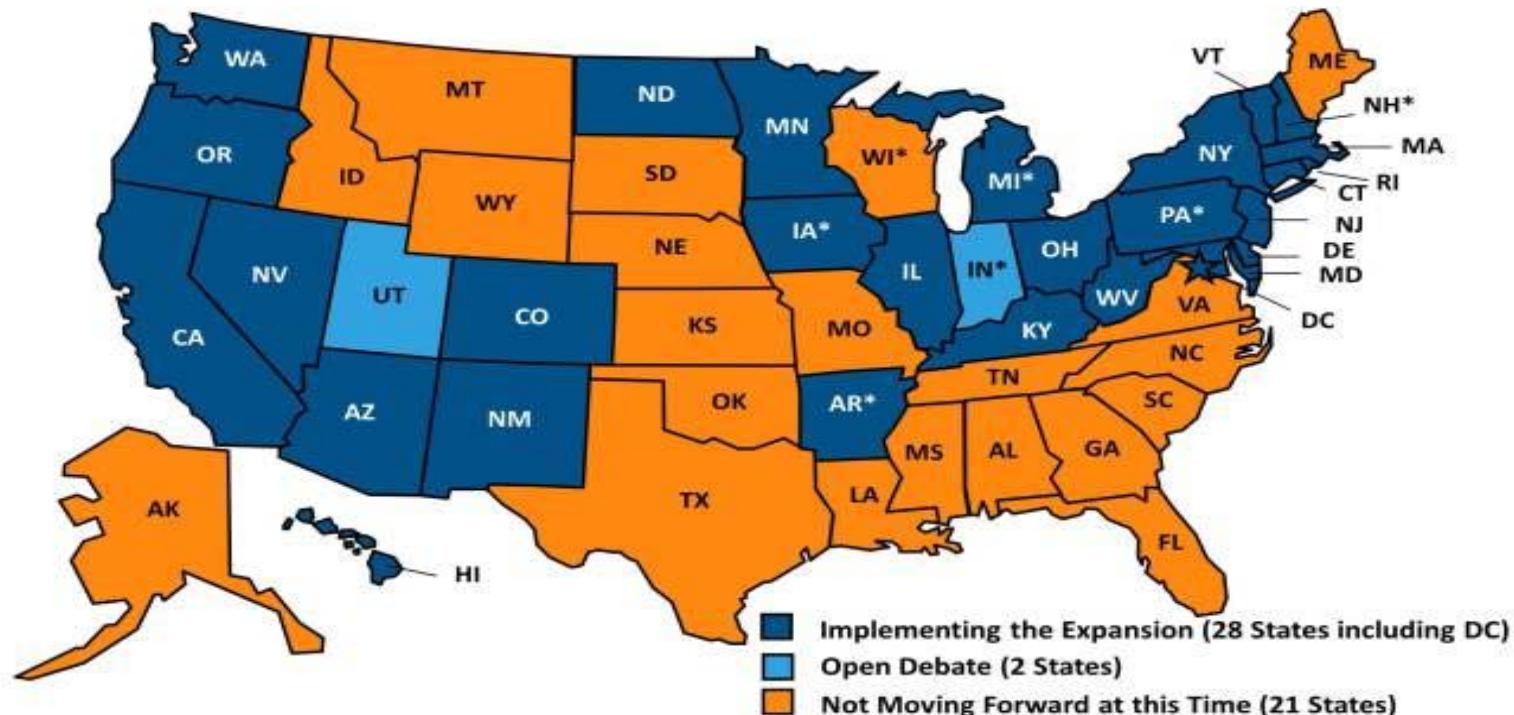
ACA Expands and Improves Medicaid in 2014 (Optional Based on Supreme Court Decision)

- Expands Eligibility to Medicaid by eliminating the disability requirement for those with income up to 138% FPL (~\$15K for an individual/~\$32K for family of four)
 - Every low-income U.S. citizen and legal immigrant (after 5 years in U.S.) is now automatically eligible
- Federal government pays 100% through 2016 and then 90% thereafter
- Includes **Essential Health Benefits**
- Based on Supreme Court decision federal government can't withhold all federal Medicaid funds if states refuse to implement Medicaid expansion

Medicaid expansion is optional and will be decided state-by-state

Uneven Implementation of Medicaid Expansion in States

Current Status of State Medicaid Expansion Decisions



NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available [here](#), and KCMU analysis of current state activity on Medicaid expansion.

