

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

State Medicaid programs are the primary source of health care coverage for the majority of people living with HIV/AIDS (PLWHA) in the United States. The Ryan White HIV/AIDS Program (RWHAP) provides supplemental coverage to PLWHA who are un- or underinsured, or who lack sufficient financial resources to support their care. Thus, coordination between a state's Medicaid agency and RWHAP is crucial to ensuring that clients have access to comprehensive care. The National Academy for State Health Policy (NASHP), in consultation with the Health Resources and Services Administration, identified and interviewed RWHAP and Medicaid representatives from 14 states to discuss state strategies for successful program collaboration. This *State Health Policy Briefing* highlights state examples of program coordination, along with additional promising practices for coordination that facilitate service delivery improvements for PLWHA.

NATIONAL ACADEMY
for STATE HEALTH POLICY

Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

NOVEMBER 2013

Strategies for Coordination Between Medicaid and Ryan White HIV/AIDS Programs

Katharine Witgert, Jennifer Dolatshahi, Rachel Yalowich

State Medicaid programs are the primary source of health coverage for the majority of people living with HIV/AIDS (PLWHA) in the United States. The coverage provided by Medicaid, particularly for prescription medications, is critical for PLWHA,¹ however, these individuals account for a small percent of the overall Medicaid population (less than .01 percent). Many of the 1.1 million PLWHA in the U.S. lack adequate health coverage² and rely on Ryan White HIV/AIDS Program (RWHAP)-funded programs, including the AIDS Drug Assistance Program (ADAP), to provide or supplement coverage of needed services. Coordination with Medicaid has always been important for state RWHAPs. In states that implement Medicaid coverage expansions under the Affordable Care Act (ACA), more RWHAP clients will gain Medicaid coverage, and the need for ensuring coordination between these two programs will remain critical to improving care and services for PLWHA.

In the summer of 2013, the National Academy for State Health Policy (NASHP), in consultation with the Health Resources and Services Administration (HRSA), identified and interviewed RWHAP and Medicaid representatives from 14 states to discuss state strategies for program collaboration that result in service delivery improvements for PLWHA. This brief highlights state examples of strategies for program coordination between Medicaid and state RWHAPs used by many of the states interviewed. Additional promising practices and the challenges of operationalizing them are also discussed. The importance of extending coordination strategies to include newly created federal and state-based health insurance marketplaces was also recognized by interviewees, but is beyond the scope of this brief. However, many of the strategies could be adapted to include coordination with marketplace systems and qualified health plans (QHPs).

STRATEGIES FOR COORDINATION

The benefits and challenges of coordination between Medicaid and RWHAP grantees are widely recognized by the state officials leading both programs. All of the states interviewed are employing strategies to improve program coordination, including the five categories of coordination strategies examined in this section.

OVERARCHING COORDINATION BETWEEN PROGRAMS

In many states, the Medicaid program and the RWHAP are housed in separate agencies. This organizational dichotomy can create a challenge to coordination, as staff may not have opportunities to meet and exchange information and ideas. In addition, the complexities of the two programs can hinder communication between them.

Strategy: Establish regular coordination between Medicaid Directors and State AIDS Directors to assist in designing a Medicaid program that meets the needs of PLWHA. Our interviewees suggested that Medicaid and RWHAPs should establish a regular means of communication and information exchange.

- In 2011, thousands of RWHAP clients became eligible for coverage under **California's** county-administered Low Income Health Program (LIHP), administered by Medicaid. This coverage transition

triggered the need for more formalized coordination between the Department of Public Health – Office of AIDS (OA) and the Medicaid program's LIHP Division. Today, these agencies work closely to coordinate on issues related to PLWHA, particularly in regard to client transitions between RWHAP and county LIHPs. Staff from the two agencies convene a bi-weekly OA/LIHP Stakeholder Advisory Committee, which includes county AIDS directors, county RWHAP and ADAP representatives, county LIHP coordinators, medical and non-medical HIV providers, advocates, and PLWHA. This model has proven to be so effective for inter-agency collaboration that it is being expanded to encompass all transitions associated with health care reform in California.

