Health Care Reform: CA Lessons Learned

Initial Implementation of California’s 1115 Medicaid Waiver, “A Bridge to Health Care Reform”

California has moved quickly toward health care reform by implementing a Medicaid 1115 Waiver approved in late 2010. The waiver was intended to expand Medicaid (Medi-Cal in California) to 500,000 low income Californians, move people with disabilities, including HIV, and seniors into Medi-Cal managed care and strengthen the safety net in anticipation of full Medi-Cal expansion in 2014.

Although California’s experience is still unfolding, there are several important lessons regarding care for people with HIV under Medicaid expansion that may prove helpful to other state advocates and people with HIV as health care reform is implemented nationwide.

The two components of the California experience most affecting people with HIV are the Medi-Cal expansion and the movement of seniors and people with disabilities, including HIV, into Medi-Cal managed care. The Medi-Cal expansion programs are developed, run and financed by the participating counties and called the Low Income Health Program (LIHPs). The counties set the income eligibility and can go up to 200 percent of the Federal Poverty Level (FPL). Currently, they range from 25 percent to 200 percent FPL. The counties also may cap the program and create waiting lists. The other important component is the movement into managed care. California is requiring all Medi-Cal beneficiaries who are seniors and people with disabilities, including people with HIV, to move into mandatory Medi-Cal managed care.

The Low Income Health Program (LIHP) and People with HIV

During the development of the waiver and its initial implementation, the Department of Health Care Services (DHCS) failed to include HIV care expertise in its Stakeholder Advisory Committee. The State Office of AIDS (SOA), which oversees much of Ryan White, and the DHCS did not communicate about LIHP coverage for uninsured people with HIV. Nor did the Centers for Medicare and Medicaid Services (CMS) communicate with the Health Resources and Services Agency (HRSA), the federal agency which oversees the Ryan White Program. As a result, the State failed to plan to cover people with HIV under the LIHP. The key misunderstanding was that the counties, lacking any guidance, believed Ryan White Programs, including ADAP, could continue to provide primary care and medications to people with HIV.
Neither the state nor the counties understood that Ryan White is the “payer of last resort,” and prohibited from covering benefits provided in a Medicaid program. Thus, the counties did not plan for costs, provider networks, or transition of people with HIV from Ryan White services to LIHPs. When the oversight was discovered, people with HIV and their providers faced an abrupt and unplanned transition.

It was extremely difficult to plan quickly because Ryan White funds and services are administered locally and through the SOA, a part of the Department of Public Health, while the LIHP is administered by the Department of Health Care Services. There was no formal liaison between the two departments, little communication, and no joint work groups or advisory committees. As a result there was no one agency or individual in charge of the inclusion and transition.

The Movement of Senior and People with Disabilities into Managed Care
Most Medicaid programs across the nation are moving towards managed care. In addition to providing better coordinate care, state Medicaids are hoping managed care will save money. However, many people with HIV already have coordinated care at clinics that utilize Ryan White funding to provide coordinated services not available under Medicaid fee-for-service structures.

California's Medi-Cal services did a poor job of informing providers who were not already contracted with managed care plans, including many HIV providers of upcoming changes. As a result, many HIV providers had not begun the often complex contracting process with Medi-Cal managed care when the transition began.

Patient protection processes, the Medical Exemption Request (MER) and the Continuity of Care Provisions (CoC), that were intended to allow vulnerable beneficiaries to continue to see their fee-for-service providers, and thus minimize disruption to essential care, were poorly understood prior to the transition due to lack of information and education. Moreover, despite protections written in law, DHCS did not implement the system appropriately.

As a result, the system failed, leading to serious disruptions in care for many with HIV. Ten months into implementation of 12,800 MERs submitted only 1,900 have been approved, 3,400 have been denied and 7,500 have been returned as incomplete. In spite of significant advocacy work at the state and federal level the system remains dysfunctional, arbitrary and subjective.

Lessons Learned and Recommendations

Leadership and Collaboration—No one agency at the state or federal level is formally charged with securing the transition for PLWHA and planning for coordinated care after 2014. A new level of innovative and collaborative leadership from HIV-specific agencies at the state and federal level, such as State Office of AIDS (SOA) or State Health Departments, and the Health Resources and Services Agency’s (HRSA) HIV Advisory
Specifically:

1. New alignment and collaboration will be necessary between CMS and HRSA and their equivalents at the state level are critical to ensure integration of HIV services into broader health care systems and develop ongoing Ryan White programs for coverage and benefit gaps after 2014.
2. New structures that support collaboration should be explored such as joint stakeholders groups and department liaisons where offices are in different agencies or departments.
3. HRSA and HAB must develop their role in health care reform efforts to include adequate, timely, formal and informal guidance to assist RW providers to appropriately integrate with and wrap around broad health care coverage.
4. State-level HIV agencies must provide leadership working with stakeholders to identify and address transition issues, assist Ryan White grantees in planning, and issue technical assistance guidance.

Planning and Engagement—Many critical decisions regarding health care reform implementation are being made at the federal and state level, including the essential health benefit package, development of the Health Benefit Exchange, and Medicaid expansion plans. Planning for the integration of HIV care services into broader systems of care and the structures and programs that will fill gaps in HIV care post 2014 must begin now to be successful.

Specifically:

1. Planning for health care reform transitions, new coverage and filling gaps post 2014 must start now at the federal, state and local level.
2. HIV care expertise, including providers, advocates and PLWHA representing the diverse scope of the epidemic, must engage in implementation decisions at the federal, state and local. Advocates must find out where decisions are being made and get involved.
3. HIV care system experts must also engage with and learn about new systems of care, including Medicaid programs and private insurance options.
4. It is critical to work with other state health advocates who often bring expertise and developed relationships with decision makers.