Enrollment of People Living with HIV in Medicaid and Marketplace Health Insurance Plans

56,000 uninsured individuals in ADAP pre-ACA



13,000 enrolled in plans offered through the Exchanges, mostly with subsidies



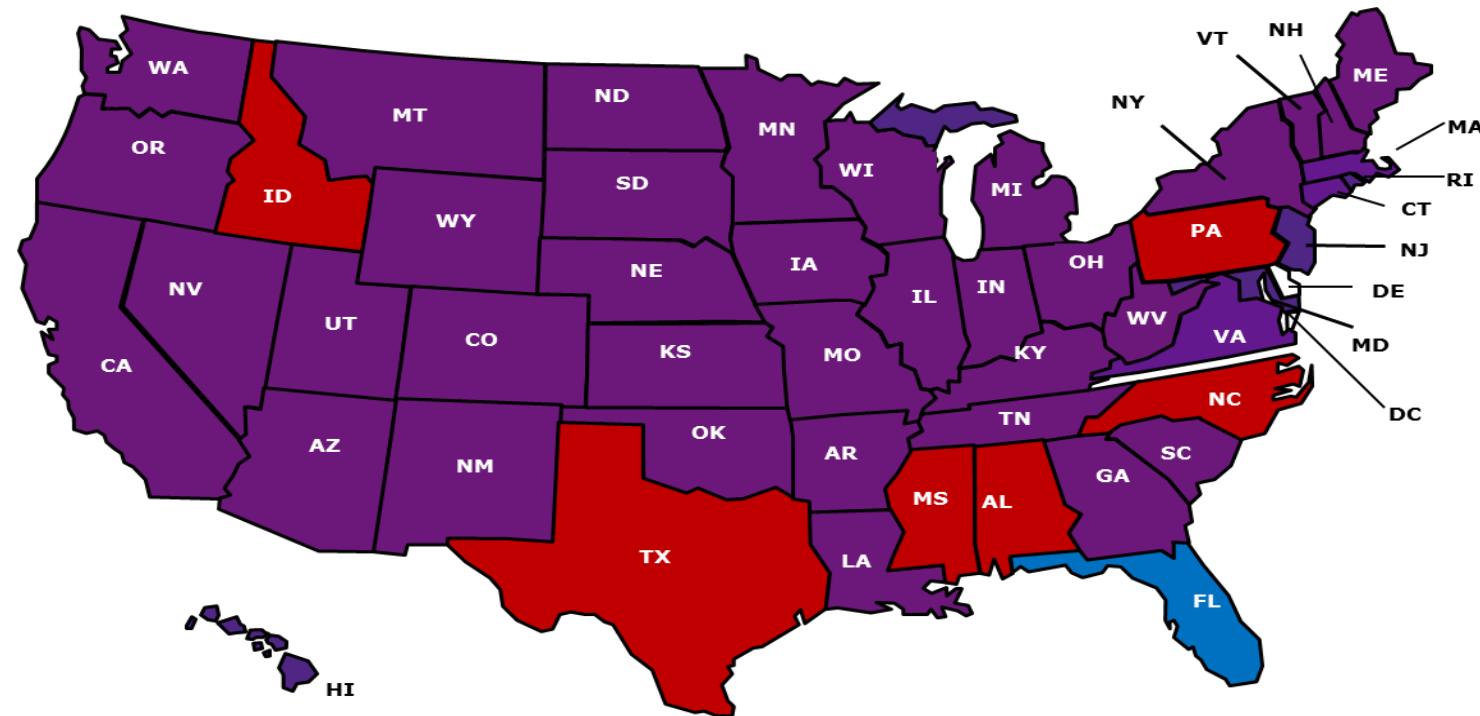
12,000 enrolled in Medicaid expansion



19,000 did not gain coverage because their states rejected Medicaid expansion

- 12 million Americans successfully transitioned from being uninsured to insured in 2014
 - Includes 8 million with new Marketplace private insurance and 4 million with Medicaid expansion coverage
 - Includes 25,000 people living with HIV or 45% of those uninsured and on ADAP pre-ACA
- It is estimated that there are over 125,000 people living with HIV who are not currently engaged in care, yet eligible for new ACA insurance coverage
- Ryan White Program continues to be needed to provide coverage completion, fill gaps in affordability, and to provide care for many living with HIV who are completely left behind (largely due to geography or immigration status)

ADAP/Part B Programs Currently Purchasing Qualified Health Plans for Clients



- ADAP purchasing QHPs (premiums, Rx co-pays, or deductibles)
- ADAP piloting QHP purchase
- ADAP not currently purchasing QHPs (*most are planning*)

Source: NASTAD, *Open Enrollment Year One: Ryan White Program Successes, Challenges, and Priorities Moving Forward*, Ryan White Working Group Call (September 19, 2014).