Strategy: Include state Medicaid representation on RWHAP Health Services planning groups. Many states and localities include Medicaid representation on HIV Health Services planning groups required under the RWHAP in order to coordinate on issues related to PLWHA. In some states, Medicaid representatives sit as non-voting members on these planning groups, while in others they serve as regular planning group members with voting authority. Though a regular point person is seen as beneficial, it has been difficult in some states to establish consistent representation from Medicaid. Large states may find it useful to coordinate between Medicaid and the RWHAP at the local level as well as at the state level.

- In **Tennessee**, the TennCare (Medicaid) Associate Medical Director is an active member of the RWHAP Part A planning councils in both Memphis and Nashville, and serves as a committee chair for the Nashville planning council. TennCare sees its engagement on these councils as a beneficial way to interact with consumers, providers, RWHAP administrators, and RWHAP grantees.

COORDINATION OF DATA SHARING

Both Medicaid and RWHAPs maintain databases to establish eligibility and track program enrollment. Information gathered by each program can be potentially helpful to the other in terms of identifying an individual's eligibility for various programs, determining their medical needs, and improving the

delivery of care and treatment services. Data sharing can also help Medicaid and RWHAPs use resources most efficiently. Barriers to data sharing include: incompatible information technology (IT) systems, legal restrictions—both real and perceived—and privacy concerns. Despite these challenges, several states have developed strategies to share data between their Medicaid and RWHAPs.

Strategy: Establish or amend existing data sharing or data coordination capacity between Medicaid and RWHAPs. Our interviewees suggested several types of data that would be useful to share between the two programs. These include eligibility information, enrollment records, and service utilization data such as that found in Medicaid Management Information Systems (MMIS). Where allowable, interviewees endorsed an option to use data to permit simultaneous eligibility determinations.

- In **Iowa**, the RWHAP worked with Medicaid and the state’s Office of the Attorney General to add a provision to Iowa Administrative Code that requires Medicaid to share client-level data with ADAP to meet the RWHAP payer-of-last-resort requirement. The programs are now working on a data-sharing agreement pursuant to the Administrative Code that will give RWHAP staff access to the Medicaid client information system.
- **Maryland’s** ADAP program (MADAP) has access to the Medicaid eligibility system and can check Medicaid eligibility status for new or recertifying MADAP clients. Further, the state’s Medicaid electronic claims system is designed to process charges to Medicaid before it processes any charges to the MADAP.
- **Minnesota’s** RWHAP and Medicaid program are fully integrated in the same MMIS and case management systems. Staff in both programs are able to view information and check the eligibility status of clients for both programs.

COORDINATION TO IMPROVE ACCESS TO CARE

People living with HIV/AIDS need access to a robust network of medical providers and non-medical supports to maintain their health. Both Medicaid and RWHAPs provide clinical and supportive services to their

enrollees. As states prepare for expected increases in demand when ACA coverage expansions unfold, coordination between Medicaid and RWHAPs can help ensure PLWHA have adequate access to care.

Strategy: Share contracting, credentialing, and billing/reimbursement resources to ensure that RWHAP providers are prepared for coverage expansions. The RWHAP requires that grantees and subgrantees that provide Medicaid-covered services be Medicaid certified. However, some RWHAP providers may not participate with all Medicaid managed care organizations (MCOs) in their areas. In other states, many RWHAP providers operate in smaller organizations that have historically had limited capacity for billing Medicaid or other payers. For them, assistance with enrollment, credentialing, and establishing billing systems can be especially helpful.

- The **Texas** Medicaid and RWHAPs have worked together over the past 18 months to assess RWHAP provider readiness for an expansion of Medicaid managed care and to develop education and training materials to assist RWHAP providers in developing billing capacities. The state will also be holding regional meetings with RWHAP providers to answer questions on Medicaid MCO credentialing, billing, and enrollment assistance for clients. Managed care organization representatives have been invited to join these meetings to help with provider education.

