Make sure ALL persons with HIV have some sort of insurance coverage!

The ACA increases access to health insurance coverage for PLWH through a number of private insurance market reforms, expansion of Medicaid eligibility in some states, and the establishment of a Health Insurance Marketplace in every state. PLWH may be eligible for Medicaid, Medicare, Children’s Health Insurance Program (CHIP), employer-sponsored health insurance, or private health insurance (both inside and outside the Marketplace). Encourage your patients to find the best plan for their needs as soon as possible. If insurance coverage is not an option or additional cost-sharing coverage is needed, AIDS Drug Assistance Program (ADAP) coverage may be applied for, but should be used only if no other options are available for medications. In some states, ADAP may be used for insurance purchasing or insurance maintenance expenses (payment of premiums, for example), as may other sources of Ryan White funding (see policies under: http://hab.hrsa.gov/affordablecareact; or http://hab.hrsa.gov/manageyourgrant/pinspals/pcn1305premiumcostsharing.pdf).

Patients not Medicaid eligible and with income between 100% and 400% of the Federal Poverty Level or FPL (in 2013, $11,490 - $45,960 for 1 adult in the 48 contiguous United States and D.C.; $13,230 - $52,920 in HI; $14,350 - $57,400 in AK), may be eligible for Advanced Premium Tax Credits and/or cost sharing reductions to help them afford a private health plan offered in the Marketplace. For those below 100% FPL, not Medicaid eligible, and in a state without Medicaid expansion, ADAP, or other Ryan White funding, may help (depends on the state) be capable of assisting these patients in getting a Marketplace insurance plan.


Become a designated ESSENTIAL COMMUNITY PROVIDER (ECP).

An ECP serves predominantly low-income, medically underserved populations, such as healthcare providers defined in the 340B program (a federal drug pricing program available to designated “safety net” providers). This includes Ryan White providers. Health plans offered in the Health Insurance Marketplace, also known as qualified health plans (QHPs), must include a sufficient number and distribution of ECPs, but inclusion of Ryan White providers is not required. It is important to know what kind of Marketplace will be operating in your state since different standards may be in place for State-Based Marketplaces compared to the Federally-facilitated Marketplaces and State Partnership Marketplaces. You can find out which type of Marketplace your state is operating at https://www.healthcare.gov/what-is-the-health-insurance-marketplace/. States that operate a State-based Marketplace will set their own standards for determining if QHPs have a sufficient number and distribution of ECPs that may vary from standards used under the Federally-Facilitated and State Partnership Marketplaces. A federal non-exhaustive list of ECPs can be found at: https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provider/ibqy-mswq.

If your clinic is part of a larger institution, be sure to engage your organization’s leadership to ensure that you and your clinic are included in the negotiation efforts of your state Marketplace insurers. If you are in a stand-alone HIV clinic, contact your state department of insurance or state department of health to identify QHP insurers in your state. Follow the tips included in the following: http://www.nashp.org/
Become familiar with your MARKETPLACE and contract with QHP insurers in your state.

The new Health Insurance Marketplace will be a “one-stop shop” for individuals to compare qualified health plan (QHP) options, enroll in QHPs, and to find out eligibility for Medicaid or CHIP or premium tax credits to purchase private insurance. There are 3 types of Marketplaces: federally-facilitated, state partnership, and state-based. To learn more about the Marketplace in your state, visit https://www.healthcare.gov/what-is-the-marketplace-in-my-state. Please note, varying levels of information are available about Marketplaces at this point.

Persons without health insurance, and ineligible for Medicaid or Medicare, will have the option of signing up for an insurance plan in the Marketplace starting October 1, 2013. Make sure that you and your institution have contracted with the Marketplace insurers in your state, and are an identified ECP by that Marketplace insurer. Again, if your clinic is part of a larger institution, be sure to engage your organization’s leadership to ensure that you and your clinic are included in their contract negotiation efforts with QHPs.

Familiarize yourself with the types of insurance plans and provider categories within each plan in your state.

