

**SUMMARY
August 2011**

**Planning for Health Care Reform:
*The HIV Care, Detection, and Prevention Perspective***

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BACKGROUND

Given the complexities of federal and state financing of medical services for people living with HIV infection and the need for HIV treatment expertise in an expanding universe of health care settings, it is critical to consider HIV-specific issues for health service delivery associated with the implementation of the Affordable Care Act (ACA). It is also important to consider the HIV testing and prevention issues and opportunities associated with ACA. Thus, the California Department of Public Health (CDPH), Center for Infectious Diseases (CID), Office of AIDS (OA) convened a stakeholder input process between May and August 2011 to assist in addressing the following objectives.

OBJECTIVES

1. Identify potential HIV-related issues associated with full implementation of ACA in 2014 and beyond.
2. Enable OA to provide technical assistance (TA) to support a seamless transition for medical care, support, testing, and prevention service delivery systems, providers, and individuals living with and at risk for HIV prior to full implementation of ACA.
3. Develop a Summary document that outlines the key HIV-specific issues in the areas of health care delivery systems (including public and private health plans both in and outside of the California Health Benefits Exchange [Exchange]), provider and workforce readiness, patient needs, and financing. When available, the summary includes experts, resources, and key outstanding questions. This Summary is not intended to be a policy paper. It is meant to assist OA in developing its TA capacity.

HIGHEST PRIORITY ISSUES/NEXT STEPS

1. Develop a multi-disciplinary infrastructure within OA to move the HIV-related health care reform (HCR) planning process forward throughout all relevant OA programs, understanding that OA's limited staff availability to develop this expertise and limited time to devote to these efforts. OA must consider potential needs to engage expert consultants during this process. This infrastructure will include an ongoing external input and advisory process that specifically includes persons living with HIV/AIDS and methods for providing updates to stakeholders.
2. Provide TA to, and develop systems of collaboration with, all current Ryan White (RW) health care providers in California who receive Part A, B, C, and D funds as well as Health Resource and Service Administration/HIV/AIDS Bureau (HRSA/HAB) and HRSA Region IX staff.
3. Provide TA to, and develop systems of collaboration with, the funders and primary TA providers that support non-Ryan White health care providers (i.e., HRSA Bureau of Primary Health Care [BPHC], HRSA Region IX, the California Primary Care Association [CPCA], Centers for Medicare and Medicaid Services [CMS], the California Department of Health Care Services [DHCS], and the Exchange).
4. Develop a communication strategy and materials for consumers with and at risk for HIV and relevant health care and support service providers as well as HIV testing and prevention providers. Ensure that OA's Web site, the Advisory Network, the

Service Referral Network and the California Planning Group are fully utilized in this communication process.

KEY ISSUES, RESOURCES, AND EXPERTS

This section is broken into four main topic areas:

Topic 1: Health Care Delivery Systems and Health Plan and Provider Readiness

Topic 2: Issues from a Consumer Perspective

Topic 3: Local, State, and Federal Fiscal Issues and Related Legislative Issues

Topic 4: Undocumented, Immigrant, Border Health, and Rural Issues

TOPIC 1: Health Care Delivery Systems and Health Plan and Provider Readiness

Much HIV-related and primary medical care for people living with HIV infection is currently provided by clinics funded through the Federal RW Program. Funding is provided through the state (Part B), to highly impacted counties (Part A), or directly to clinics (Parts C and D). Medi-Cal and Medicare are also significant payers of HIV-related medical care. There are also HIV-specific pharmacies and pharmacy reimbursement concerns. We would like to understand the preparedness issues and challenges for these HIV-specific health care delivery systems in the 2014 health insurance context. The current Medi-Cal 1115 “Bridge to Health Care Reform” Waiver is starting to provide insight into these challenges. HRSA is supporting conversions of some RW clinics to Federally Qualified Health Center (FQHC) status through its TA providers, CPCA. In addition, HRSA/BPHC-supported community clinics will face the burden of caring for many more people with HIV infection than ever before and it is important that we understand their challenges. BPHC and HRSA/HAB are collaborating on an initiative to integrate HIV care and screening into the primary care settings through HealthHIV, a HRSA/HAB’s contractor based in Washington, DC.

Topic 1 is broken into eight sub-topic areas:

A. HIV-Focused Clinics: Ryan White Issues

B. HIV-Focused Clinics: Medicaid (Medi-Cal) Issues

C. Clinics Without Significant Past HIV Experience

D. Pharmacies

E. Reimbursement and Standard of Care Issues

F. Testing, Prevention, Behavioral Health, and Support Services

G. Data Systems and Reporting Requirements

H. Workforce Capacity Issues

A. HIV-Focused Clinics: Ryan White Issues

- 1. Many HIV-focused clinics in California may not have the information, education, and TA they need to prepare to participate in the Exchange-associated health plans associated with ACA.**
 - *Until it becomes clear that HRSA, other federal partners, and/or the Exchange will develop guidance to assist with the transition of RW clinics to these health plans, OA may choose to take the lead in developing such guidance. Such work should occur in collaboration with these federal and state partners.*
- 2. If RW clinics do not contract with Exchange providers, their patient population will contain more disenfranchised, resource-poor, higher needs individuals. RW clinics will need to assess if they will they be able to survive financially with a smaller patient load, covered only by Medi-Cal (for the documented) and RW (for the undocumented).**
- 3. All RW clinics, regardless of funding source, will need to prepare to participate with Exchange-associated health plans relatively soon; however, the time pressures are not clearly understood.**
 - *OA will need to closely monitor this situation, including understanding when the contracting process for Exchange plans is occurring, and develop a work plan and RW clinic communication strategy to accommodate the timing issues.*
 - *It would be helpful to identify partners at the Exchange who can assist in ensuring that OA has this information as it becomes available.*
- 4. There may be unique HIV-related preparedness concerns for clinics funded by RW Parts A, B, C, and D.**
 - *OA is likely to have much more expertise to offer, and access to, RW Part B Programs. OA will need to work with HRSA and their Part A, C, and D grantees to facilitate coordinated and consistent outreach, communications, and TA.*
- 5. To qualify to become an FQHC, clinics have to demonstrate need exists and that they can meet this need completely. Clinics applying for FQHC status will need to know how to demonstrate the need to see HIV-positive patient in community clinics. This will be especially challenging for clinics that do not have HIV medical expertise and would need to refer out all other patients.**
 - *OA will need to work with CPCA to understand how they are working with RW clinics now to assist in conversion to FQHC status and to provide TA to CPCA to maximize availability of these resources for all relevant RW clinics.*
 - *OA should become familiar with the Office of Statewide Health Planning and Development (OSHPD) work to assist clinics with FQHC applications.*

HRSA / HAB	Laura Cheever
HRSA / HAB	Steven Young
HRSA / BPHC	Seiji Hayashi
HRSA Region IX	John Moroney and Lorenzo Taylor
HealthHIV	Brad Ward
CPCA	Tahire Bazile
OSHPD / Shortage Designation Unit	Konder Chung
Exchange	Peter V. Lee
American Academy of HIV Medicine (AAHIVM)	Holly Kilness and Bruce Packett
HIV Medicine Association (HIVMA)	Andrea Weddle
Los Angeles Gay and Lesbian Center (LAGLC)	Quentin O'Brien
Project Inform	Anne Donnelly
Los Angeles Commission on AIDS	Craig Vincent-Jones
Consultant	Julie Cross

6. **There may be duplication in services between a patient’s new Community Health Center (CHC)-associated Patient-Centered Medical Home (PCMH) and RW service providers that consumers may continue to see on a referral basis from PCMH.**
- *RW grantees (Parts A, B, and C) will be responsible for ensuring that Payer of Last Resort federal statutory requirements are met for consumers who receive both referral services in RW clinics and care in CHCs as their PCMH. This issue should be addressed in the communication and TA strategy that HRSA and OA develop, with the goal of coordination and eliminating duplication and gaps in needed services.*

HRSA / HAB	Steven Young
HRSA / BPHC	Seiji Hayashi
HRSA Region IX	John Moroney and Lorenzo Taylor
California HIV/AIDS Research Program (CHRP)	John Mortimer
Center for AIDS Prevention Studies (CAPS)	Wayne Steward
Pacific AIDS Education and Training Center (PAETC)	Kathleen Clanon and Mona Bernstein
Patient-Centered Primary Care Collaborative (PCPCC)	No Contact Identified

B. HIV-Focused Clinics: Medicaid (Medi-Cal) Issues

1. Will Medi-Cal require persons with disabilities be served by medical homes through managed care for seniors and persons with disabilities (SPD) and/or the Medi-Cal expansion in 2014?
2. Medi-Cal/Medi-Cal Managed Care (MMC) plans need to have access to, or develop standards of care for treating people with HIV/AIDS.
3. Issues that are and will be experienced with the SPD portion of the Medi-Cal 1115 Bridge to Health Care Reform Waiver now and up to 2014 may provide insight into potential issues with full ACA implementation. Such issues to date have included the need to provide support and assistance to help transition providers and consumers to managed care and challenges with exemption requests during this transition.
 - *It would be helpful if DHCS could collect and share with OA any HIV-specific TA requests during this transition.*

Table 3. Potential Resources/Experts Issues 1 – 3	
DHCS / Medi-Cal Managed Care Division	Tanya Homman
DHCS / Health Care Programs	Toby Douglas

4. It is not yet known how managed care systems will be applied to dual eligible (Medi-Cal and Medicare) persons living with HIV infection.
 - *OA will need to work with DHCS to understand how this issue is evolving at the federal and state level and to consider potential implications for people living with HIV infection.*

Table 4. Potential Resources/Experts Issue 4	
DHCS / Medi-Cal Managed Care Division	Tanya Homman
DHCS / Health Care Programs	Toby Douglas
Federal Coordinated Health Care Office	No Contact Identified

C. Clinics Without Significant Past HIV Experience

- 1. Many HRSA/BPHC-supported CHCs may not be prepared to care for any, or more, people living with HIV infection.**
 - *OA and local health jurisdictions, working with CPCA, may be able to facilitate relationships to allow clinics with HIV experience that cannot gain FQHC status to become referral centers for FQHC clinics.*
- 2. CHCs will need to provide regular access to HIV-knowledgeable specialty medical services (e.g., psychiatry) and psychosocial support services within and/or external to CHC.**
 - *OA will have to determine its role in facilitating relationship and collaboration building between new clinics and the existing HIV social service provider community.*
 - *Many of PAETC 's local sites have the capacity to provide TA and/or training to CHCs newly offering HIV care. PAETC has the recent experience in Sonoma County's transition from HIV specialty county clinic to CHC-based care (see Appendix A, page 34).*
- 3. Some CHCs will need training to recognizing and address substance use (especially methamphetamine) as it is related to HIV risk.**
- 4. CHCs will need to know how to provide medical and psychosocial care to transgender people and those who inject drugs.**
- 5. CHCs with PCMH models may be especially well-suited to provide HIV care if they can develop adequate expertise.**
- 6. HRSA/HAB recently funded an initiative called the AIDS Education and Training Centers (AETC) National Center for HIV Care in Minority Communities (NCHCMC) (<http://www.nchcmc.org/>) to develop the organizational capacity of CHCs that are not directly funded through the RW Program. NCHCMC is led by HealthHIV in collaboration with the National Association of Community Health Centers (NACHC). HealthHIV provides HIV-related TA, capacity building, and medical education services to advance effective prevention, care and treatment, and support for people living with, or at risk for, HIV. NACHC provides education, training, TA, and leadership development to health centers to promote excellence and cost-effectiveness in primary care. Twenty-four health centers, including six in California, have been selected for NCHCMC's new initiative. While the application period for the HIV in Primary Care Learning Community is now closed, NCHCMC will begin accepting applications for their next cohort in early Fall 2011.**
 - *OA will need to monitor NCHCMC's impact and work with HRSA to enable scale up across California if it is successful.*