Strategy: Assess and ensure provider and pharmacy network adequacy, particularly within Medicaid managed care plans. Network adequacy for PLWHA can be difficult to define because there is not a single definition of a HIV clinician. Several states interviewed told us that their RWHAPs had been helpful in developing standards for provider and pharmacy networks in previous managed care expansions. Similar coordination will be helpful in the current wave of transitions to managed care to ensure continuity of care.

- As the **Washington** State Health Care Authority (Medicaid) continues to transition more Medicaid enrollees to managed care, the need for coordination between Medicaid and the RWHAP to ensure provider and pharmacy network adequacy is

of utmost importance to them. In May 2013, officials from Medicaid met with their RWHAP counterparts to learn more about the specific needs of RWHAP clients. The RWHAP shared their prescription drug formulary and a list of contracted providers. Medicaid passed this information to managed care plans to ensure smooth transitions of care for PLWHA. The RWHAP also shared information about their case management program to assist managed care plans in establishing the case management services newly required by their Medicaid contracts.

COORDINATION TO ENSURE COMPREHENSIVE SERVICES

Though Medicaid's medical benefits are typically quite comprehensive relative to many private insurance options, Medicaid often does not provide extensive non-medical supportive services. For PLWHA, the RWHAP may provide case management, transportation to non-medical appointments, or financial assistance with Medicaid copayments. Though at times it can be challenging to coordinate which program provides or is reimbursed for which service, our interviewees support coordination between Medicaid and RWHAPs to ensure that a comprehensive package of services is provided to PLWHA.

Strategy: Analyze covered services under Medicaid and the RWHAP to identify gaps and opportunities for coverage completion by the RWHAP. Interviewees recommend a gap analysis as the first step to determining what services might be needed from the RWHAP by Medicaid enrollees. Additional work is then needed to ensure those identified benefits are provided. This type of analysis will be particularly important as clients shift from the RWHAP to Medicaid in Medicaid expansion states.

- **Massachusetts** transitioned many of its RWHAP clients to Medicaid (MassHealth) in 2001. Despite expanded Medicaid eligibility for PLWHA in the state, the RWHAP continues to fill essential coverage gaps by funding supportive services that enable these clients to navigate the health system and maximize the benefits of their care. The ADAP component of the RWHAP provides insurance copayment assistance, premium continuation, and treatment

continuity during coverage gaps to Medicaid clients. The RWHAP also continues to fund medical case management in both clinical and community settings and services that facilitate linkage, engagement, and retention in care, such as transportation assistance, mental health and substance abuse treatment, and nutrition counseling.

- In recognition of community-based organizations' (CBOs) important roles as non-clinical partners in the RWHAP system, the **District of Columbia** is working to link stand-alone CBOs to medical clinics to better coordinate care for PLWHA. A recently released Request for Applications requires CBOs to formally establish contractual links with clinics. CBOs and clinics will co-manage a roster of patients, ensuring they receive all needed services.

COORDINATION OF PHARMACY BENEFITS

Medications to treat HIV/AIDS are often expensive. Costs are borne by Medicaid programs, the RWHAP ADAP, and patients. Thus, decisions about pharmacy benefits should take into account the implications for each of these payers.

Strategy: Use ADAP formularies as a comparison point for the HIV-related medications included on Medicaid formularies. Most states interviewed reported active collaboration between Medicaid and the RWHAP to establish Medicaid formularies for HIV-related medications. Interviewees stressed that the ADAP formulary makes a good comparison list for HIV-related drugs, but that a broader formulary must remain available in Medicaid to treat other conditions associated with HIV/AIDS.

- The RWHAP in **Louisiana** has been working closely with Medicaid MCOs since 2011 when pharmacy benefits were first included in managed care plans. At that time, a provider noticed that the covered dosage of some medications did not align with U.S. Public Health Service (USPHS) recommendations. The RWHAP worked with Medicaid and the MCOs to update the covered dosage so that providers who prescribed the USPHS recommended dosage no longer required prior approval from the plan.

