# Special Study-Emerging Issues Related to ACA Implementation.

# The Future of Ryan White Services: A Snapshot of Outpatient Ambulatory Medical Care*

Presentation to the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC)

November 4, 2015

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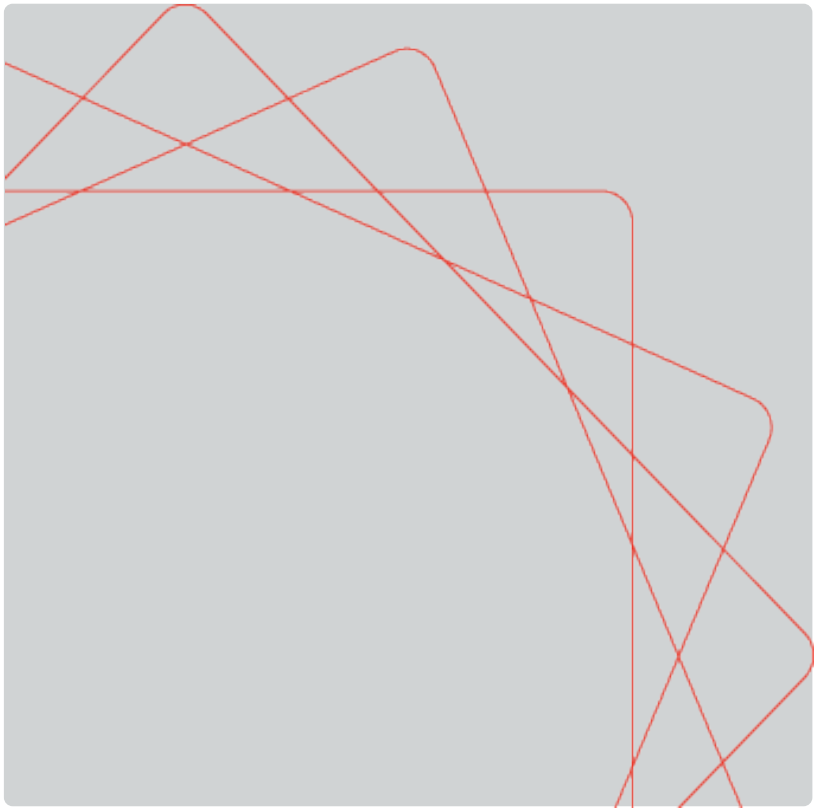


# Briefing Outline

- Study Overview
- Selected Findings
  - Provider-Level
  - Services and Service Utilization
  - Client Characteristics and Outcomes
- Recommendations
- Questions

# Acknowledgments


- Robert Mills, PhD.
- Antigone Dempsey, MEd.
- HAB Advisory Group
- All of the participating RWHAP site staff

# Study Purpose

- To assess:
  - the current status of Ryan White services during the early and later stages of ACA implementation;
  - how well the RWHAP is positioned to improve clinical outcomes, including viral suppression, retention to care, and linkage to care services; and,
  - the efforts of RWHAP providers to adapt to the implementation of the ACA
- Collect information on service provision, quality of care, barriers, gaps, and challenges related to ACA implementation in 2014.

# Mixed Methods Design

- Qualitative Analyses:
  - 2 sets of Interviews with 30 RWHAP sites: June – July 2014 and February – March 2015.
  - Grant application narratives.
  - State Insurance Department info re: Qualified Health Plans (QHP) Benchmark and Medicaid Alternative Benefit Plans.
- Quantitative Analyses:
  - 2013 and 2014 RSR client-level data (preliminary).
    - ~44,000 cases/yr.
  - Interview data.

# Site Sample Criteria

| Criteria | Site Selection |
|---|---|
| Medicaid expansion | 10 Expansion / 5 Non-Expansion |
| Prevalence | 1/3 of sites are high, mid or low prevalence<br>(4=ECHPP “12 Cities”) |
| Population density | Metropolitan, Micropolitan, and Rural |
| # and types of RWHAP services | 1 – 21 services<br>23 serve > 50% OAMC clients / 7 serve < 50% OAMC clients |
| Numbers of clients served | 116 – 4,286 |
| Part funding | 92% have Parts A and/or B funding<br>33% have Parts C and/or D funding<br>26% have a funding from both of the above categories |

