

# POLICY AND PRACTICE

## HIV/AIDS and Health Care Reform: Implications for Safety-Net Clinics

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### Introduction and Summary

**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 Policy and Practice analysis paper provides a national perspective on 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 was 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.

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**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. Because of the central role of public insurance in HIV care, health care reform – which is largely health insurance reform – will fundamentally change the delivery of HIV/AIDS prevention, testing, and care. Because so many lower-income people living with HIV and AIDS (PLWHA) depend on safety-net clinics for care, clinics will strongly influence and be influenced by the changes in the delivery of HIV/AIDS care as a result of health care reform.

**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:

- **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,” which required disabled people living with AIDS to pay about \$3,610 annually in medication copays and deductibles, and a provision that allows the Ryan White Program to pay true out-of-pocket (TrOOP) expenses related to the donut hole for clients on Medicare
  - 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

**Implications for Safety-Net Clinics:** 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)<sup>1</sup> 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

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<sup>1</sup> 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.

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.

CHCs/FQHCs and clinics that want to attain FQHC status will benefit from the \$11 billion ACA investment designed to double CHC/FQHC capacity from 20 to 40 million patients.

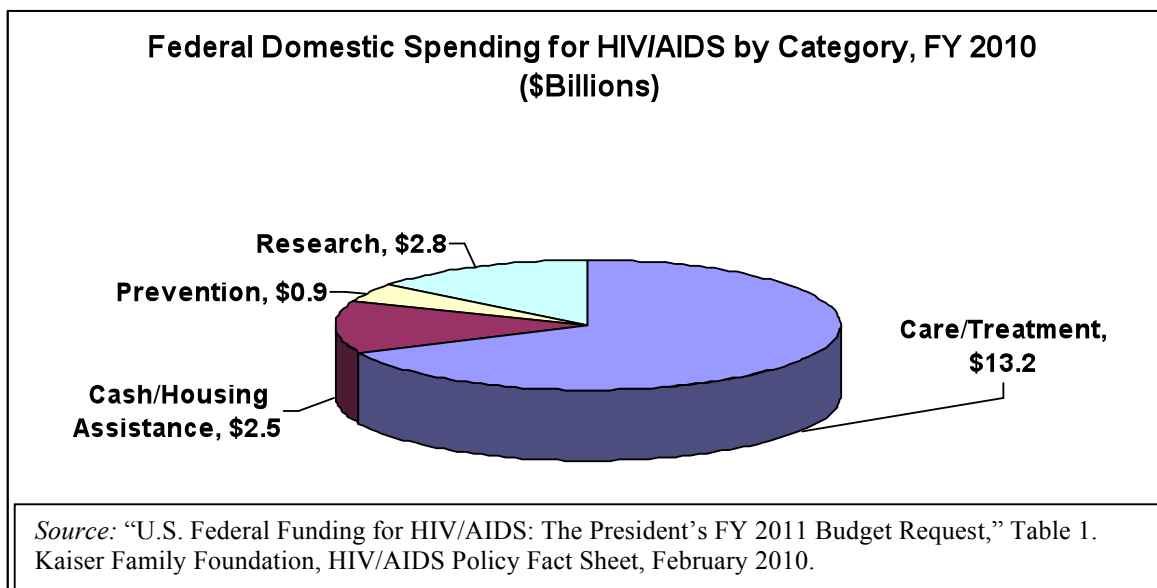
Free clinics will benefit from the expansion of medical malpractice coverage through the Federal Tort Claims Act to include “an officer, governing board member, employee, or contractor of a free clinic” in addition to volunteer health care providers. Other clinics will need to weigh their options and decide whether to seek expanded opportunities for third-party reimbursements.

**Issues to Monitor:** Important issues to monitor include key aspects of health reform planning and early implementation, particularly the lessons from states already implementing Medicaid expansion, including impact on HIV/AIDS care and on clinics that are not FQHCs. This includes exploring models for safety-net clinic collaboration to maximize benefits and minimize challenges of health care reform, and consideration of how 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.

## Structure of HIV/AIDS Funding and Service Delivery

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 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.

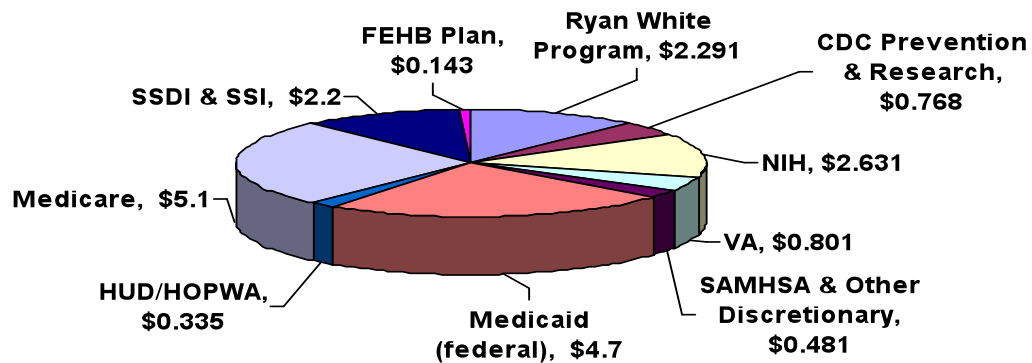
**The U.S. invests a great deal of money in preventing and treating HIV/AIDS.** The funds are used for a variety of purposes and come from a wide range of sources, most of them *not* HIV-specific. As shown in the chart that follows, total federal domestic spending for HIV/AIDS was about \$19.4 billion in FY 2010, with more than two-thirds of those funds going to care and treatment. States, local governments, insurance companies, and private-sector entities like pharmaceutical companies also provide resources for HIV prevention, testing, and care and treatment.



The structures and sources of public funding and delivery of HIV/AIDS services are extremely complex. HIV/AIDS-related funding is largely federal, and comes primarily from several sources within the U.S. Department of Health and Human Services (HHS), through different and not always coordinated channels. The Ryan White Program is the largest source of HIV/AIDS-specific funding, providing more than \$2.3 billion in FY 2010 including \$835 million for the AIDS Drug Assistance Program (ADAP). However, Medicare (\$5.1 billion) and Medicaid (federal share totaling \$4.7 billion) are the largest sources of funds for HIV/AIDS services, primarily for care and treatment. HIV/AIDS funding comes from both discretionary and mandatory/entitlement sources, as shown in the chart below. Many safety-net clinics receive federal funding specifically for HIV prevention, testing, or care, either directly or through state and local governments. Some safety-net clinics that receive no Ryan White funding do obtain substantial third-party reimbursements from Medicare and Medicaid for HIV/AIDS care.