Strategy: Medicaid and Medicaid MCOs should consider allowing providers to choose the prescription refill period that most effectively meets a patient’s needs. Some Medicaid and RWHAPs recommend shorter refill periods, such as 30 days, to protect programs from paying for medications that go unused. Other Medicaid and RWHAPs prefer longer prescription refill periods, such as 90 days, because cumulative pharmacists’ fees are lower. In addition, each patient’s individual circumstances will affect the optimal refill period.

- Medicaid programs in **Louisiana** and **New York** currently allow physicians to write either 30- or 90-day prescriptions. Some patients may face socioeconomic restrictions, such as lack of access to transportation, that make 90-day prescriptions preferable. Others may have medical or socioeconomic circumstances that require shorter refill times. Shorter refill times can help patients manage copayments and establish ongoing ties with a pharmacist. Additionally, some patients may need only 30 days of medication while their medication regimens are being adjusted.

ADDITIONAL PROMISING PRACTICES

Our interviewees also identified strategies that were not in wide use among the 14 interview states, but did have the support of most of the interview states. A few interviewees have implemented these practices, and their examples are shared here.

Promising Practice: Equip Medicaid eligibility specialists, case managers, and ACA-related eligibility navigators and assisters with information about the RWHAP. Outreach and enrollment efforts that are part of ACA implementation provide an opportunity to also identify individuals eligible for RWHAP services.

- After its coverage expansions in 2001, **Massachusetts** Medicaid worked with the RWHAP program to include an HIV-positive check box on the basic Medicaid application, allowing new applicants who are HIV-positive to easily identify themselves and qualify for the state’s higher Medicaid income eligibility limit of 200 percent Federal Poverty Level (FPL) for PLWHA.

- In preparation for coverage expansions, **California** is equipping Medicaid eligibility specialists, case managers, and navigators with information about the RWHAP. In addition, the RWHAP has created fact sheets for Medicaid providers to help them identify patients who are potentially eligible for RWHAP services.

Promising Practice: Implement Medicaid health home programs that include HIV as an eligible chronic condition. The ACA, under Section 2703, established the Medicaid Health Home State Plan Option, which allows states to design health homes to deliver care to eligible Medicaid beneficiaries with chronic conditions. States with an approved Health Home State Plan Amendment (SPA) will receive a two-year 90 percent federal match for services delivered through this integrated model of care.³

- **Wisconsin** submitted a Medicaid SPA specifically for HIV health homes. The RWHAP worked in collaboration with Medicaid to develop the SPA, design the reimbursement methodology, and identify performance measures for evaluation.
- In addition, **Alabama**, **New York**, and **Oregon** have included HIV as an eligible condition in their health homes SPAs.⁴

Promising Practice: Support the HIV standards of care and quality measures by reviewing federal treatment guidelines and National Quality Forum (NQF)- and HRSA-endorsed quality measures. Measuring quality of care for PLWHA will be especially crucial as many states expand Medicaid and transition clients from the RWHAPs to Medicaid, often in managed care plans.

- **New York** has incorporated three HIV/AIDS quality measures into its Quality Assurance Reporting Requirements (QARR) for all Medicaid managed care plans. The state’s HIV-specific managed care plans report on 11 quality indicators. New York uses QARR data to monitor managed care plan performance and determine pay for performance incentive payments. The RWHAP staff participate on Medicaid Division of Managed Care committees to review HIV standards of care and aid in the development of quality initiatives.

Promising Practice: Medicaid and Medicaid MCOs should consider allowing clients to opt out of mail order pharmacy requirements. For some clients, mail order requirements have the potential to breach confidentiality. In addition, medications that are delivered unattended could be lost, stolen, or left in an environment that compromises a drug's effectiveness. Finally, access to only mail order pharmacies can mean lost opportunity for clients to consult with pharmacists about potential drug interactions. Although many of our interviewees are supportive of this promising practice, they acknowledge the challenges to securing a comprehensive network of retail pharmacies.

- Of those states we interviewed that use mail order pharmacies, Medicaid programs in **California, Louisiana, Massachusetts, and Washington** told us they do not require mail order prescriptions.
- In **New York**, Medicaid managed care plans require mail order for some drugs but allow clients to fill other prescriptions at retail pharmacies.