Transition—Most uninsured people with HIV will be moving from Ryan White to new coverage. It is unlikely that new health care systems will be fully ready to support a smooth transition for all eligible HIV-positive people without disruptions or loss to care. In order to fulfill the promise of health care reform for people with HIV, transition strategies, including communication and education, must be developed that will minimize disruption to care.

Specifically:
1. Developing health care reform task forces at the federal, state and where appropriate local level is important.

2. HRSA should consider allowing Ryan White grantees to phase-in screening for new coverage over the course of one year, using clients’ birth month, allowing for a more manageable transition for PLWHA, case managers and administrators.

3. Federal, state, and local agencies should plan now for what types of flexibility in funding may be needed to facilitate a more secure transition. Where might ADAP need to fill gaps in access of new systems or between systems?

4. Local and state agencies should begin planning resource allocation that addresses outreach, linkage, engagement and retention in new care systems. One example would be to increase the medical case management and health benefit counseling resources available to PLWHA.

5. Some transitions have already occurred. In those cases, best practices need to be collected and shared as widely as possible.

6. Patient protections need to be developed, with stakeholders, and disseminated to both providers and patients prior to transition. Problem resolution protocols must be clear and usable by both providers and clients.

The Ryan White Program—Many Ryan White providers will integrate into larger systems of care after coverage expansion in 2014. However, Ryan White programs will continue to be essential in filling gaps in coverage and benefits under full ACA implementation.

**Specifically:**

1. HRSA and community stakeholders need to articulate and plan for the discrete services that are likely to need continued funding through Ryan White to ensure successful implementation of the testing, linkage to and engagement in care goals of the National HIV/AIDS Strategy (NHAS)
   - HRSA should also participate in defining the unique HIV needs in services such as medical case management and peer advocacy and determining if additional training or certification should be required for those services.

2. As payer of last resort, Ryan White cannot pay for services covered under other programs for which the client is eligible. Operating within this statute presents challenges during a transition as large and complex as that of health care reform. HRSA needs to allow for the broadest interpretation of payer of last resort in order to appropriately leverage Ryan White funds to wrap around other payer sources.
   - When Ryan White funds cannot be used, states should explore the use of other funds, such as state and rebate monies, to ensure continuity of care.

3. Advocates should also consider the feasibility of other legislative vehicles to broaden HRSA’s authority to waive payer-of-last-resort for limited periods of time under specified circumstances during the health care reform transition.
Capacity Building, Technical Assistance and Infrastructure—To ensure successful integration and continuity of all aspects of quality HIV care, Ryan White providers will require timely and reliable information, updates, technical assistance and guidance.

Specifically:
1. HRSA should develop capacity building and technical assistance grants aimed at helping medical providers navigate moving from grant-driven systems to negotiating, contracting, and interacting with multiple coverage products.
2. Non-medical providers will need technical assistance from HRSA, states and localities about how to best align with and wrap around insurance coverage.
3. State and local AIDS offices may also need technical assistance to develop systems that support and interact with new health care delivery systems.
4. Provider rates, both medical and pharmacy, will be lower under new systems of care and may be completely inadequate under Medicaid programs. Strategies and technical assistance with securing more adequate reimbursement rates will have to be pursued.

Education and Communication—Ryan White providers have developed a relatively seamless continuum of care that PLWHA have come to depend on for necessary information about their health care benefits and rights. However, many PLWHA and their providers in the Ryan White system are not well connected with broader systems of care; therefore general health care education and communication is often inadequate. It will be essential to develop improved stakeholder education and communication networks in this rapidly changing environment. Additionally, more individual assistance for people with HIV will be necessary to navigate, access, and utilize patient protections under new systems of care.

Specifically:
1. HIV entities, including the statewide HIV-specific agencies and the AIDS Education and Training Centers (AETC), need to take a stronger role in creating good communication networks and ensuring that accessible and usable information regarding changes in all systems of care gets distributed regularly.
2. Ryan White allocation planners need to increase resources for individual health benefits counseling and navigation assistance.

Medicaid Programs—People with HIV already rely heavily on Medicaid for their health care services in spite of the disability requirement that still exists in most states. Initial estimates in California suggest that as many as 70 percent of the uninsured HIV positive Ryan White clients will be eligible for Medicaid in 2014. At the same time, most state Medicaid programs are moving to managed care and often instituting increased beneficiary cost burdens and cuts in provider rates to respond to severe budget deficits. HIV Advocates need to directly engage with both traditional and expansion Medicaid programs and policy to ensure that Medicaid programs continue to meet the needs of people with HIV.
Specifically:

1. HIV care experts need to learn about and participate in state Medicaid policy development and implementation, including waiver, expansion programs, and movements to mandatory managed care.
2. CMS needs to ensure adequate oversight of state waivers and should consult with HRSA on any waiver that would affect people with HIV.
3. CMS should direct state Medicaid programs to reach out to Ryan White grantees in addition to other providers during waiver or program development.
4. HIV advocates need to be involved with the development and monitoring of patient protections in Medicaid programs
5. Advocates need to organize and oppose cost-cutting proposals that negatively affect Medicaid benefits.
6. Policies and strategies will need to be developed at the federal and, importantly, state levels to ensure that HIV providers receive adequate reimbursement for the delivery of coordinated chronic care for PLWHA.