

# IMPACT OF MEDICAID 1115 WAIVERS ON THE RYAN WHITE HIV/AIDS PROGRAM

CASE STUDIES ON EXPERIENCES OF RWHAP PROVIDERS AND CLIENTS

APRIL 2015

## EXECUTIVE SUMMARY

This report examines State use of waivers of Medicaid requirements to enhance access to Medicaid-provided care for people living with HIV (PLWH) and the resulting impact on the Ryan White HIV/AIDS Program (RWHAP). Eight case studies were undertaken in an effort to project how implementation of the Patient Protection and Affordable Care Act—including Medicaid expansion—might affect RWHAP clients and service providers.

The study was carried out in 2012-2014 on behalf of the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) under contract with JSI, Inc. The reader should be aware that the study did not take into account the changes that were occurring throughout late 2014 as a result of the Affordable Care Act. The study population of eight case studies in six states consisted of jurisdictions that used Medicaid 1115 waivers in some manner to enhance access to PLWH (and other populations in many cases). Sites also had variable characteristics in terms of their overall health insurance expansion activities, waiver start dates and eligibility criteria, and percentage of PLWH in the state covered by Medicaid.

The study determined that new Medicaid coverage provided PLWH with access to a broad array of primary care services but posed the following challenges, demonstrating a continued and pivotal role for RWHAP in filling gaps and ensuring ongoing engagement in care.

Notably, RWHAP programs developed a number of solutions, which are more fully described in the summary of findings attached to this report.

- Client challenges included new cost sharing requirements and variable access to services under new rules—from new pharmacies and new drug access rules to limitations on the services they could access. That learning, however, will serve clients well in managing their new Affordable Care Act coverage.
- RWHAP administrators needed to establish new coordination and planning with state Medicaid offices to ensure smooth transitions to care across both public health programs. Those collaborative activities are a foundation for future cross-program cooperation.
- RWHAP grantees and planning bodies carried out ongoing adjustments in allocations and priorities as Medicaid took on more of the cost of core medical services. This entailed shifting funds to address new and changing gaps in both primary care and support services. Those efforts will continue with implementation of health care reform.
- Providers funded under RWHAP had to adjust their operations to participate in Medicaid third party reimbursement systems. Changes in fiscal systems will continue as RWHAP providers transition away from grant-funded services.

What follows is additional background about the study purpose and case study methods, findings, and concluding observations and policy implications that suggest a need for careful transitional planning to minimize service and system disruptions and increased flexibility for RWHAP to implement change.

## STUDY FINDINGS

- 1. Medicaid Does Not Replace RWHAP**  
Under Medicaid expansion, RWHAP funding is still critical for filling gaps for PLWH in clinical and supplementing care completion services.
- 2. Pivotal Role of ADAP: Insurance Purchasing/Costs**  
AIDS Drug Assistance Program (ADAP) funding has been pivotal in supporting insurance continuation, and coverage of deductibles and co-payments for PLWH.
- 3. Medicaid Coverage Decreases Demand for RWHAP Core Medical Services**  
Expanded Medicaid coverage decreases the demand for RWHAP core medical services.
- 4. Medicaid/RWHAP Data Sharing and Communications Crucial**  
Data sharing and effective communication between HIV and Medicaid stakeholders is critical to planning for and/or implementing Medicaid expansion.
- 5. Medicaid Churning Creates Burdens, Risks Coverage Loss**  
Medicaid “churning” is common for low-income PLWH and creates an administrative burden and a risk of coverage loss.
- 6. Medicaid/Health Plan Rules Can Complicate Access to HIV Care**  
New rules about health plan and Medicaid care networks can create access barriers for PLWH to HIV medications and specialty physicians.
- 7. Novel Contracting Approaches for RWHAP Providers**  
Novel RWHAP contracting approaches can enhance efficiency and cost-effectiveness in a changing health insurance environment.
- 8. Fiscal Challenges for HIV Safety Net Providers**  
Some HIV safety net clinics will be challenged to maintain a strong medical home model of care as PLWH clients shift to the Medicaid program.
- 9. Transitioning Requires Clear Client Communications**  
Transitioning to Medicaid requires ongoing support of clients and clear and ongoing communication.
- 10. Lessons for Medicaid Enrollment/Future Waivers**  
Transitions to Medicaid are complex and should not be undertaken through interim and short-term steps.

## BACKGROUND

Section 1115 of the Social Security Act allows states to try new approaches to providing Medicaid coverage that differ from federal program rules. Some states have used Section 1115 demonstration waivers to expand eligibility to individuals who would otherwise not be eligible (e.g., adults without dependent children), provide services not typically covered by Medicaid, or implement innovative service delivery models.

In September 2012, Health Resources and Services Administration's, HIV/AIDS Bureau (HRSA/HAB) contracted with John Snow, Inc. (JSI) to conduct a study of states that have implemented 1115 waivers in ways that have expanded Medicaid eligibility for people living with HIV (PLWH) who would otherwise have been ineligible. The purpose of the study was to understand the nature of the waiver, any effects on the Ryan White HIV/AIDS Program (RWHAP), including clients and service providers, and implications for RWHAP after implementation of the Patient Protection and

Affordable Care Act (ACA) in 2014. The study methodology is described in the Appendix.