Promising Practice: If a mail order pharmacy is used, Medicaid and Medicaid MCOs should ensure that the pharmacy recognizes the ADAP as a third party payer and establishes a mechanism to facilitate payment coordination. In states where clients can simultaneously qualify for both Medicaid and the RWHAP, it is important that Medicaid recognize ADAP as a third party payer to ensure prescription continuity and prevent potentially prohibitively large out-of-pocket copayments for clients.

- The RWHAP in **Massachusetts** recently worked with a major commercial payer, who covers a large number of PLWHA, to revise a newly enacted policy that did not allow payment from third party payers, including from the state ADAP.

CONCLUSION

Collaboration between state Medicaid programs and the RWHAP can be challenging: multiple agencies, differing

federal requirements, and policy complexities can hinder the desire to establish a coordinated program to serve PLWHA. Despite these challenges, our interviewees provided examples of state successes in implementing strategies to establish and maintain collaboration between Medicaid and the RWHAP agencies with great benefit to the clients served by both programs. In addition, our interviewees identified and endorsed promising practices that are already being implemented in select states. Our interviewees felt that the most critical areas for collaboration are in data sharing and access to care.

Finally, our interviewees suggested actions HRSA could take to help support collaboration between Medicaid and RWHAPs. Suggestions include:

- Develop a primer on Medicaid for new AIDS directors and program staff. In parallel, develop a primer on the RWHAP for new Medicaid directors and program staff.
- Define more concretely the active liaison role and expected responsibilities of a Medicaid representative at RWHAP planning groups.
- Issue joint recommendations with the Centers for Medicare and Medicaid Services (CMS) that specify what Medicaid data should be available to RWHAPs and vice versa.
- Improve coordination of documentation and reporting requirements among federal programs that provide funding for PLWHA, including HRSA, CMS, and the Centers for Disease Control and Prevention (CDC).
- Provide resources to help RWHAP providers who are not yet enrolled with Medicaid MCOs or qualified health plans (QHPs) become credentialed and establish billing and coding systems.
- Share strategies that can help the RWHAPs advocate with their Medicaid counterparts for Medicaid health homes focused on HIV/AIDS.

NOTES

1 The Henry J. Kaiser Family Foundation, *Fact Sheet: Medicaid and HIV/AIDS* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, March 2013). <http://kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/aids>.

2 U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services & the Health Resources and Services Administration. "Coordination between Medicaid and Ryan White HIV/AIDS Programs." May 1, 2013. <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-01-2013.pdf>.

3 Charles Townley and Mary Takach, *Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues* (Portland, ME: National Academy for State Health Policy, July 2012).

4 The Henry J. Kaiser Family Foundation, *Quick Take: An Update on the ACA & HIV: Medicaid Health Homes* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, December 10, 2012). <http://kff.org/health-reform/fact-sheet/quick-take-an-update-on-the-aca>.

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Acknowledgments

The authors wish to thank the state officials from Medicaid agencies and the RWHAP programs who spoke with us through key informant interviews and advisory groups, and who thoughtfully reviewed this brief. We are grateful for the time and expertise of officials from: Arizona, California, District of Columbia, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, New York, Tennessee, Texas, Washington, and Wisconsin.

We wish to acknowledge the Health Resources and Services Administration (HRSA), specifically Heather Hauck of the HIV/AIDS Bureau for her consultation on this project, and our Project Officer, Lynnette Araki, for her continued support and guidance. Many thanks also to our NASHP colleague, Neva Kaye, for her advice and assistance. This publication was made possible by HRSA grant number UD30A22891. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

Citation:

Katharine Witgert, Jennifer Dolatshahi, Rachel Yalovich, *Strategies for Coordination Between Medicaid and Ryan White HIV/AIDS Programs*, 2013 (Portland, ME: National Academy for State Health Policy).

Portland, Maine Office:

10 Free Street, 2nd Floor, Portland, ME 04101
Phone: [207] 874-6524

Washington, DC Office:

1233 20th Street NW, Suite 303, Washington, DC 20036
Phone: [202] 903-0101