# Study Sites States

## Expansion

- Arizona
- Arkansas
- Colorado
- Illinois
- Maryland
- Michigan
- New Jersey
- New Mexico
- Oregon
- Washington

## Non-Expansion

- Alabama
- Florida
- Louisiana
- New Hampshire
- Texas

# Overall Conclusions

- RWHAP funding continues to be critical to ensure the care necessary to fill gaps in essential services for clients.
- There is a divergence of experience between expansion and non-expansion states that will likely continue over the immediate future.
- RWHAP sites are successfully adapting to ACA, but challenges remain.
- Some RWHAP clients experienced fragmentation of care due to RWHAP sites' lack of contracts with new insurers.
- Sites have added additional insurance enrollment and billing staff.
- Fewer clients received OAMC services in expansion states after ACA implementation (though we cannot statistically distinguish this reduction from an overall downward trend in all states).

# Selected Findings

## Provider Programs and Staffing

# Leveraging of ACA

- **Cost Savings.** Some sites that successfully established billing agreements with MCOs and private insurers offering QHPs reported increased revenues. These increased revenues allowed them to increase staff, as well as to offer additional services by reprogramming the additional funds.
- **Increased Access to Specialty Providers and Services.** Sites in 3 expansion states and 1 site in a non-expansion states (TX) noted that clients who gained insurance through MCOs and QHPs experienced increased access to both providers and services.
- **Continued Availability of RWHAP Funding.** All sites noted that sustained RWHAP funding is essential to maintaining the level and quality of care needed by RWHAP clients.
  - 1 site credited RWHAP funding for their being able to provide all the services necessary to function as a PCMH for its HIV-positive clients.
  - Sites with QHP insured clients support client premiums and deductible using RWHAP cost-sharing support services (ADAP and HIA), without which clients could not maintain coverage.

# RWHAP Services Remain Available to Almost All

- Nearly all sites noted that they still provide all RWHAP services as needed to newly-insured clients regardless of their insurance status or ability to meet cost-sharing requirements
- However, one site noted they would not provide non-urgent care to insured RWHAP-eligible clients without co-pay

# Staffing Changes

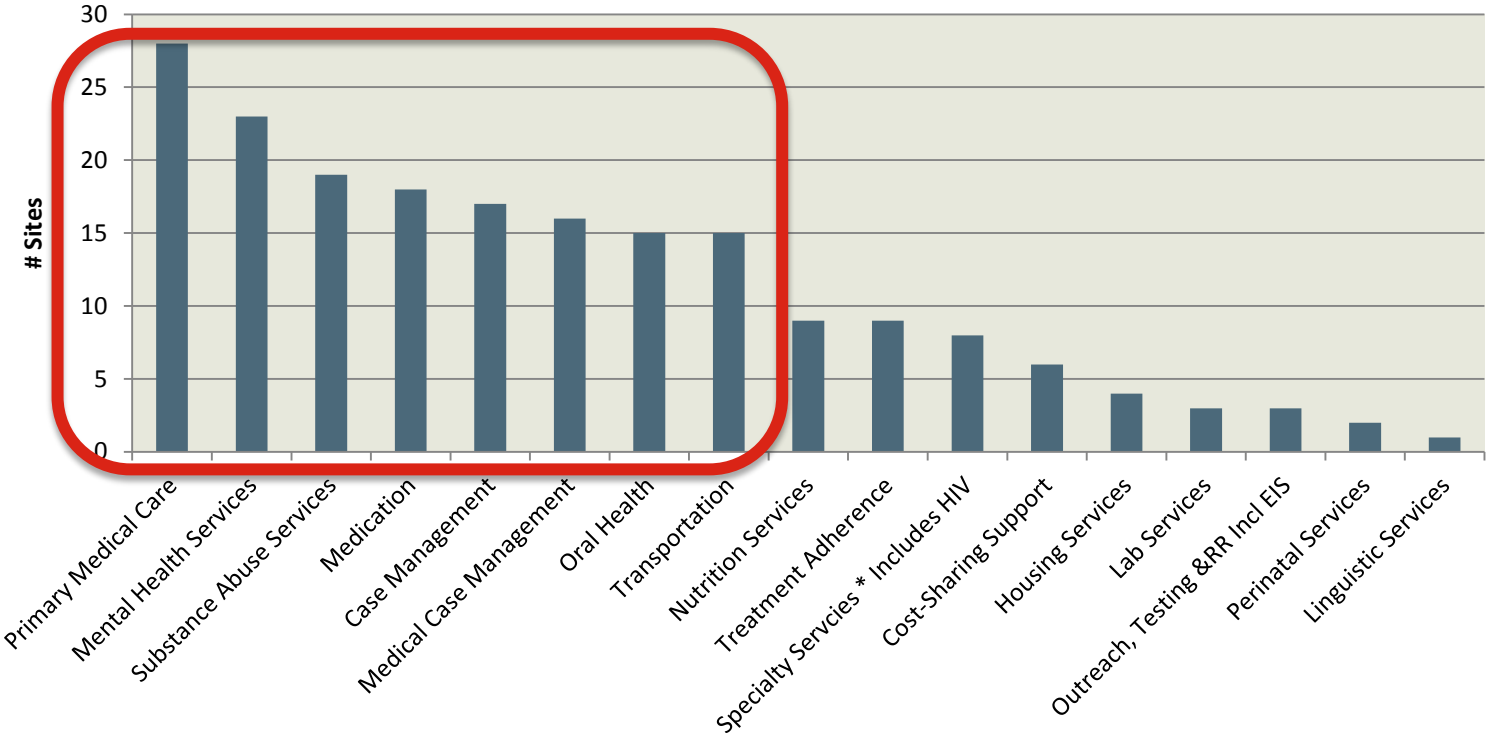
- The majority of sites reported increasing staff to assist with client enrollment and new insurer requirements:
  - Case Managers
  - Benefits Counselors
  - Resource Specialists
  - Certified Application Counselors
  - Billing Specialists
- Staff were also hired to assist with:
  - Early Intervention Services (EIS)
  - Patient navigation services
  - Mental health services