**Funds for Prevention and Testing:** These funds come primarily from the Centers for Disease Control and Prevention (CDC). Most prevention funding comes in a block grant to each state. The state then allocates funds to various programs and parts of the state. The states provide some federal HIV prevention funds to local health departments, but most also fund community-based providers. Health districts and local health departments sometimes subgrant some of their prevention funds to clinics. The CDC also has some competitive prevention programs through which clinics and other community-based nonprofit groups as well as public clinics, hospitals, and universities can apply for direct funding, though funds are limited and the competition is heavy. One current priority for funding through state health departments is programs to support routine opt-out testing for HIV in all types of healthcare facilities, including clinics.

Federal Domestic Funding for HIV/AIDS, FY 2010 (\$Billions)



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.

**Funds for Care and Treatment:** Most recently reauthorized in October of 2009 as the Ryan White HIV/AIDS Treatment Extension Act, the Ryan White Program provides funding through multiple "parts"; safety-net clinics are funded through all five parts:

- *Part A* funds go to metropolitan areas with large numbers of living and new AIDS cases, including Washington, DC. The prime grantee subcontracts to providers, mostly public and nonprofit organizations including safety-net clinics, through competitive requests for proposals (RFPs).
- *Part B* funds go to the states, and then are allocated regionally or subcontracted directly by the state to providers. Maryland, Virginia, and the District of Columbia all receive Part B funding, which includes funds for HIV-related primary medical care and other medical-related and support services. Part B includes ADAP, which provides HIV-related medications.
- *Part C* funds are awarded competitively directly to local providers by the HIV/AIDS Bureau (HAB) for medical care and related services. Many of the grantees are community health centers (CHCs) and other Federally Qualified Health Centers (FQHCs) or FQHC look-alikes or public clinics.
- *Part D* funding is also competitive. Part D has two components: funding for services to women, infants, children, and youth and funding for youth/adolescents. Children's hospitals and safety-net clinics often compete for such funds.
- *Part F* includes Minority AIDS Initiative (MAI) funds, which are awarded on a formula basis along with Part A and Part B grants. Part F also includes AIDS Education and Training Centers (AETCs), which train clinical staff that provide HIV/AIDS care, as well as oral health programs associated with dental schools or based in the community.

## Safety-Net Clinics and HIV/AIDS Services

Safety-net clinics have played a key role in HIV care since the early days of the epidemic, particularly as providers of HIV-related medical care and other core

**medical-related services.** Some services have been supported through Ryan White – particularly Parts C, A, and B. According to the National Association of Community Health Centers (NACHC), about 10% of the nation’s 1,250 community health centers receive funding through Ryan White Part C.<sup>2</sup> Ryan White data indicate that 11% of Ryan White service providers are community and mental health centers and another 43% are other types of community-based organizations.<sup>3</sup> However, Ryan White dollars are not sufficient to meet demand for services. According to the HIV Medicine Association, funding for Part C has grown just 9% since 2001, while the number of patients who rely on clinics funded through Part C has increased 59%.<sup>4</sup> While there have been some increases in funding, particularly for ADAP, Ryan White funding has been increased only slightly, despite the emphasis on bringing additional people into care. The President’s budget request for FY 2011 was for an increase of 1.7% for Ryan White overall and 2.4% for ADAP. Federal funding for HIV prevention fell during most of the last decade, but has increased slightly beginning in 2010; The President requested a 4% increase for FY 2011.<sup>5</sup> Some clinics provide HIV/AIDS services to clients with public insurance and are reimbursed through Medicaid and Medicare (People living with AIDS who are disabled are eligible for Medicare). Care is also supported through a wide range of other funding sources, including general section 330 grants. Some community health centers that have no Ryan White funding provide primary care to people living with HIV and AIDS, while Ryan White pays for specialty care from infectious disease physicians.

**Safety-net are valued Ryan White service providers and partners.** Part C grantees, funded directly by the HIV/AIDS Bureau, are very often FQHCs or look-alikes but may also be other nonprofit clinics or public clinics. Many Part A and Part B programs contract with safety-net clinics for medical care, medical case management, and dental care, as well as other services. The Ryan White legislation has some specific provisions related to clinics. For example, the listing of groups eligible for Part C funds begins with community health centers and specifically includes other community-based nonprofit clinics. Ryan White clients whose incomes are above 100% of the poverty level are expected to pay fees based on a sliding fee scale; clinics are expected to charge these fees and to ensure that no client pays more than the allowable annual maximum fee, depending on income. However, specific waiver provisions ensure the eligibility of free clinics and other safety-net clinics that do not charge fees or accept third-party reimbursements. Generally, Ryan White-funded providers are expected to be Medicaid-certified, to help ensure that Ryan White funds are in fact used as a “last resort,” only when other public or private resources are not available, but this requirement is waived for such clinics. The legislation also provides a waiver that exempts such clinics from the requirement to charge fees based on a sliding scale to clients with incomes above 100% of the federal poverty level.<sup>6</sup>

<sup>2</sup> See HIV and Health Centers, [www.nachc.org/clinicalhiv.cfm](http://www.nachc.org/clinicalhiv.cfm).

<sup>3</sup> HIV/AIDS Bureau, “Ryan White HIV/AIDS Program Annual Data Report (RDR),” 2007. Available at <http://hab.hrsa.gov/stateprofiles/states/us/print.htm>.

<sup>4</sup> “This HIV Testing Day, HIV Clinics Face Funding Shortfall for Lifesaving Patient Care,” June 18, 2010, press release, HIV Medicine Association, [www.hivma.org](http://www.hivma.org).

<sup>5</sup> “U.S. Federal Funding for HIV/AIDS: The President’s FY 2011 Budget Request,” HIV/AIDS Policy, Fact Sheet, February 2010. See <http://www.kff.org/hivaids/upload/7029-06.pdf>.

<sup>6</sup> See Ryan White HIV/AIDS Treatment Extension Act of 2009, Sections 2604(g), 2616(c), 2652(a) and (b), 2654(e).

**Many safety-net clinics are also engaged in prevention and testing.** Since 2003, NACHC has been involved in efforts to increase the involvement of non-Ryan White-funded health centers in HIV prevention, with support from CDC. According to national data submitted to the Bureau of Primary Health Care, community health centers provided HIV testing to 691,280 patients in 2009.<sup>7</sup> Such efforts have increased since 2006, when CDC recommendations for routine opt-out HIV testing in all healthcare settings were issued. Non-FQHCs – including AIDS service organizations, free clinics, and other nonprofit clinics, as well as public clinics – serve as testing sites and sometimes do outreach and testing. However, because there is no single database that reports their efforts, their aggregate engagement in testing is not well documented.