This report summarizes the primary findings from eight case studies involving six states and the District of Columbia (see Figure 1). Because California implemented its 1115 waiver at the county level, we included two major counties (Alameda and Los Angeles). Also included in the study were two locations (DC and MA) that implemented HIV-specific waivers before expanding Medicaid more broadly in advance of full implementation of the Affordable Care Act. Other states (MN and OR) were early adopters of health insurance expansion for low-income residents via state-funded programs and/or groundbreaking waivers. States in which waivers were narrowly defined or "frozen" due to adverse economic and political forces were also included (AZ and CO). The geographic distribution of the sites was constrained by the lack of Medicaid expansion waivers in southern states.

**FIGURE 1: MAP OF STUDY SITES**

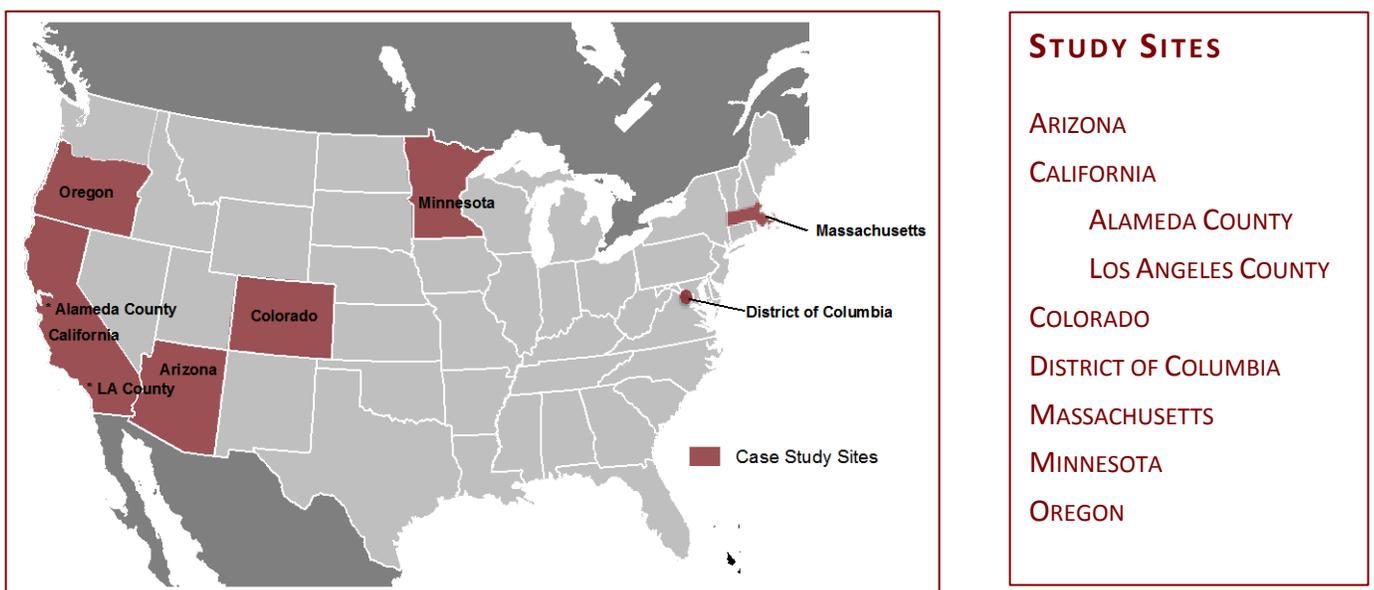


Table 1 summarizes the year of waiver implementation and the income eligibility criteria (based on percent of Federal Poverty Level or FPL) for each location studied. Two states (CA and MN) offered different levels of Medicaid benefits in a tiered income category system. In several states, the economic downturn of 2008 resulted in 1115 waiver

adjustments, including tightening of eligibility and/or the use of enrollment caps, lotteries or waiting lists. As a group, our eight case studies provide a diverse cross-section of context and experiences that can inform policy makers and other stakeholders about the impact of Medicaid expansion on PLWH and RWHAP.

**TABLE 1: CASE STUDY SITES: MEDICAID WAIVER AND HIV BACKGROUND**

	AZ	CA	CO	DC	MA	MN	OR
Medicaid waiver/expansion implemented (year)	2001	2011	2012	2004 (HIV) broadened in 2010	2001 (HIV)	2011	1994
Waiver eligibility % FPL*	100	133 & 200	10	200	200	75 & 250	100
Total PLWH (2010)	12,532	111,666	11,006	14,359	17,502	6,564	5,130
PLWH on Medicaid (2010)	2,964	24,129	751	4,879	7,901	1,618	1,019
% PLWH on Medicaid (2010)	24%	22%	7%	34%	45%	25%	20%