ACA Includes Other Medicaid Improvements: Supports Primary Care Providers and Medicaid Health Home

- Improves reimbursement rates for primary care providers (up to Medicare reimbursement rate) for 2013 and 2014
 - Legislation to continue enhanced reimbursement rate in 2015 and beyond is pending in Congress
- Gives states the **option** to provide cost-effective, coordinated and enhanced care and services to people living with chronic medical conditions through Medicaid Health Home Program
 - HIV and HCV not on original list of covered chronic health conditions, but now on the list as a result of successful advocacy
 - NY the first state to adopt Medical Health Home and includes all 55,000 people living with HIV and AIDS

ACA Includes No Cost Sharing for Preventive Care

- All private insurance plans, Medicare and Medicaid (for new expansion population only) must provide free preventive services
- States also have the option of providing free preventive services to all traditional Medicaid beneficiaries
 - If states opt-in they receive a 1% increase in federal funding
- Free preventive services include broad-based screening related to disease prevention and sexual health (eg, HIV, HCV, STI screening)
- Free preventive services also include a broad range of women's health screenings and access to contraception

ACA Includes Strong Overarching Anti-Discrimination Provisions

- ACA prohibits discrimination based upon race, color, national origin, disability, age or sex
- HHS has said includes prohibition against discrimination based upon gender identity and sex stereotypes, but not necessarily sexual orientation
- Cannot be denied participation in, denied benefits of, or be subjected to discrimination in the provision of health care under any health program or activity established under the ACA

Key Considerations for AIDS Service Organizations (ASOs):

Risk Sharing Creates Opportunities for ASOs in New Health Care Financing Systems

- Increasing use of risk sharing
 - Providers are being offered a chance to share in any cost savings from efficient treatment of patients, but are also being asked to share in any losses resulting in expensive treatments
 - Strong incentives for providers to improve the cost efficiency of the care they provide, while maintaining quality services
- Examples of increased opportunities/risk exposure: bundled/global payments
 - A single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment
 - Providers to assume financial risk for cost of services for a particular treatment or condition, as well as costs associated with preventable complications
 - Payments are made to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, settings of care, and services or procedures over time

New Service Delivery/Financing Models Also Provide Opportunities for ASOs in Medicaid

- Non-medical providers certified as Medicaid practitioners
 - Medicaid is now allowed to pay for preventive services recommended by a physician but performed by other practitioners
 - State Medicaid programs have the authority to define required practitioner qualifications: Important to advocate to include ASOs
- Expanded eligibility to preventative services produces increased demand for those qualified to provide services such as HIV testing, care coordination and medication education and support
- CMS's Bundled Payments for Care Improvement Initiative is piloting bundled payments in almost 100 settings from 2014-2017 and provides opportunities for the provision enhanced and coordinated care that reduces costs, improves outcomes, and increases patient satisfaction (the triple aim)
- CMS's Medicare Shared Savings Program has established multiple accountable care organizations (ACOs) around the country that will need to incorporate interventions demonstrated to meet the triple aim

Key Opportunities for ASOs in the Private Sector

- More and more health plans are experimenting with bundled payments
 - Blue Cross/Blue Shield of North Carolina implemented bundled payments for knee replacement surgery; Geisinger Health System for CABG surgery, elective coronary angioplasty, bariatric surgery, perinatal care and treatment for chronic conditions
 - ASOs should reach out to private insurers to encourage them to offer bundled payments for HIV treatment
- Increasing popularity of ACOs, both among providers and health insurers
 - ASOs should reach out to be included in ACOs
- Insurers continue to resist improving services for patients with serious and chronic conditions due to fear of attracting these patients
 - ASOs must push for enforcement of ACA anti-discrimination provisions and educate insurers on the importance of the services they provide

Strategic Options for ASOs Looking to Diversify Funding

Subcontract with Health Providers to provide the following services:

- Population access and outreach
- Patient navigation
- Linkage, retention in care and coverage completion/facilitative services
- Case management
- Treatment adherence promotion
- Health outcomes

Strategic alliances/mergers with Health Providers

- Supply effective chronic disease management and other services similar to the subcontracting option, but sharing in costs and revenue through a more formal contractual relationship
- Provider supplies medical and reimbursement expertise