## Overview of Key ACA Provisions Affecting Low-Income People

**Health care reform will affect HIV/AIDS care and safety-net clinics because of its focus on expanding access to prevention and care.** ACA includes several key provisions of great importance for individuals and families with limited incomes, including people with HIV/AIDS. They include the following:

- **Medicaid expansion:** Under ACA, Americans with incomes below 133% of the federal poverty level will be eligible for Medicaid without the current categorical requirements such as pregnancy, disability, or having a child under 18.<sup>8</sup>
- **Expanded preventive care:** Medicaid, Medicare, and private insurance will be required to pay for additional preventive services, including individual wellness plans, screenings, and vaccinations.
- **Closing of the Medicare donut hole:** ACA will gradually fill the gap in Medicare prescription drug coverage that requires recipients to pay for their own medications after an initial level of expenditure is reached and before expenses reach the “catastrophic” expense level.
- **Elimination of insurance exclusion for pre-existing conditions:** Insurance companies will no longer be allowed to deny insurance to individuals with pre-existing conditions.
- **Access to subsidized insurance:** U.S. citizens and permanent residents who have held that status for at least five years and have incomes between 133% and 400% of the federal poverty level will be expected to purchase health insurance through an insurance exchange and will receive an income-based federal subsidy to help pay for it.
- **Community health center expansion:** To increase access to preventive care and treatment, and to help assure that medical homes are available for people who will become eligible for public or publicly subsidized insurance, ACA provides funds to double the service capacity of community health centers from 20 to 40 million people.

<sup>7</sup> See HIV and Health Centers, [www.nachc.org/clinicalhiv.cfm](http://www.nachc.org/clinicalhiv.cfm).

<sup>8</sup> The official level income limit for Medicaid expansion is 133%. However, there is an automatic 5% income “disregard,” so in effect the income limit under Medicaid expansion is 138%, and the insurance exchanges will cover individuals with incomes between 138% and 400% of poverty. This analysis paper uses the 133% level because it is stated in ACA and is used in most analyses, but with a recognition of the additional 5% built into the process. See “The Uninsured; A Primer, Key Facts about Americans without Health Insurance,” Kaiser Commission on Medicaid and the Uninsured, December 2010, available at <http://www.kff.org/uninsured/7451.cfm>.

The remainder of this paper explores the specific provisions and key implications of these components of health care reform for HIV/AIDS services and for safety-net clinics.

## Health Reform and HIV/AIDS

### Overview

**Since health care reform will increase access to health care for most lower-income Americans, it will increase access to health care for people living with HIV/AIDS (PLWHA).** This includes both individuals who are low income and cannot afford to pay for their health care and those who have some resources but have been “uninsurable.” ACA is also designed to reduce health disparities for communities of color – and the HIV epidemic disproportionately affects communities of color, particularly African Americans. ACA is expected to increase PLWHA access to:

- Preventive care such as HIV testing and flu shots
  - Medical care and medications as well as some support services
  - Private health insurance obtained individually or through a small employer group
- Most of the ACA provisions affect PLWHA as part of larger populations of individuals with chronic illnesses and/or people with limited incomes.

### Context

**Health care reform is occurring at the same time as other important changes in HIV/AIDS services and systems, positive and negative.** These include:

- CDC 2006 recommendations for routine opt-out HIV testing in all healthcare settings
- The National HIV/AIDS Strategy (NHAS) and related federal implementation plan
- Attempts to manage HIV/AIDS as a chronic illness, with focus on early treatment and front-loaded efforts to teach disease self-management
- Initiatives designed to increase safety-net clinic involvement in HIV/AIDS services
- Efforts to maintain or expand treatment capacity and meet new legislative requirements for outreach and testing at a time of state and local budget limitations
- Increased use of community health workers (CHWs), especially peers, in HIV prevention and care

**CDC recommendations for routine opt-out HIV testing:** These revised recommendations, issued in September 2006, urge that “In all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13-64 years.” Individuals should know that they are going to be screened and should have the opportunity to refuse screening; they need not receive pre-test counseling. Routine screening as part of a medical examination is relatively low cost and will lead to earlier detection, earlier entry into care, improved medical outcomes, and reduced transmission. People who know their status are less likely to engage in risky behaviors. Research also indicates that PLWHA whose medications have led to viral suppression (undetectable viral loads) are less likely to infect others if they engage in risky behaviors.<sup>9</sup>

<sup>9</sup> Kevin M. DeCock, et al., “Preventing HIV transmission with antiretrovirals,” *Bulletin of the World Health Organization* 2009; 87:488-488. Available at <http://www.who.int/bulletin/volumes/87/7/09-067330/en/index.html>.

**National HIV/AIDS Strategy:** Issued by the White House Office on National HIV/AIDS Policy (ONAP) in 2010, the Strategy identifies three goals:

- Reducing new HIV infections
- Increasing access to care and improving health outcomes for people living with HIV
- Reducing HIV-related health disparities

A key focus in working towards these goals is achieving a more coordinated national response to the HIV epidemic. A federal implementation plan has been developed, and the various public agencies all have action steps to implement. New, collaborative initiatives are emerging.

**HIV/AIDS as a chronic illness:** In the early days of the epidemic, an HIV/AIDS diagnosis was usually a death sentence. As treatments were developed, survival rates improved. Antiretroviral therapy has been available for well over a decade, and PLWHA who enter care promptly and adhere to treatments can live long and productive lives. Physicians such as the HIV/AIDS Bureau's Deputy Administrator, Dr. Laura Cheever, now describe HIV/AIDS as a chronic illness. Effective treatment can be facilitated by adoption of some of the practices effective in treating other chronic diseases such as diabetes – among them a “front-loaded” effort to educate people about the disease, provide appropriate medications early, and encourage disease self-management. The current HIV/AIDS system of care reflects a medical model, but not yet a chronic care model. Service systems are often based on the assumption that PLWHA will continue to need wraparound services indefinitely, and do not educate PLWHA on how to navigate the health care system, emphasize disease self-management, or make full use of peers or other community health workers to connect people to care and help keep them in care.

**Initiatives to increase safety-net clinic involvement in HIV/AIDS services:** Both the federal HIV/AIDS Bureau (HAB) and the Bureau of Primary Health Care (BPHC) – two components of the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS) – are supporting efforts to increase the involvement of safety-net clinics in HIV care. The focus is primarily on CHCs/FQHCs and FQHC look-alikes. HealthHIV, in cooperation with NACHC, was funded in September 2010 to run the AIDS Education and Training Center (AETC) National Center for HIV Care in Minority Communities. Its purpose is to “develop, improve, and enhance the organizational capacity of non-Ryan White funded community health centers (CHCs) to provide primary medical care and treatment to racial and ethnic minorities living with or affected by HIV/AIDS.” BPHC held a national technical assistance call on January 31, 2011, on the National HIV/AIDS Strategy and “Improving HIV/AIDS Care in the Health Center Community;” focus was on how health centers can become more engaged in HIV/AIDS care and help meet the NHAS goals.

**Maintaining and expanding treatment capacity:** About 56,000 people become infected with HIV each year,<sup>10</sup> and about 16,000 die. Each year there are about 40,000 more people living with the disease. The 2009 Ryan White legislation continues to focus on addressing unmet need – finding people who know they are HIV-positive but are not

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CDC Revised Recommendations, op. cit.