\*Tiered benefit levels offered in CA and MN

Data Source: Kaiser Family Foundation State Health Facts [kff.org], 2010 data

## STUDY FINDINGS

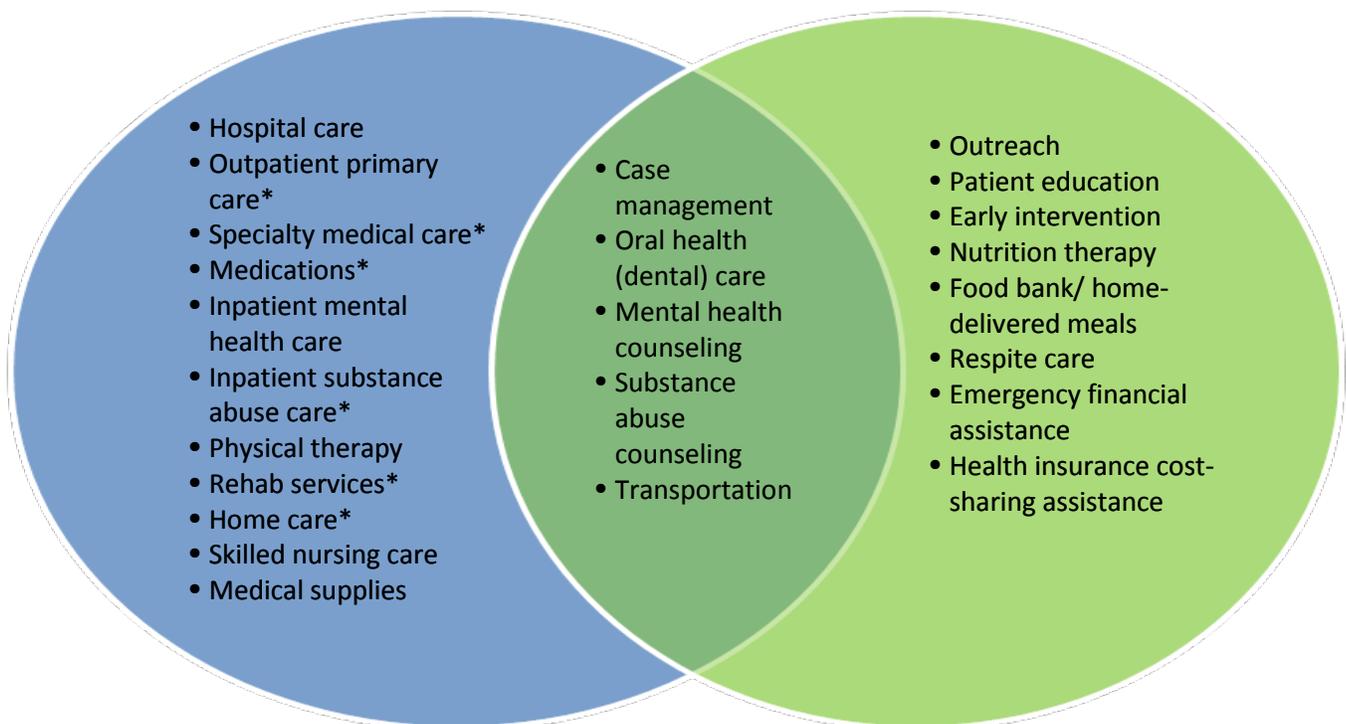
### FINDING 1:

#### **UNDER MEDICAID EXPANSION, RWHAP FUNDING IS STILL CRITICAL FOR FILLING GAPS FOR PLWH IN CLINICAL AND SUPPLEMENTING CARE COMPLETION SERVICES.**

A universal theme of the case studies is that Medicaid coverage for PLWH does not replace or eliminate the need for the RWHAP. In each location, a service crosswalk comparing RWHAP core medical and support services to Medicaid covered services showed in detail the service needs that would remain for PLWH. While hospital physician and pharmacy benefits are covered under Medicaid, several pivotal RWHAP services that help link and retain PLWH in care and keep them healthy are not. When necessary, RWHAP can support care completion if Medicaid either does not cover key services (e.g., treatment adherence counseling) or if there are limitations on coverage (e.g., limits on the number of drugs).

Based on discussions with case study participants, Figure 2 illustrates the coverage situation for selected, common services used by a typical RWHAP client enrolled in Medicaid. The left column shows services that are mainly charged to Medicaid, even though several are also eligible for RWHAP funding according to the statute. The right column shows the services that only RWHAP covers. The five services in the center varied in the extent to which Medicaid coverage was available in the study sites. As a result, RWHAP often supplemented or was the sole provider of this group of services.

**FIGURE 2: TYPICAL PLWH MEDICAID ENROLLEE: COVERAGE OF SELECTED SERVICES AS DESCRIBED BY STUDY SITES**



\* Services that sites described as covered by Medicaid but in some cases RWHAP may cover care completion of supplemental services.

Case study key informants, particularly those from Part C clinical programs, noted that the availability of specialty medical and inpatient care through Medicaid was an important improvement for their PLWH clients who transitioned from RWHAP to Medicaid coverage. Although RWHAP grantees could use funds for these needs, complex reimbursement arrangements would be required that were not undertaken by the RWHAP stakeholders we interviewed.

In most locations studied, Medicaid and RWHAP both offer case management, oral health care, behavioral health care and transportation services but the intensity and scope are generally lower or more limited under Medicaid.

### *SELECT INSIGHTS ON SERVICE VARIATIONS*

To convey a meaningful sense of how Medicaid and RWHAP differences impact individual PLWH and the RWHAP more broadly, examples from two representative locations (CO and MN) are described below for five service categories.

