POLICY AND PRACTICE
HIV/AIDS and Health Care Reform: Implications for Safety-Net Clinics
HIGHLIGHTS

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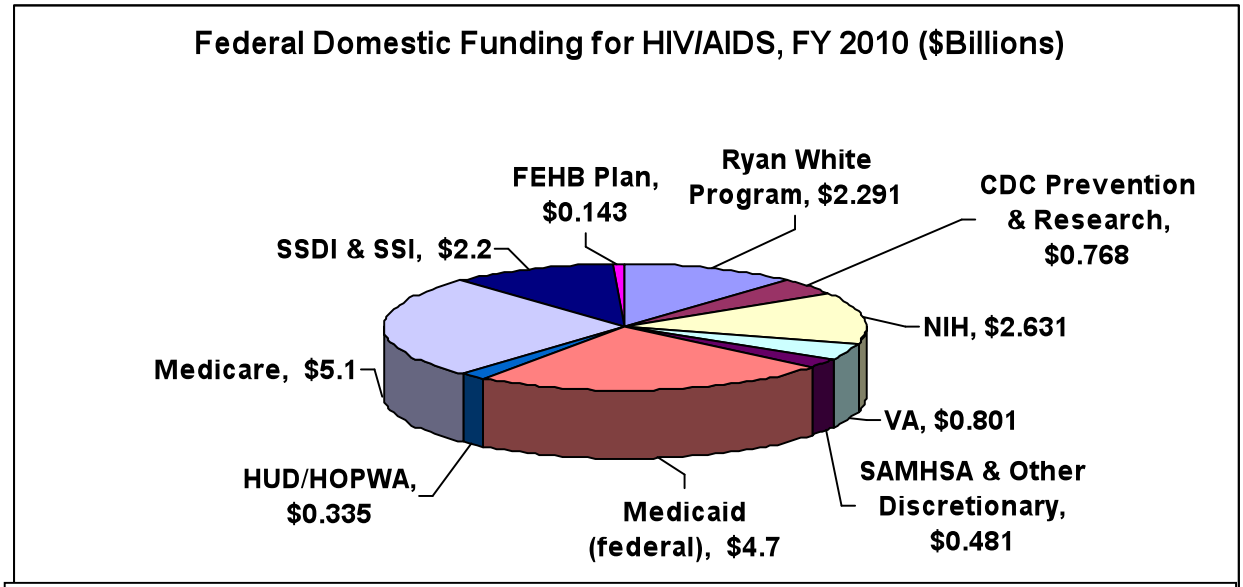
Background: The implementation of the Patient Protection and Affordable Care Act (ACA) will create fundamental changes in the structure and delivery of health care in the United States. Implications will be particularly significant for lower-income Americans and for individuals with chronic health conditions – including people living with HIV and AIDS (PLWHA). This summary highlights how health care reform is likely to affect the system of community-based HIV/AIDS services, with a special focus on implications for safety-net clinics that provide HIV/AIDS prevention, testing, and/or care. It is a summary of a larger Policy and Practice analysis requested by the Regional Primary Care Coalition (RPCC), a learning community of associations of safety-net clinics and health care funders in the Washington, DC region, and prepared by Mosaica: The Center for Nonprofit Development and Pluralism, a values-based nonprofit that works extensively with HIV/AIDS programs and safety-net clinics in the Washington, DC area and nationally.



Source: "U.S. Federal Funding for HIV/AIDS: The President's FY 2011 Budget Request," Table 2. Kaiser Family Foundation, HIV/AIDS Policy Fact Sheet, February 2010.

Health Care Reform and HIV/AIDS: The United States currently invests more than $19 billion a year in federal funds for domestic HIV/AIDS research, prevention, testing, care and treatment. The Ryan White Program is the largest HIV/AIDS-specific funding source, but Medicare and Medicaid are the two largest sources of funds for HIV/AIDS services, primarily care and treatment.

Key ACA Provisions for HIV/AIDS Care: Health care reform will significantly increase access to health care for most lower-income Americans, primarily by enabling them to obtain public or private insurance. This is true for people living with HIV/AIDS (PLWHA) – both low- income people who cannot afford to pay for their health care and individuals who have some resources but have been "uninsurable." Key ACA provisions most affecting HIV/AIDS services include the following, as detailed in Figure 1.

