UNDERSTANDING AND MONITORING FUNDING STREAMS IN RYAN WHITE PROGRAM CLINICS:

FINAL REPORT EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

In 2014, the Ryan White HIV/AIDS Program (Ryan White Program) is at an important crossroads with the implementation of national health reform under the Patient Protection and Affordable Care Act (ACA). Reauthorization of the Ryan White Program was postponed in 2013, in part to better understand the impact of the ACA on HIV care in the U.S. (HIV Health Reform, 2013). A number of the reforms in the ACA increase the likelihood that previously uninsured people living with HIV (PLWH) will have access to affordable health coverage. Individuals can no longer be denied coverage due to HIV or AIDS as a pre-existing condition, and insurers can no longer impose lifetime caps on insurance coverage. Individuals can purchase coverage through the Health Insurance Marketplaces (exchanges), and those with incomes up to 400% of the federal poverty level (FPL) may be eligible for tax credits to reduce premium costs. Individuals with lower incomes may also be eligible for reductions in cost such as subsidized health insurance premiums. States also have the option to expand Medicaid to individuals younger than 65 years of age with incomes up to 138% of the FPL, regardless of whether they are disabled or have dependent children (KFF, 2014). Twenty-seven states implemented Medicaid expansion in 2014, and a handful of states are still debating expansion.

As PLWH gain insurance coverage under the ACA, the Ryan White Program's role in providing HIV care will change. More clients will have access to insurance coverage for outpatient ambulatory medical care (OAMC) and other core medical services for which the Ryan White Program has provided most of the coverage for uninsured or underinsured clients. However, Medicaid and private insurance may have limitations and caps on some services; Ryan White Program funds will be needed to fill in the gaps. Moreover, support services such as case management, health education, counseling, and emergency financial assistance are rarely covered by health insurance, yet they are an integral part of HIV care in order to improve adherence and retention in care.

These considerations are particularly true for clinical care providers funded under Parts C and D of the Ryan White Program. Part C grants support early intervention services, including preventive, diagnostic, and therapeutic services for PLWH. This support includes a comprehensive continuum of outpatient HIV primary care services, including HIV counseling, testing, and referral; medical evaluation and clinical care; other primary care services; and referrals to other health services. Part D grants support coordinated family-centered outpatient care for women, infants, children, and youth infected with HIV and their affected partners and family members.

Given these changes, Part C and D grantees face a more complex task in meeting the needs of their clients while ensuring that Ryan White Program funding is used as effectively as possible.

Grantees will need to effectively track changes in clients' insurance status and covered services for accurate third party reimbursement. In many cases, grantees will need to be in managed care organizations' (MCOs') provider networks, since most plans through the exchanges and Medicaid expansion use the managed care model. At the same time, there may still be notable gaps in health coverage because subsidies for private insurance do not extend to individuals below 100% of the FPL. This creates an insurance coverage gap for low income PLWH in states that do not expand Medicaid.

Overview of the Report

The HIV Bureau conducted a survey of Part C and D grantees that directly provide clinical care (providers) for PLWH. It addressed three questions:

1. For what services do providers find patients to be underinsured (due to limitations in Medicaid, Medicare, or private insurance) and require Ryan White Program support to provide PLWH with the full continuum of HIV care?
2. Do Part C and D providers have the infrastructure for effectively tracking changes in client insurance?
3. To what degree are these providers positioned to adapt to new opportunities under the ACA?

In addition, a Ryan White Program Services Tracker tool (the Tracker) was developed. The Tracker provides "a methodology for monitoring and assessing the interrelationship among funding streams in clinical settings."[1] The Tracker was built to help grantees conduct this monitoring within complex data management environments and variations in data collection approaches. The Tracker enables grantees to document the ongoing role of Ryan White Program funding and how their client bases and services change over time as the ACA is fully implemented. It is designed for grantees' internal use, including reporting to their stakeholders.