- **Case Management Services.** MN Medicaid provides only “targeted case management” for mental health clients and the other public programs do not have a standardized approach to care coordination. The RWHAP investment in medical case management continues, as there is no other coverage for the comprehensive care coordination services needed by many PLWH. In CO, each regional Medicaid network has its own approach to case management services, so the degree of overlap with RWHAP-funded case management varies from region to region. Generally both Medicaid and RWHAP case managers focus on linking clients to primary medical care but Medicaid also closely monitors inappropriate service use for cost-containment purposes, while RWHAP-funded case management focuses on overall service coordination.
- **Transportation.** MN Medicaid provides transportation services for medical appointments, but patients must schedule the service five business days in advance. However, when a provider or clinic calls to schedule transportation, it can be arranged for that day. Because patients quickly learn that it is easier for the clinic to call and schedule transportation, the current system adds (non-reimbursed) burden to the front line clinic staff. Also, counties have different rules about how they administer transportation under Medicaid, and the way it is done is not equitable across the state. To complement what Medicaid covers, RWHAP funds are used (largely through bus cards in the metro area) to transport clients to support groups, case management visits, and other appointments that are not allowed under Medicaid’s transportation benefits. In CO, Medicaid non-emergency transportation is available with 72-hour notice, so the more responsive and flexible RWHAP transportation services fill a significant gap.
- **Mental Health.** Medicaid mental health care in MN is provided through a managed care arrangement that establishes a cap on the number of annual visits. RWHAP pays for mental health services after Medicaid covered services have been exhausted, or for services not covered by Medicaid. Inpatient psychiatric care in the waiver population is subject to a \$10,000 annual cap. There is also a severe shortage of psychiatrists, making access to mental health treatment very limited for Medicaid clients. The annual cap on visits exists in CO Medicaid, but behavioral health organizations have some flexibility in how services are provided under the capitated

system. Nevertheless, RWHAP mental health benefits are more comprehensive and are used to address needs and service gaps for PLWH.

- **Substance Abuse Treatment.** Because MN's substance abuse treatment services are available to PLWH through the state's alcohol and drug program, RWHAP does not have a need to fund them. CO's RWHAP-funded substance abuse treatment services allow for more visits than Medicaid, which provides limited inpatient care for substance abuse when necessary.
- **Oral Health Care.** While Medicaid provides basic dental services in MN, some dental needs are not covered. In MN, caps restrict the number of procedures, rather than overall cost. If enrolled in RWHAP, a client can get service gaps met after having used all of their available Medicaid benefits. Medicaid patients can go to any Medicaid-qualified dentist, but there is a shortage of Medicaid oral health providers and most limit their Medicaid panel at the state-required 10% of total clients. CO had no dental benefit at all under the waiver but planned to offer coverage when Medicaid expanded through the Affordable Care Act.

## **FINDING 2:**

### **AIDS DRUG ASSISTANCE PROGRAM (ADAP) FUNDING HAS BEEN PIVOTAL IN SUPPORTING INSURANCE CONTINUATION, AND COVERAGE OF DEDUCTIBLES AND CO-PAYMENTS FOR PLWH.**

Since 2000, HRSA has allowed RWHAP grantees to use ADAP funds to pay insurance premiums and deductibles and cover co-payments on prescriptions, provided the insurance product has comparable formulary benefits.<sup>1</sup> Purchasing insurance through state high risk-pools or extending private insurance benefits under COBRA has proven to be cost-effective for states. Rather than covering only medication costs, ADAP funds can be used to continue insurance for PLWH. This makes available a full range of services, including hospital and outpatient care, and reduces the need for RWHAP to support medical and/or behavioral health care.

Most of the jurisdictions studied used ADAP to cover insurance, deductibles, and co-pays for eligible PLWH and considered it vital to the state's ability to address increasing demand, avoid waiting lists for drug access, and prevent lapses in medication adherence. Table 2 provides state-specific ADAP utilization data from the 2014 ADAP Monitoring Report.

Under Medicaid expansion waivers, cost-sharing requirements such as medication co-payments and deductibles are often imposed that create a real financial burden on low-income PLWH. Prior to obtaining Medicaid coverage, RWHAP clients were not typically subject to these out-of-pocket expenses; new Medicaid enrollees often find these requirements difficult, particularly if they are on multiple medications. In 2013, co-payments represented more than 40% of total ADAP drug expenditures in AZ, MA and OR, while the national average was 5%.<sup>1</sup> In CO, where income eligibility under the 1115 waiver was set extremely low (10% of FPL), the co-payment problem was not anticipated before the waiver's implementation. But once the ADAP leadership recognized the issue, a mechanism was established to address these costs for PLWH on Medicaid. Similar solutions were implemented in the other study locations to address the out-of-pocket expense barrier.