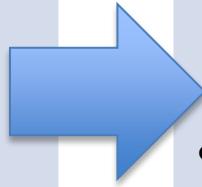
Transition from social services to medical services

- Requires a change in focus (both in terms of services provided and populations served)
- Need to build expertise in medical services, reimbursement and regulatory compliance

Patient-Centered Medical Homes (PCMH)

Structure of PCMH

- Coordination and integration of whole person care:
 - Physician arranges care, oversees and coordinates the team
 - Providers use electronic health records; patient registries; care coordinator services
 - Providers deliver comprehensive care
- Quality and safety: Decision support based on updated practice guidelines
- Payment: Quality-based, shared savings; reimbursement for care coordination; account for complexity and severity of illness



ASO skill sets and services critical for making PCMHs work:

- ASOs are experts at managing care and improving adherence for hard-to-reach, expensive patient populations
- ASO services have always been built around the “whole-person” care concept
- ASOs have expertise in cultural and linguistic competence
- ASO services improve health care outcomes and reduce health care costs

Medicaid Health Homes (MHH)

- Option for states to pay for care coordination services for Medicaid enrollees with chronic illnesses
 - Emphasis on connection to community-based resources
- Required to help enrollees get non-medical supports and services
- Social workers, nutritionists, dieticians, behavioral health providers, and others may be part of provider teams
- Several states have established HIV focused MHH:
 - Alabama: Uses existing enhanced primary care practices
 - New York: Health homes contract with organizations to provide additional care
 - Washington: Regional health homes contract with community-based care coordination organizations
 - Wisconsin: Utilizes ASOs, provides one time payment for assessment/care plan development

Accountable Care Organizations (ACOs)

- A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients
 - The ACO may use a range of payment models such as capitation, fee-for-service with asymmetric or symmetric shared savings
- CMS established the Medicare Shared Savings Program (MSSP) in 2012 to create Medicare ACOs
 - Each ACO must define processes to promote evidence-based medicine and patient engagement, monitor and evaluate quality and cost measures, meet patient-centeredness criteria and coordinate care across the care continuum
 - ACOs can choose between a one-sided model where they only share in the savings or a two-sided model where they share in the savings and the losses
- As discussed above, ACOs are popular in the private sector as well

Care Integration/Administration Projects for Dual-Eligibles

- CMS is launching demonstrations that seek to improve care and control costs for people who are dually eligible for Medicare and Medicaid
 - Goal: provide better, more efficient care to these individuals
 - Includes care coordination and integrated behavioral health care
- These three year demonstrations are introducing changes in:
 - The care delivery systems through which beneficiaries receive medical and long-term care services
 - The financing arrangements among CMS, the states, and providers
- As of July 2014, CMS entered into memoranda of understanding with 12 states to implement 13 demonstrations
 - Some states, such as Washington, target high cost/high risk beneficiaries with chronic conditions