Table 5. Potential Resources/Experts Issue 1-7	
HRSA / HAB	Steven Young
HRSA / BPHC	Seiji Hayashi
HRSA Region IX	John Moroney and Lorenzo Taylor
HealthHIV	Brad Ward
CPCA	Tahire Bazile
Exchange	Peter V. Lee
PAETC	Mona Bernstein
The National Clinicians Consultation Center	Ron Goldschmidt
AETC: The HIV in Primary Care Learning Community Initiative	Brad Ward and Kathy McNamara
AAHIVM's high-volume to low-volume provider consultation program	Holly Kilness and Bruce Packett
HIVMA	Andrea Weddle
CHCs and non-CHC RW clinics in similar areas that provide HIV care	Laura Cheever, Seiji Hayashi, and John Moroney
"HIV Screening and Access to Care; Health Care System Capacity for Increased HIV Testing and Provision of Care," Institutes of Medicine (IOM)	N/A
Free HIV Performance Improvement Continuing Medical Education for Primary Care Providers	N/A
Center for Integrated Health Solutions guides to integrating substance use and mental health into care	N/A

D. Pharmacies

1. **HIV-specific pharmacies, other pharmacies that currently serve clients living with HIV, and pharmacies that do not currently serve consumers living with HIV, may have reimbursement concerns.**
 - *Working with pharmacy colleagues identified below, and potentially in collaboration with the AIDS Drug Assistance Program (ADAP) Pharmacy Benefits Manager, OA may survey or conduct conference calls with pharmacies in the ADAP network to more completely understand their concerns and devise strategies to address these concerns, wherever possible.*

2. **Some health care systems may have limited pharmacy networks, creating challenges with patient access to pharmacies.**

3. **Pharmacies throughout California that serve consumers under expanded insurance options available through ACA will need to stock the full spectrum of antiretrovirals and other medications currently on the ADAP formulary to minimize the risk of the development of antiretroviral resistance due to delays in accessing stock.**
 - *OA may consider providing TA to Medi-Cal and the Exchange, utilizing existing ADAP, RW care, prevalence and new diagnosis data, to predict potential current and future caseload for consumers seeking HIV-related medications at pharmacies throughout California.*

4. **Consumers who are not eligible for ACA insurance will still have access to ADAP. It may be challenging to maintain the ADAP network when the program is smaller.**
 - *OA will carefully monitor federal policy and anticipate potential challenges in this area.*

5. **It is not known if ACA-associated health care systems will have mechanisms to provide medications to consumers when billing problems emerge or if they will have the ability to quickly resolve such issues.**
 - *OA may consider providing TA to Medi-Cal and the Exchange to assist them in understanding the need to avoid missing any doses of antiretrovirals.*

Table 6. Potential Resources/Experts Issues 1-6	
ADAP Medical Advisory Committee (MAC) Pharmacists	Craig Ballard, Michelle Sherman, and Jennefer Yoon
MOMS Pharmacy	Gilbert Melo, Andrea Hotton, and Michael Tubb
California Pharmacists Association	Jeff Goad
Walgreens Pharmacy	Chris Nguyen
LAGLC	Quentin O'Brien

E. Reimbursement and Standard of Care Issues

- 1. Relative reimbursement rates across Medi-Cal, Medicare, and Exchange products may impact provider choices about consumer payer mix (i.e., how many patients they will accept with each payer type including Medi-Cal, Medicare, and private insurance) and thus access to care for consumers living with HIV.**
 - *OA, working with state partners in DHCS and the Exchange, will monitor rate schedules across these programs.*

- 2. As payment systems and reimbursement rates shift, existing HIV medical system for the uninsured may be challenges to transition and to remain economically viable.**

- 3. As treatments and the standard of care change, it will be important that a more diffused landscape of providers stays abreast of changes. OA will have no direct access to providers it does not fund, creating additional challenges to access and communicate with them.**
 - *OA, working with HRSA/HAB, HRSA/BPHC, DHCS, Exchange, CPCA, AAHIVM, PAETC, and others, may want to develop mechanisms to identify all providers of HIV care in California and provide available clinical guidelines updates and Continuing Medical Education resources to them. This leveraging and communication function could be built into the current Advisory Network structure.*

- 4. It will be important that care models that separate out HIV “specialty” and “primary” care have high quality systems for communication and collaboration to avoid fragmented care. Existing co-management systems (i.e., partnerships between CHCs and external HIV clinical experts) may be effective models. The collaborative and referral relationships between traditional HIV providers and CHC providers are complicated.**
 - *OA may want to invest in developing a comprehensive understanding of these issues in order to identify mechanisms to support integrated and effective medical care for this population.*

HRSA / HAB	Steven Young
HRSA / BPHC	Seiji Hayashi
HRSA Region IX	John Moroney and Lorenzo Taylor
Exchange	Peter V. Lee
AAHIVM	Holly Kilness and Bruce Packett
California Medical Association (CMA)	Michelle Chapanian
CPCA	Tahire Bazile
HIVMA	Andrea Weddle
Association of Nurses in AIDS Care (ANAC)	Adele Webb
NACHC and local CHCs	Ann McNamara

- 5. Some people living with HIV infection (who may or may not know it) will enter the health care systems because they have developed co-morbidities (e.g., concurrent tuberculosis or another sexually transmitted disease). Given the history of categorical Centers for Disease Control and Prevention (CDC) funding and resulting public health system structure, it may be challenging to shift the future care of these populations from a disease-focused approach to one that is more holistic. This issue is relevant to other populations living with diagnosed or undiagnosed HIV infection, such as those seeking family planning services and those with other chronic diseases, such as hepatitis C.**
- OA, CID, and CDPH will need to determine if and how to prioritize partnering with other public health and health care programs to encourage a patient centered approach.*

Table 8. Potential Resources/Experts Issue 5	
HRSA / HAB	Steven Young
HRSA / BPHC	Seiji Hayashi
HRSA Region IX	John Moroney and Lorenzo Taylor
DHCS / Health Care Programs	Toby Douglas
DHCS / Medi-Cal Managed Care Division	Tanya Homman
CDPH Leadership	Ron Chapman, Kathleen Billingsley, and Jean Iacino
CID Leadership	Gilberto Chavez, Drew Johnson, and James Watt
CID ACA Lead	Jessica Nunez de Ybarra
CDPH / Office of Family Planning (OFP)	Laurie Weaver
CDPH / Center for Chronic Disease Prevention and Health Promotion	Linda Rudolph
CDC / Division of HIV/AIDS Prevention (DHAP) Prevention Through Health Care Lead (To Be Hired)	Jono Mermin (while hire pending)
CHRP	John Mortimer
CAPS	Wayne Steward

6. Lessons learned and resources acquired regarding RW, CHC, and Low-Income Health Program (LIHP) providers: NCHCMC and LIHP

- *OA has requested all HRSA/HAB RW and HRSA/BPHC-funded CHC information for California. HealthHIV also provided OA with a related list when OA was assisting with clinic application recruitment for the new NCHCMC initiative. DHCS has provided OA with LIHP-contractor information. OA is in the process of identifying or creating a directory of all such clinics in California and will need to decide if it can devote ongoing resources to keeping this directory up-to-date and how best to do so in this shifting environment.*
- *RW clinics and county administrators are starting to collaborate with local LIHP administrators to identify needs and opportunities for RW clinics to contract with county LIHPs. OA is providing TA to LIHP to ensure they have the appropriate contact information. OA will need to decide if and how it can devote ongoing resources to support this RW-LIHP collaboration.*
- *OA will continue to be engaged in the LIHP implementation process and watch for best practices and lessons learned to share at the local level both during LIHP implementation and as we consider the implications for health care delivery and consumer coverage transitions in 2014.*

**Table 9. Potential Resources/Experts
Issue 6**

HRSA / HAB	Steven Young
HRSA / BPHC	Seiji Hayashi
HealthHIV	Brad Ward
DHCS / LIHP	Jalynne Callori and Jane Ogle

F. Testing, Prevention, Behavioral Health, and Support Services

- 1. The elements of the essential benefits packages for HIV testing, prevention, and behavioral health services are yet unknown. It is also not known how HIV-specific HRSA and CDC resources will integrate or wrap around the essential benefits packages for Medi-Cal expansion and Exchange.**
 - *OA will continue to monitor and plan for potential program and policy implications, as well as provider and consumer education and TA needs, regarding the outcome of these decisions.*

- 2. HIV testing is only covered under U.S. Preventive Services Task Force (USPTF) for “high-risk” people. However, in August 2011, at the recommendation of IOM, the U.S. Department of Health and Human Services (DHHS) Secretary recently made the decision to add sexually active women to the list of covered individuals. Screening is not currently covered under Medi-Cal and it is not known if it will be covered.**

- 3. Many clinical settings do not yet have the expertise or interest in implementing routine HIV screening.**
 - *OA has a large and growing focus on this area. We will need to expand our CDC- and HRSA-funded work to increase the identification of those with unknown HIV status and to ensure linkage to and retention in care for all people living with HIV. Furthermore, OA will need to ensure that this direction corresponds with ACA regulations – and subsequently those of CDC and HRSA in order to effectively take on this issue. Scale-up will require working with numerous partners throughout the state.*

- 4. Some CHCs, and managed care providers specifically, will need HIV-specific cultural competency and stigma reduction training. They will need to be aware that some consumers transitioning to CHCs may be uncomfortable in a “blended,” rather than in an HIV-specific, clinic setting. Clinics will also need to be able to integrate prevention strategies like behavioral risk assessment and counseling, prevention with positives, partner services, intensive adherence assessment, and support.**

Table 10. Potential Resources/Experts Issues 1 – 4	
HRSA / HAB	Laura Cheever and Steven Young
HRSA / BPHC	Seiji Hayashi
HRSA Region IX	John Moroney and Lorenzo Taylor
HealthHIV	Brad Ward
CPCA	Tahire Bazile
Exchange	Peter V. Lee
CDC / DHAP Prevention Through Health Care Lead (to be hired)	Jono Mermin (while hire pending)
CID ACA lead	Jessica Nunez de Ybarra
National Alliance of State and Territorial AIDS Directors (NASTAD)	Contact Not Identified
CHRP	John Mortimer
CAPS	Wayne Steward
The AIDS Institute	Carl Schmid
PAETC	Mona Bernstein
The National Clinicians Consultation Center	Ron Goldschmidt
California community-based organizations with expertise in HIV testing and prevention	Contact Not Identified
CMA	Michelle Chapanian

G. Data Systems and Reporting Requirements

1. **Information technology funds and TA may be needed for RW clinics to meet the standards for integration into the Exchange-associated health plans.**
 - *OA will need to develop increased expertise in Health Information Technology and Meaningful Use in order to provide TA on these issues. It would also be helpful for OA to identify any funding resources and share within the RW care provider network.*

2. **It is not known what kinds of HIV-specific outcomes or performance measures new providers will be expected to meet, who will develop and monitor them, and if it will be possible to incorporate the reporting requirements for RW and CDC into existing clinic databases. It is also not known how data collection and reporting will occur in CHCs not funded by RW or if there will be any access to client-level data from these sites. If not, this may adversely impact OA’s ability to monitor trends, particularly if OA does not have access to non-OA-funded clinical service data.**
 - *OA will need to monitor the development of these requirements and their implementation to ensure that OA surveillance and program staff and our clinical provider stakeholders are informed about and prepared to respond to new reporting requirements.*