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<sup>1</sup> National Association of State and Territorial AIDS Directors (NASTAD) ADAP Monitoring Report 2014

**TABLE 2: ADAP INSURANCE CONTINUATION IN CASE STUDIES, 2013**

	AZ	CA	CO	DC	MA	MN	OR
ADAP clients served (6/13)	1,831	22,702	2,265	872	4,153	640	2,849
ADAP % of PLWH	15%	20%	21%	6%	24%	10%	56%
ADAP eligibility (% FPL)	300	400	400	500	500	300	300
Total ADAP \$ (mil) FY 2013*	\$27.03	\$426.54	\$20.53	\$14.65	\$24.58	\$11.00	\$9.80
Insurance continuation clients	961	8973	989	340	4011	233	2382
% ADAP clients on insurance continuation	52%	40%	44%	39%	97%	36%	84%
Includes all federal, state, rebate and other revenue Data Source: National Association of State and Territorial AIDS Directors (NASTAD) ADAP Monitoring Report 2014							

Expansion of Medicaid excludes certain populations of PLWH based on their immigration status, creating a significant need in some of the study locations that the RWHAP has been able to address thus far through ADAP and insurance purchasing. Legal immigrants are restricted from Medicaid during a five-year waiting period but are eligible for tax credits and subsidies, in accordance with income and other eligibility provisions. Under the Affordable Care Act, undocumented immigrants will remain ineligible for Medicaid and will be ineligible for the premium tax credits; they also will be prohibited from purchasing exchange coverage at full cost. RWHAP stakeholders raised concern about what future options will be available to their immigrant populations.

### **FINDING 3:**

#### **EXPANDED MEDICAID COVERAGE DECREASES THE DEMAND FOR RWHAP CORE MEDICAL SERVICES.**

RWHAP allows grantees to support both “core medical services” and “support services” for PLWH. Core medical services include outpatient and ambulatory health services, ADAP (medications), oral health care, medical case management, including treatment adherence, early intervention services, health insurance premium and cost-sharing assistance, home health care, medical nutrition therapy, hospice care, home and community-based health services, mental health, and outpatient substance abuse care.

Services that support PLWH to achieve their medical outcomes include respite care (for caregivers), outreach services, medical transportation, food bank and home delivered meals, residential substance abuse care, psychosocial support, emergency financial assistance, housing, legal and linguistic services, and referrals for health care and support services.

As of the 2006 reauthorization of the RWHAP legislation, Part A, B, and C grantees are required to spend at least 75% of funds on core medical services so that limited federal resources were used for services most likely to have a positive health impact for PLWH. However, HRSA/HAB has the authority to waive this requirement if there are no waiting lists for ADAP and core medical services are available to all individuals in the service area. In MA, where Medicaid was expanded in 2001 to

include non-disabled PLWH up to 200 percent of FPL (and universal healthcare legislation was implemented in 2006), the need for RWHAP-funded core medical services has declined. As such, the Boston Part A grantee has been granted a waiver every year since the 2006 reauthorization. In the Boston EMA, Part A funding allocations for primary care have fallen from over \$330,000 in FY2000 to \$53,000 in FY2013. Similarly, funding for mental health services have fallen from over \$545,000 to \$45,000 over the same time period. Other Part A grantees interviewed for this study expressed concern that shifting a greater proportion of RWHAP funds toward support services as a result of Medicaid expansion would require them to apply for a waiver, which is an additional administrative burden.

In 2013, HRSA/HAB revised the core medical services waiver application to give grantees more flexibility in the timing of waiver requests. Grantees can apply for a waiver concurrently with, or at any time up to, their annual Part A, B, or C application submission, or up to four months after their grant award each year. The hope is that grantees can now plan with more certainty and have the flexibility to adjust their RWHAP-funded systems in response to changes in service needs in their local area.

#### **FINDING 4:**

#### **DATA SHARING AND EFFECTIVE COMMUNICATION BETWEEN HIV AND MEDICAID STAKEHOLDERS IS CRITICAL TO PLANNING FOR AND/OR IMPLEMENTING MEDICAID EXPANSION.**

Clear communication and collaboration between federal, state, and local stakeholders is critical to achieving the goal of coverage expansion and ensuring smooth transitions for vulnerable groups such as PLWH. Unfortunately, in the early stages of CA's 1115 waiver development and implementation, the state's Medicaid program did not understand RWHAP's "payer of last resort" rule, which stipulates that RWHAP funds cannot be used to pay for any services that are eligible for coverage by other federal or state programs, or by private health insurance. As a result of poor communication, CA's Medicaid program assumed that RWHAP clients would not transition to Medicaid. Consequently, the economic impact of medical care and medication costs was not factored into waiver forecasting.

After federal guidance confirmed that eligible RWHAP clients would need to transition to Medicaid coverage through the waiver, formal coordination was set in motion between Medicaid and RWHAP partners (state and federal). The most helpful coordination and communication strategies included: a new liaison position between CA Medicaid and RWHAP Part B program, a statewide stakeholder advisory committee, written guidance addressing key concerns, and opportunities for federal, state, and local stakeholders to ask and respond to questions. Fostering transparency and real-time information exchange was also important at the local level, especially where payer and provider agencies may not interact on a regular basis. In addition, development and use of a unified vision to guide activities related to the transition helped Los Angeles County prioritize client access to their providers and pharmacy, and avert a dangerous backward step in the HIV epidemic.

Stringent privacy rules often complicate or completely obstruct the appropriate use of programmatic data for Medicaid waiver planning and implementation. Data sharing between RWHAP and Medicaid administrators is essential to planning for a smooth transition. Lack of access to RWHAP data made it difficult for California's Alameda County Medicaid administrators to predict client transition; this was

eventually resolved with statutory changes. More formal data-sharing arrangements across public agencies and other key stakeholders will be necessary to identify transitioning clients and anticipate provider and pharmacy network issues.