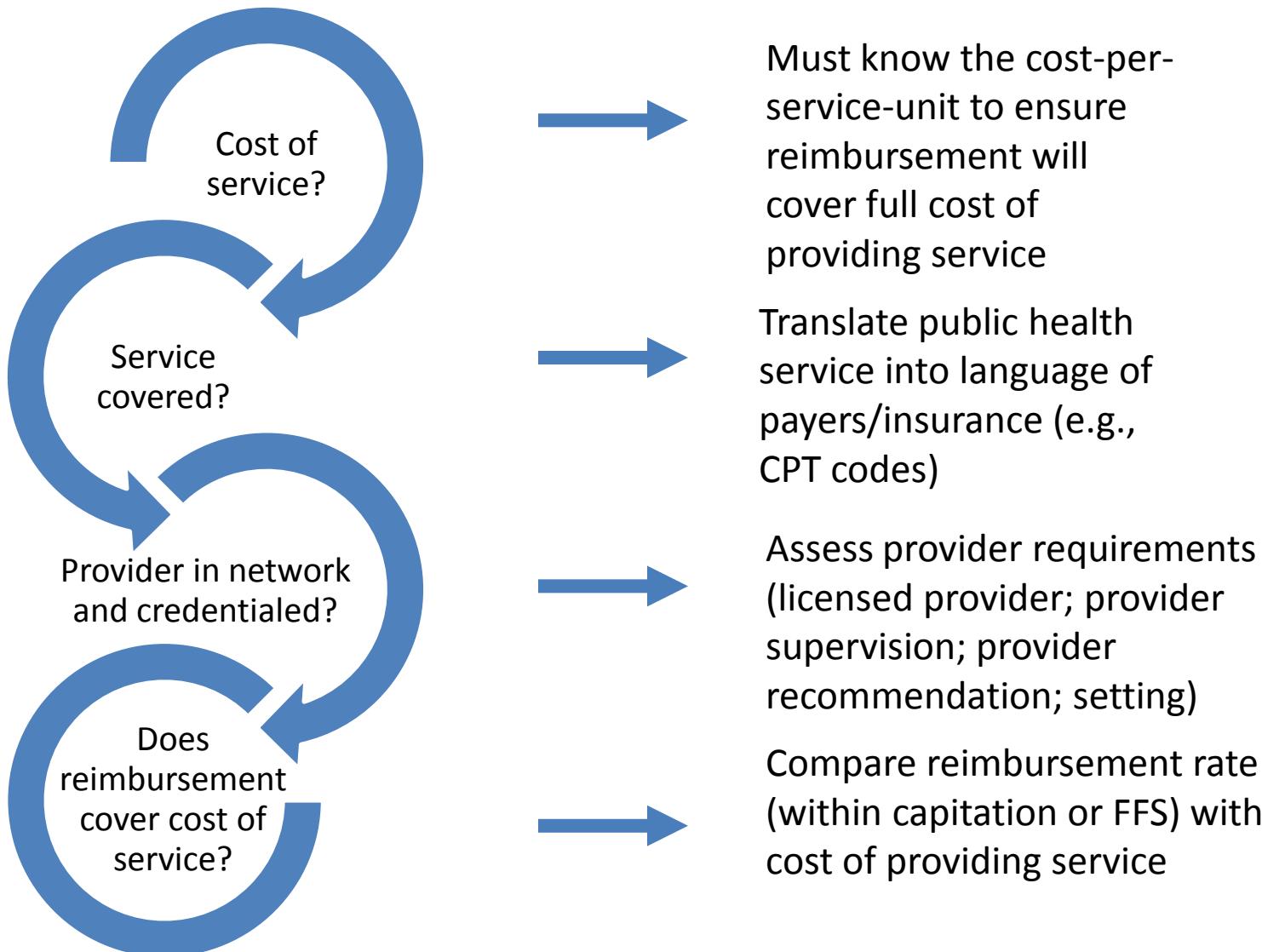
Considerations for Integration into New ACA Health Care Delivery Systems

- The administrative burden of third party reimbursement
- Building knowledge of state-specific health care structures and key players in the field
 - Understand the language of health care service providers
 - Coordinated care methodology
 - Medicaid health home
 - NCQA standards and guidelines for patient-centered homes
- Conducting research and using data to justify integration of ASOs
- Organizational readiness
 - What services are reimbursable?
 - What relationships does the ASO have with medical clinics?

Questions for ASOs to Consider

- How many clients now have access to insurance?
- What services does the ASO provide that could be reimbursable by Medicaid or private insurance?
 - *E.g.*, case management, care coordination, mental health or substance abuse services, nutritional counseling, medically-tailored meals
- What would be “reasonable” reimbursement rates?
- How does the ASO’s services promote the triple aim of improved health outcomes, reduced costs, and increased patient satisfaction?
 - Do they promote, engagement in testing, linkage or retention in care

Summary for Evaluating ASO Services Integration into Health Services



Massachusetts Case Study:

Well-Implemented Health Reforms Can Dramatically Improve Health Outcomes and Service Delivery Integration

- Expanded Medicaid coverage to pre-disabled people living with HIV with an income up to 200% FPL (2001)
- Enacted private health insurance reform with a heavily subsidized insurance plan for those with income up to 300% FPL (2006)
- Protected a strong Medicaid program for “already” & “newly” eligible
- Integrated HIV care & services into new health care delivery systems

The MA case study provides insight into how health reforms work

Financial Constraints, New Investments and Reformed Delivery Systems Support Integration of ASOs and Health Centers

- ASOs encouraged to integrate into health care delivery systems
 - FQHCs increasing play leading role in provision of HIV care, even prior to new ACA investments
 - Free standing ASOs increasingly unable to respond to the needs of an increasing number of patients with a decreasing amount of public funding
- New investments and delivery systems encourage stronger integration between health and social service providers
 - Example: Fenway Health and AIDS Action Committee of MA entered into a strategic partnership
 - One corporate structure, with joint governance and back office services
 - Each entity retains its nonprofit status, CEO, name and brand identities
 - Fenway Health provides medical services & AIDS Action provides housing, transportation, community and care coordination services