# New Insurer-Related Challenges

- Sites in 6 states noted that some clients experienced a disruption in care due to providers experiencing difficulty with obtaining contracts with insurers.
  - No contract with insurers
  - Contracts with insurers that designated HIV providers as specialty care providers, not PCPs.
- Some sites were able to ameliorate the impact, others were not.

# Essential Set of RWHAP Services

Sites identified essential RWHAP services.




Interview Data

# RWHAP Services Received by Newly Insured Clients

Insured services do not always fulfill the range of services or intensity needed.

| Service | Expansion 18 Sites # (%) | Non-Expansion 12 Sites # (%) | Total 30 Sites |
|---|---|---|---|
| Medical Case Mgt | 11 (61) | 4 (33) | 15 (50) |
| Oral Health | 8 (44) | 6 (50) | 14 (47) |
| Mental Health | 7 (39) | 6 (50) | 13 (43) |
| Case Management | 5 (28) | 6 (50) | 11 (37) |
| Nutritional Assistance | 2 (11) | 3 (25) | 6 (20) |
| Transportation | 4 (22) | 2 (17) | 6 (20) |
| Substance Abuse Svc | Reported by less than 20% of either group | | |
| Alternative Care | | | |
| Treatment Adherence | | | |
| Lab Work | | | |
| Social Services | | | |

Interview Data

# OAMC Use

8.0% decrease in OAMC services in expansion state sites. Other core medical services and support services, showed little change.