<sup>10</sup> Hall H.I., Song R., Rhodes P., *et al.* Estimation of HIV incidence in the United States. *JAMA* 2008;300(5):520-529.

receiving HIV-related primary medical care and helping them enter and remain in care. It adds a new responsibility for Ryan White programs, Early Identification of Individuals with HIV and AIDS (EIIHA), finding individuals who are unaware of their HIV status, getting them tested, and helping those who test positive enter and remain in care. Success will mean a continuing increase in the number of people entering care – creating major challenges for both providers and funders of care. These priorities come at a time when many states and local government face major budget crises that have led to cuts in their expenditures for ADAP and other HIV/AIDS services. As of January 20, 2011, ten states including Virginia had waiting lists for ADAP that included a total of 5,550 people who need HIV/AIDS drugs, have no other way to obtain them, and qualify for Ryan White assistance. Eight of these states plus 11 others had taken cost-containment measures such as reducing the drug formulary, capping enrollment, or reducing financial eligibility (in some cases removing clients who previously obtained their medications through ADAP, in other cases retaining current clients but applying the lower limits to new applicants).<sup>11</sup>

**Increased use of community health workers, especially peers, in HIV prevention and care: Over the past decade, the HIV/AIDS Bureau has funded several initiatives to encourage and** support the use of peer community health workers – individuals who are themselves HIV-positive – in HIV care. These include several Part F SPNS grants to develop peer models and training materials and cooperative agreements to engage Ryan White consumers in bringing other PLWHA into care.<sup>12</sup> In February 2009, HAB’s Division of Training and Technical Assistance (DTTA) held a consultation on the *Utilization of Peers in Ryan White Programs as Part of the Interdisciplinary Care Team*.<sup>13</sup> A “Dear Colleague” letter to Part A and Part B programs from the head of DTTA in 2010 noted that “The consensus opinion of the meeting, as described in the proceedings report, was that peers are uniquely positioned to effectively engage and help retain PLWHA in care and treatment programs and, further, with appropriate training and supervision, they make remarkable contributions to the interdisciplinary team. The rewards of placing peers on interdisciplinary teams bring benefits to all patients and their families, clinical and support services providers, line staff, and the peers themselves.” The letter, written after the 2009 Ryan White reauthorization with its focus on HIV-positive unaware individuals, also noted that: “HAB supports these efforts as important ways to meet legislative requirements for reducing unmet need. Such strategies will likely become even more important as we strive to meet new legislative requirements related to identifying individuals who do not know their status and making them aware of their status, with referral and linkage to care for those who are seropositive.”<sup>14</sup>

<sup>11</sup> The ADAP Watch, January 20, 2011. National Association of State and Territorial AIDS Directors (NASTAD), [http://www.nastad.org/InFocus/InfocusResultsDetails.aspx?infocus\\_id=355](http://www.nastad.org/InFocus/InfocusResultsDetails.aspx?infocus_id=355).

<sup>12</sup> The PEER (Peer Education & Evaluation Resource) Center at Boston University (<http://peer.hdwg.org/>) and Cicatelli Associates and its Peer Advocates Program in New York (<http://www.cicatelli.org/PeerMDHT/>) have developed models and training manuals to support peer programs. Mosaica’s cooperative agreement, Project Consumer LINC (Linking Individuals to Needed Care), works with Part A and Part B programs and planning bodies to implement four different volunteer- and staff-based strategies for involving PLWH in bringing and retaining other PLWH in care. See [www.mosaica.org/Resources/HIVAIDS/ProjectConsumerLINC.aspx](http://www.mosaica.org/Resources/HIVAIDS/ProjectConsumerLINC.aspx).

<sup>13</sup> The report from the consultation is available at <http://hab.hrsa.gov/publications/PeersMeetingSummary.pdf>.

<sup>14</sup> “Dear Colleague Letter” on the Utilization of Peers in Ryan White Programs, signed by Stephen Young, Director of the Division of Training and Technical Assistance and Douglas Morgan, Director of the Division of Service Systems, HIV/AIDS Bureau, February 18, 2010.

Peer models are being tested throughout the country, with Ryan White and other funding. For example, the Charlotte, NC Part A program has funded a PLWHA group, Positive Connections, to bring PLWHA into care, and the County has trained members of the group to do rapid testing in the community. The Michigan Part B program is supporting several providers to implement a peer-based early intervention services model to help PLWHA enter care. Minnesota’s Part B program has supported development of a training curriculum and demonstration project that prepares peers to work intensively to help PLWH return to care. The peers receive training, supervision, and stipends through the African American AIDS Task Force.

### Health Care Reform and HIV/AIDS Services

Figure 1, below, summarizes key components of ACA that will directly affect HIV/AIDS service availability and access. It separately addresses prevention and treatment and includes changes to Medicare, Medicaid, and private health insurance. These provisions are further described below in terms of their implications for HIV/AIDS prevention and treatment.

**Figure 1: Overview of ACA Provisions Affecting HIV/AIDS Prevention and Care & Treatment<sup>15</sup>**

Pre-Health Care Reform	Under Health Care Reform
<b>Prevention</b>	
<ul style="list-style-type: none"> <li>Limited coverage of preventive care under both public and private insurance</li> <li>CDC recommendations issued in 2006 for routine HIV testing in all healthcare settings, but implementation limited and varied</li> </ul>	<p>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</p> <p><b>Specifics:</b></p> <ul style="list-style-type: none"> <li>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</li> <li>Preventive services to be covered if they receive <i>A</i> or <i>B</i> recommendations from the U.S. Preventive Services Task Force (USPSTF)<sup>16</sup></li> <li>Vaccines to be covered if they are recommended by the Advisory Committee on Immunization Practices</li> </ul>

<sup>15</sup> Various analyses consulted; information confirmed on federal website, Understanding the Affordable Care Act Provisions, <http://www.healthcare.gov/law/provisions/index.html>.