- Prevention: Elimination of cost sharing and provision of incentives to states to provide preventive services, including HIV testing and access to certain vaccines through Medicaid, and similar requirements for Medicare and new private insurance plans
- Care and treatment:
  - Medicaid expansion to cover individuals with incomes up to 133% of the federal poverty level and elimination of categorical requirements
  - Gradual closing of the Medicare "donut hole" that required recipients to pay 100% of their drug costs after they reach a specified maximum and before they reach the "catastrophic" coverage level
  - Removal of insurance exclusions for people with pre-existing conditions
  - Elimination of lifetime caps on coverage
  - Establishment of insurance exchanges that provide federal subsidies to help people purchase health insurance

Figure 1: Overview of ACA Provisions Affecting HIV/AIDS Prevention and Care & Treatment[1]

Pre-Health Care Reform	Under Health Care Reform
Prevention	
• Limited coverage of preventive care under both public and private insurance • CDC recommendations issued in 2006 for routine HIV testing in all healthcare settings, but implementation limited and varied	Increased preventive services including HIV testing supported through elimination of cost sharing and provision of incentives to states to provide preventive services including testing through Medicaid and Medicare **Specifics:** • Increased funding for prevention, wellness, and public health activities, through appropriation of $7 billion for FY 2010–2015 and $2 billion annually after FY 2015; includes prevention research, health screenings, immunizations, and education and outreach • Preventive services to be covered if they receive *A* or *B* recommendations from the U.S. Preventive Services Task Force (USPSTF)[2]

[1] Various analyses consulted; information confirmed on federal website, Understanding the Affordable Care Act Provisions, http://www.healthcare.gov/law/provisions/index.html.

[2] USPSTF is an independent panel of non-federal health care experts that evaluates scientific evidence on clinical preventive services such as screening, counseling, and preventive medications, and develops recommendations for primary care clinicians and health systems. The recommendations are published in the form of "Recommendation Statements" that are available at www.uspreventiveservicestaskforce.org. Recommendations have letter grades from *A* through *D* or an *I* statement if evidence is insufficient. An *A* rating indicates that "there is high certainty that the net benefit is substantial"; a *B* rating indicates that "there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial." The "suggestion for practice" for both *A* and *B* recommendations is "offer to provide this service."

Pre-Health Care Reform	Under Health Care Reform
	• Vaccines to be covered if they are recommended by the Advisory Committee on Immunization Practices (ACIP) • USPSTF *A* recommendations for HIV testing by all clinicians for all adolescents and adults at increased risk for HIV as well as all pregnant women
Medicaid	1% increase in federal match (Federal Medical Assistance Percentage) provided to states that offer Medicaid coverage and remove cost sharing for USPSTF *A* and *B* recommended services and ACIP recommended immunizations, as of 2013
Medicare	• Cost sharing eliminated for Medicare-covered preventive services that are A and B recommended by USPSTF • Secretary of Health and Human Services (HHS)authorized to modify Medicare coverage of preventive services based on USPSTF recommendations
Private Insurance	New health plans required to cover certain preventive services without cost-sharing for plans or policy years beginning September 23, 2010, including: • Preventive care for infants, children, and adolescents recommended by Health Resources and Services Administration (HRSA) • Additional preventive care and screenings for women recommended by HRSA • ACIP-recommended vaccinations • Evidence-based services/items rated *A* or *B* by the USPSTF
Care and Treatment	
Medicaid • Eligibility is categorical (e.g., pregnant women, women with children under 18) – poverty alone is insufficient • Income eligibility varies by state • Most people with HIV/AIDS are not eligible unless they become disabled	• Eligibility based on income, without categorical requirements • Minimum income limit of 133% of federal poverty threshold • Implementation required as of January 1, 2014, and permitted any time after April 1, 2010 at state option • Requirement for coverage continues through 2019 • Federal government to provide 100% federal match for newly eligible from 2014-2016, gradually reduced to a permanent federal match of 90% in 2020 • Temporary reimbursement for Medicaid providers at higher Medicare rate in 2013 and 2014 • Medical Home Demonstration Projects including a Medicaid State Plan Option that provides an enhanced Federal Medical Assistance Percentage (FMAP) – the federal share of costs – for states that enable Medicaid enrollees with two chronic conditions to choose a qualified provider (which could be a safety-net clinic) as their medical home. States could use this option to serve Medicaid enrollees with HIV/AIDS and another chronic medical condition