FIGURE 1: MA OUTCOMES VS NATIONAL OUTCOMES

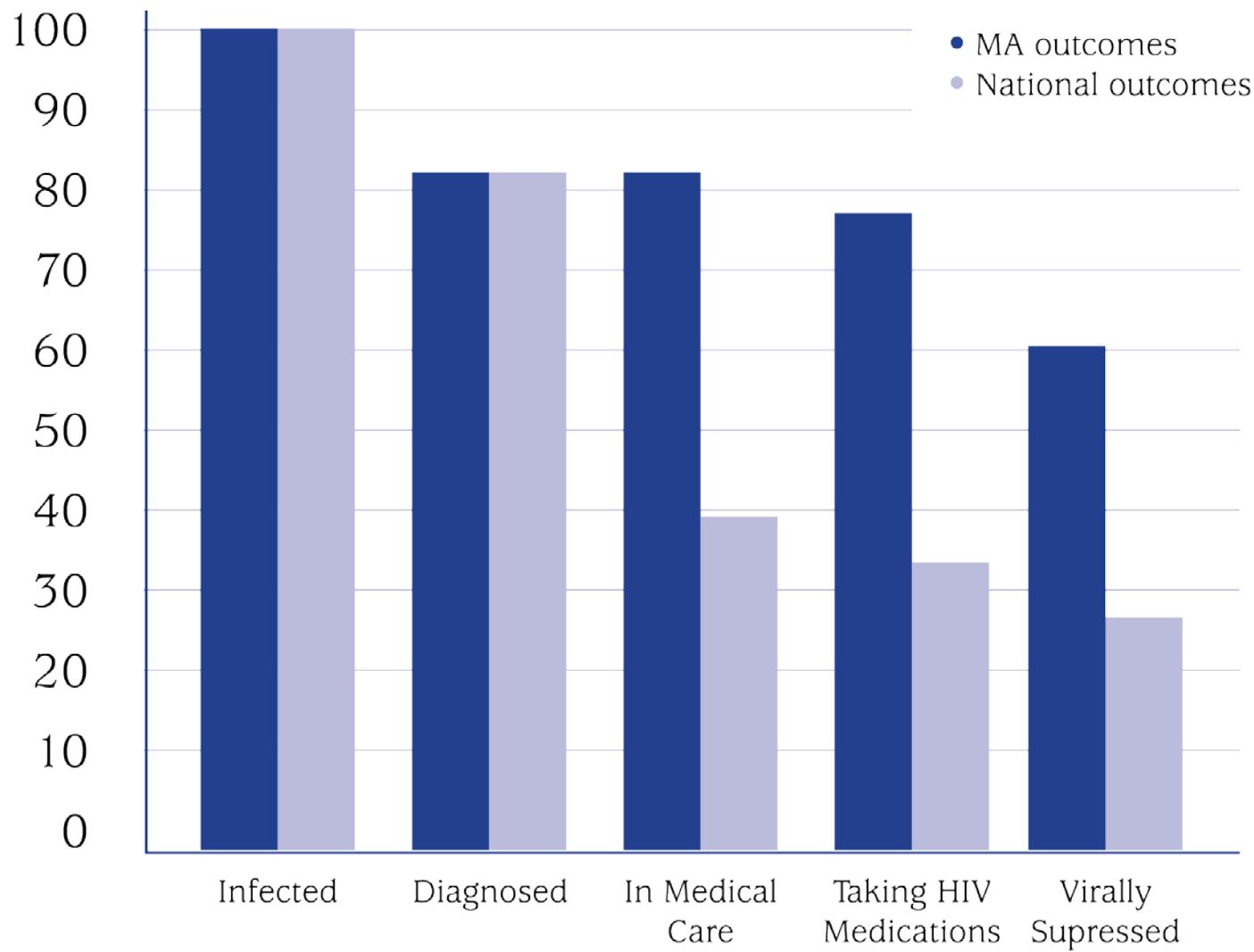
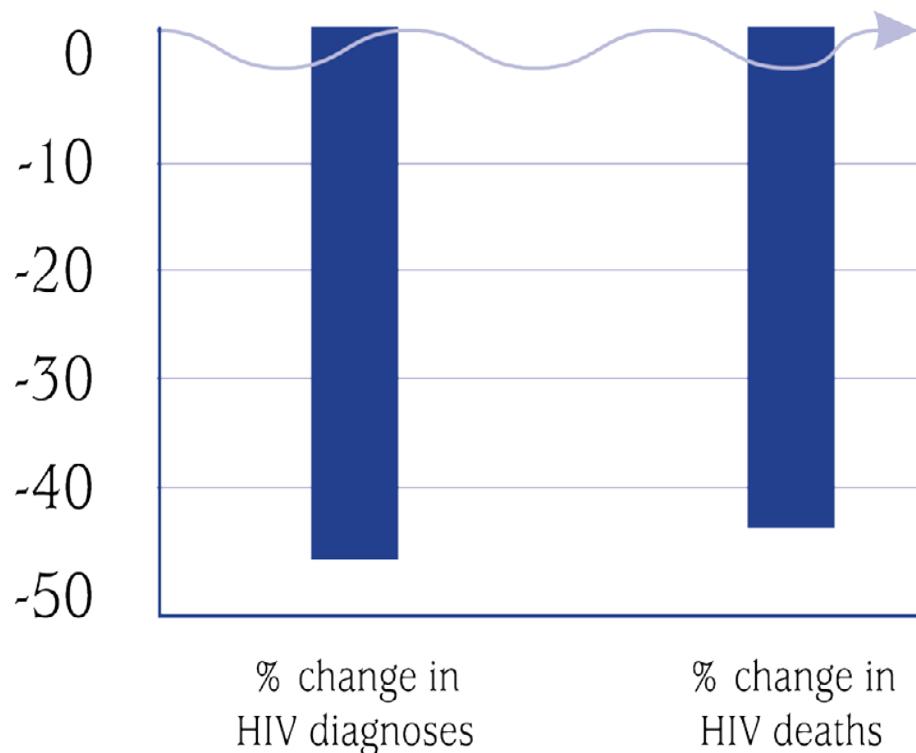