<sup>16</sup> 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](http://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
	<p>(ACIP)</p> <ul style="list-style-type: none"> <li>USPSTF <i>A</i> recommendations for HIV testing by all clinicians for all adolescents and adults at increased risk for HIV as well as all pregnant women</li> </ul>
<p><b>Medicaid</b></p>	<p>1% increase in federal match (Federal Medical Assistance Percentage) provided to states that offer Medicaid coverage and remove cost sharing for USPSTF <i>A</i> and <i>B</i> recommended services and ACIP recommended immunizations, as of 2013</p>
<p><b>Medicare</b></p>	<ul style="list-style-type: none"> <li>Cost sharing eliminated for Medicare-covered preventive services that are <i>A</i> and <i>B</i> recommended by USPSTF</li> <li>Secretary of HHS authorized to modify Medicare coverage of preventive services based on USPSTF recommendations</li> </ul>
<p><b>Private Insurance</b></p>	<p>New health plans required to cover certain preventive services without cost-sharing for plans or policy years beginning September 23, 2010, including:</p> <ul style="list-style-type: none"> <li>Preventive care for infants, children, and adolescents recommended by HRSA</li> <li>Additional preventive care and screenings for women recommended by HRSA</li> <li>ACIP-recommended vaccinations</li> <li>Evidence-based services/items rated <i>A</i> or <i>B</i> by the USPSTF</li> </ul>
<p><b>Care and Treatment</b></p>	
<p><b>Medicaid</b></p> <ul style="list-style-type: none"> <li>Eligibility is categorical (e.g., pregnant women, women with children under 18) – poverty alone is insufficient</li> <li>Income eligibility varies by state</li> <li>Most people with HIV/AIDS are not eligible unless they become disabled</li> </ul>	<ul style="list-style-type: none"> <li>Eligibility based on income, without categorical requirements</li> <li>Minimum income limit of 133% of federal poverty threshold</li> <li>Implementation required as of January 1, 2014, and permitted any time after April 1, 2010 at state option</li> <li>Requirement for coverage continues through 2019</li> <li>Federal government to provide 100% federal match for newly eligible from 2014-2016, gradually reduced to a permanent federal match of 90% in 2020</li> <li>Temporary reimbursement for Medicaid providers at higher Medicare rate in 2013 and 2014</li> <li>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</li> </ul>
<p><b>Medicare</b></p> <ul style="list-style-type: none"> <li>Eligibility if &lt; 65 only with</li> </ul>	<ul style="list-style-type: none"> <li>Donut hole closing gradually – as of 2011, 50% discount for recipients on brand-name drugs and</li> </ul>

<b>Pre-Health Care Reform</b>	<b>Under Health Care Reform</b>
<p>long-term disability</p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Ryan White funds not permitted to be used to cover True out-of-pocket (TrOOP) expenses for medications or help fill donut hole</li> </ul>	<p>biologic drugs and 7% discount on generic drugs and some Part D supplies. Discounts to increase until 2020, when donut hole is eliminated, though there will be a 25% copay</p> <ul style="list-style-type: none"> <li>• 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) <sup>17</sup></li> </ul>
<p><b>Private Insurance</b></p> <ul style="list-style-type: none"> <li>• HIV-positive individuals generally uninsurable as individuals or in small-employer group policies</li> <li>• Lifetime limits and disease-specific caps on payments permitted</li> <li>• No limits on premiums for those with HIV/AIDS</li> </ul>	<p>Changes already in place:</p> <ul style="list-style-type: none"> <li>• 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)</li> <li>• 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)</li> <li>• Lifetime payment caps eliminated on policies issued or renewed as of September 23, 2010</li> <li>• Children able to stay on parents' insurance until age 26 (effective for any plan or policy year beginning after September 23, 2010)</li> </ul> <p>Changes as of January 1, 2014:</p> <ul style="list-style-type: none"> <li>• Insurance exchanges to be established – state can establish its own or use the federal exchange <ul style="list-style-type: none"> <li>– 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)</li> <li>– Differences in premium permitted only based on age, geography, and smoking history, not health status or pre-existing conditions</li> </ul> </li> <li>• No pre-existing condition exclusions for adults</li> <li>• Insurance coverage required for routine costs associated with participation in clinical trials</li> </ul>

All these provisions of ACA have specific, largely positive, implications for both prevention and treatment.

<sup>17</sup> 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.

**Changes involving HIV-related prevention services:** ACA increases access to preventive services, including HIV/AIDS testing and some vaccines:

- **HIV testing:** ACA should lead to significant increases in the implementation of the 2006 CDC recommendations for routine opt-out HIV testing in all health care settings because costs of testing will be covered. ACA calls for implementation of prevention services identified as *A* or *B* recommendations of the U.S. Preventive Services Task Force (USPSTF). HIV testing by all clinicians for “all adolescents and adults at increased risk for HIV” as well as all pregnant women is an *A* recommendation of USPSTF. A person is considered to be at increased risk for HIV infection if s/he reports one or more individual risk factors or receives health care in a high-prevalence or high-risk clinical setting.
- **Vaccines:** ACA provides for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP). The ACIP recommendations will result in access to influenza, pneumococcal, and hepatitis B vaccinations without cost sharing for individuals with both public and private insurance. All three of these vaccines are considered safe for most HIV-positive individuals since they do not involve live viruses. PLWHA are at increased risk for pneumococcal disease and are generally encouraged to get flu shots. Individuals with HIV who have hepatitis C and other sexually active adults are often encouraged to get the hepatitis B vaccination. Thus the availability of such vaccines without cost sharing should improve access to needed preventive care.

ACA requirements are as follows:

- **Medicare:** Cost sharing is eliminated for Medicare-covered preventive services that are *A* and *B* recommendations of USPSTF and for the ACIP-recommended vaccinations. ACA also authorizes the Secretary of Health and Human Services (HHS) to modify Medicare coverage of preventive services based on USPSTF recommendations. Free HIV testing under Medicare is now in effect, and can be provided as a part of the new annual Medicare “wellness visit” implemented as of January 1, 2011, which allows for development of a personalized prevention plan for each Medicare recipient.
- **Medicaid:** States that (1) offer Medicaid coverage and (2) remove cost sharing for *A* and *B* recommended preventive services will receive a 1% increase in their federal Medicaid match starting in 2013, an important incentive.
- **Private insurance plans:** Health plans must cover *A* and *B* recommended preventive services and additional preventive services for infants, children, and adolescents and for women that are recommended by HRSA. These services must be offered at no cost in all new group and individual health plans as of September 23, 2010; existing plans are exempted.

**Changes Influencing HIV/AIDS Care and Treatment:** Several broad provisions of ADA have very significant implications for HIV care and treatment. They include the following:

- **Medicaid expansion:** The health care reform provision likely to have the greatest effect on HIV/AIDS care is the elimination of the categorical requirement for Medicaid eligibility – to be eligible, individuals will no longer need to be pregnant women, women with children under age 18, or individuals who are disabled under federal

standards. As of 2014, categorical eligibility will end, and all citizens and immigrants who have held legal resident status for at least five years will be eligible for Medicaid if their incomes are below 133% of the federal poverty threshold. States must implement the expansion as of 2014, but were permitted to do so in 2010 at state option. The cost of implementation will be very low for the states. The federal government will provide a 100% federal match for these newly eligible patients from 2014-2016, and the match will gradually decrease to a permanent 90% as of 2020.