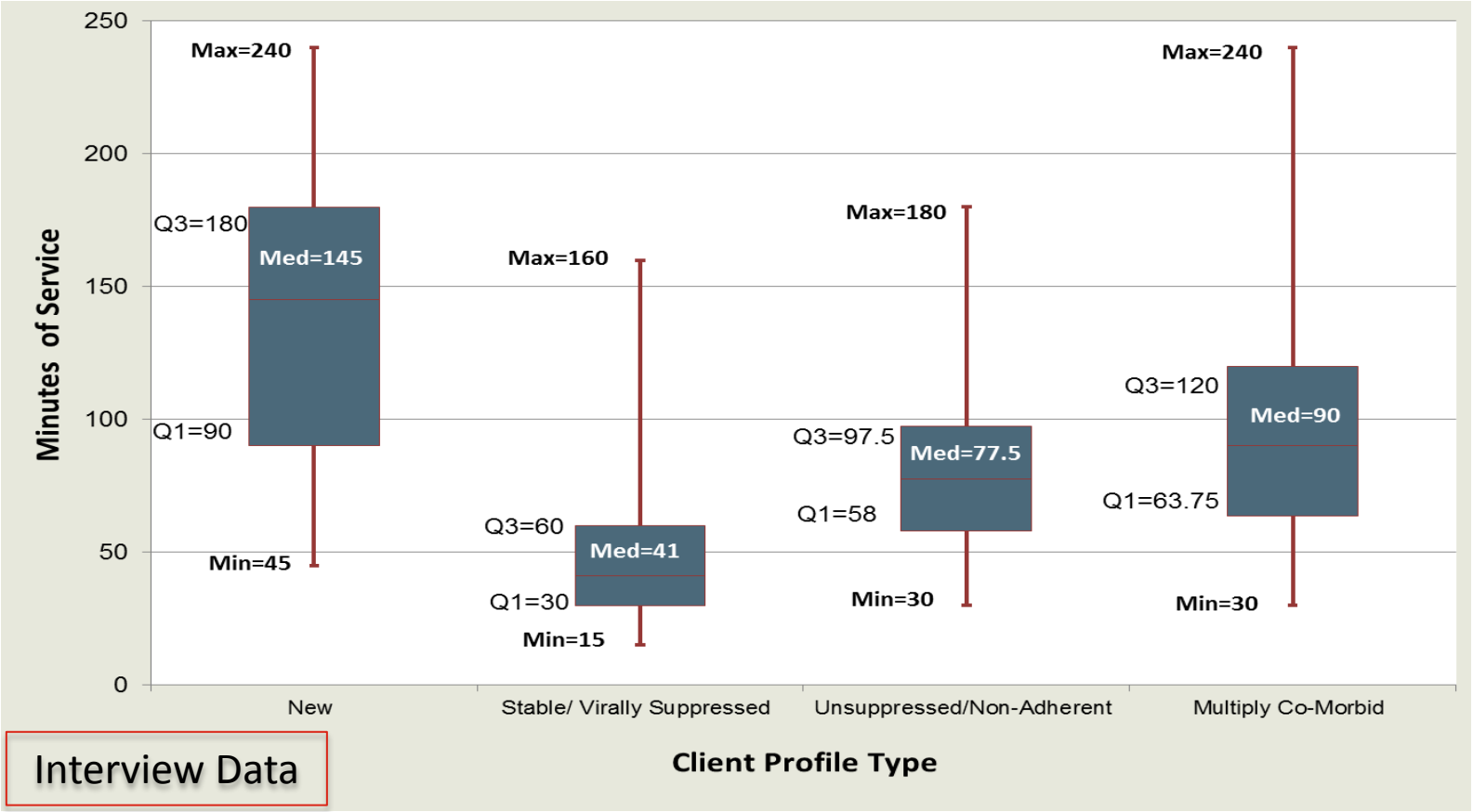
| | 2013 | 2014 | Change[1] |
|---|---|---|---|
| **OAMC Services** | | | |
| **Expansion** | 59% | 55% | -8.0%* |
| **Non-Expansion** | 59% | 57% | -3.0% |
| **Other Core Medical Services** | | | |
| **Expansion** | 71% | 70% | -2.0% |
| **Non-Expansion** | 62% | 63% | 1.0% |
| **Support Services** | | | |
| **Expansion** | 46% | 47% | 1.0% |
| **Non-Expansion** | 68% | 67% | -2.0% |

Preliminary RSR Data

[1]No statistically significant differences in 2013-2014 changes between expansion & non-expansion sites. *p<0.05