Study results

The Ryan White Program funds services not only for uninsured individuals, but also for underinsured individuals. In particular, Ryan White Program funding may be used to fund completion of care when clients' existing health insurance—whether Medicaid, Medicare, or private insurance—does not cover HIV health care and support services needed to retain clients in care and help them achieve viral load suppression. In addition, many support services that are essential to maintaining PLWH in care are rarely covered by health insurance. Even for those services covered by insurance, insurance plans may impose utilization restrictions, such as limits on the number of procedures or office visits allowable in a given year. Insurance may also establish clinical guidelines that restrict access to services, such as step therapies, threshold CD4

[1] Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). *Request for Quotation, Understanding and Monitoring Funding Streams in Ryan White Clinics,* Page 9. 2012.

counts, or prior authorization justifying medical necessity. The survey asked providers whether their agencies sometimes had to use Ryan White Program funding to cover an array of OAMC subservices, related health services, and support services for insured patients and, if so, what types of insurance limitations created this necessity. Summarized below are some findings from the survey:

- Respondents report a greater use of Ryan White Program funding for insured clients for services beyond purely OAMC services.
- For OAMC services other than diagnostic testing, respondents are as likely to cite the clinical requirements, such as prior authorization, as the reason as they are to cite utilization limits.
- Respondents sometimes use Ryan White Program funds to manage timing issues. This includes covering services while insurance coverage is pending, especially for Medicaid.
- Respondents also use Ryan White Program funds as a bridge when insurers initially deny reimbursement, such as denying a prior authorization request or rejecting a submitted claim.
- More than half of respondents sometimes use Ryan White Program funds for treatment adherence counseling, HIV risk counseling, and early intervention and risk management services for insured clients.
- About one in four of the respondents who sometimes used Ryan White Program funds for specialist care indicated that this is because such care is never covered. A number of respondents indicated that they sometimes use Ryan White Program funds for specialists because specialists in the area will not accept Medicaid or HIV specialists are not available.
- Respondents use Ryan White Program funds to support clients' share of costs. These include premiums, and cost sharing, such as deductibles and co-pays.
- Among respondents offering medical and non-medical case management services, most provide them to insured clients using Ryan White Program funds
- Mental health, oral health, and substance abuse treatment are services highlighted by respondents as problematic for coverage by health insurance. The challenges for these services are generally utilization limits or clinical requirements, although oral health is often not covered at all.

Use of the Tracker

The purpose of the Tracker is to enable grantees to document the ongoing role of Ryan White Program funding and how their client base and services change over time as the ACA is fully implemented. To facilitate this, the Tracker imports a grantee's data and generates reports that support the tracking of client health insurance status, sources of funding for individual services,

and prices of services throughout the rollout of the ACA. Specifically, the Tracker creates tables and graphs describing data relevant to each of these purposes:

1. Client health insurance status
2. Services by funding source
3. Most common Ryan White Program-funded OAMC subservices
4. Price of services by funding source
5. Ryan White Program-funded service information by funding Part

Through these reports, grantees can document the contribution of Ryan White Program funds to providing comprehensive HIV care. In addition, they can make data-driven decisions in response to changes in insurance coverage – adjusting service profiles and targeting underinsured and uninsured clients.

The survey captured grantees' approaches in collecting and managing data on client insurance status and services. Specifically, questions were asked about the frequency with which grantees collect insurance status data. In addition, grantees reported the systems and approaches used to collect service data – namely whether they assign funding streams and dollar amounts to services or collect services at the subservice or procedure level. These survey results allow us to determine the share of grantees that can use the different features of the Tracker. Respondents reported the systems and approaches used to collect service data – namely whether they assign funding streams and dollar amounts to services or collect services at the subservice or procedure level. Only 40 percent of respondents collect all HIV care in a single system. This means that a majority of respondents are not able to assess Ryan White Program funding relative to other funding sources and gain a comprehensive picture on how HIV care is funded. Another 36 percent collect *most* data in a single system. In addition, 57 percent of respondents assign *all* services a funding source, and 27 percent assign *some* services a funding source. Most respondents capture services at the service level (86%) and visit level (73%).