- **Medicare changes:** Individuals under age 65 are eligible for Medicare only if they have long-term disability status, as do some people living with AIDS. While Medicare covers some prescription drug costs for such individuals, there is a donut hole in this coverage. After Medicare has paid a specified level of drug costs (\$2,840 in 2010, including deductibles and copays), the individual is required to cover all costs (about \$3,610) until total out-of-pocket expenditures (including the \$310 deductible, copayments, and payments for medications) reach a specified level (\$4,550 in 2010). Then Medicare again pays drug costs with a small copay (5%) under what is called catastrophic coverage. The use of Ryan White funds to cover true out-of-pocket (TrOOP) expenses for people living with AIDS was forbidden before health care reform, but is permitted through ADAP and local pharmacy programs as of January 1, 2011. This means that people living with AIDS who are Medicare recipients will find their medication expenses greatly reduced. In addition, the donut hole is gradually being reduced in size through mechanisms such as deductions in costs for brand-name and generic drugs. As of 2020, the donut hole will be replaced by a copay of 25%.
- **Changes in private insurance:** HIV-positive individuals who are part of small employer groups or have no employer-based health insurance have often found it impossible to obtain health insurance due to their pre-existing condition. Individuals with insurance have faced lifetime caps and sometimes disease-specific caps on payments. An insurance company that is willing to provide insurance to a PLWHA has had no limits on premiums that could be charged. Under ACA, all these limitations are being reduced or eliminated. As of July 1, 2010, adults with HIV/AIDS have access to subsidized health insurance – provided by the state or by the federal government – along with other people who have been denied coverage due to a pre-existing condition. Exclusions for children due to pre-existing conditions (including HIV/AIDS) have already been eliminated from private insurance, and children will now be permitted to stay on their parent's insurance until age 26. Lifetime payment caps have also been eliminated. In 2014, insurance exchanges will be available at the state or federal level that will subsidize insurance costs for citizens and eligible legal residents earning up to 400% of the federal poverty threshold. Premium differences in the exchanges must be based only on age, geography, and smoking history, not health status or pre-existing conditions. Private insurers will no longer be permitted to deny coverage to adults based on pre-existing conditions. Insurance coverage will also be required for routine costs associated with participation in clinical trials, an important benefit for low-income PLWHA.

## 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 Ryan White clients will become eligible for Medicaid or for federal subsidies to purchase health insurance through the exchanges.

**Transitioning PLWHA to Medicaid:** Under ACA, very low-income Ryan White clients with AIDS and with HIV/non-AIDS will transition to Medicaid. In addition, 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.<sup>18</sup> Moving such clients off Ryan White funds will make resources available for new clients who are not Medicaid-eligible.

Washington, DC and Connecticut were the first jurisdictions to take advantage of Medicaid expansion. The District of Columbia began the transition in fall 2010, and obtained 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) have been transferred to Medicaid. The District estimates overall savings of \$56 million over the next four years.<sup>19</sup> Minnesota will transition individuals with incomes up to 75% of poverty to Medicaid as of March 2011, and California will make the transition to MediCal in July 2011.

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, non-FQHC clinics 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.

**It is not yet clear how many PLWHA now served by Ryan White will be served under Medicaid as a result of the expansion, but the number is expected to be substantial.** Ryan White does not yet have unduplicated client data.<sup>20</sup> The HIV/AIDS Bureau estimates that the program serves more than 529,000 PLWHA each year. Available data indicate that about one-third of Ryan White clients have no insurance (52% have Medicaid, Medicare, or some other form of public insurance) and that about 56% of clients

<sup>18</sup> Kevin Sack, “Economy Hurts Government Aid for H.I.V. Drugs,” *New York Times*, June 30, 2010.

<sup>19</sup> Darryl Fears, “Mental health providers grapple with Medicaid expansion,” *Washington Post*, October 12, 2010.

<sup>20</sup> 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.

have incomes below the federal poverty level.<sup>21</sup> Thus it is likely that a substantial minority of Ryan White clients – perhaps 175,000 nationally – will be enrolled in Medicaid by 2014. In Washington, DC, an estimated 1,000 PLWHA had been transferred to Medicaid by January 2011.<sup>22</sup> 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.

**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<sup>23</sup>). Eligibility for Ryan White medical and support services in the jurisdictions within the National Capital Region is shown below.

As the table indicates, at least a small number of PLWHA receiving care through Ryan White have incomes too high to qualify for either Medicaid or the exchange. Some 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 <sup>24</sup>	500%	500%
Northern Virginia <sup>25</sup>	333%	400%
Suburban Maryland <sup>26</sup>	500%	500%

## Health Reform and Safety-Net Clinics: A Broader View

### Provisions Referencing Safety-Net Clinics

**Health care reform is likely to have far-reaching implications for safety-net clinics of all types – CHCs/FQHCs as well as free, other nonprofit, and public clinics.**

<sup>21</sup> Ryan White 2008 State Profiles; available at <http://hab.hrsa.gov/stateprofiles/index.htm#>.

<sup>22</sup> Personal communication with staff of the HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA) within the DC Department of Health.

<sup>23</sup> *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-63.

<sup>24</sup> DC Department of Health, HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration, Notice of Funding Availability, FY 2011 Part A, Client Eligibility, p 9.

<sup>25</sup> Northern Virginia Regional Commission, Ryan White Income Guidelines & Eligibility, NVRC website, <http://www.novaregion.org/index.aspx?NID=902>.

<sup>26</sup> Specified in the Ryan White Part A Suburban Maryland RFA, 2011, <http://www.co.pg.md.us/Government/AgencyIndex/Health/ryanwhiterfa.asp>.

Among the most important are increased resources for CHCs/FQHCs, expanded malpractice insurance protection for free clinics, and opportunities for additional third-party reimbursements for most safety-net clinics, public and nonprofit. These provisions have major programmatic and financial implications for safety-net clinics. While the potential benefits can be significant, they are not automatic, especially for non-FQHCs. For example, many low-income clients who were formerly uninsured will now be insured, but clinics will benefit from this opportunity for third-party benefits only if they have both agreements with major providers under Medicaid and the insurance exchange and the capacity to maintain required records, document costs of care, and handle often-complex third-party billing. CHCs/FQHCs are the clinics likely to benefit most directly from health care reform. Figure 3 summarizes key ACA provisions specifically related to various types of safety-net clinics.

**Figure 3: Potential Benefits for Safety-Net Clinics under Health Care Reform**

Type of Safety-Net Clinic	Health Reform Provisions
Community Health Centers/Federally Qualified Health Centers (CHCs/FQHCs)	<ul style="list-style-type: none"> <li>• \$11 billion authorized and appropriated over five years for expansion of community health centers/FQHCs <ul style="list-style-type: none"> <li>– 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</li> <li>– Includes \$1.5 billion in capital for facility improvements and construction of new facilities</li> </ul> </li> <li>• 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</li> </ul>
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

### Implications of Health Care Reform for Safety-Net Clinics

Some of the implications of health care reform for safety-net clinics are largely positive, while others could be negative, as summarized below.