3. **The way that HIV surveillance in California is performed will need to be able to adapt to the much more diffuse landscape that HIV-positive and at-risk consumers will be interacting with in order to ensure accurate surveillance data are available.**
 - *OA surveillance staff and program staff will need to be prepared to work closely with existing and new providers to ensure that they are prepared for the reporting requirements that come with treating people living with HIV infection.*

Table 11. Potential Resources/Experts Issues 1 – 2	
HRSA / HAB	Faye Malitz
CDPH / Division of Communicable Disease Control / CID	Jessica Nunez de Ybarra
CDPH / Health Information and Strategic Planning (HISP)	Linette Scott
CDC / DHAP Prevention Through Health Care Lead (to be hired)	Jono Mermin (while hire pending)

H. Workforce Capacity Issues

- 1. Given the current provider workload, it will be challenging to devote the time and resources necessary to successfully implement changes associated with ACA**
- 2. The existing and projected HIV workforce capacity in California must be clearly understood.**
 - *There are not high quality data to quantify the concern about an aging HIV specialty workforce and few new providers entering into this specialty.*
 - *It would be very helpful to know how many physicians, nurse practitioners, and physician assistants provide all medical care (HIV and primary) versus just HIV and just primary medical care to HIV-positive consumers in California now and in what clinical settings.*

Table 12. Potential Resources/Experts Issues 1 – 2	
University of California, Los Angeles (UCLA) School of Public Affairs	Arleen Leibowitz
HRSA/ HAB	Laura Cheever
CMA	Michelle Chapanian
AAHIVM	Holly Kilness and Bruce Packett
HIVMA	Andrea Weddle
List of RW Parts A, B, C, and D Providers	Under Development (Karl Halfman)

TOPIC 2: Issues from a Consumer Perspective (see also TOPIC 1)

Background

Changes in the health care delivery systems and health plans, as well as health care provider capacity, will have implications in the lives of consumers. Newly eligible consumers will need to navigate the state portal to acquire insurance through Medi-Cal (expansion and regular) and the Exchange or acquire insurance on their own. There is potential for consumers already in the health care system to experience disruption in clinic and provider relationships.

This section is broken into three sub-topic areas:

- A. Educating, Informing, and Supporting Consumers**
- B. Ensuring Continuity of Care**
- C. Consumer and Stakeholder Input Opportunities Within the Health Care System**

A. Educating, Informing, and Supporting Consumers

- 1. Change is scary. It will be important to mitigate fear about changes in the health care delivery system and insurance structures and all of their implications as much as possible.**
 - *OA staff, consumers, and advocates can learn from our collective experiences from Senate Bill (SB) 699, the HIV names reporting law. The “story” of the fears, communication, and success around this process could provide a useful set of lessons for consumers, advocates, and OA staff.*
- 2. Consumers need easy and ongoing access to information regarding HCR.**
 - *The National Library of Medicine has “Instant Grants” and other grants to foster medical literacy and access to online medical resources. OA will want to monitor for the availability of similar grants available through or to support ACA. The OA Advisory Network is one mechanism through which information of this nature will be disseminated to appropriate stakeholders.*
- 3. Consumers may be confused and/or unaware about when various components of ACA are being instituted nationally and specifically in California, including the current:**
 - **Enrollment of current Medi-Cal SPDs into managed care (California-specific).**
 - **Availability of Pre-existing Condition Insurance Program (PCIP - national) and now OA-PCIP (California-specific).**
 - **Expansion of Comprehensive AIDS Resources Emergency/Health Insurance Payment Plan (HIPP) to the new OA-HIPP (California-specific).**
 - **Development of LHPPs (California-specific).**

and the 2014:

- **Medi-Cal expansion.**
 - **Exchange availability.**
 - *Identifying or creating easy to understand “big picture” resources to explain this for consumers, providers, and OA staff would be very helpful. Note that the [OA Insurance Assistance Section](#) has created some consumer and provider education materials to explain OA-HIPP, PCIP, OA-PCIP and ADAP. In addition, OA is working with LIHP to develop an implementation plan to screen RW consumers for LIHP eligibility that will also include consumer and provider education materials. All of these can be considered “living” resources and can also be used to create a single or multi-stage comprehensive big picture resource. Such resources will be shared through the Advisory Network and posted on OA’s Web site as appropriate.*
- 4. Consumers as well as OA staff may benefit from high-quality orientation and education about Medi-Cal and Exchange-related managed care for people living with HIV by state partners that administer those programs and other experts.**
 - *OA will need to monitor and understand how managed care may impact consumers who also receive RW Part B services.*
 - 5. Consumers may need guidance about and/or assistance with using the Web-based portal.**
 - *OA will need to monitor and understand how the “navigator” component of ACA is implemented and how this can be used by our consumers and the providers who work with them. We will also need to be aware of the limitations of the navigator system and direct resources to any unmet needs identified in this area, to the extent that these resources are available.*
 - 6. Consumers may have concerns about information-sharing that results from ACA (e.g., electronic medical records, information required to ensure that consumers access insurance resources and use RW as a payer of last resort, etc.)**
 - *OA will need to decide how many resources to devote to monitoring and understanding the information-sharing requirements related to ACA in order to educate consumers and provide TA to their providers and advocates. OA will need to monitor the implications of any existing or proposed statute in California that may have implications in these areas.*
 - 7. Consumers may have concerns that their care will not be up to the standards of expert HIV medical care.**
 - *OA will need to monitor and understand the grievance processes that are available to consumers through Medi-Cal and the Exchange, as well as RW.*

Federal Coordinated Health Care Office	Contact not identified
DHCS / Medi-Cal Managed Care Division Exchange	Tanya Homman
DHCS / Health Care Programs	Peter V. Lee
CPCA	Toby Douglas
AAHIVM for private providers	Tahire Bazile
HIVMA	Holly Kilness and Bruce Packett
Kaiser Family Foundation Web Site	Andrea Weddle
California Health Care Foundation (CHCF)	Jen Kates
Asian/Pacific Islander (API) Wellness Center /California Statewide Training & Education Program(CSTEP)	Sandra Shewry and Mark Smith
HelpWithBenefits.com	Lance Toma, Jane Dalugdugan, and Lina Sheth
Consultant	Jacques Chambers
AIDS Service Center	Julie Cross
Western Center For Law and Poverty	Vicky Pulatian
Los Angeles Commission on HIV	Elizabeth Landsberg
Office of AIDS Programs and Policy/ Prevention Planning Committee (PPC)	Craig Vincent-Jones and Brad Land
Health Insurance Counseling and Advocacy Program (HICAP)	Jeff Goodman
HealthCare.gov	Contact Not Identified
Positive Resource Center	NA
Existing state and local planning bodies	NA

B. Ensuring Continuity of Care

1. Consumers who already have a health care provider may experience disruption in clinic and provider relationships.
2. Consumers may have problems obtaining subsidies for Exchange-purchased insurance.
3. Consumers may experience negative fiscal or other consequences if they do not report income increases or if they have pending applications in multiple programs.
4. It is not clear what the “navigation” system will consist of and how/if current benefits counselors/case managers (including RW-funded staff) and others will be trained to assist consumers in working with Medi-Cal or other county programs as consumers’ circumstances change.
 - *OA will need to monitor the development of this system and associated training resources and plan for additional training of OA-funded staff and others as needed and feasible.*
 - *OA will need to monitor for available funding and TA partners to develop and update training for enrollment workers at the county level and to provide ongoing training so that all patients can be navigated through changes by someone who understands the implications for the individual.*

DHCS/ Medi-Cal Managed Care Division	Tanya Homman
DHCS / Health Care Programs	Toby Douglas
Exchange	Peter V. Lee
API Wellness / CSTEP	Lance Toma, Jane Dalugdugan, and Lina Sheth
HICAP	Contact Not Identified
Positive Resource Center	Contact Not Identified

C. Consumer and Stakeholder Input Opportunities Within the Health Care System

1. Both CHCs and RW Part A (county health department) and B (state health department) grantees have existing but different community input processes. It may be valuable to integrate or coordinate these processes to allow consumers to voice concerns about, and have a voice in, issues related to service delivery in CHCs, RW Part A and B grantee clinics, and RW Part C grantee clinics that are not also CHCs.
2. Grievance processes will need to be easy to navigate and adequate.
3. Consumer education and empowerment to facilitate good working relationships with medical professionals may be increasingly important as HIV care is integrated into the larger health care system.
4. Consumer education about HIV and associated diseases including aging issues such as cardiac concerns, dementia, and osteoporosis may also be increasingly important as HIV care is integrated into the larger health care system.

**Table 15. Potential Resources/Experts
Issues 1 - 4**

Western Center For Law and Poverty	Elizabeth Landsberg
Kaiser Family Foundation	Jen Kates
Los Angeles Commission on HIV – Standards of Care Committee	Craig Vincent Jones
Western Center For Law and Poverty	Elizabeth Landsberg
Public Law Center (or similar HIV specific legal counsels)	Contact Not Identified
CHC Community Input Process	NA
RW Part A Guidance on Community Planning	NA
RW Part B Guidance on Community Planning	NA
Current recommendations from New York State Department of Public Health	NA
Existing state and local planning bodies	NA

TOPIC 3: Local, State, and Federal Fiscal Issues and Related Legislative Issues

Background

Financing of health care for people living with HIV infection is likely to shift with full implementation of ACA. OA will need to be aware of potential shifts in federal and state funding and private insurance systems. OA will also need to anticipate the impact of the evolution of the Exchange, Medi-Cal Expansion, and regular Medi-Cal on publically funded HIV care and treatment programs financed by the federal government and the state and administered by the state and local governments and clinics. Specifically, OA's HIV Care Program (RW financed), ADAP (RW and state financed), and insurance premium payment programs (RW financed) are likely to be affected. Substantial federal financing through the RW Care Act, historic state support of HIV medical care and treatment through ADAP, and significant county support in highly impacted areas, have created a comprehensive safety net system of HIV primary and specialty care and access to critical medications has been established in California. With ACA, there are likely to be considerable shifts in RW funding as of 2014. These shifts will affect the state, counties, clinics, providers and patients, with unknown impact the existing safety net of HIV-related services. HRSA has started working on some of the critical transition issues, but there are still many questions to be considered and addressed.

1. The content of the RW Care Act as of the 2013 reauthorization is unknown.

- **It is possible that there may be a loss of RW funding to pay for support services to link and maintain people with HIV infection in care.**
- **Federal policies about the use of RW funds to pay for health insurance premiums, out-of-pocket costs, and wrap-around services may or may not change.**

If RW policies change, this will likely have an impact on OA's programs as well as Part A, C, and D RW Programs.

2. It is not know what criteria Congress or HRSA may develop regarding premium payments for those eligible for subsidies in the Exchange and for those with higher income levels and how these policies will be prioritized relative to maintaining basic care for those not eligible for ACA-associated health insurance coverage.

3. The availability of CDC testing and prevention resources and how these resources and funding policies will be coordinated with HRSA funding and policies remains unclear in the ACA context.

4. The state and/or counties may eliminate or restructure the use of HIV-specific funding.

- *OA will need to monitor closely the potential shifts in HIV-specific funding at the state level for implications on RW Maintenance of Effort (MOE) and Match requirements.*

Table 16. Potential Resources/Experts Issue 1 – 4	
HRSA / HAB	Laura Cheever
CDC / DHAP	Jono Mermin
Exchange	Peter V. Lee
NASTAD	Julie Scofield, Murray Penner, and Ann Lefert
Urban Coalition of HIV/AIDS Prevention Services (UCAPS)	To Be Determined
Trust for America's Health	Jeff Levi
Communities Advocating Emergency AIDS Relief (CAEAR) Coalition	Ernest Hopkins

TOPIC 4: Undocumented, Immigrant, Border, and Rural Population Issues

Background

ACA will not provide new coverage opportunities for undocumented populations. The future availability and extent of RW funding to serve this population is unknown. There are also unique access, retention and quality issues for immigrants, border populations, and rural populations.