ACA Readiness

With the new health insurance landscape, grantees may need to make structural and operational changes to benefit from the provisions under the ACA. As mentioned above, the ACA increases the insurance options available to individuals, which could significantly reduce the number of clients for which the Ryan White Program has to act as a primary source of healthcare coverage. Providers must be able to effectively direct their clients to new insurance options and bill insurance programs for newly-covered services to ensure that Ryan White Program funding is used as effectively as possible. For this reason, it is very important for grantees to assess clients' health insurance eligibility and status on a regular basis. The survey results demonstrate that respondents are well prepared to meet this need, and have the following infrastructure in place:

- solid systems to track insurance status and check for eligibility
- procedures to assess their clients' eligibility for some form of insurance
- the ability to monitor changes in insurance status over time

To establish reimbursement rates with MCOs, grantees must have mechanisms to accurately calculate the cost of services. In addition, the ACA contains many programs to encourage cost containment, such as measuring hospital readmission rates, the implementation of EMRs, and care coordination. In order to evaluate the effectiveness of these programs in actually reducing costs, there must be mechanisms to track costs and revenues at both the client and service levels. Survey results show the following:

- About half of the respondents are able to routinely calculate the average cost of care per HIV client for planning and budgeting purposes.

- Most respondents can calculate revenue per service type. However, for about 40 percent of grantees, the process is cumbersome. About one-sixth responded that they were not able to calculate these revenues at all.

It is also important to examine whether grantees are participating in or designated as part of care delivery models promoted under the ACA that enhance reimbursements for Medicaid clients or provide opportunities to reduce costs. These models include MCO networks, Patient-Centered Medical Homes (PCMHs), and health homes under Medicaid. Survey results about these efforts include the following:

- Most respondents participate in either Medicaid or private MCO networks.

- About one-third of respondents are recognized as PCMHs. Another third are currently seeking recognition.

- Fifteen respondents, representing seven of the 15 states with approved health homes plans, said they were designated health homes under Medicaid. An additional seven respondents indicated that they are working with their Medicaid agency to develop a state plan.

Conclusion

As PLWH gain insurance coverage under ACA, grantees funded through Ryan White Program Parts C and D face new challenges in meeting the needs of their clients while ensuring that Ryan White Program funding is used as effectively as possible. This report presents findings on the responses of 110 grantees at the front line of these changes; Part C or D funded grantees who are also direct providers of OAMC. Their experiences as of April–May 2014—early in the first year of the full ACA implementation—suggest that grantees are adapting to the greater role of insurance, but still see ongoing need for Ryan White Program funding.

- **About one-third of respondents sometimes need Ryan White Program funding to provide OAMC to insured clients due to inadequate insurance coverage.** Barriers to insurance reimbursement include utilization limits on how many diagnostic tests can be

run per year, delays or refusals associated with prior authorization requirements for care services, and lack of access to specialists.

- **Among respondents that provide medical or non-medical case management, 80 percent sometimes need Ryan White funding to cover these services for insured clients.** Most respondents reported using Ryan White Program funds for medical and non-medical case management because Medicare, Medicaid, and private insurance did not cover these services. Utilization limits are sometimes a barrier for medical case management.
- **Utilization limits or clinical requirements are barriers for non-OAMC medical services such as mental health, oral health, and substance abuse.** About two-thirds of respondents that provide these services sometimes use Ryan White funding to provide these services to insured clients.
- **The vast majority of respondents are carefully monitoring the insurance status of their clients and working to move clients onto insurance.** Almost 84 percent of respondents confirm insurance status at every visit, far exceeding Ryan White Program requirements to check insurance status semiannually. About half of these also assess client eligibility for new insurance options at every visit, with most others checking at least semiannually.
- **Except for health departments, most respondents indicate that their agencies are working to participate in a range of care options under the ACA.** More than 80 percent of respondents from organizations other than health departments report that their agencies participate in managed care networks, more so for Medicaid networks than private networks. Either the agency itself or at its clinicians may participate in the networks. Almost all respondents from publicly funded community health centers indicated that their centers have or are seeking recognition as patient-centered medical homes. Many hospital- and university-based clinics and other community-based organizations are also pursuing patient-centered medical home status. In addition, under the ACA, fifteen providers from 7 States with approved health home plans have also indicated that they are designated health homes.