Pre-Health Care Reform	Under Health Care Reform
Medicare • Eligibility if <65 only with long-term disability • Donut hole in prescription drug coverage – once donut hole was reached, recipient paid 100% of drug costs until a specified total was reached and participant qualified for catastrophic coverage, with 5% copay for rest of year • Ryan White funds not permitted to be used to cover True out-of-pocket (TrOOP) expenses for medications or help fill donut hole	• Donut hole closing gradually – as of 2011, 50% discount for recipients on brand-name drugs and biologic drugs and 7% discount on generic drugs and some Ryan White medical-related supplies. Discounts to increase until 2020, when donut hole is eliminated, though there will be a 25% copay • As of January 1, 2011, Ryan White permitted to pay TrOOP costs such as co-pays and drug costs associated with the donut hole through state AIDS Drug Assistance Program (ADAP)[3]
Private Insurance • HIV-positive individuals generally uninsurable as individuals or in small-employer group policies • Lifetime limits and disease-specific caps on payments permitted • No limits on premiums for those with HIV/AIDS	Changes already in place: • Immediate access (as of July 2010) to subsidized insurance for people who have been denied coverage due to a pre-existing condition through a federal or state Pre-Existing Condition Insurance Plan (PCIP) • Pre-existing condition exclusions for children under 19 eliminated for all group insurance plans and all new individual plans issued after March 23, 2010 (becomes effective for plan and policy years beginning after September 23, 2010) • Lifetime payment caps eliminated on policies issued or renewed as of September 23, 2010 • Children able to stay on parents' insurance until age 26 (effective for any plan or policy year beginning after September 23, 2010) Changes as of January 1, 2014: • Insurance exchanges to be established – state can establish its own or use the federal exchange – Under exchanges, subsidies provided for citizens and eligible legal residents earning 100% to 400% of the federal poverty threshold – both premiums and cost sharing (such as copays) – Differences in premium permitted only based on age, geography, and smoking history, not health status or pre-existing conditions • No pre-existing condition exclusions for adults • Insurance coverage required for routine costs associated with participation in clinical trials

[3] Letter to Ryan White grantees from Dr. Deborah Parham Hopson, Assistant Surgeon General and Deputy Administrator, HRSA, authorizing Ryan White payment of true out-of- pocket (TrOOP) expenses under Medicare as of January 1, 2011.

Implications for Ryan White Programs and Providers: The client base and roles of the Ryan White Program will change significantly affected as various components of health care reform are implemented – although the precise nature of these changes is not yet known.

Ryan White is by law the "payer of last resort" for PLWHA with limited incomes who are unable to obtain these services through Medicaid, Medicare, private insurance, or other third-party payer sources. In 2014, once Medicaid expansion occurs and health insurance exchanges are implemented, many of the lowest-income Ryan White clients will become eligible for Medicaid, and others will receive federal subsidies to purchase health insurance through the exchanges. Any state that has been using state general funds to provide health care to low-income individuals previously not eligible for Medicaid will realize considerable savings by transferring these individuals to Medicaid. The average cost per client for HIV/AIDS medications alone is $12,000 per year.[4] Moving such clients off Ryan White funds will make resources available for new clients who are not Medicaid-eligible.

The District of Columbia and Connecticut were the first jurisdictions to implement Medicaid expansion. DC began the transition in fall 2010 and obtaining a waiver to include individuals with incomes up to 200% of poverty. At least 35,000 uninsured individuals formerly covered through the DC Healthcare Alliance (with DC general funds) had been transferred to Medicaid by early 2011. The District estimates savings of $56 million over the next four years.[5] Minnesota and California will begin their transitions to Medicaid in 2011.

Nationally, the number of PLWHA now served by Ryan White will be served under Medicaid as a result of the expansion is expected to be substantial. Ryan White does not yet have unduplicated client data.[6] The HIV/AIDS Bureau estimates that the program serves more than 529,000 PLWHA each year. About one-third of Ryan White clients have no insurance (52% have Medicaid, Medicare, or some other form of public insurance) and about 56% of clients have incomes below the federal poverty level.[7] A substantial minority of Ryan White clients – perhaps 175,000 nationally – may be enrolled in Medicaid by 2014. In Washington, DC, an estimated 1,000 PLWHA had been transferred to Medicaid by the end of January 2011.[8] The Los Angeles Ryan White Part A program estimates that 12-15% of current Ryan White clients will move to Medicaid managed care in 2011. By 2014, after insurance exchanges are implemented, up to 70% of Los Angeles County's Ryan White clients are expected to receive medical care outside the Ryan White system.

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[4] Kevin Sack, "Economy Hurts Government Aid for H.I.V. Drugs," *New York Times,* June 30, 2010.
[5] Darryl Fears, "Mental health providers grapple with Medicaid expansion," *Washington Post,* October 12, 2010.
[6] Currently each Ryan White provider reports unduplicated data on its clients, but an individual who receives services from three different providers is counted three times in the Ryan White Data Report (RDR). The legislation requires a transition to client-level data, so unduplicated client data should be available in the next 2-3 years.
[7] Ryan White 2008 State Profiles; available at http://hab.hrsa.gov/stateprofiles/index.htm#.
[8] Personal communication with staff of the HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA) within the DC Department of Health.

