NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Ryan White Provider Experiences & the ACA

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Background

- HIV care providers play a critical role in helping people with HIV engage and stay retained in care and treatment
- Provider experience with the ACA, coverage reforms, and movement of clients to coverage is important to fully understand in order to best support them (and their patients)
- This presentation and forthcoming report seeks to understand how HIV care providers have been impacted by the ACA
  - Across different states, different Medicaid expansion decisions
  - Examine experiences across a range of provides types
  - Identify best practices and challenges

Methodology

- 19 interviews conducted, representing 17 clinics/health systems in CA, FL, GA, NY, and TX
- Many Part C grantees, most w/ other Ryan White funding
- 15/17 providers offer primary/HIV care
  - 1 support service and mental health provider; 1 support service and premium assistance provider
- 4 hospital clinics; about half FQHCs; other organizations were ASOs or CBOs with targeted service for HIV+ and LGBT populations
- High level administrators; often RWP grant managers; sometimes a case work manager with program oversight/big picture ACA perspective

Enrollment – General

- Variety of enrollment strategies specific to organization type, client needs, state policy environment
- Strategies evolved over time
- Significant staff & client education in advance of OE1
- ACA and enrollment trainings aimed at case managers, social workers, front office, and others in administrative roles
  - NY organization, conducts periodic 15min provider trainings
- Most enrollment occurred in-clinic, incl. at larger hospital settings – feeling that one-stop-shop improved retention; allows for HIV specific conversations (though some wo/ capacity OE1)
- Enrollment also conducted off-site through targeted outreach

Enrollment - Strategies

- Many developed specific tools and strategies during or after OE1:
  - Shared Outlook enrollment calendar among navigator team
  - Tracking system noting clients progress in enrollment process
  - Weekly calls w/ state enrollment grantees and state officials
  - Use of targeted “in-reach” lists of potentially eligible clients
  - ACA point person to educate, coordinate staff, and liase with external partners
  - Internal plan reviews

ENROLLMENT – OE1 v OE2/3

- Stakeholders uniformly described OE1 as frustrating, challenging, and as a learning process. Partly as a result of infrastructure/technological challenges; partly confidence and competence
- All said that their organization was more comfortable as time went on
  - OE2 and OE3 were more "controlled", better "organized" and providers were "better prepared" to answer questions and meet client needs
- Communications w/ patients got easier as patients and staff became more familiar with coverage opportunities, more insurance literate, and the screening process
- Some increased community outreach and more nuanced internal messaging in OE2 and OE3

Enrollment Barriers

- Medicaid expansion was the most significant barrier in non-expansion states, prevented many from gaining coverage
  - Biggest difference between experience in CA and NY sites
- Internal enrollment challenges: Not having enough/the right staff trained as enrollers/navigators; other staff and facility capacity issues, not being able to be explicit about the which plans are the “best”
- External enrollment challenges: No time to review plans prior to OE = hard to advise clients during first weeks; varying ability to help with OOP costs; problems w/ physician rolls appearing full at enrollment means clients can’t select long term providers
- Those that remain uninsured

Financial Assistance

- Providers leveraging wide range of resources to help clients w/ affordability of marketplace coverage
- In all states but Texas, providers reported using ADAP funds to help with the premiums, and in some cases other cost-sharing
  - ADAP premium payment challenges persist: narrow deadlines for payment due dates make timely 3rd party payment challenging; clients/providers often pay first few months' premiums OOP
  - Once enrollment stabilizes, providers generally report ADAP assistance goes more smoothly

Financial Assistance II

- Aside from ADAP, great variability in how providers help with OOP costs, relying on a patchwork of approaches:
  - Part A
  - 340B/pharmacy revenue
  - Hospital charity funds
  - Industry copay programs
  - Private foundations such as PAN and PAF - Many heavily reliant on PAN so concern around the suspension of the HIV fund
- Navigating these resources takes up considerable staff time
- Some confusion as to whether providers must rely on sources like PAN before RW support under payer of last resort provision

Impact on Staffing

- One of the biggest impacts of the ACA on providers
  - Driven by the increase in clients and increase those w/ new coverage
- Some organizations have not had resources to increase staffing and are either making due or reorganizing existing roles
  - Some feel this has limited their ability to provide support for patients
- Other providers have made new hires to meet growing needs in addition to having existing staff take on new responsibilities
  - Some (e.g. enrollment) clearly connected to ACA; others harder to identify impact health reform (e.g. when organizations transformed structurally or took on new clinical responsibilities)

Examples of New Hires

- Several added medical providers (physicians, mental health, and medical support staff)
- Other hires included high level administrative staff: public/government relations, marketing, compliance, audits
- Some increased staff to handle the rise in utilization management clients faced (e.g prior authorizations and appeals)
- CA provider hired staff to handle specialty referral increase, more primary care visits resulted in uptick
- Several sites added billing staff- increase in clients with coverage, increased billing work
- FL clinic brought in ID specialist 1x/wk to treat hep C