FIGURE 2: PERCENTAGE CHANGE IN HIV DIAGNOSES AND DEATHS, 2000-2011, MA AND US



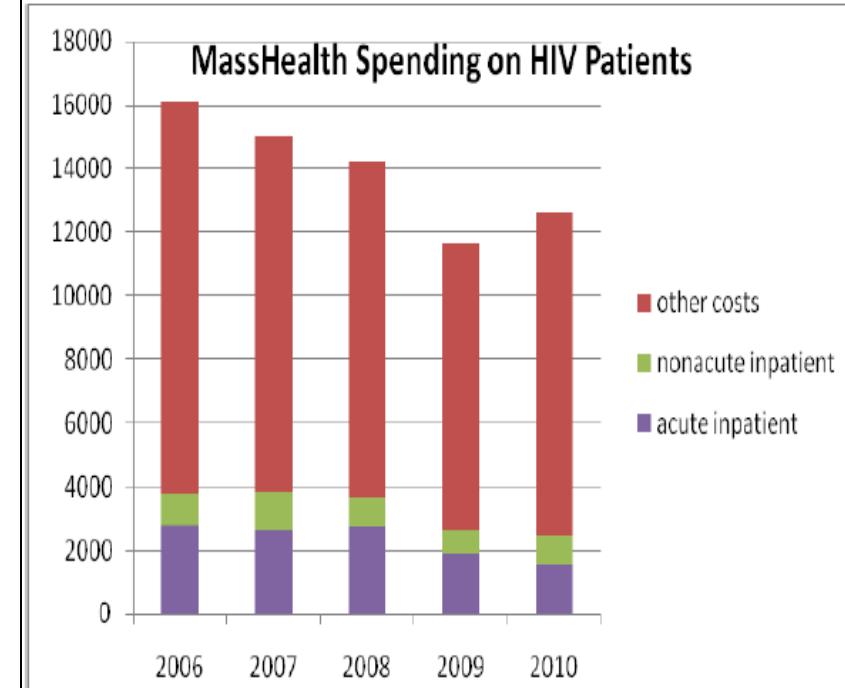
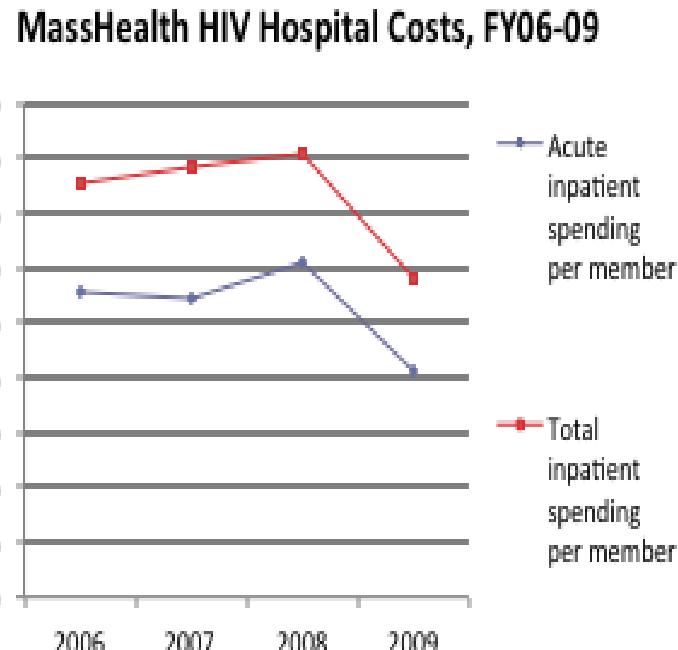
- Massachusetts
- United States