The transfer creates a number of HIV-related challenges. *Some* PLWHA will have to change medical providers if their physicians and clinics are not Medicaid providers or do not have contracts with their Medicaid Managed Care Organization (MCO). This creates a danger that some may drop out of care. Medicaid reimbursement rates in many states are well below the Ryan White rate, so some providers, particularly private-practice physicians, are expected to refuse to participate. Generally, safety-net clinics that are *not* Community Health Centers or Federally Qualified Health Centers (CHCs/FQHCs)[9] receive a higher level of funding per unit of service from Ryan White than from Medicaid reimbursement, so non-FQHC providers are likely to lose income when PLWHA move from Ryan White to Medicaid, including Medicaid managed care. Some PLWHA will continue to need wraparound services from Ryan White, but only 25% of service funds may be used for support services.

Some Ryan White clients will not be eligible for Medicaid or for subsidies through the insurance exchange. Some will be excluded due to their immigration status. Others will have incomes too high to qualify for federal subsidies in the insurance exchanges. Income limits for Ryan White eligibility are set by state and local programs, but typically range from 200% to 500% of the federal poverty level, depending on jurisdiction (The 2011 federal poverty level is $10,890 for an individual and $22,350 for a family of four[10]). Eligibility for Ryan White medical and support services in the jurisdictions within the National Capital Region is shown below. PLWHA receiving care through Ryan White with incomes too high to qualify for either Medicaid or the exchange may be able to afford private health insurance through PCIPs or through private insurers once pre-existing condition exclusions are eliminated.

Figure 2: Income Eligibility for Ryan White Programs in the National Capital Region

Jurisdiction	Ryan White Program Eligibility – Percent of Federal Poverty Level	
	Core Medical & Support Services	Medications – ADAP (Set by the State)
Washington, DC[11]	500%	500%
Northern Virginia[12]	333%	400%
Suburban Maryland[13]	500%	500%

Implications for Safety-Net Clinics: Safety-net clinics play a large and growing role in the delivery of both HIV testing and HIV/AIDS care and treatment. Their role is

[9] Community Health Centers, along with migrant, homeless, and public-housing-based health centers, are authorized under section 330 of the Public Health Service Act. Federally Qualified Health Centers include other health centers that meet the same eligibility requirements and receive funds through section 330. FQHC look-alikes meet the same requirements but are not funded under section 330. FQHCs and look-alikes are defined under the Medicare and Medicaid statutes and receive enhanced Medicare and Medicaid reimbursements and other benefits.
[10] *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-63.
[11] DC Department of Health, HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration, Notice of Funding Availability, FY 2011 [Ryan White] Part A, Client Eligibility, p 9.
[12] Northern Virginia Regional Commission, Ryan White Income Guidelines & Eligibility, NVRC website, http://www.novaregion.org/index.aspx?NID=902.
[13] Specified in the Ryan White Part A Suburban Maryland RFA, 2011, http://www.co.pg.md.us/Government/AgencyIndex/Health/ryanwhiterfa.asp.

strongly influenced by the current structure of HIV/AIDS funding and service delivery – and is likely to change significantly as that structure is fundamentally changed through the implementation of various ACA provisions between 2011 and 2014.

Medicaid expansion and the establishment of insurance exchanges will mean the transition of a significant number of Ryan White Program clients to Medicaid and to private insurance. Community Health Centers/Federally Qualified Health Centers (CHCs/FQHCs) already engaged in HIV/AIDS care can continue to serve their HIV clients and receive enhanced Medicaid reimbursement rates from both Medicaid and insurance companies that are part of the exchanges. Their greatest challenges are likely to be managing increased demand for services. The situation is more complex for other safety-net clinics. Some have the capacity to manage complex third-party reimbursements, are Medicaid-eligible, and have or can establish contractual relationships with Medicaid Managed Care Organizations (MCOs) and private insurance providers. They will have opportunities to expand third-party reimbursements and may fare well under ACA. However, compared to CHCs/FQHCs, they will receive a much lower Medicaid reimbursement rate, often providing less revenue than their Ryan White contracts. Some of these clinics will choose to seek FQHC status, taking advantage of planning grants and other resources for increasing the number of CHCs/FQHCs. Others may be able to contract with CHCs/FQHCs and take advantage of their reimbursement rates and relationships.