### **FINDING 5:**

#### **MEDICAID “CHURNING” IS COMMON FOR LOW-INCOME PLWH AND CREATES AN ADMINISTRATIVE BURDEN AND A RISK OF COVERAGE LOSS.**

Several states have frequent reassessment of Medicaid eligibility, some as often as monthly. The result is frequent “churning” – meaning clients move on and off the program when their income is in flux or the required eligibility documentation is lacking. Churning was identified by Part C stakeholders as a workflow burden for front line staff in large provider agencies and was more of an issue when Medicaid income eligibility was set very low (e.g., 10% FPL in CO). Some Medicaid programs and high-risk insurance products purchased through ADAP had restrictions on retroactive coverage and waiting periods (e.g., six months in MN) that result in uncompensated care periods.

Data sharing limits and communication barriers can further complicate the challenges of churning. In CO, only certain entities have access to the Medicaid eligibility systems. There was no data sharing agreement that allowed ADAP and Medicaid to share information with each other about their clients and thus determine which ADAP clients were enrolled in Medicaid. Clinical providers are able to use the system to identify whether or not a client is actively enrolled in Medicaid, but are unable to access information on the status of an application that has not yet had a determination. The provider look-up ability in Medicaid does not allow providers to identify whether a client without existing Medicaid coverage has an application in pending status, an application approved but on the waiting list, or a denied application. In addition, the notices sent to clients about their eligibility status were confusing, sometimes involving multiple notices on the same issue. RWHAP providers reported spending considerable time helping clients determine the status of their application, and following up as needed.

To the extent that states can anticipate the potential negative impact of churn on PLWH and provider agencies, policies and funding arrangements can be optimized accordingly. Creative strategies are needed under the RWHAP to fill temporary gaps in benefits, particularly to provide continuity of medications and other beneficial treatment.

### **FINDING 6:**

#### **NEW RULES ABOUT HEALTH PLAN AND MEDICAID CARE NETWORKS CAN CREATE ACCESS BARRIERS FOR PLWH TO HIV MEDICATIONS AND SPECIALTY PHYSICIANS.**

A major trend in the current health reform environment is the creation of accountable care organizations (ACOs), providing a network of care services often on a regional basis. While originally a model for Medicare under the Affordable Care Act, several state-initiated Medicaid ACO model programs are under way including three of the study sites (CO, MN, OR). In ACOs, typically the primary care provider (PCP) directs a patient’s care, calling upon specialists only when necessary. Medicaid policies are sometimes narrowly defining who can act as a PCP, excluding physicians like

infectious disease specialists who often provide primary care to PLWH. In several states, PLWH have been required to change providers under the new ACO network system. This is particularly a problem in rural areas when no HIV specialists may be participating in the regional network. .

Medicaid expansion in CA's Alameda County caused difficulties for some clients in maintaining care continuity when four large HIV care sites were not originally part of the Medicaid network after expansion. The local RWHAP immediately reached out to these organizations and encouraged them to become Medicaid providers. At the time of the Alameda County case study interviews (June 2013), all four entities had submitted applications and three had met the requirements for inclusion; however, PLWH on Medicaid were not able to receive care until the qualification process was complete.

In Alameda County, discrepancies between the Medicaid and ADAP pharmacy networks were described by one interviewee as "the biggest challenge of the whole process." Prior to the waiver, pharmacies dispensing medications to ADAP clients were reimbursed at higher dispensing fees than those available through Medicaid. Because of the low fees, persuading ADAP pharmacies to participate in the Medicaid network was difficult. The Medicaid pharmacy network was ultimately smaller than the ADAP network so some clients had to switch after they enrolled in Medicaid. Ensuring adequate pharmacy networks and assisting both pharmacies and medical providers in meeting network certification requirements was a time-intensive process, but was essential to a smooth transition.

In CO, new Medicaid enrollees who were taking HIV medications had to adapt to a new, mail order method for obtaining and refilling prescriptions. This was particularly challenging since the very low-income eligibility for the program (10% FPL) meant that many eligible clients were homeless, highly mobile, and hard to reach.

DC was able to ensure comprehensive provider networks and pharmacy coverage during its most recent Medicaid expansion waiver process. By designating PLWH and others with chronic and complex conditions as "medically frail," eligible individuals were enrolled in traditional fee-for-service Medicaid rather than managed care. This enabled greater choice for PLWH and ensured provider continuity. Ultimately, this resulted in continuous care with enhanced health insurance benefits for many PLWH who had previously been subject to service limitations.

## **FINDING 7:**

### **NOVEL RWHAP CONTRACTING APPROACHES CAN ENHANCE EFFICIENCY AND COST-EFFECTIVENESS IN A CHANGING HEALTH INSURANCE ENVIRONMENT.**

RWHAP Part B stakeholders have developed unique ways to optimize RWHAP funding in response to their individual state conditions and needs. Some of these strategies may be applicable to other states as they adapt to conditions under the Affordable Care Act. For example, DC has aligned its funding strategy with the goals of the National HIV/AIDS Strategy and HHS quality of care indicators. For the first time, the funding guidance required formalized partnerships between providers, particularly clinical providers and community-based organizations (CBOs). Recognizing the vital role that CBOs play in providing support services, particularly to DC's priority populations (e.g., African

American men, Latinos, women, adolescents), a new funding strategy strategically encourages applicants to provide services in support of the care continuum, and to augment services offered through the Medicaid managed care plans.