- **Community Health Centers/Federally Qualified Health Centers:** ACA allocates funds to expand both the number and current service capacity of

comprehensive primary care health centers authorized under section 330 of the Public Health Service Act – community health centers, migrant health centers, health centers for the homeless, and public housing-based centers. The intent to double CHC/FQHC capacity to 40 million people reflects the expectation that these clinics will play a crucial role in making health care more accessible, serving as medical homes for individuals and families newly eligible for Medicaid or the exchange, including PLWHA. FQHCs are assured the same enhanced reimbursement rates through insurance exchanges that Medicaid provides.

Despite the expansion funds and reimbursement rates, some CHCs/FQHCs are concerned that they will be unable to meet the increased demand for services under health care reform. Washington, DC clinics report a large and immediate increase in demand for mental health services resulting from the transition to Medicaid. Mary's Center, an FQHC that serves many Latino and other immigrants, reported a 70% increase in screenings for depression after clients enrolled in Medicaid.<sup>27</sup> There is also the continued expectation that FQHCs will continue providing medical homes for recent immigrants and undocumented residents. Capacity is a significant issue, in terms of clinic space and trained personnel.

- **Other safety-net clinics:** The implications of health care reform for safety-net clinics that are not FQHCs are far less clear. They are not specifically assisted through the legislation, though they have a number of options for participation:
  - **Seek FQHC status** during this period of health center expansion
  - **Merge or contract with CHCs/FQHCs** and benefit from their higher Medicaid reimbursement rate and their experience in managing third-party reimbursements
  - **Maintain their current structure but ensure capacity to maximize third-party reimbursements** – through both contractual relationships with Medicaid MCOs and insurance companies in the exchanges and the internal systems and staffing to meet complex documentation and billing requirements

An important first step for non-FQHCs is to explore how health care reform is likely to affect them, given their own specific client demographics, revenue sources, and relationships.

Non-FQHCs that are Medicaid-certified are reimbursed at a much lower rate than FQHCs, since they are not eligible for the special rate contained in the Medicare and Medicaid statutes. Medicaid reimbursement rates also vary considerably by state. However, revenues should increase when clinics are able to obtain even limited reimbursements for clients previously served without fees.

*Free clinics* that do not accept third-party reimbursements may operate as they have in the past, with additional malpractice protection. However, free clinics that accept Ryan White or other disease-specific funding may lose clients. This will occur when clients who enroll in Medicaid or buy insurance through the exchange are expected to choose a primary care provider that accepts third-party reimbursements. Current clients not eligible for Medicaid or exchanges are likely to continue to depend on free clinics for care.

<sup>27</sup> Darryl Fears, *Washington Post*, *op. cit.*

*Public clinics:* Health reform does not specifically focus on public clinics. Since most serve largely low-income people, many of their clients will become eligible for Medicaid. Some public clinics (e.g., the Cheverly Clinic in Prince George's County, MD) already accept Medicaid reimbursements and may continue providing services to PLWHA and other low-income individuals who move to Medicaid without disruption. Others have traditionally served only individuals without insurance, public or private. They have several options:

- **Contract with a health center to deliver primary care** – for example, the Casey Clinic in Alexandria is now contracting with Alexandria Neighborhood Health Services, Inc., a CHC, to provide some health care services, including HIV/AIDS services.
- **Assist a nonprofit clinic to obtain FQHC status or help start a new FQHC, then contract with it** – public clinics are eligible to apply for health center planning grants.
- **Obtain Medicaid certification and begin third-party billing** – for example, Maricopa County's clinic, the primary care provider for most PLWHA in the Phoenix metro area who are enrolled in Ryan White, recently obtained Medicaid certification that will enable it to continue services to clients after they transition to Medicaid.
- **Close the clinic and transition clients to CHCs and other safety-net clinics** – something that has not yet been reported, although public mental health, dental, and STD clinics have closed due to budget cuts over the past several years.

**Some safety-net clinics fear that private-sector fundraising may become more difficult**, as donors assume that the government is now ensuring access to health care.

**A question for all safety-net clinics is how many people will become eligible for Medicaid under expansion and what proportion of them will seek care from community-based clinics.** Nationally, a study by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, estimates that Medicaid enrollment will increase by 15.9 million to 22.8 million participants by 2019. A study by the Weldon Center at the University of Virginia estimates that 464,000 Virginians will become eligible for Medicaid under the expansion, and between 240,000 and 339,000 will enroll during the first few years of eligibility.<sup>28</sup> Maryland estimates about 133,000 additional individuals will become eligible for Medicaid.<sup>29</sup> It is not clear how many of those eligible will apply for Medicaid, or how quickly.

## Seeking FQHC Status

**Obtaining FQHC status is an important but challenging option for safety-net clinics.** It requires meeting a number of demanding clinical and administrative requirements and developing a Board of Directors that is majority consumers.

<sup>28</sup> Dustin A. Cable, "Virginia Medicaid Now and Under Health Reform," Weldon Cooper Center, University of Virginia, *Numbers Count*, September 20, 2010.

<sup>29</sup> Estimates based on what were then House and Senate proposals for Medicaid expansion. Jennifer B. Chasse and Simon G. Powell, "Updated Estimate of the Cost to Maryland Medicaid of Federal Health Care Reform." Department of Legislative Services, Office of Policy Analysis, January 14, 2010.

Organizations seeking designation as comprehensive health centers are expected to provide clients access not only to preventive and primary medical care but also to mental health, substance abuse, and oral health care.

Health care reform makes available planning grants to help in the formation of new FQHCs and in the transitioning of non-FQHC safety-net clinics to FQHC status. A Funding Opportunity Announcement issued March 18, 2011 for Affordable Care Act Health Center Planning Grants provides for 125 \$80,000 planning grants to public and nonprofit entities to develop comprehensive primary care health centers as defined in section 330. The intent is to “expand the current safety-net on a national basis by targeting health center planning and developmental efforts in areas not currently served by a section 330 funded health center and/or in areas of unmet need.”<sup>30</sup> Preference is indicated for rural areas (less than 7 people per square mile) and extra points in the scoring are provided to clinics in high-poverty areas (locations with poverty rates above the 14.3% national rate).

**To attain community health center designation, a clinic must serve HRSA-designated Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP).** It may be able to obtain such designation for census tracts it plans to serve, provided the medically needy populations are sufficiently concentrated. Centers proposing to serve migrant workers, the homeless, and public housing residents do not need to identify an MUA/MUP. MUAs/MUPs are “areas or populations designated by HRSA as having: too few primary care providers, high infant mortality, high poverty, and/or high elderly population.”<sup>31</sup> The designations are used to target funds to areas of need. In the National Capital Region:

- The District has numerous designated MUAs/MUPs, as does Prince George’s County.
- Montgomery County has a few census tracts that are designated MUPs, as do most counties/health districts in Northern Virginia.
- Fairfax County has no MUAs/MUPs.