Some clinics will face different challenges. Most free clinics, many public clinics, and some other nonprofit clinics do not accept third-party reimbursements, but do receive Ryan White funding. These clinics could suffer financially through the loss of grant or contract funds. They will lose some PLWHA clients who will need to find primary care providers that accept third-party reimbursements and are a part of their MCO or insurance plan network or are Medicaid-eligible. Other Ryan White provider clinics would like to obtain third-party payments but lack the internal systems to manage complex documentation and reporting. They will need to develop this capacity. An unknown for all clinics is the effect of health care reform on private donations.

Broader Implications of Health Care Reform for Safety-Net Clinics: The benefits and challenges related to PLWHA services reflect the broader implications of health care reform for safety-net clinics – particularly the centrality of third-party reimbursements as a way to be a part of expanded public and private insurance coverage. Figure 3 summarizes some key ACA provisions that will affect safety-net clinics.

Figure 3: Potential Benefits for Safety-Net Clinics under Health Care Reform[14]

Type of Safety-Net Clinic	Health Reform Provisions
Community Health Centers/Federally Qualified Health Centers (CHCs/FQHCs)	• $11 billion authorized and appropriated over five years for expansion of community health centers/FQHCs – Includes $9.5 billion to expand the operational capacity of current CHCs to serve almost 20 million new patients and to expand medical, mental health, substance abuse, and oral health services

[14] See HIV and Health Centers, www.nachc.org/clinicalhiv.cfm.

Type of Safety-Net Clinic	Health Reform Provisions
	– Includes $1.5 billion in capital for facility improvements and construction of new facilities • Insurance plans that are part of the health insurance exchange required to pay FQHCs a rate at least equal to their Medicaid PPS (prospective payment system) rate, rather than a fixed Medicaid reimbursement rate
Free Clinics	Expansion of medical malpractice coverage through the Federal Tort Claims Act, which already covered CHCs/FQHCs, to cover "an officer, governing board member, employee, or contractor of a free clinic" (Volunteer health care providers were already covered)
Other Safety-Net Clinics	Opportunity to apply for FQHC status under health center expansion financed through ACA
All Safety-Net Clinics	Opportunities for additional third-party reimbursements as a result of increase in the number of individuals with health insurance coverage resulting from Medicaid expansion and the health insurance exchange

The ACA and Community Health Workers: The ACA includes several provisions that may encourage the training and employment of community health workers (CHWs), including peers. CHWs have been engaged in HIV/AIDS prevention, testing, and care since the beginning of the epidemic, and play many other roles in health care as employees and volunteers of all kinds of health care providers, including safety-net clinics. Their value has been well documented in such areas as diabetes care and patient navigation, but they received designation as a unique occupation with a standard occupational code in 2010 (SOC 21-1094).

ACA includes one specific discretionary program specifically involving CHWs in preventive health services and numerous provisions that may support their role in health care. The Community Health Worker Program requires CDC to make grants "to promote healthy behaviors and outcomes for populations in medically underserved communities through programs of training and supervision of CHWs." The program has no specific authorization level, merely "such sums as may be necessary" (SSAN). Public entities are eligible to apply, as are hospitals, CHCs/FQHCs, and free clinics. Preference is to be given to "populations with high uninsurance, chronic illness, or infant mortality."[15] Patient navigator programs can also be used to help support CHWs including peers to assist individuals with HIV/AIDS and other chronic illnesses to navigate the system of care. The ACA reauthorizes a HRSA grant program that supports patient navigators, some of whom might be CHWs, to improve health outcomes for individuals with chronic diseases, with a focus on populations likely to have health disparities. Safety-net clinics are eligible applicants. The ACA also requires patient navigators to assist individuals within the planned insurance exchanges. They will "conduct public education about qualified health

[15] Congressional Research Service, "Discretionary Funding in the Patient Protection and Affordable Care Act," September 2, 2010. Available at https://www.aamc.org/.../**crs**_report_on_aca_**discretionary_programs**.pdf.

plans; facilitate plan enrollment; provide referrals to consumer assistance offices; and, ensure that information is provided in culturally and linguistically appropriate ways."[16]

Issues to Monitor: Areas to monitor include key aspects of health reform planning and early implementation, particularly the lessons from states already implementing Medicaid expansion, including the proportion of Ryan White clients moving to Medicaid and other impacts on HIV/AIDS care and on clinics that are not FQHCs. Also of importance are models for safety-net clinic collaboration to maximize benefits and minimize challenges of health care reform and ways in which ACA expansion of preventive care can be used to increase routine opt-out HIV testing in clinics. Another area for monitoring is ACA's potential for expanding community health worker – especially peer – training and employment opportunities.

[16] National Association of Community Health Centers, Comments to the Secretary of HHS regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, October 3, 2010. Available at www.naccho.org/advocacy/healthreform/upload/exchanges-comments-9-28-10.pdf.