In MA, use of an independent agency to administer the state's ADAP insurance purchasing program has been extremely helpful, particularly in this medium size state. The Community Research Initiative of New England (an independent non-profit agency) administers the state's ADAP, including the state's insurance purchasing program for PLWH. With the rapidly changing coverage environment, staying adequately informed and responsive is very challenging and would be difficult for a medium size state to effectively manage with internal staff in the MA Department of Public Health. The use of a separate agency to analyze insurance options, ensure adequacy of coverage, and implement necessary premium and co-pay assistance has been important for the effective implementation of this program. Smaller states have lower volume and larger states are likely to have better internal systems and capacity.

### **FINDING 8:**

#### **SOME HIV SAFETY NET CLINICS WILL BE CHALLENGED TO MAINTAIN A STRONG MEDICAL HOME MODEL OF CARE AS PLWH CLIENTS SHIFT TO THE MEDICAID PROGRAM.**

Providing primary medical care to PLWH with complex needs through a comprehensive, interdisciplinary model is very costly and not adequately compensated by reimbursement rates from Medicaid and Medicare. The Part C clinics interviewed had many years of experience providing comprehensive services and achieving quality outcomes for their complex patient populations of disadvantaged PLWH. Under Medicaid expansion waivers and early Affordable Care Act expansion, it is becoming clear that this resource-intensive approach will be more fiscally challenging. Moving from a cost-reimbursement model of RWHAP funding toward public insurance reimbursement rates and managed care/capitation is expected to mean a reduction in revenues, at least for those who are not federally qualified health centers (FQHCs). In general, Medicare reimbursed FQHCs and look-alike clinics an all-inclusive, per-visit payment based on reasonable costs prior to October 1, 2014. On or after October 1, 2014, Medicaid pays FQHCs based on the prospective payment system. Medicare also uses a prospective payment system. These payment methodologies result in a Medicaid and Medicare reimburse FQHCs usually higher reimbursement to non-FQHC providers, leading some Part C clinics to consider pursuing FQHC status in the future. Another consideration is that as an FQHC, the clinic can become eligible for other sources of federal funding earmarked for these organizations.

### **FINDING 9:**

#### **TRANSITIONING TO MEDICAID REQUIRES ONGOING SUPPORT OF CLIENTS AND CLEAR AND ONGOING COMMUNICATION.**

Flexibility and timely problem-solving helped prevent loss of coverage as PLWH transitioned to Medicaid. Transition of a high-needs population to a new service delivery system takes time. Clients experienced multiple challenges to enrollment, including frequently changing addresses and/or phone numbers, lack of familiarity with health insurance or its value, and reluctance to apply for government assistance. For clients who were used to having their care met by RWHAP-funded

providers without any out-of-pocket expense, service and pharmacy co-pays served as a disincentive to enrollment. Clients required substantial assistance with the enrollment process and with interpreting and following up on notices received from Medicaid. Flexibility about the timing of the transition was necessary to ensure that no client was lost to care. Guidance and sharing of best practices, rather than hard deadlines, may be useful for frontline outreach and enrollment staff to help facilitate client transitions to new coverage options.

Targeted, clear messages, delivered through trusted communication sources are the key to adequately informing and motivating the diverse RWHAP consumer population about Medicaid expansion. RWHAP clients are accustomed to a model that anticipates and addresses their needs on many levels. As a result, many clients are not interested in moving to a different model of care or acquiring insurance coverage. Messages should recognize and address client suspicion and fear of government programs, given that many PLWH have no experience with, or understanding of, insurance concepts. It is important to be honest and up-front with clients about any practical or financial changes that will occur as a result of gaining insurance coverage. Tapping into established RWHAP communication channels (rather than standard Medicaid outreach) and trusted advocates was found to be most successful for reaching these clients. When attempted, group enrollment events and written general promotional materials are not particularly helpful for outreach to PLWH.

#### **FINDING 10:**

#### **TRANSITIONS TO MEDICAID ARE COMPLEX AND SHOULD NOT BE UNDERTAKEN THROUGH INTERIM AND SHORT-TERM STEPS.**

To the extent possible, avoid excessive and inefficient administrative burdens associated with planning and implementing small or short-term Medicaid expansion waivers. The study sites reported that the benefits of short-term “bridge” waivers often did not outweigh the costs. Despite having good intentions and believing in the importance of health insurance, states found the complexity and uncertainty involved with coverage transitions very challenging for RWHAP providers, staff and clients. The shifting political and economic conditions during the waiver phase in some states added to the difficulties when access to coverage was restricted for cost-containment reasons.

## CONCLUSION AND POLICY IMPLICATIONS

For two decades, various states have expanded Medicaid coverage through HIV-specific and more general 1115 waivers. In this study, we leveraged this opportunity for insight into how low-income, previously uninsured PLWH and the RWHAP providers serving them are affected in this context. Now that at least 28 states including the District of Columbia (as of October 2014) are expanding Medicaid under the Affordable Care Act, understanding the system- and client-level impacts and operational issues in early expansion jurisdictions will be extremely valuable.