- 1. ACA will not provide new coverage opportunities for undocumented people living with and at risk for HIV in California.**
 - *OA will need to pay close attention to the options for this population as guidance is developed at the federal level.*
 - *Ensuring that county and local providers are aware of their resource options for this population will be critical to ensuring that individuals are adequately connected with HIV prevention and care resources.*
 - *It might be helpful to develop a comprehensive description of how undocumented people living with HIV infection in California are currently able to access health care, prevention, and social services through state and county-specific programs. This description could include estimates of the number and proportion of consumers currently receiving RW services who are undocumented and in need of ongoing services in 2014, as well as an estimate of the cost of those services. Development of such a resource would need to be done in a sensitive manner that does not endanger programs or the undocumented or increase mistrust in these populations of institutions.*
- 2. The future availability and extent of RW funding to serve the undocumented is unknown. Financing will still be necessary to provide medical care and treatment to undocumented people living with HIV infection.**
 - *OA will need to be sensitive to the privacy needs of consumers with legal concerns about their immigration status when creating messaging for programs around serving the undocumented.*
- 3. Additional burdens will be placed on OA when managing two different systems – one for undocumented populations and the other for documented populations.**
- 4. As programs will be under increased pressure to screen for eligibility, addressing the fears of undocumented consumers regarding deportation will be especially important.**
 - *OA will want to monitor for any tools that HRSA provides to address this sensitive set of issues.*

- 5. There are unique access, retention, and quality issues for immigrant populations (regardless of legal status) among those living with and at risk for HIV in California.**
 - *Ensuring that providers have access to training for cultural and linguistic appropriateness of care and outreach materials (including for API communities) will be especially important as the safety net for these populations changes. The Advisory Network will disseminate information about cultural competency trainings to clinicians.*

- 6. The social conditions in which border populations exist pose unique access, retention, and quality of care issues. Consumers living with HIV may choose to return their country of origin, due to safety concerns and fears of discrimination and/or deportation, opting to discontinue treatment rather than to receive treatment in an environment that feels hostile.**

Table 17. Potential Resources/Experts Issue 1-6	
NASTAD / Government Relations	Ann Lefert
National Center for HIV Care in Minority Communities (NCHCMC)	Brad Ward and Kathy McNamara
The National Clinicians Consultation Center	Ron Goldschmidt
AAHIVM's high-volume to low-volume provider consultation program	Holly Kilness and Bruce Packett
HIVMA	Andrea Weddle
The United Health Group	Catherine Anderson
University of California, San Francisco / San Francisco General Hospital Positive Health Program	Rebecca Schwartz
University of California, San Diego (UCSD) Binational Program	Contact Not Identified
UCSD / Division of Global Public Health	María Luisa Zúñiga and Steffanie Strathdee
UCSD / Department of Political Science	Wayne A. Cornelius
UCSD / Fellow	Gina Osorio
University of Iowa, College of Public Health / Department of Health Management and Policy	Clinton MacKinney
Los Angeles County Department of Public Health	Mario Perez
California Conference of Local Health Officers (CCLHO)	N/A
California Conference of Local AIDS Directors (CCLAD)	N/A
Exchange	Peter V. Lee
PAETC	Mona Bernstein
Union of Pan Asian Communities	AsherLev Santos
Alliance for Health Reform	Ed Howard
AIDS Healthcare Foundation	Jorge Saavedra
California Center for Connected Health Policy	Mario Gutierrez
CPCA	Tahire Bazile
HIV and Undocumented Immigrants , 2010, AIDS Legal Council	N/A
Variations in Healthcare Access and Utilization among Mexican Immigrants: The Role of Documentation Status , Arturo Vargas, et al 2010	N/A
Left out under Federal Health Reform: Undocumented immigrant adults excluded from ACA Medicaid Expansions , 2011	N/A

7. Health care providers in rural populations may not get adequate exposure to these issues, and consequently, may not participate in the health plans. This may result in consumers living with HIV in these areas being denied access to their providers.
8. The utilization of technology may provide critical tools to help to mitigate shortages of providers with adequate expertise in rendering services to rural populations and other communities with an inadequate access to providers. Especially telemedicine and support programs for providers (i.e., Service Referral Network and other hotlines, and mentoring programs, such as the low/high-volume HIV provider partnership offered by AAHIVM). These may.
 - OA will want to monitor and disseminate the status of reimbursement options for these resources within Medicaid, Medicare, the Exchange, and RW systems.

**Table 18. Potential Resources/Experts
Issue 1-2**

HRSA / Office of Rural Health Policy	Tom Morris
The National Clinicians Consultation Center	Ron Goldschmidt
AAHIVM's high-volume to low-volume provider consultation program	Holly Kilness and Bruce Packett
NACHC	No Contact Identified
HealthHIV	Brad Ward
San Francisco State University (SFSU) / Cesar Chavez Institute	Rafael Diaz
University of California, Davis (UCD) / Center for Health Technology	Thomas Nesbitt
California Telehealth Network	Christine Martin
San Francisco AIDS Foundation	Jorge Zepeda
Getting Connected: Can the ACA Improve Access to Health Care in Rural Communities? October 13, 2010	N/A

Appendix A: Contact Information for Identified Experts

Agency	Contact Person	Contact Information
ADAP MAC Pharmacists	Craig Ballard	(619) 543-3714 craigball@aol.com
	Michelle Sherman	(714) 317-4481 michrx@earthlink.net
	Jennefer Yoon	(408) 885-7636 jennefer.yoon@hhs.co.scl.ca.us
<u>AETC: The HIV in Primary Care Learning Community Initiative</u>	Brad Ward	(202) 507-4735 brad@healthhiv.org
<u>AIDS Service Center</u>	Vicky Pulatian Comprehensive AIDS Resources Emergency(CARE)/HIPP Enrollment Worker	(626) 441-8495
<u>The Alliance for Health Reform</u>	Ed Howard Executive Vice President	edhoward@allhealth.org
<u>AAHIVM</u>	Bruce Packett Deputy Executive Director	(202) 659-0699 ext. 12 Bruce@AAHIVM.org
	Holly Kilness Director of Public Policy	(202) 659-0699 ext. 20 Holly@AAHIVM.org
<u>API Wellness Center / CSTEP</u>	Lance Toma Executive Director	(415) 292-3420 ext. 355 lance@apiwellness.org
	Jane Dalugdugan Community Development Program Manager	(415) 292-3420 ext. 329 jane@apiwellness.org
	Lina Sheth, Director Community Development and External Affairs	(415) 292-3420 ext. 320 lina@apiwellness.org

<u>ANAC</u>	Adele Webb	(330) 670-0101 adele@anacnet.org
<u>The Exchange</u>	Peter V. Lee	N/A
<u>CHCF</u>	Mark Smith President and Chief	msmith@chcf.org
<u>CHRP</u>	John Mortimer Program Officer Health Systems & Policy	john.mortimer@ucop.edu
<u>CMA</u>	Michelle Chapanian	(916) 444-5532 MChapanian@cmanet.org
<u>CPCA</u>	Tahire Bazile Senior Policy Analyst	tbazile@cpca.org
California Pharmacists Association (<u>CPA</u>)	Jeff Goad	(323) 442-1907 Goad@usc.edu
<u>California Center for Connected Health Policy</u>	Sandra Shewry President and CEO	Sandra.Shewry@ConnectedHealthCA.org
	Mario Gutierrez Policy Associate	Mario.Gutierrez@ConnectedHealthCA.org
<u>CCLHO</u>	N/A	N/A
CDC / Prevention Through Health Care Reform (PTHCR)		
<u>CDC / DHAP</u> PTHCR Lead (to be hired)	Jono Mermin (while hire pending)	(415) -514-8105 jmermin@ke.cdc.gov

CDPH Leadership	Ron Chapman, Director	(916) 558-1700 Ron.Chapman@cdph.ca.gov
	Kathleen Billingsley Deputy Director	(916) 558-1700 Kathleen.Billingsley@cdph.ca.gov
	Jean Iacino Special Assistant to the Director	(916) 558-1700 Jean.Iacino@cdph.ca.gov
Centro Nacional para la Prevención y el Control del VIH/SIDA (CENSIDA)	Jorge Saavedra, M.D., M.P.H. Director of National HIV/AIDS Programme in Mexico	General Contact: telsida@salud.gob.mx
<u>CAPS</u>	Wayne Steward	(415) 597-8121 Wayne.Steward@ucsf.edu
CDPH / <u>Center for Chronic Disease Prevention and Health Promotion</u>	Linda Rudolph Deputy Director	(916) 445-0663 Linda.Rudolph@cdph.ca.gov
<u>CHRP</u> - Coordinated Multi- Site HIV/AIDS PCMH demonstration project in California	John Mortimer Program Officer Health Systems & Policy	john.mortimer@ucop.edu
CDPH / CID ACA Lead	Jessica Nunez de Ybarra Public Health Medical Officer	(916) 650-6875 Jessica.NunezdeYbarra2@cdph.ca.gov
CDPH / CID Leadership	Gilberto Chavez Deputy Director	(916) 445-0062 Gil.Chavez@cdph.ca.gov
	Drew Johnson Assistant Deputy Director	(916) 445-0062 Drew.Johnson@cdph.ca.gov
	James Watt, Chief Division of Communicable Disease Control	(510) 620-3056 James.Watt@cdph.ca.gov

<u>CAEAR Coalition</u>	Ernest Hopkins San Francisco AIDS Foundation Board Chair	(415) 487-3096 ehopkins@sfaf.org
Consultant	Julie Cross, Consultant	(626) 358-0996 cross_jl@msn.com
Consultant	Ron G	
<u>DHCS</u>	Toby Douglas Chief Deputy Director Health Care Programs	(916) 440-7400 Toby.Douglas@dhcs.ca.gov
	Tanya Homman, Chief Medi-Cal Managed Care	(916) 449-5040 Tanya.Homman@dhcs.ca.gov
<u>East Bay AETC</u>	Kathleen Clanon	(512) 474-2166 kclanon@jba-cht.com
<u>Existing state and local planning bodies</u>	N/A	
<u>Federal Coordinated Health Care Office</u>	No Contact Identified	
<u>HealthHIV</u>	Brad Ward Senior Capacity Building Manager	(202) 507-4735 brad@healthhiv.org
<u>HelpWithBenefits.com</u>	Jacques Chambers Benefit Consultant and Counselor	(323) 665-2595 jacques@helpwithbenefits.com
<u>CDPH / HISP</u>	Linette Scott Deputy Director	(916) 440-7350 Linette.Scott@cdph.ca.gov
<u>HIVMA</u>	Andrea Weddle Executive Director	(703) 299-0915 aweddle@idsociety.org

<u>HRSA</u>	John Moroney Acting Regional Administrator Region IX	(415) 437-8090 <u>John.Moroney@hrsa.hhs.gov</u>
	Lorenzo Taylor Acting Deputy Regional Administrator Region IX	(415) 437-8125 <u>Lorenzo.Taylor@hrsa.hhs.gov</u>
HRSA / <u>BPHC</u>	Seiji Hayashi Chief Medical Officer	(301) 443-1454 <u>SHayashi@hrsa.gov</u>
HRSA / <u>HAB</u>	Laura Cheever Deputy Director Chief Medical Officer	(301) 443-1993 <u>lcheever@hrsa.gov</u>
	Steven Young, Director Division of Training & TA	(301) 443-7136 <u>syoung@hrsa.gov</u>
HRSA / Office of Rural Health Policy	Tom Morris Associate Administrator	(301) 443-4269 <u>tmorris@hrsa.gov</u>
Individual	Gina Osorio, M.D.	<u>geosorio@ucsd.edu</u>
Individual	Dr. Thomas Nesbitt	
<u>Kaiser Family Foundation Web sSite</u>	Jen Kates Vice President and Director Global Health Policy and HIV Kaiser Family Foundation	(202) 347-5270
<u>Los Angeles Commission on HIV</u>	Craig Vincent Jones Executive Director	(213) 639-6714 <u>cvincent-jones@lachiv.org</u>
Los Angeles County Department of Public Health	Mario Perez, Director Office of AIDS Programs and Policy	(213) 351-8001