Over the period from 2000-2011, the number of HIV infection diagnoses in MA decreased 44 % and deaths declined 41 %.

In contrast, across the United States, HIV diagnoses and deaths remained relatively stable.

Sources: US Centers for Disease Control and Prevention; Massachusetts Department of Public Health

MA Reform Demonstrates Successful Health Reform Implementation Reduces Costs



- Massachusetts cost per Medicaid beneficiary living with HIV has decreased, particularly the amount spent on inpatient hospital care
- Massachusetts DPH estimates reforms reduced HIV health care expenditures by ~\$1.5 billion in past 10 years

Challenges in New Health Insurance Plans: Systemic Issues for Consumers

Transparency

- Changing formularies and hidden utilization management , including prior authorization and mail-order pharmacy requirements

Coverage

- Random exclusions of HIV medications and inadequate coverage of single-tablet regimens tablets (STRs)

Cost/Affordability

- Placing all HIV/AIDS drugs on the highest cost-sharing tiers

Recommendations for Addressing Challenges in Transparency, Coverage and Cost

- Require all Marketplace plans to provide complete, accurate and accessible formulary information in a standard format, including the actual out-of-pocket costs that will be imposed on enrollees
- Limit the ability of plans to change benefits and costs after close of open enrollment period
- Amend the Essential Health Benefits rule to require coverage of all specialty drugs that are widely accepted in treatment guidelines or best practices
- Prohibit excessive coinsurance for specialty drugs (where no generic equivalent exists) that are widely accepted in treatment guidelines/best practices
- Enact regulations defining ACA non-discrimination protections to ensure that formularies and utilization management do not discriminate against people living with HIV and other chronic health conditions

Systemic Issues and Recommendations for Providers

Medicaid

- Seeing only partial integration of non-medical providers
 - Food and nutrition advocacy organizations have successfully advocated for the inclusion of nutrition services in Dual-Eligibles Integration Projects and other Medicaid programs.
- ASOs need to advocate to participate in bundled payments & ACOs

Private Insurers

- Insurers are resistant to improving services for consumers with chronic and serious conditions
 - Don't want to attract these patients
- ASOs need to convince insurers that they will be responsible for these consumers regardless
 - Will realize cost-savings by incorporating effective care coordination providers

When You See Discrimination Related to Transparency, Coverage, Cost or Any Other Issue: SPEAK UP!!!

- A team of national and state partners has established “SPEAK UP” to monitor, assess and document barriers to HIV care
- Through SPEAK UP we see patterns of discrimination emerging that need to be addressed, educate state and federal officials about what’s happening on the ground, advocate for change, and report back to the community
- We need to help inform and shape state and federal policy to ensure the needs of people living with HIV are addressed as the ACA is implemented

To SPEAK UP, visit:

<http://www.hivhealthreform.org/speakup/>



Resources

- www.hivhealthreform.org
- www.statereforum.org
- Center for Budget and Policy Priorities - www.cbpp.org
- Center for Health Law and Policy Innovation - www.chlpi.org
- Families USA - www.familiesusa.org
- National Health Law Program – www.nhelp.org

Questions?





- Webinars will soon be available on our website for on-demand viewing: www.nationalhivcenter.org
- Slides from today's presentation will be emailed to all webinar participants later this afternoon.
- Please complete the evaluation at the end of the webinar. Your feedback will inform our programming.
- If you are interested in individualized technical assistance, please email us at nationalhivcenter@fenwayhealth.org.
- Join us for our next webinar!

Sector Transformation & Organizational Sustainability

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