Availability of Medicaid coverage for PLWH in our study sites has been viewed as a significant advantage for the individual clients who gain access to additional hospital services for non-HIV care. In settings where the RWHAP grantees did not allocate funding for a full complement of medical specialty and behavioral health services, new Medicaid coverage was also a positive change. However, careful planning is necessary to prevent disruption in care if some HIV providers (including physicians, pharmacies and clinics) are not included in the Medicaid networks. A major shift to Medicaid may adversely impact the financial situation of Part C safety net clinics due to lower reimbursement rates. In clinical settings where the payer mix is not robust, movement of PLWH to Medicaid from a high-risk pool product that is more like commercial insurance can significantly reduce revenues. For populations of RWHAP clients

that are excluded from Medicaid and insurance marketplace expansion (i.e., recent and undocumented immigrants), an adequate safety net of care sites and medications will still be needed.

Planning for payer transitions or service delivery system transformations that may affect vulnerable populations with complex needs requires clear guidance and understanding federal and local regulations. Communicating the necessary information effectively to clients of RWHAP requires adequate time and thoughtful, targeted approaches. Based on the feedback from our study sites, continued evolution of the RWHAP may be required to stabilize the continuum of care and prevent unintended negative consequences on critical medical providers. Adequately covering the operational costs of a multidisciplinary care model will be difficult for non-FQHC clinics with high proportions of Medicaid clients, if their RWHAP funding is reduced.

Modifications to the programmatic requirements that enhance flexibility in response to the dynamic health reform environment will be welcomed by RWHAP grantees. Through active, real-time program assessment and monitoring, issues can be recognized early and adjustments made accordingly so that care disruptions are minimized.

## **ACKNOWLEDGEMENTS**

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## **NOTES**

This study was conducted by JSI with funding provided by HRSA/HAB under contract #HHS2502006460261. This summary (and the case studies upon which it was based) was prepared by the JSI research team; any errors of fact are their responsibility and should not be ascribed to any participant in this study.

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## APPENDIX: STUDY METHODOLOGY

JSI used a case study approach for examining the experiences of a select set of states that implemented 1115 waivers. A case study is an empirical inquiry that “investigates a contemporary phenomenon within its real-life context, when the boundaries between the phenomenon and context are not clearly evident, and in which multiple sources of evidence are used.”<sup>2</sup> As this definition suggests, a strength of case studies is the ability to use multiple methods and data sources to develop a rich and in-depth assessment of a particular case. For this study, JSI’s methods included interviews with Medicaid and RWHAP grantees (Part A, B, and C), a review and analysis of secondary sources (e.g., websites, journal or news articles), and a review of data provided by participants.

JSI defined selection criteria for identifying potential states for inclusion in the study. Criteria included: (1) implementation of an 1115 waiver with potential implications for PLWH, (2) time since implementation of the waiver, (3) size of the population of PLWH in the location, (4) size of the RWHAP service provider community, and (5) willingness and availability of RWHAP and Medicaid representatives to participate. After examining all possible locations, JSI identified eight potential sites, plus two alternates, and the list was approved HRSA/HAB. After contacting the sites and assessing potential interest and/or appropriateness for the study, JSI and HRSA/HAB agreed on a revised list of eight sites, listed below. The sites include six states (AZ, CA, CO, MA, MN, OR) and the District of Columbia (see Figure 1 map). In California, two counties were chosen given the size of the state and the different ways that Medicaid expansion was implemented.

To ensure a broad and thorough understanding of the 1115 waiver’s development and implementation, JSI developed an overall study protocol, as well as interview guides for each type of participant, including one for Medicaid program representatives, one for Part A grantee staff and/or Planning Council members, one for Part B grantee staff (including ADAP), and one for Part C grantee staff. The tools were reviewed by HRSA/HAB and pilot tested in May and June 2013 with select participants from two of the participating sites. The tools were then submitted for Office and Management and Budget (OMB) review and approval was received in August 2013 (OMB#0915-0365, expiration 08/31/2014). The study protocol and interview guides were also submitted to JSI’s Institutional Review Board (FWA#00000218), and an exemption to human subjects review requirements was granted on May 28, 2013.

Between October 2013 and March 2014, JSI visited each of the participating sites, and conducted in-person interviews with Medicaid and RWHAP representatives. Prior to the visit, JSI distributed a copy of the interview tool so participants could prepare. Some interviews were conducted by phone if a participant could not attend an in-person interview. Each visit lasted one to two days and included at least two members of the JSI research team. JSI worked with key contacts in each jurisdiction (using HRSA/HAB’s grantee contact list) to identify individuals for interviews and invite them to participate. JSI staff recorded and prepared summary notes for all interviews. Using these notes, as well as materials and data provided by participants, and secondary research, JSI staff prepared a written case study for the sites that they visited. The case study was reviewed by two additional members of the team, and then submitted to HRSA/HAB for review.

The individual case studies were reviewed by the team and key themes were identified. This summary report was prepared for HRSA/HAB to synthesize the findings across the sites, and identify broader implications for the RWHAP. In addition to the case studies, JSI staff also analyzed RWHAP data provided by HRSA/HAB for the seven participating states. The goal was to identify, if possible, any trends or changes in clients and/or utilization of RWHAP services. A separate summary report of the quantitative analysis was provided to HRSA/HAB.

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<sup>2</sup> R. Yin. 1989. *Case study research: Design and methods*. Newbury Park, CA: Sage Publications.