<u>LAGLC</u>	Quentin O'Brien, Director Health and Mental Health Services	(323) 993-7596 gobrien@lagaycenter.org
<u>MOMS Pharmacy</u>	Gilbert Melo, Pharmacist	(310) 464-8241 GMelo@MomsPharmacy.com
	Andrea Hotton, Pharmacist	ahotton@momspharmacy.com
	Michael Tubb, Pharmacist	MichaelTubb@momspharmacy.com
<u>NASTAD</u>	Ann Lefert Associate Director Government Relation	(202) 434-8090 alefert@nastad.org
<u>NACHC</u>	Kathy McNamara Assistant Director Clinical Affairs	(301) 347-0400 http://www.nachc.com/contact-us.cfm?StaffID=54
CDPH / <u>OFF</u>	Laurie Weaver, Chief	(916) 650-0429 Laurie.Weaver@cdph.ca.gov
OSHPD / <u>Shortage Designation Unit</u>	Konder Chung, Chief	(916) 326-3706 Konder.Chung@oshpd.ca.gov
Office of AIDS Programs and Policy / Prevention Planning Committee (<u>PPC</u>)	Jeff Goodman	jeffgoodman@jeffgoodman.biz
<u>PAETC</u>	Mona Bernstein, Director	(415) 597-8134 mona.bernstein@ucsf.edu
	Kathleen Clanon Clinical Director	(510) 835-3700 ext.123 kclanon@jba-cht.com
<u>PCPCC</u>	No Contact Identified	

<u>Positive Resource Center</u>	N/A	
<u>Project Inform</u>	Anne Donnelly Director of Public Policy	(415) 640-6103 adonnelly@projectinform.org
San Francisco AIDS Foundation	Jorge Zepeda	jzepeda@sfaf.org
San Diego State University	Asherlev Santos	asherlev.santos@gmail.com
SFSU	Rafael Diaz, Professor	rmdiaz@sfsu.edu
<u>Trust for America's Health</u>	Jeff Levi Executive Director	jlevi@tfah.org
<u>The AIDS Institute</u>	Carl Schmid Deputy Executive Director	cschmid@theaidsinstitute.org
<u>The National Clinicians Consultation Center</u>	Ron Goldschmidt, Director	(415) 206-5792 rgoldschmidt@nccc.ucsf.edu
<u>UCLA / School of Public Affairs</u>	Arleen Leibowitz Medi-Cal and Medicare Providers	(310) 206-8653 arleen@ucla.edu
UCD / <u>Center for Health Technology</u>	Thomas Nesbitt Associate Vice Chancellor for Strategic Technologies and Alliances	thomas.nesbitt@ucdmc.ucdavis.edu

UCSD	Wayne A. Cornelius, Distinguished Professor Emeritus of Political Science	wcorneli@ucsd.edu
	María Luisa Zúñiga Associate Professor and Behavioral Epidemiologist	mzuniga@ucsd.edu
	Steffanie Strathdee, Chief Division of Global Public Health	(858) 822-1952 sstrathdee@ucsd.edu
UCSF / Positive Health Project	Rebecca Schwartz	rschwartz@php.ucsf.edu
United Health Group	Catherine Anderson Regional Vice President	
UCAPS	To Be Determined	
University of Iowa, College of Public Health / <u>Department of Health Management and Policy</u>	Clinton MacKinney Clinical Assistant Professor	(319) 384-5122 clint-mackinney@uiowa.edu
Walgreens Pharmacy	Chris Nguyen HIV Clinic Pharmacy Manager	(415) 292-3420 ext. 328 Chris.Nguyen@ucsf.edu
Western Center For Law and Poverty	Elizabeth Landsberg, Lobbyist	(916) 442-0753 ext. 18 elandsberg@wclp.org .

Appendix A: Relevant OA Programs and Contacts

CDPH / OA	Michelle Roland, MD, Chief	(916) 449-5905 Michelle.Roland@cdph.ca.gov
	Karen Mark, MD, MPH, Chief Surveillance, Research, and Evaluation Branch	(916) 449-5832 Karen.Mark@cdph.ca.gov
	Brian Lew, M.A., Chief HIV Prevention Branch	(916) 449-5812 Brian.Lew@cdph.ca.gov
	Ayanna Kiburi, Chief HIV Care Branch	(916) 449-5819 Ayanna.Kiburi@cdph.ca.gov
	Jill Somers, Chief ADAP Branch	(916) 449-5942 Jill.Somers@cdph.ca.gov
	Celia Banda-Brown, Chief ADAP Section	(916) 449-5943 Celia.Banda-Brown@cdph.ca.gov
	Richard Martin, Chief CARE/HIPP Section	(916) 449-5974 Richard.Martin@cdph.ca.gov

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Appendix B: Orientation Webinar Presentations and Recordings

<http://www.cdph.ca.gov/programs/aids/Pages/OAHCRIntroWeb.aspx>

Appendix C: Orientation Webinar Speaker Biographies

Planning for HCR

The HIV Care, Detection, and Prevention Perspective

Sponsored by CDPH/OA

Speakers

Katie Marcellus, Assistant Secretary, California Health and Human Services Agency

Appointed Assistant Secretary of the California Health and Human Services Agency in January 2010; Ms. Marcellus' policy responsibilities include the Medi-Cal and Healthy Families Programs, along with other state health care programs administered by DHCS, Managed Risk Medical Insurance Board (MRMIB) and the California Department of Aging. From 2007 to 2009, Ms. Marcellus served as a policy analyst in the Director's Office at DHCS. Prior to her appointment at DHCS, she served as an executive fellow in the former California Department of Health Services. She holds a Bachelor of Science Degree and a Master of Public Health Degree from UCLA.

Tanya Homman, Chief, Medi-Cal Managed Care Division, DHCS (Bio coming soon)

Chief of Medi-Cal Managed Care Division, she tenured in Medi-Cal eligibility and later worked as section chief in the Third-Part Liability and Recovery Division, she assisted DHCS in its Medi-Cal Redesign and HCR efforts. She attended the Medi-Cal redesign stakeholder sessions and was considered an expert resource related to the Medi-Cal eligibility program's policies and procedures. In HCR, she was responsible to re-organizing and consolidated information from all the DHCS's Divisions with respect to resources and funding needs.

Eric Alborg, Deputy Director, HRSA Region IX

Currently works as Regional Outreach Specialist for the DHHS Regional Director's Office. He serves as the lead liaison at DHHS for all policy, communication, and policy issues in Region IX (Arizona, California, Hawaii, Nevada, and the Pacific Islands and Territories) and is works with government and non-governmental stakeholders to implement the ACA. Previously, Alborg worked for the Office of Governor Arnold Schwarzenegger in several capacities, including most recently managing communications and providing policy recommendations on the implementation of President Barack Obama's America Recovery and Reinvestment Act of 2009.

Chantelle Britton, Policy Advisor, Office of National AIDS Policy

Chantelle is a detailee from CMS at DHHS and serves as a Policy Advisor in the Office of National AIDS Policy. Her portfolio includes serving as policy lead on issues related to women and HIV/AIDS. She also works on the Domestic Policy Council health team on Medicaid and other low-income health policy issues. Chantelle began her career at DHHS as an Emerging Leader Intern and has worked in several components of the Department

including the National Institutes of Health (NIH) and the Administration on Aging. Her most recent position was with CMS, Office of Legislation. In this capacity, Chantelle served as a legislative analyst, providing technical consultative services to congressional members, their staff and the public on Medicaid and the Children's Health Insurance Program in the areas of eligibility and enrollment, benefits, and Medicaid drug pricing. Chantelle received a Bachelor's Degree from James Madison University, and a Master's Degree in public administration from Howard University.

Don Novo, Medicaid Program Branch Manager, CMS HRSA Region IX

His areas of responsibility include oversight of the Region IX Medicaid programs for the states of Arizona, California, Hawaii, Nevada, and the Pacific Territories which include American Samoa, Northern Mariana Islands, and Guam. Don's Federal experience spans four years in both the Boston and San Francisco Regional Offices. Prior to his Federal involvement, he served as the Director of Member Policy Implementation and Evaluation Services with the Massachusetts Medicaid Agency. In this role he streamlined the State's Medicaid eligibility determination process, implemented their online Virtual Gateway application process for the MassHealth Medicaid program and developed the eligibility and systems processes necessary to implement the State's Universal Healthcare expansion in Massachusetts.

CAPT John F. Moroney, M.D., M.P.H., Regional Administrator, HRSA Region IX

Dr. Moroney has worked in HRSA's San Francisco Office of Regional Operations since 1999 and has served as Regional Administrator since March 2010. Prior to joining HRSA, Dr. Moroney was a headquarters-based Epidemic Intelligence Service Officer at CDC where he also completed his Preventive Medicine Residency. He received both his baccalaureate and medical degrees from Cornell University and completed a residency in internal medicine at the Hospital of the University of Pennsylvania before embarking upon his Federal career.

Murray N. Ross, Ph.D., Vice President, Kaiser Foundation Health Plan Director, Kaiser Permanente Institute for Health Policy

Murray Ross is Vice President, Kaiser Foundation Health Plan, and leads the Kaiser Permanente, Institute for Health Policy in Oakland, California. The Institute seeks to leverage evidence and experience from the nation's largest private integrated health care delivery system to shape policy and practice. His current work focuses on how the U.S. health system can make more effective use of new drugs, devices, and medical procedures and how to encourage greater integration of care delivery to improve quality. Before joining Kaiser Permanente in 2002, Dr. Ross was a policy advisor to the U.S. Congress. He served five years as the executive director of the Medicare Payment Advisory Commission, an influential nonpartisan agency charged with making recommendations on Medicare policy issues to Congress. Previously, he spent nine years at the Congressional Budget Office, ultimately leading the group charged with assessing the budgetary impact of legislative proposals affecting Medicare and Medicaid. Dr. Ross

earned his doctorate in economics from the University of Maryland, College Park, and completed his undergraduate work in economics at Arizona State University. He enjoys distance running, writing, and traveling

Carl Schmid, Deputy Executive Director, The AIDS Institute (Washington, DC)

Carl Schmid was named Deputy Executive Director of The AIDS Institute, a national public policy, advocacy, and research organization, in June 2009. Prior to that he served as the Institute's Director of Federal Affairs, a position he held since February 2004. Prior to joining The AIDS Institute, he served as a consultant to a number of HIV/AIDS and civil rights organizations. He has worked in Washington for over 20 years, and began his public policy work in the energy arena, which continued through 2003. Mr. Schmid is co-convenor of AIDS In America, a coalition of national AIDS organizations that focus on federal HIV policy; co-chair of the AIDS Budget and Appropriations Coalition; and a Convening Group member of the Federal AIDS Policy Partnership. He is a former chair of the HIV Prevention Action Coalition and the Ryan White Reauthorization Work Group. He remains active in those coalitions along with others that advocate for Medicaid, Medicare, and HCR; ADAP, HIV testing and Hepatitis issues. Mr. Schmid currently serves as a member of NIH, National Institute of Mental Health's Alliance for Research Progress. He was a member of the Presidential Advisory Council on HIV/AIDS from 2007 to 2009, and Chaired its Domestic Subcommittee. Recently, he was named by POZ Magazine as one of the 100 most effective AIDS fighters in the nation. Mr. Schmid earned a B.A. in Public Affairs and a M.B.A. in International Affairs from the George Washington University in Washington, DC.