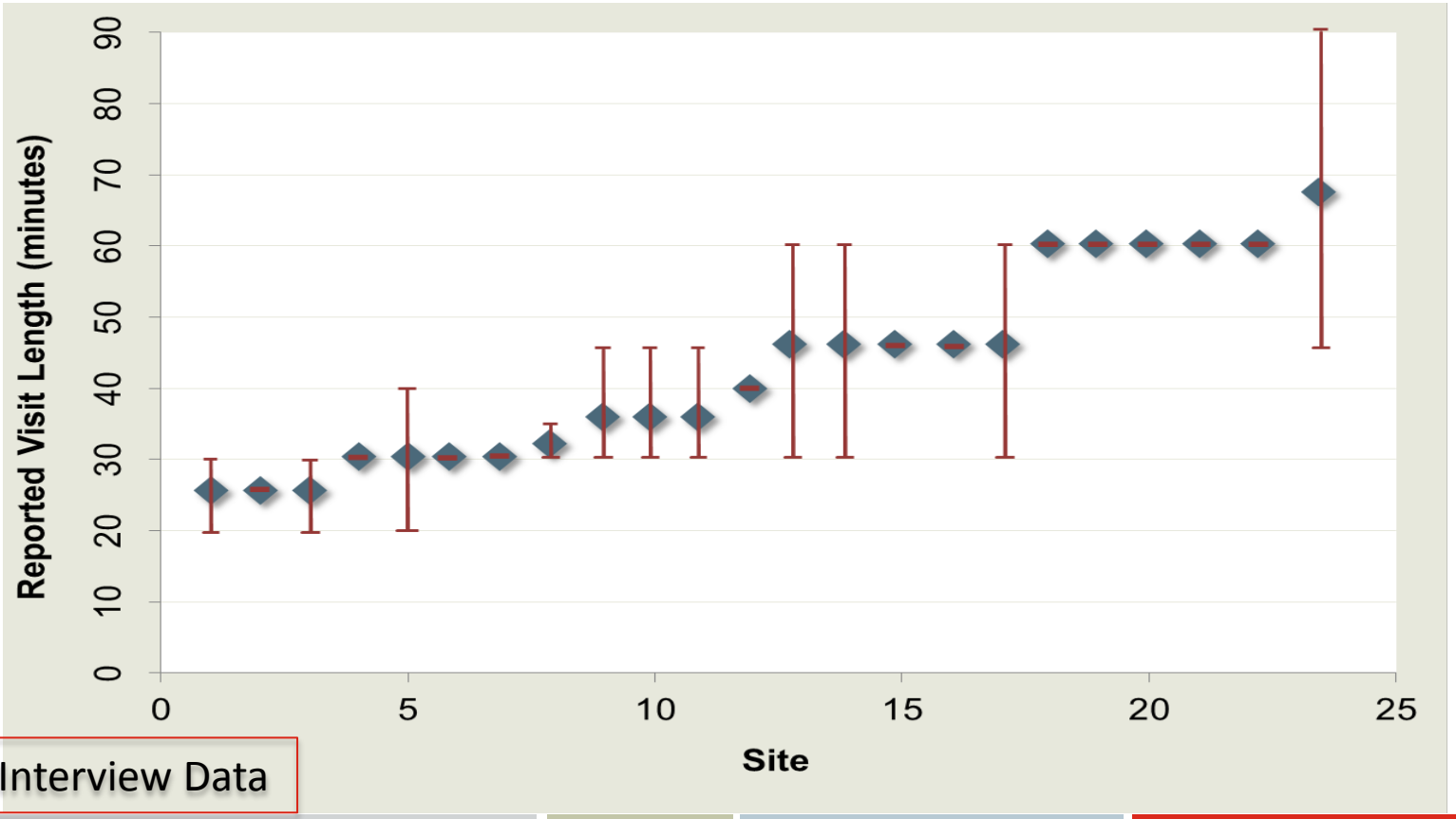
# Service Visit Length

Clinic visits can vary in length from 15 minutes to four hours, the median times reported ranged from 41 minutes to 145 minutes.