Key Questions to answer concerning the insurance plans and provider categories in your state include:

- Does your state have expanded Medicaid (Medicaid eligibility for residents with incomes ≤138% FPL)?
- Is your state’s Medicaid provided by a Managed Care Organization (MCO) or Health Maintenance Organization (HMO)? If so, you will need to be contracted with that organization in order for those with that insurance plan to be able to continue seeing you. (https://careacttarget.org/library/aca-update-negotiating-contracts-managed-care-organizations)
- What types of plans does your state Marketplace offer: an HMO, a Preferred Provider Organization (PPO — in network or out-of-network providers without PCP designation and referrals), Point of Service (POS— in network PCP with referrals needed for in network and out-of-network specialists), or an Exclusive Provider Organization (EPO—in network providers without designated PCP)?
- MAKE SURE that you are on the list of participating providers with each insurance organization contracted with your institution or organization.
- What is included with each plan and what are conditions for provider reimbursement?
- When will a referral be needed for a specialty service?
- You may be contracted as either a Primary Care Provider (PCP) or as a Specialty Provider (definitions may vary among plans). Each state is different, and each plan may define primary care and specialty care providers differently. In addition, the credentialing criteria for each type of provider and type of insurer organization may differ. For HMO marketplaces (or the similar MCOs), a referral may be needed for specialty consultations or any care received from a provider outside of the PCP or HMO network.

The HIV Medicine Association (HIVMA) offers the following advice on these issues:

http://www.hivma.org/uploadedFiles/HIVMA/Policy_and_Advocacy/Policy_Priorities/Healthcare_Reform_Implementation/Comments_on_Health_Care_Reform_Implementation/ACA%20Health%20Coverage%20Exp_Fact_Sheet_final.pdf

The AETC Program is funded by the Health Resources and Services Administration, HIV/AIDS Bureau (HRSA HAB) and is the training arm of the Ryan White Program. 8/21/13
Estimate the cost to provide quality, evidence-based healthcare to your patients.

Calculate your current costs for care provided, and estimate how this will change once the ACA is fully unrolled. For example, how many uninsured patients now will be eligible for insurance after 1/1/14? How will that affect clinic care reimbursement and operations? Will the reimbursements be fee-for-service (dependent on diagnoses, time spent, procedures) or capitation/global fees (one fixed fee for care provided)? Is your agency’s medical case management policy consistent with your state’s Office of Medicaid for Medicaid reimbursement for case manager services provided? Utilize a template/guideline for assisting you in your clinic cost analysis:

http://www.hivhealthreform.org/2013/05/02/planning-for-implementation-what-should-you-think-about/;

Assess your clinic’s strengths and weaknesses.

Some areas that you may want to focus on in your assessment include accounting systems, patient information systems, and scheduling/enrollment systems. You may also want to examine your physical space to gain a better understanding of your ability to expand. Work to strengthen your infrastructure to make your clinic more user-friendly and accessible to new and current patients with as few barriers as possible. Then, market your clinic to insurers and your community. To increase care coordination, Medicaid reimbursement, and to maximize “meaningful use” of medical records and billing systems, utilize a certified medical/health record (EMR or EHR) system. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/MedicaidStateInfo.html;

Consider becoming a Patient-Centered Medical Home (PCMH) or Patient Centered Health Home (Health Home).

A PCMH or Health Home both provide comprehensive care and assume accountability for managing a patient’s physical and mental healthcare needs, including prevention, wellness, acute and chronic care. Care is coordinated across all elements of the healthcare system through effective communication at each juncture. Enhanced access to care is promoted through shorter waiting times for care needs, expanded office hours, around the clock telephone and electronic access and is committed to quality and safety. There are a number of PCMH/Health Home recognition and/or accreditation possibilities. There are also distinguishing features of each of these. National Committee for Quality Assurance’s (NCQA’s) PCMH recognition process followed by the Joint Commission’s Primary Care Medical Home certification option for accredited ambulatory care centers are the most widely sought. In addition the URAC (formerly the Utilization Review Accreditation Commission), the Accreditation Association for Ambulatory Health Care, state Medicaid and private health insurance programs offer recognition options.