Staff Time

- How staff spend time has been significantly impacted by the ACA
- Time spent on enrollment and insurance literacy increased
- Time spent addressing insurance issues increased (e.g. referrals, PAs, denials, whether coverage is active, understanding client benefits)
  - Managed in different ways: back office staff, nurses assigned to work on insurance issues, onsite pharmacy staff assisting w/ Rx realted challenges
- Billing has become cornerstone activity for many with some devoting new staff to the activity and one provider taking up billing for 1st time
- A few providers said they were not burdened by these issues and continued to operate business as normal
  - Either because roll out has been small or they were part of a larger system with institutional support

Networks

- Stakeholders did not have a uniform experience with negotiating to get into networks under the ACA
- Negotiations sometimes (not always) easier for the hospitals/health systems when it came to coverage of primary & and HIV providers
  - Typically handled by a credentialing or other department, relieving HIV clinic of burden; more leverage with insurance companies
- Some organizations, with less negotiating power, slimmer staffing, and less experience had more difficulty negotiating networks
- In one case an FQHC was accepted in-network but classified as a specialist by one issuer (provider learned all local FQHCs also classified this way) triggering higher cost-sharing for clients

Networks II

- Even when a provider's HIV physicians were accepted in-network, did not always translate to other aspects of care delivery system
  - Mental health providers, onsite pharmacies sometimes excluded
- Providers struggled to make specialty referrals when plans have limited networks
  - At same time clients with insurance for the first time are seeking out specialists at high rates

Organizational Structure

- About half respondents identified major structural changes occurring within their clinics or health systems
  - E.g. Hospital mergers, opening new specialty clinics (incl. mental health), opening new sites, taking over local public health services, forming alliances with non-traditional services
- In many cases changes were seen apart from or ancillary to the ACA
- Changes seen as more closely tied to restructuring health systems or becoming more sustainable than health reform
  - though some in FL, GA, TX felt state's decision not to expand Medicaid impeded ability to transform

Changing Use of RWP Funds

- Significant variation as to whether organizations changed how they used Ryan White funds
- Expansion state providers more commonly changed use of funds as more clients gained insurance coverage
  - When funding was reallocated (or when planning for future reallocation), support services incl. oral health, housing, & transportation emphasized
- Those in non-expansion states less frequently changed use of funding; most remained ineligible for coverage and dependent on RWP for HIV care and treatment
  - However, expansion decision was not the only factor governing this
- Those who shifted use of funds were sometimes able to do so internally but some dependent on grantee reallocation of funds
  - Some providers felt external reallocation decisions were premature

ACA Impact on Bottom Line

- ACA impact on provider bottom line varied but in most cases movement of clients to coverage represented a financial loss
  - For most decrease in reimbursements was minimal
  - Sometimes this was offset by other factors, e.g. becoming an FQHC
- Providers that saw a loss in revenue were enthused clients gained insurance but aware of fiscal realities
- Providers seeing both HIV+ and HIV- clients had a harder time parsing out impact of HIV+ clients (previously on RW) moving to coverage
- Some larger providers saw overall fiscal gains (outside HIV clinic) as past care for negative clients was often wholly uncompensated

ACA Impact on Bottom Line II

- Others were more cautious assessing impact on bottom line
  - Increased cost of new hires, time spent on insurance issues, not accounted for when looking only at reimbursement rates
  - While more existing clients are insured, picking up new uninsured clients
  - Figuring out the balance between fiscal gains and losses is complex:
    - Medicaid and QHPs reimburse differently
    - Some able to get better lab reimbursement than via RWP but lower provider visit reimbursement
    - Bundled payments mean winning some and losing some

Ongoing Need

- Information about marketplace plans in advance of OE periods
- Resources for additional staffing (esp. enrollment, case managers, social workers and providers)
- Additional clinical space
- State specific training and educational materials to give to patients
- Regionally specific/appropriate training from HRSA/HAB
- HRSA/HAB TA related to infrastructure issues/growth (incl. re billing) especially in regions where states provide little ACA guidance
- Wider dispersal of HRSA/HAB guidance/PCNs (esp. for sub-grantees without direct contact with HAB)
  - E.g. none interviewed knew of HAB policy on repayment of APTCs
- Desire for honest conversation with HRSA/HAB about future of Ryan White Program

Looking Forward

- Providers report they are now better prepared to navigate ACA landscape but worry about future of the RWP, feel uncertain
- Providers continue to experience challenges
  - For those in non-expansion states, obtaining coverage key issue
  - For all, marketplace OOP costs continue to be a concern
  - Financial assistance resources are unstable (foundations, industry)
- Despite challenges, many, especially those in Medicaid expansion states and w/ support for insurance purchasing/cost-sharing are positive about ACA era changes and believe clients have benefited

In summary, I just want to say Affordable Care Act has done some incredible things for patients. Incredible things I've seen. Affordable …health insurance and has changed their lives. But it takes effort. It takes work for it to be successful. – New York Provider