As the Ryan White Program moves toward reauthorization, the implementation of the ACA will have a significant impact on the role of funding for Parts C and D. With Ryan White Program funding, Part C and D grantees have developed a robust delivery system that coordinates health care and support services to link PLWH to care, retain them in care, ensure adherence to antiretroviral medications, and ultimately to achieve viral load suppression. Despite opportunities such as PCMHs, the day-to-day experience of the grantees responding to this survey show important areas where the mainstream health systems do not meet the standard of care needed by Ryan White Program clients. Even as grantees and their clients move more fully into the health insurance system, many of the services that have made the Ryan White Program a model of HIV care will still need funding outside the ACA.

Recommendations for Enhancing the Use of the Tracker

The Tracker was built for compatibility with CAREWare and ARIES. These systems are commonly used by Ryan White Program grantees, and developers were willing to work together to create import files into the Tracker. However, not all grantees use these systems, and the data grantees capture in these systems are limited. Although most grantees collect and assess insurance status on a frequent basis, these data are not always tracked in a Ryan White Program-specific system. Grantees are far more likely to track insurance status in electronic health records (EHR) systems. Similarly, grantees are more likely to assign funding sources and dollar amounts to services and collect comprehensive HIV care data at the procedure level in their EHR systems than in their Ryan White Program-specific data management systems.

Given these challenges, HAB can either encourage grantees to collect more comprehensive data in their Ryan White Program-specific systems or work with EMR systems, such as Epic and eClinicalWorks, to promote the Tracker's reports. Given HAB's increasing priority to coordinate with EMR systems, especially for RSR reporting, the second strategy may be more aligned with HAB's goals. HAB could work with vendors of other data management systems to create better and more integrated solutions in one of three ways:

- *Encourage grantee data management vendors to incorporate custom reports that generate Tracker's import files in the correct format*. To start this process, HAB could meet with grantee data management system vendors to present the goals of the Tracker and an overview of the input file content and structure. The data elements required by the Tracker are straightforward; ARIES and CAREWare administrators were able to create reports containing the import files within hours. The relatively low cost should encourage vendors to invest the resources required to support the tool. Once the vendors have agreed to support the process, HAB would send them the technical specifications of the files, including an XML schema or Excel tables structure, depending on how data are commonly extracted from the given data management system. The vendors would then create instructions for grantees to generate these files (either through custom reporting features or step-by-step instructions).

- *Consider making modifications to the Tracker to accommodate systems that are unable to export data that conforms to the Tracker specifications*. If vendors are unable to create reports that match the exact specifications of the open version's import files, HAB can consider creating additional versions of the Tracker to accommodate differences in data collection and reporting protocols.

- *Encourage vendors to adopt the Tracker's reporting structure and protocols without necessarily using the Tracker itself.* The code and logic contained in the Tracker are not proprietary; HAB can share them with grantees and data system vendors. Grantees would then be free to adopt the logic and create their own versions of the Tracker reports. Grantees or vendors that would adopt these reports can deduce the logic from the existing Tracker application. However, if HAB wanted to promote this alternative, more detailed specifications could be developed.

For the grantees that *can* use the full features of the Tracker, we recommend the development of a Tracker Data Work Group, which can allow HAB and grantees to explore and share the

findings of the Tracker over time. As we envision it, this work group could be composed of grantees that can use all of the features of the Tracker and are affected differently by the changing healthcare landscape. They would share findings (reports) with HAB and other work group members. These findings could then be repackaged for dissemination across wider groups, including funders, other grantees, and policy makers. Based on reports generated by the Tracker, members of the work group could articulate the importance of the Ryan White Program in providing comprehensive HIV care. HAB could identify members of this work group through the survey responses or the process of providing technical assistance on Tracker use.