What you can do to get started is to review each recognition and/or accreditation entity to assess which is the best fit for your organization. http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/PCMH2.aspx;

To assess the extent to which your practice functions as a PCMH, and track your progress toward practice transformation you may wish to use the Patient-Centered Medical Home Assessment (PCMH-A) which was jointly developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health for the Safety Net Medical Home Initiative. http://www.safetynetmedicalhome.org/resources-tools/assessment
For the Center for Medicare and Medicaid Services (CMS) Health Home, states agree to utilize this model for the care of individuals receiving Medicaid or Medicare who have a designated chronic illness. “HIV/AIDS” has been added to a list of designated chronic illnesses making supplemental, federally funded insurance (Medicaid and Medicare) reimbursement available for the care of patients in these designated Health Homes. [http://www.kff.org/hivaids/quicktake_mhh_hiv.cfm; http://www.hhs.gov/news/press/2012pres/11/20121129a.html; http://www.integratedcareresourcecenter.com/hhstateresources.aspx]

In addition, The HIV-Medical Home Resource Center (HIV-MHRC), a HRSA funded cooperative agreement with the François Xavier Bagnoud Center, Rutgers University provides health centers and Ryan White agencies with the technical assistance and guidance needed to become a PCMH. Guidelines, tools, webinars, and on-line resources related to certification and practice transformation to become a PCMH are all available on the HRSA Target Center website.


**Familiarize and educate your patients about insurance lingo and options.**

Counsel patients on need to choose a plan, select a PCP if applicable, and to enroll in an insurance plan as soon as possible starting on October 1, 2013, if ineligible for insurance before then. This will assure health care coverage beginning as soon as January 1, 2014 (for those enrolling no later than December 15, 2013). Customize a guide for your patients using a template created by the San Francisco HIV Health Care Reform Task Force: [http://www.hivhealthreform.org/2013/05/07/download-and-customize-health-reform-q-a-for-ryan-white-program-clients/]. Also, provide education regarding which insurance card is needed for which services. For example, an MCO card is needed at health centers/clinics/EDs, and a Medicaid card is needed by pharmacies and transportation providers in Delaware. [http://dhss.delaware.gov/dhss/dmma/faqs.html#q11]

**Stay connected with local, state, and national organizations.**

Information about the ACA and its implementation in your state is evolving, so staying connected is more important now than ever.

- Participate in the quarterly HHS/CMS stakeholder calls for your state: [http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_HealthInsuranceMarketplace.html].
- Join the mailing lists of organizations, for example [https://www.healthcare.gov/subscribe/](https://www.healthcare.gov/subscribe/) and [http://profile.kff.org/](http://profile.kff.org/), working on providing ACA information for healthcare providers as well as healthcare consumers.

**Connect with the AIDS Education and Training Centers.**

There are many people living with HIV in the United States who are not receiving adequate care at this time. Multiple barriers currently exist for persons with HIV in getting on-going care, and in becoming and staying HIV undetectable. Increasing quality of care will lower long-term costs of care. Increasing quality and decreasing costs are main components of the ACA. We must continue to identify unresolved and new barriers in eliminating the HIV treatment cascade, and work to eliminate them. For continued updates and resources on ACA and HIV, stay connected to the AIDS Education and Training Center National Resource Center (AETC NRC) website ([www.aidsetc.org](http://www.aidsetc.org)). For your training and technical assistance needs, connect with the AETC in your geographic area ([http://www.aidsetc.org/aidsetc?page=ab-00-00](http://www.aidsetc.org/aidsetc?page=ab-00-00)).

---

The AETC Program is funded by the Health Resources and Services Administration, HIV/AIDS Bureau (HRSA HAB) and is the training arm of the Ryan White Program. 8/21/13