As required under ACA, the criteria for designating MUAs are being reviewed by a commission established by HRSA. Its recommendations are due in July 2011.<sup>32</sup> It is possible that the revised criteria will make it easier for some safety-net clinics to qualify for FQHC status – particularly suburban clinics located in relatively affluent counties that have significant low-income residents who are not geographically concentrated.

## Accountable Care Organizations (ACOs)

**Accountable Care Organizations may provide an opportunity for safety-net clinics to play an innovative role in health system reform.** ACA provides for the establishment of ACOs, provider-led entities whose members work together to manage a system of comprehensive care for a defined population, control costs, and ensure quality of

<sup>30</sup> Announcement number HRSA-11-021, Affordable Care Act Health Center Planning Grants, available at <https://grants.hrsa.gov/webExternal/SFO.asp?ID=FC476C74-CD9D-420B-9563-7D42952B70B1>.

<sup>31</sup> HRSA definition, at <http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>. Designation as an MUA or MUP requires showing a score of 62 or less on the Index of Medical Underservice (IMU), which is based on the following: ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. See <http://bhpr.hrsa.gov/shortage/muaguide.htm>.

<sup>32</sup> See <http://www.hrsa.gov/about/news/pressreleases/2010/100709shortagecommitteeappointments.html>.

care. They will be able to share in the cost savings they achieve for Medicaid and Medicare. ACOs could include networks of safety-net clinics and other providers. ACO networks could provide important opportunities for improve systems of care, and help non-FQHCs and their clients benefit from health care reform. They may have special relevance for safety-net clinics that are AIDS service organizations (ASOs). These clinics have a clear interest in ensuring appropriate care for PLWHA, and ACOs may provide an opportunity for linkages with hospitals, HIV/AIDS specialists, and other provider groups.

## The ACA and Community Health Workers

**The ACA includes several provisions that may encourage the training and employment of community health workers, including peers.** Community health workers 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.”<sup>33</sup> 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 are expected to “conduct public education about qualified health plans; facilitate plan enrollment; provide referrals to consumer assistance offices; and, ensure that information is provided in culturally and linguistically appropriate ways.”<sup>34</sup>

<sup>33</sup> 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](https://www.aamc.org/.../crs_report_on_aca_discretionary_programs.pdf).

<sup>34</sup> 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](http://www.naccho.org/advocacy/healthreform/upload/exchanges-comments-9-28-10.pdf).

## Issues to Watch/Actions to Consider

### **As of early 2011, implementation of health care reform is in the early stages.**

Twenty-six states are in court trying to have either the entire Act or the mandatory insurance provisions declared unconstitutional. The House of Representatives has voted to repeal ACA. Many members of Congress want to cut off appropriations for implementation. It is highly unlikely that the Act will be repealed by this Congress or that the entire Act will be declared unconstitutional. Funding may be affected by budget cuts, though most core provisions of ACA (including health centers expansion) were both *authorized* and *appropriated* in the legislation and the accompanying Omnibus Budget Reconciliation Act. Many important provisions are already in place. However, many states will not implement Medicaid expansion until 2014, and how the insurance exchanges will work in each state is still being explored.

**Many ACA provisions clearly have implications for HIV/AIDS services and for safety-net clinics.** These issues need to be monitored and where possible influenced by those most concerned with ensuring that health care reform is successful in expanding access to high quality, patient-centered care, provided through medical homes. Following are some issues to monitor in 2011 and beyond:

- **Efforts to repeal, change, or deny implementation funds for health care reform:** Repeal during this Congress is extremely unlikely but some changes are possible. They seem unlikely to directly affect reform components most relevant for HIV/AIDS and for safety-net clinics more broadly. However, if budget bills are not passed and the government operates under a continuing resolution for the entire fiscal year, it may be difficult to implement ACA provisions requiring funding beyond what was provided in 2010.
- **Commission recommendations regarding the criteria used to define Medically Underserved Areas and Health Professional Shortage Areas:** The commission established by HRSA is scheduled to present its recommendations in July 2011.<sup>35</sup> The outcome of this effort could – but may not – provide new opportunities for safety-net clinics in the region, particularly the suburbs, to qualify for FQHC status.
- **Medicaid expansion,** particularly lessons from early implementation in this region and others. Among the key issues to watch: service mix and caps or limitations on doctor visits or specific services such as substance abuse treatment, number of Ryan White clients enrolled and how they fare in the transition, and the impact on demand for primary care, mental health, and other services at both FQHCs and other safety-net clinics – including clinics that have Ryan White funding.
- **Planned changes in HIV prevention and care in light of ACA and their implications for safety-net clinics.** Some of these changes will be reflected in the three-year comprehensive HIV/AIDS regional care and treatment plan for 2012-2014 that the Ryan White Part A program must develop by January 1, 2012, the Enhanced

<sup>35</sup> See <http://www.hrsa.gov/about/news/pressreleases/2010/100709shortagecommitteeappointments.html>.

Comprehensive Prevention Plan being developed for the District of Columbia this year with CDC funds, and state and regional HIV prevention plans. Clinic engagement in such planning would be beneficial.

- **Expansion of routine opt-out HIV testing in safety-net clinics**, given new insurance coverage, public and private, for preventive services including testing. Opportunities for reimbursement created by ACA need to be developed into policies and protocols for use by safety-net clinics.
- **Efforts to increase clinic involvement in HIV care and treatment**, already a priority of the Bureau of Primary Health Care. FQHC expansion may provide opportunities for area clinics to build HIV capacity and obtain additional resources, and non-FQHCs need to be a part of the discussion.
- **Changes in the Ryan White Program**, which is due to be reauthorized in 2013 (though the legislation is no longer sunsetted and the program could continue in its current form if no action is taken). Only after 2014 will there be information on how many PLWHA transition to Medicaid or to the health insurance exchanges, and how many are ineligible and will continue to depend on Ryan White. Also to be determined are what package of services Medicaid covers in each state, what services Ryan White still needs to provide, and how the transition affects AIDS service organizations including safety-net clinics. An important concern is public support for Ryan White if a majority of its clients are immigrants or higher-income individuals. A related question is whether the focus of services may need to change, so that Ryan White provides services that are not covered or have caps or limits under Medicaid or private insurance, such as substance abuse and mental health services and psychosocial support. Also possible would be a focus on services that find individuals with HIV/AIDS, get them into care, and help retain them in care, perhaps using peer or other innovative models.
- **Collaborative efforts to maximize benefits of health care reform for safety-net clinics that are not FQHCs**, through improvement of capacity for third-party billing and related fiscal and data systems, contracts with FQHCs, or other means. RPCC could work with its members to identify and test innovative models, and keep them informed of work being done in other regions.
- **Health care worker programs and patient navigator programs**, and the extent to which they provide opportunities for training and employment of community health workers, especially peer CHWs.
- **Models for Accountable Care Organizations (ACOs)**, which may offer opportunities for improving the system of care through networks involving all types of safety-net clinics.