Mark Netherda, M.D., Interim Health Officer and Division Director, Public Health Division, Department of Health Services, County of Sonoma

Dr. Netherda completed his undergraduate studies and received his Bachelor and Master of Science degrees from Stanford University and his medical degree from the George Washington University, School of Medicine and Health Sciences. He is board certified in Family Medicine. From 1992-1993, he was designated a "Key Physician" by PAETC, to be trained in educating and training other health care professionals in caring for people infected with HIV.

In 1995, Dr. Netherda became the Medical Director of the Sonoma County Center for HIV Prevention and Care, a position he held until 2006. He also worked as a clinical preceptor at the Santa Rosa Family Medicine Residency Program from 1995–2003, and is an Associate Clinical Professor in the Department of Family Medicine at UCSF. In 2003, Dr. Netherda began working with the International Training and Education Centers for Health, working in the Republic of Namibia to help train clinicians in HIV care and to help develop the country's HIV/AIDS treatment program guidelines. In 2006, Dr. Netherda, his wife, and three children spent a year in Namibia where he worked as the Senior Technical Advisor on HIV Treatment and Care and Acting Deputy Director for CDC.

In 2008, Dr. Netherda became the County of Sonoma's Deputy Health Officer and was recently named the Interim Health Officer and Division Director for the Public Health

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Division in the Sonoma County Department of Health Services. He also continues to provide consultation and treatment for patients with hepatitis C for the West County Health Centers of Sonoma County.

Appendix D: Presentation and Questions and Answer Notes from Orientation Webinar

***Planning for HCR
The HIV Care, Detection, and Prevention Perspective
Webinar Sponsored by CDPH/OA
Friday May 13, 2011***

Introduction

This document contains notes from presentations given by speakers from several different perspectives on HIV-specific issues in the context of HCR which might affect OA and questions and answers from Webinar participants. The notes have been edited for content and relevance for planned inclusion in the final Summary document which will also highlight key issues and present resources, experts, and questions which OA will need to consider when moving forward in the HCR context.

Below is a link to the three- Webinar from which these notes were transcribed and edited down for content. [Teleconference presentation of the meeting held on May 13, 2011 \(Video\)](#).

1. The Federal Perspective

A. DHHS

[U.S. Department of Health and Human Services \(DHHS\) \(PDF\)](#)

The Federal government's efforts through the Regional Director for DHHS Region IX (which includes California) are focused on creating a place where the public can give feedback formally and informally on all issues relevant to DHHS. A major priority of Regional Director's office is to implement ACA; specifically in:

- Collaboration;
- Troubleshooting problems; and
- Educating the public on benefits of HCR.

The Regional Director's Office plays an advocate role in helping different branches of government in the implementation of ACA by addressing any issues that require guidance from the Federal government. ACA has a number of consumer protections which have significance for the HIV/AIDS community.

B. Office of National AIDS Policy (ONAP)

(No presentation link available)

ACA greatly expands coverage for people with HIV/AIDS and provides a platform for improvements in health care coverage and quality. The National HIV/AIDS Strategy is

the first comprehensive plan to respond to the current domestic HIV epidemic. The Strategy has three main goals: 1) to reduce HIV infections; 2) increase access to care; and 3) improve health outcomes for people with HIV and to reduce HIV-related health disparities.

The goal of increasing access to care is the cornerstone of many provisions in ACA. One of the key coverage provisions which will greatly impact low-income people with HIV is the expansion of Medicaid in 2014. California is taking proactive steps in its Medicaid Section 1115 Demonstration Waiver.

A major initiative that was announced recently was the availability and access to Medicare data to help better coordinate health care for populations that are eligible for both Medicare and Medicaid (dual-eligible). Having access to Medicare data is an essential tool for states to better coordinate and improve quality and control costs for dual-eligible populations. Fifteen states, including California, were selected to design new ways to meet the often complex medical needs of the nation especially among low-income and chronically ill citizens. These states were awarded contracts to offer person-centered approaches to coordinated care across primary, acute care, and behavioral health programs, and long-term support services for dual-eligible citizens.

CMS will issue a State Medicaid Director's letter to states to inform them of all of the opportunities available to provide Medicaid coverage to individuals living with HIV to support the Strategy. These are new provisions that are included in ACA. Tools that ACA gives states through Medicaid to provide long-term care services and support include programs such as Health Home Coverage for enrollees with chronic care needs including people with HIV. This program supports both physical and behavioral health and allows states to provide coordinated care to individuals with chronic conditions. To date, no state has submitted a formal proposal for the state plan option; however, CMS has confirmed that five states have submitted draft proposals for consideration. CMS is offering financial support to states in planning their health home proposals. There have been seven states that have received health home planning funds.

ACA has provided meaningful support for people living with HIV by ending lifetime limits on benefits and offering other consumer protections most of which went into effect in 2010. Also in 2010, a \$50 rebate was offered to people living with HIV/AIDS (PLWH/A) in the Medicare Part D gap known as the donut hole. ADAP will be considered contributions to Medicare Part D True Out-of-Pocket (TROOP) spending limit.

The issue of coverage is addressed as a workforce provision item in ACA. Under the goals of increasing access to care, ACA calls for taking delivery steps to increase the number and diversity of available providers of clinical care and related services for PLWH/A. The workforce provisions are grounded in strengthening the nation's primary care through improving education and offering scholarships and incentives to recruit providers into the field and for providers to work in under-served areas.

There is also need to focus on the problem of the lack of HIV providers. These problems include:

- Aging HIV care providers, many of whom are retiring;
- Need for new providers;
- Absence of HIV curriculum in the health professional schools;
- Removal of provider stigma and comfort level when caring for PLWH/A;
- Need for focusing on regions of the country wherever deficiency is the greatest;
- Creating incentives for HIV specialists; and
- Training primary care providers and physician-extenders like nurse practitioners and physician's assistants.

IOM issued a report commissioned by ONAP documenting HIV workforce and clinical provider issues to address the people diagnosed with HIV and the resources available to treat them.

C. CMS Not reviewed
[Centers for Medicare and Medicaid Services \(CMS\) \(PDF\)](#)

ACA includes a number of initiatives geared towards expanding and improving health insurance coverage. Some of the most visible and important of these initiatives include: the prohibition of pre-existing condition exclusions, the creation of the temporary PCIPs, and expanded Medicaid eligibility.

Section 2001(a)(1)(C) of ACA creates a new Medicaid eligibility category effective January 1, 2014, that will create Medicaid coverage for adults with incomes under 133 percent of the federal poverty level (FPL).

- Section 2001(a)(4)(A) of ACA allows early adoption option for states to create this new eligibility category as early as April 1, 2010. New eligibility groups can be created all at once or eligibility can be phased in by income level between April 2010 and January 2014. If eligibility is phased in, it must be extended to individuals with the lowest income levels before being extended to those with a higher income level. California will expand our eligibility early LIHP.

Section 1201 of ACA amends the Public Health Services Act to prohibit any group or individual health insurance plan from imposing pre-existing condition exclusion. This prohibition does not take effect until January 1, 2014. In order to create a bridge to 2014 for individuals unable to obtain insurance, ACA provides funding for PCIPs.

- Section 1101 of ACA funds the creation of PCIPs, which serve as high-risk insurance pools for individuals with pre-existing conditions who are unable to obtain other health insurance. Participation in a PCIP is available to any individual who is a U.S. Citizen or National, or is lawfully residing in the United States, who has been

uninsured for a minimum of six months and has a pre-existing condition that prevents him or her from obtaining other coverage.

- PCIPs can be administered at either the federal or state level. California has opted to administer the plan at the state level, through its MRMIB, which also administers California's State-funded High-Risk Insurance Pool.

D. D. HRSA/HAB/BPHC and Region IX

PART 1: RW and ACA

[HRSA HIV/AIDS Program \(HAB\) \(PDF\)](#)

ACA provisions which impact RW in 2011 include PCIP and ADAP counting towards TROOP expenses for Medicare Part D.

HRSA is committed to maintaining RW delivery systems and, through national cooperative agreements, to address ongoing capacity building needs. A new National AETC has been funded to support HIV care and treatment in CHCs without direct RW Part C or D funding.

RW is designed to fill gaps which are identified through local needs assessment. Gaps in existing Medicaid programs will likely remain (i.e., the number of prescriptions allowed through some Medicaid programs, dental services, and support services to link consumers to and retain them in care).

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PART 2: Health Center Program: Partnering with Communities [Bureau of Primary Health Care \(BPHC\) & Region IX \(PDF\)](#)

For the purposes of this presentation, CHCs are synonymous with FQHCs and are located in high need communities which are a designated Medically Underserved Area or Population. CHCs are governed by a community board composed of a majority (51 percent or more) of health center consumers who represent the population served. CHCs provide comprehensive primary health care services as well as supportive services (education, translation, and transportation, etc.) that promote access to health care. Fees at CHCs are adjusted based on ability to pay. These services meet other performance and accountability requirements regarding administrative, clinical, and financial operations.

In 2010, nearly 20 million people were served at CHCs. The additional \$11 billion allocated is to double the capacity efforts to serve up to 40 million by 2015. In 2009, CHCs served nearly 19 million people.

The role of CHCs is to develop and enhance access points and provide PCMHs. Additionally, CHCs recruit, develop, and retain skilled workforce by providing incentives for recruitment and retention of workers. Under the Recovery Act and ACA, there has been a reduction in restraints for qualifying for loan repayment or scholarships for primary care workforce.

Other quality improvement strategies for CHCs include: integration of health centers into local health systems and aligning policies and programs where possible. There are 161 health centers that are also RW Part C recipients. Some health centers indirectly also receive RW Parts A and/or B funding.

NACHC and NCHCMC are collaborating to reduce HIV-related health disparities by helping non-RW-funded community health centers to develop, improve, and enhance their organizational capacity to provide primary medical care and treatment to racial and ethnic minorities living with or affected by HIV/AIDS.

<http://www.hivta.org/content/index.php>

Questions & Answers for Federal Perspective Presenters

Q: Will RW funds dwindle over time given increased health insurance coverage via ACA?

A: (Moroney). There is an upcoming call on June 15, 2011, by AIDS.gov on the State and Future of HIV/AIDS: <https://www2.gotomeeting.com/register/947461010> that may address this issue.

A: (Britton). This administration strongly supports RW and its place now and in the future. It will still play a significant role in providing wrap around coverage for people in Medicaid expansion and Exchanges. The question now is “how” not “if.”

Q: If RW will be more for wrap around services, what will happen to medical services for undocumented HIV and individuals?

A: (Britton). To the extent that RW covers those individuals now, the Administration’s position is that it will continue to do so in the context of ACA.

Q: Some of FQHC requirements are restrictive to traditional RW providers (e.g., need to provide services to across age and disease spectrums). Is HRSA exploring options to make it easier for RW providers to become FQHCs?

A: (Moroney). Those are statutory requirements that health centers address a full age spectrum in terms of care and that consumers receive care regardless of their ability to

pay. However, this full spectrum of care can be achieved through a system of referrals that may ease the perception of restrictiveness.

Q: Since only about one third of RW clinics are FQHCs and many of the rest will not be able to meet FQHC requirements, what are HRSA's plans for working with other RW medical grantees to ensure sustainability and continuity of care?

A: (Roland Clarification). What will happen to RW-funded HIV-specific clinics that do not become FQHCs?

A: (Moroney). This requires speculation but you can feel reassured by the position that the administration has taken on the RW Program.