# OAMC Visit Length

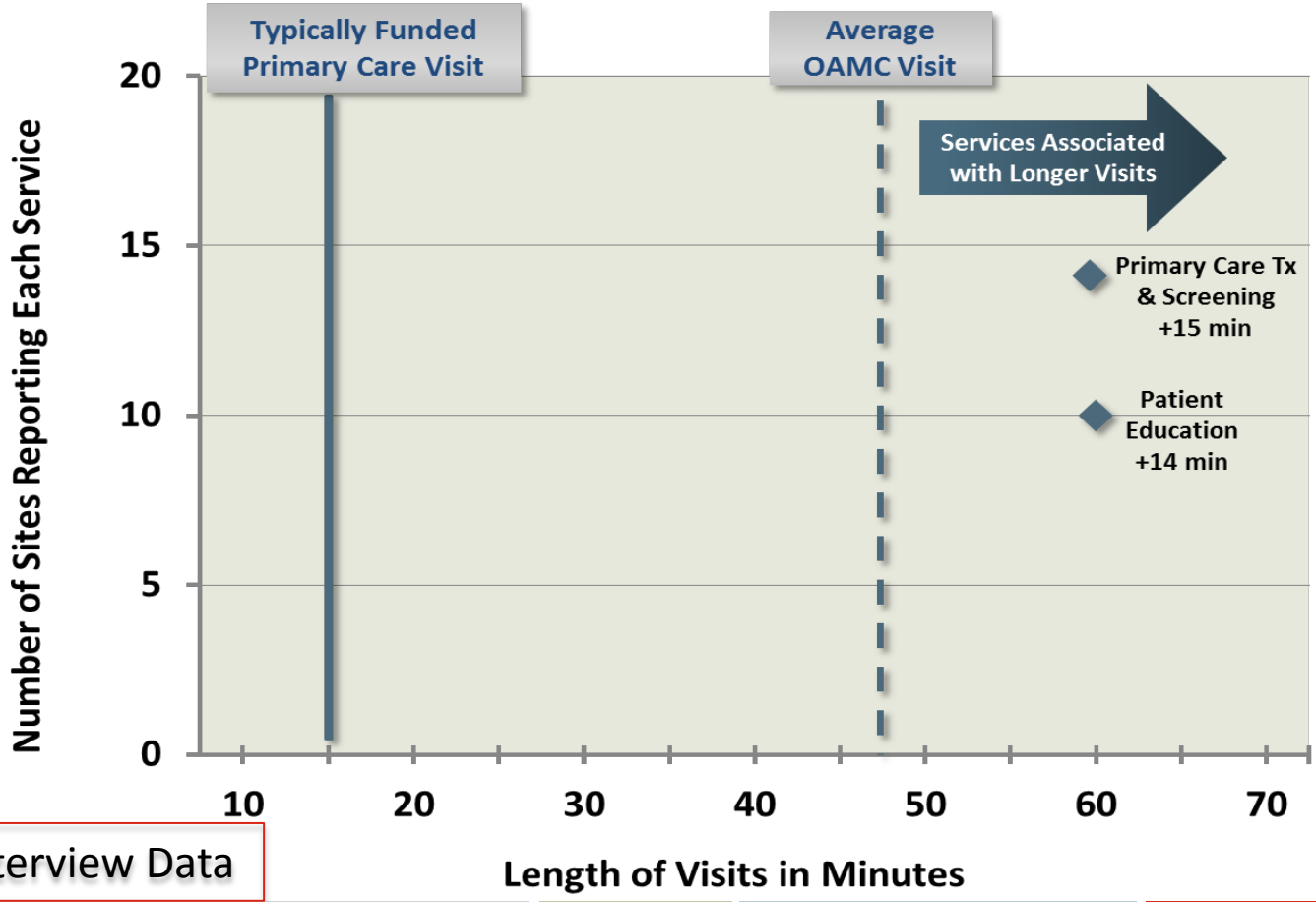
OAMC visit times ranged from 20-30 minutes to 45-90 minutes; average length across sites 47 minutes. Variability in length is due to the number and type of activities considered part of the OAMC visit reported by different sites.




Interview Data

# Drivers of OAMC Visit Length

The activities most often associated with longer OAMC times are primary care treatment and screening and patient education.




Interview Data

# Medication Barriers

Denials of certain HIV (and other) drugs and high cost-sharing challenges continued to be reported throughout the first year of ACA implementation

| HIV | HCV | Other |
|---|---|---|
| Aldara<br>Egrifta<br>Serostim<br>Stribild<br>Tivicay<br>Truvada | Sovaldi | Beclomethasone |