Q: When is the cutoff, or is there a cutoff, for organizations to become qualified health centers?

A: (Moroney). December 2010 was the last deadline for new access point applications for fiscal year (FY) 2011. A record number of applications were received. There is some uncertainty in the program about how the recent budget cuts will be addressed. The intention is for there to be new opportunities for new access points (i.e., new FQHCs, or new satellite clinics from existing FQHCs) to be created under ACA through the end of 2014.

Q: What will be the impact of the \$600 million cut to CHCs in the FY 2011 budget?

A: (Moroney). The CHC Program is facing uncertainty around the new access points in the current year as the program received a \$600 million reduction in the FY 2011 budget. At the time of writing, we are still waiting to hear about how the budget reduction will be addressed.

Q: What are your thoughts about general primary care providers being able to fill the gap in available trained HIV specialists? What do we need to ensure that they have appropriate knowledge to meet standards of care?

A: (Moroney). The National Health Service Corps are focused on building the capacity of primary care providers in family practice, internal medicine, Ob-Gyn, psychiatry, and other eligible primary care disciplines. (Since the May 13 Webinar, a Funding Opportunity Announcement (FOA) was released for grants supporting developmental work toward expanding existing accredited primary care residency programs to include an HIV focus. Click [HERE](#) for more information.)

A: (Britton). There are certainly opportunities in ACA for primary care workforce development. Other health care workers can be trained in HIV curriculum. As a community, we need to look at how HIV workforce capacity issues went unresolved for so long. However, we are heading in the right direction with ACA.

Q: Are any incentives planned to specifically promote medical students to go into HIV medicine as a specialty such as loan forgiveness? Would training primary care practitioners in HIV care solve our workforce problems?

A: (Moroney). To address the shortage of primary care providers, HRSA's Bureau of Health Professions have been making grants to residency and training programs to help increase the number of providers to specialize and serve under-served communities for many years. There are State-administered programs as well (such as Song Brown and the University of California [UC] system's PRIME Program) with similar aims. Support is available through the National Health Services Corps (<http://nhsc.hrsa.gov/>) and has been augmented by ACA. The Bureau of Health Professions has been making grants to medical residency programs to increase the number of primary care providers and to encourage these providers to work in under-served areas. Additionally, the UC system has similar programs. There are also workforce programs that have been augmented with ACA that continue to produce incentives and increase the number of primary care providers. (Since the May 13 Webinar, an FOA was released for grants supporting developmental work toward expanding existing accredited primary care residency programs to include an HIV focus. Click [HERE](#) for more information.)

Q: How will the new legislation support PLWH/A as being active participants in the planning of their local services and in making sure that the centers where community needs are not being met are being closed? PLWH/A are concerned that existing RW planning councils will not be allowed to continue, shutting down a valuable feedback mechanism in designing service delivery and increasing local access for the consumers. What provisions are being made?

A: (Moroney). The first part of the question is speculative because there is no information validating the claim that RW planning councils will be eliminated. As previously discussed, CHCs are community-based and the governing board must consist of more than 50 percent of individuals from the community that the health center serves and who use the health center.

Q: We have been working with the CMS Center for Innovation to look at HIV Center of Excellence and RW-supported medical homes as demonstration projects to establish effectiveness and cost effectiveness of delivery care and optimizing health outcomes. If we are successful in establishing that, does the Secretary have the authority to allow a special HIV/AIDS rate based on success of demonstration projects for qualified sites/entities in Medicaid after the enactment of Medicaid expansion in 2014?

A: (Britton). There are waiver programs that exist for states to tap into to get enhanced financial Medicaid matching, one of which is Health Home Option because chronic conditions are eligible. This is a key resource for people with HIV.

Q: Aren't the increased rates for medical home models under the waiver just a two-year rate?

A: (Britton). Yes.

Q: We are working with DHCS to see if there is a way to exclude SPDs who will be aging into or finishing their disability waiting period, making them eligible for Medicare in the near future, from mandatory MMC. If they will soon become dual eligible, they will no longer be required to enter managed care. Up until now Medi-Cal has said they will have no easy access to when someone will become Medicare eligible. Will the increased Medicare data sharing start to solve this problem?

A: (Britton). It remains to be seen what states can do with the data but the states have repeatedly requested this information and it will make care coordination much easier for dual-eligibles.

Q: In an effort to meet the goals of the National HIV/AIDS Strategy, we are trying to ensure that USPSTF review of routine testing results in a higher grade, ensuring coverage with various payers. In the meantime, not all Medicaid programs cover routine testing. What are the panelist thoughts about the viability of getting routine HIV testing covered in the Essential Benefits Package (EBP)?

A: (Britton). EBP is still being developed but partners will be working with ONAP about what will be included in the package. One of the key goals is reducing new infections.

2. **The California Perspective**

A. **The Exchange Not reviewed** *(No presentation link available)*

The Exchange is an organized competitive market for health insurance that offers multiple options for established plans. Exchanges under ACA are a marketplace that provides individuals and small businesses a place to purchase coverage for essential health benefits. Individuals can shop and compare plans. In order to be a qualified health plan, a plan will have to agree to cover essential health benefits and agree to limit cost sharing for individuals who are purchasing insurance through the Exchange. The specific benefits covered by qualified health plans will be determined by the Secretary of DHHS.

Qualified health plans will offer four different levels of coverage, often referred to as heavy metals: bronze, silver, platinum, and gold plans. These refer to the costs or percentages of the costs that plans cover. For example the bronze plan covers up to 70 percent of costs. The Exchange plans will not only cover essential health benefits but catastrophic coverage for qualified individuals.

Role of Exchanges are:

- To certify, decertify, and recertify health plans that offer coverage through the Exchange;
- Provide customer service to consumers (i.e., creating an Internet Web site which provides information to help individuals have a first class shopping experience through the Exchange and establish hotlines to assist consumers;
- Use federal quality ratings to compare plans;
- Provide standardized information on plan benefits for comparison;
- Screen and enroll individuals and businesses; and
- Screen for individuals who qualify for other health benefits as well.

By January 2013, the Federal government has to certify that a state will have an operational Exchange up and running by January 1, 2014. By 2013, states will have to finish the electronic online portal and be able to provide a first class online shopping experience for consumers. By mid- to late-2013, open enrollment will begin. By January 1, 2014, the Exchanges will be fully running. Exchanges will open on January 1, 2014, and will rely on federal funding until January 1, 2015, when they must be fully self-sustaining.

California was the first state to enact health benefits exchange legislation. California established a five-member governing board whose duties include meeting the requirements of state and federal law. The board's priorities include getting federal funding for entire four-year period through January 1, 2014. For information about The Exchange visit: www.Healthexchange.ca.gov.

**B. Medi-Cal 1115 Bridge to HCR Waiver and MMC Models
(No presentation link available)**

The Medi-Cal 1115 Waiver was finalized on November 2010 and goes through October 31, 2015. The new waiver allows California to:

- begin early enrollment of a new eligibility group in LIHP;
- better organize systems of care for vulnerable populations;
- prepare an accounting system for Medicaid expansion;
- incorporate ACA and care and delivery system reform;
- institute payment reforms for value-based purchasing, transitioning away from fee for service and costly care;
- provide incentives for high-quality care; and
- develop an incentive pool for delivery system reform which will allow 17 major hospitals to implement a series of projects and meet specific milestones for infrastructure development, population-focused improvement and urgent improvements in care.

LIHP offers enrollment to non-disabled childless adults with incomes up to 200 percent of FPL. It gradually aligns eligibility, benefits, and cost sharing rules over the newly covered populations. It prepares for a seamless transition into the Medi-Cal expansion coverage in 2014. DHCS will monitor plans with regards to implementation, access, and quality to ensure that the needs of the population are met. DHCS will also continue to evaluate and monitor the programs to ensure that they are meeting the needs of these populations. LIHP will be available in all 58 counties with an estimated enrollment 512,000 individuals between the ages of 19 and 64. The LIHP process is from 2011-2014.

The current Medi-Cal SPD population began to transition into managed care through health reform on June 1, 2011. SPDs are individuals identified as SPDs who do not have Medicare entitlement or any other health care coverage. Impacted SPDs are within the two-plan and geographic care model counties. This will impact a total of 16 counties and approximately 300,000 individuals. The 1115 Waiver and SB 208 allow members to retain their fee-for-service provider for up to 12 months. DHCS will provide health plans data about these individuals and the health plan can in turn determine if they are high risk or low risk to allow health plans to engage in care and case management for high-risk individuals.

There are no specific requirements for specialty care other than demonstrating access to specialty care. However, DHCS is assessing the utilization patterns in counties with county organized health systems and will use that information to estimate the specialty care needs of these new plans. DHCS will identify plans that are not already within the county network in order to reach out to them and allow them to build upon their network to serve these members moving forward.

Questions & Answers for California Perspective Presenters
Exchange not reviewed

Q: If the Exchange Board pursues a lock in for eligibility would it also lock in the subsidies associated with the exchanges?

A: (Marcellus). The Board cannot take the first step with this issue; the Federal government will have to come up with guidance about what their expectations are. One of the components of ACA is an individual mandate. Consumers can access competitive premiums in the Exchange. If consumers do not report changes in income and end up getting more of a subsidy than they should have, at the end of the year there is a penalty to pay. Federal guidance will have to lead with that and the board can decide what to do from there. If it is not possible to fix this with eligibility, the Exchange may be able to contact people who receive subsidies and inform them that it is important to notify the Exchange whenever there is a change in income or circumstances that could change their premiums and subsidies.

Q: I am concerned about persons with HIV at the margins of eligibility between Medi-Cal and the Exchange. Studies show that income fluctuates frequently for these folks. Will the Exchange take into account the problem of churning (which could lead to people with HIV being lost to care) in its rules, certification, and recertification?

A: (Marcellus). The issue of program integration has not been fully discussed by the Board in terms of integrating the Exchange and other federal and public programs, including Medicaid. How transitioning between programs happens is an issue to be discussed. The Board needs to look at offering continuity and plans between those programs and look at policies that would lock in an individual's eligibility for a period of time in case one's income changes. Some of these decisions will be informed by federal guidance and released with any continuity policies to benefit people purchasing coverage. ACA provides a basic health program which provides federal subsidies for people between 134 percent and 200 percent of FPL. California has a lot of decisions to make about how we will be facilitating, combining, and administering public coverage programs

Q: What quality measures are being developed specifically for HIV in both Exchanges in MMC?

A: (Marcellus). The federal level is still looking at the essential health benefits and quality rating system that state Exchanges will be using. Stakeholders are encouraged to get involved with federal and state partners to determine which measures should be used as a starting point for when the Exchanges are set up.

A: (Homman). In MMC, we already have measures in place, but those are pretty specific to families and children. With the transition of SPDs, we are looking at ones that will serve this population, but at this time, those are under development.

All of the following questions relate specifically to current transition issues, not to the 2014 context which is the focus of this process and the Summary.

Q: There has been a request to DHCS to send a separate continuity of care explanation for SPDs and their providers. Can you provide an update on where that stands? Most PLWH/A are not aware of continuation-of-care provisions and have only gotten information about Medi-Cal exemption requests.

A: (Homman). Staff are working with stakeholders in the development of that notice informing individuals about where they go regarding issues like staying with their fee-for-service providers as well as informing them of their right to specialty care and timely and physically accessible health care and services. Notices were sent informing members that they need to reach out to their health plans to assist them in getting them what they need.

Q: What if a person does not respond to the transition to managed care - if they do not comply with whatever action steps they should do as they are transitioned into managed care?