Interview Data

# Selected Findings

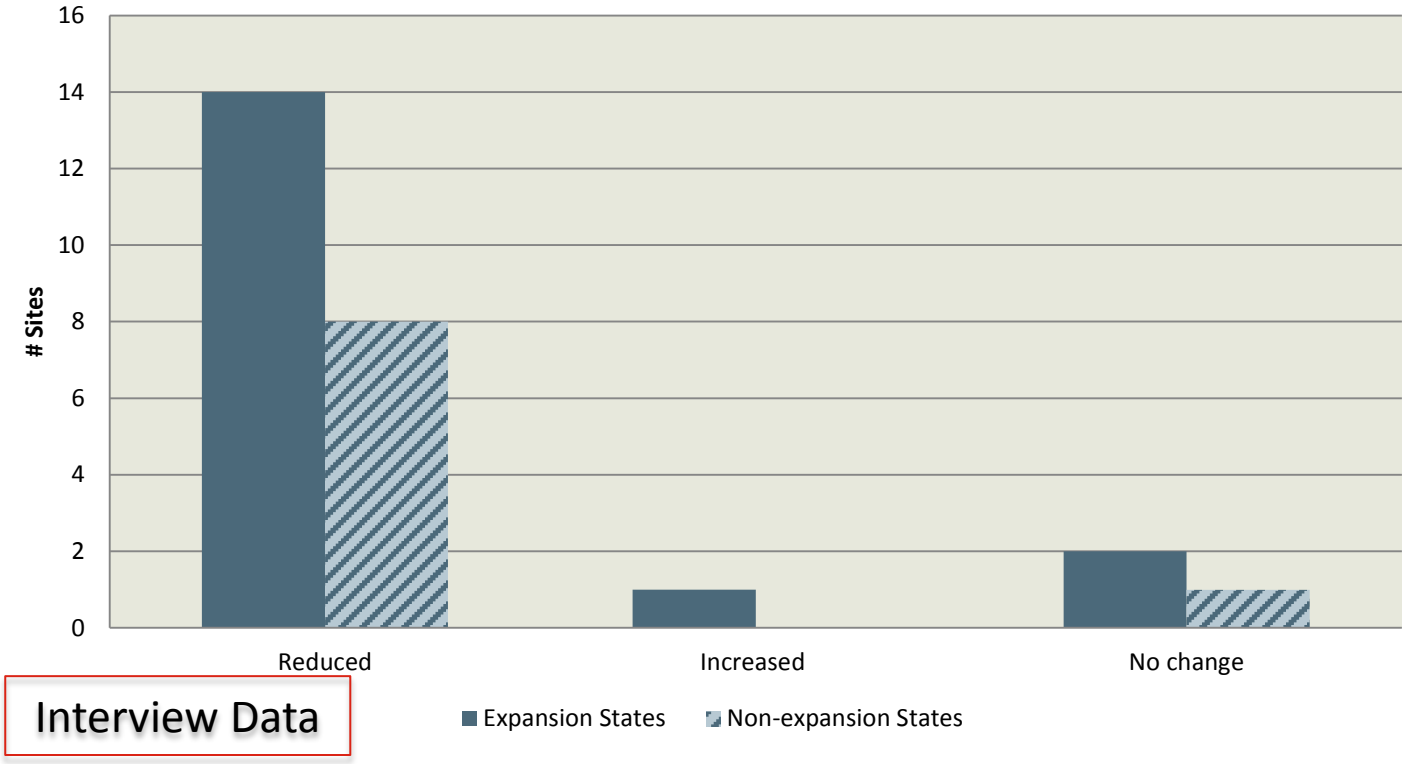
## Client Characteristics and Outcomes

# Change in Numbers of RWHAP Clients Expansion Sites: 2013 to 2014

- No statistically significant change in the numbers of RWHAP clients in either the expansion or non-expansion groups despite fluctuations within sites.

# Rates of Uninsured Clients

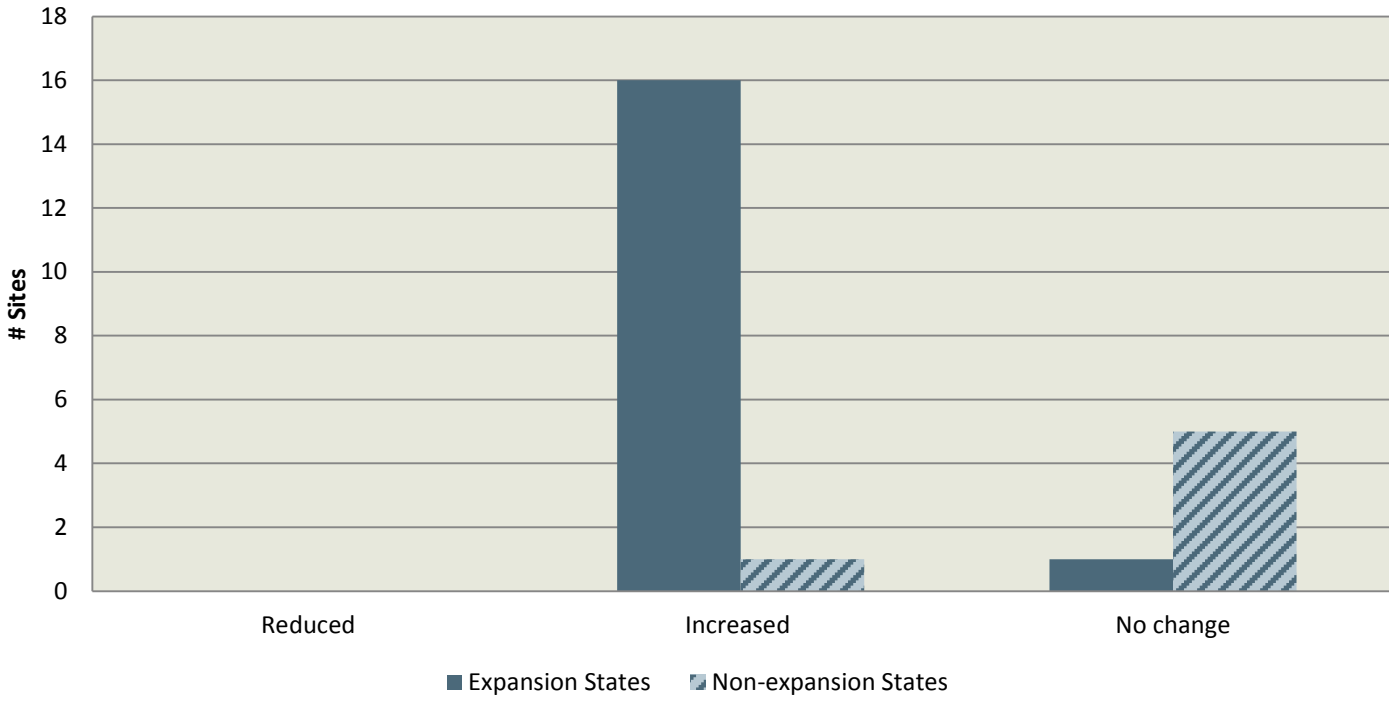
22 sites (73%) reported a reduction in the proportion of RWHAP clients who were uninsured (expansion and non-expansion states).




Interview Data

# Rates of Medicaid Coverage

17 sites (57%) reported an increase in Medicaid recipients.




Interview Data

# Rates of Viral Suppression – Changes from 2013 to 2014

Viral Suppression increased by 7% in expansion state sites between 2013 and 2014; but no statistically significant change in non-expansion sites.

| | 2013 | 2014 | %Change[1] |
|---|---|---|---|
| **Expansion** | 67% | 71% | 7%** |
| **Non-Expansion** | 62% | 64% | 4% |

[1]No statistically significant difference in 2013-2014 change between expansion & non-expansion sites.

**p<0.01

Preliminary RSR Data

# Recommendations

- Parse OAMC Visit into More than One Category
  - First category:  services that HAB expects should be covered by an insurer (e.g., diagnostic testing, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment).
  - Second category: intensive OAMC activities such as prescribing and managing of ARVs, education and counseling on health issues, care management of chronic HIV-related conditions and referral/provision of specialty care (e.g. behavioral health and support needs).
  - Third category: cost-sharing support.

# Recommendations

- Training and TA to RWHAP Grantees and Providers to Help Maximize RWHAP Services
  - Flexibility of HIA and ADAP across Services and Medications.
  - Appropriate Reallocation of Funds for Services now Covered by Insurance.
  - Improving Health Insurance Literacy for Both Providers and Clients.
  - Contracting with MCOs and Marketplace Insurers, including:
    - Billing by different levels of severity to account for longer site visits
    - Contracting with MCOs and Marketplace insurers
    - Getting RWHAP providers designated as Primary Care Providers (PCPs)
    - Obtaining authorizations for medications, services, and testing
- Better categorizing recording and reporting RWHAP services.

# Questions?

# Thank You