A: (Homman). The system currently uses a default algorithm that is based on quality and performance of the plan. Generally, default enrollments will be in a plan that has better performance. However, when an SPD member fails to make a choice, rather than just referring them to the default process, we will take a look at their historical data, locate their most frequently used provider over the last 12 months and then determining what plans are available to them based upon their provider's participation in the plan.

Q: Can you talk about specifics of how a patient may obtain an exemption to stay with their fee-for-service provider?

A: (Homman). The best way is to contact their health plan. SB 208 requires the health plan to allow the member to continue with their fee-for-service health provider for up to 12 months. However, in a situation where a fee-for-service provider refuses to give treatment because they do not want to deal with the health plan, in this situation Medi-Cal will intervene to get a resolution.

Q: Is there a hotline for consumers to call, ask questions for all Medi-Cal, Medicare, Medi-Medi HCR-related questions?

A: (Homman). Not specific to all of those three programs. The DHCS Web site has a great deal of information. A Web site inbox is available mmcbpmb@dhcs.ca.gov for questions about transition of SPDs. Contact information for the programs mentioned above:

Overall 1115 Waiver:

<http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

SPD's – Lead: Tanya Homman (Medi-Cal Managed Care Division):
<http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDEnrollment.aspx>

LIHP – Lead: JalyneCallori (LIHP):
<http://www.dhcs.ca.gov/provgovpart/Pages/LIHP.aspx>

Duals – Acting Lead: Dennis Owen (Long Term Care Division):
<http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupDE.aspx>

California Children's Services – Lead: Louis Rico (Systems of Care Division):
<http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>
<http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupCCS.aspx>

HCR:
<http://www.healthcare.ca.gov/>

Q: Can you talk about whether there is an enhanced rate for all Medi-Cal enrollees with HIV/AIDS? What components does it include (e.g., hospitalization, pharmacy, specialty, etc.) and to what entity does the State pay it?

A: (Homman). All two-plans and San Luis Obispo, Santa Barbara, and San Mateo of County Organized Health Systems (COHS) plans have separated AIDS rates. Other COHS plans and Geographic Managed Care plans do not have separated AIDS rates, although Medi-Cal consumers diagnosed with AIDS and AIDS-related services are covered by those plans.

There are no specific aid codes assigned to Medi-Cal AIDS consumers. As a result, if they are enrolled in a managed care plan that has separated AIDS rates, the plan will be paid based on the member's aid code initially. Once the plan reports to the state that a particular member is diagnosed with AIDS, the plan will be paid the balance between the AIDS rate and the rate paid initially. For example, John Doe is Medi-Cal only member and is an AIDS patient who has a family aid code, the plan will be paid the family rate first (say it is \$100). Assume the AIDS rate for Medi-Cal only members is \$800. The difference of \$700 (\$800 - \$100) will be paid to the plan once the plan certifies to the state that John Doe is an AIDS patient.

The AIDS rates (as all other rates) include the following components (service categories): Inpatient Hospital; Outpatient Facility; Emergency Room; Long-Term Care; PPC; Physician Specialty; FQHC; Other Medical Professional; Pharmacy; Laboratory and Radiology; Transportation; All Other.

Q: We understood that there is an AIDS rate with drugs carved out – is that not the case?

A: (Homman). AIDS rates for all two-plans, San Luis Obispo and Santa Barbra of COHS plans exclude AIDS-specific drugs (carved out). AIDS rates of San Mateo include AIDS-specific drugs. AIDS Health Foundation (a special program) currently covers AIDS drugs approved prior to January 1, 2007. All AIDS rates, like other rates, include regular, non-AIDS-specific drugs.

Q: Clinical research is leading to beginning highly active antiretroviral thereapy (HAART) as soon as infection is identified. Have all MMC plans adopted this standard?

A: (Roland). Clarified, the DHHS recommendations for people with CD4+ T-cell counts between 350 and 500 (fairly strongly recommended) and those over 500 (moderately recommended). As the science evolves as in the study referenced by the questioner, we should expect to see those recommendations get stronger at all CD4+ T-cell levels.

A: (Homman). I can not answer if those have been adopted as standards, however, health plans are required to provide any needed care for members - so if they are standards they are covered. This is something that should be shared with the DHCS medical policy side.

Q: Will DHCS consider a county addendum to the LIHP application that would allow counties to detail how they could include people with HIV? Questioner understands that counties are unclear about how RW would interact with LIHP. We can not transition all PLWH/A to RW services without having expertise and capacity.

A: (Roland). There has been quite abit of discussion surrounding RW and LIHP and guidance has been sought at CMS and HRSA level.

A: (Britton). We are trying to coordinate ourselves with the advocates: CMS will talk to Medicaid office in California and then loop back with HRSA about what is acceptable in the guidelines and go from there. There are a lot of issues associated with this topic.

3. A Non-Governmental Perspective

Private Health Plans: Managed Care Models

[Private Health Plans: Managed Care Models \(PDF\)](#)

The great contribution of ACA is that it could result in almost universal health coverage for the nation. Additionally it introduces insurance market reforms, Exchanges, and Medi-Cal expansion. There are general issues of timing and complexity of establishing the insurance Exchanges as well as issues of addressing risk selection to support high-quality care and addressing churn to preserve continuity of care. The longer term challenges, however, are the enormous budgetary challenges.

Adverse selection hits plans/providers who excel in treating chronic, high-cost conditions. The issue here is that it is easier to get sick people into the market than it is to get healthy people into the market. Additionally, adverse selection hits inside Exchanges and between the Exchange and outside market. Invariably there are certain predictable costs that cannot be offset by premiums.

The development and implementation of Exchanges creates a heavy list of expectations and it presents a lot of challenges, some federal and some state. There are a host of administrative functions to get up and running.

Tools to reduce adverse selection or ameliorate its impact will include benefit standardization, making enrollment easy, limiting enrollment periods, enforcing the individual mandate, etc.

Narrow eligibility threshold between Medi-Cal and premium subsidies in Exchanges will be affected by fluctuations in income/family status as people move around. Studies have estimated that 35 percent will change their insurance plan within 6 months, 50 percent within 12 months. This is an enormous amount of movement if these predications come true. The consequences will be care continuity and benefit changes as incomes fluctuate, confusion for beneficiaries, and administration that gets more tedious and costlier. However, a potential solution is to create continuity between the Exchange programs and Medi-Cal. All this is tentative until EBP is complete and when we know which plans can participate in which markets. Support of beneficiary decision-making is critical.

The major contributing factor to the issue of churn is health care cost growth which presents serious questions for federal and state budgets. Questions like: When will policymakers begin to address fiscal issues? How will they proceed with these measures? What about regulatory, premium control, and delivery system reform?

Questions & Answers for Non-Governmental Perspective

Q: Provision of primary care to an HIV population is more expensive (even exclusive of pharmacy). Doesn't ensuring that our current standard of care is preserved as consumers transition to Medi-Cal and Exchange managed care programs require enhanced rates for HIV to cover the cost?

A: (Ross). Yes. Basic primary health care is going to be more costly. If there are going to be more visits, and doing more business and running more labs and more morbidities even separate from pharmacy costs, we are looking at higher health care costs.

Q: Do you have concrete ideas that we should be considering to avoid the adverse risk selection that sounds as though it could make the Exchanges unworkable?

A: (Ross). This is an issue that people spend a lot of time thinking about and experts on the Exchanges talk about running an enforceable individual mandate. Most people will want to comply with the law and we want to do what we can to make compliance easy.

Q: Can you explain further how benefit standardization will ameliorate adverse risk selection?

A: (Ross). The issue is, are people who have fewer health expenses more likely to choose high cost sharing plans with high deductibles? To the extent that you can standardize it keeps people in one common pool and ultimately that is what you need to make these programs work.

Q: Do you see anything in the National policy debate that actually addresses cost of health care? Seems that all of the major policies (e.g., block granting and privatization) simply shift costs, but do not do anything to lower costs.

A: (Ross). There are provisions in ACA, particularly the creation of the innovation center at CMS trying to think about new payment models and delivery system models. One hopes that within the Exchanges themselves provider networks will work to ameliorate costs. The premise of the question is correct, you do not want to just move costs around, that may protect the budget of one department at the expense of another without addressing the underlying issues.

Q: Are there efforts within ACA to expand the RW-funded "wrap around" services (i.e., registered nurse case management, pharmacists, social work, substance use, mental health) that have been key to success in HIV care within the CHC medical home model for consumers with other chronic diseases?

Provided after the Webinar

Posted 8/31/2011

FQHC Advanced Primary Care Practice demonstration project:

<http://www.hhs.gov/news/press/2011pres/06/20110606a.html>

HRSA Patient Centered Medical/Health Home Initiative:

<http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>

PCMH:

<http://www.ncqa.org/LinkClick.aspx?fileticket=|KicggGGsQ%3d&tabid=1302&mid=5343&forcedownload=true>

4. The HIV Prevention Perspective

[Opportunities for Expanding HIV Testing through Health Reform \(PDF\)](#)

ACA presents opportunities to cover preventive services including HIV testing. This is done through a Grade A or B level rating by USPSTF. This will expand testing for high-risk populations.

USPSTF is sponsored by Agency for Health Care Research and Quality at the DHHS. It is the leading independent panel of private-sector experts in prevention and primary care. It conducts rigorous, impartial assessments of scientific evidence for effectiveness of clinical preventive services, including screening, counseling, and preventive medications. USPSTF recommendations are considered the "gold standard" for clinical preventative services.

Examples of Grade A recommendations include: strong recommendation that clinicians screen for HIV in all adolescents and adults at increased risk for HIV infection and that clinicians screen all pregnant women for HIV.

HCR changed rules to dictate that Medicare can cover some preventative services with no co-pays in January 2011 (i.e., HIV testing for high-risk individuals as noted above). Additionally, Medicare has an annual wellness visit which can cover HIV screening. Medicare is a good opportunity to find people infected with HIV if in the annual wellness visit providers discuss sexual and injection drug use history to help identify people who are at risk.

Private insurance is also a good opportunity to diagnose people living with HIV. Some plans cover routine testing while others do not. All new plans must cover services that receive Grade A or B from USPSTF with no cost sharing. Exchanges comprise private insurance plans which will cover Grade A and B and EBPs.

Other services covered by HCR which fall under A and B and are related to HIV include: depression screening, gonorrhea screening, healthy diet counseling, hepatitis A and B vaccination, hepatitis B screening for pregnant women, sexually transmitted infections counseling, syphilis screening. Other possible programs: condom distribution, syringe exchange, counseling, sexuality education, post-exposure prophylaxis, and pre-exposure prophylaxis.

Questions & Answers for Prevention Perspective

None.

5. A Local Success in Transitioning HIV Care

[Sonoma County Experience \(PDF\)](#)

In 1988, Sonoma County HIV Center was established, utilizing a Family Medicine Clinic model. Between 1995 and 2009, HIV medicine changed dramatically. In 2009, 600 patients were receiving care at the HIV Center. In 2009, local and federal HIV funding decreased significantly, and was scheduled to decrease further, as the county lost its Transitional Grant Area status. At the same time, FQHCs were expanding throughout the county.

In order to remedy the situation, Sonoma County Department of Health Services convened a planning process to evaluate the provision of HIV medical services going forward. The goal was to review current the HIV care system and formulate the best model for the provision of quality HIV medical care for all HIV-positive Sonoma County residents utilizing realistically projected resources.

The process began in July 2009, including hiring consultants and holding the first stakeholders meeting in October 2009. Thereafter, we held high-level meetings and ran transparent working meetings to sort out issues. One helpful resource was the county's HIV section manager who was instrumental in making sure communication was ongoing with service providers, consumers in the community, staff in FQHCs, the board of supervisors, local newspapers, and through public forums.

Among the many participants were representatives from: Public Health, the HIV Center, Alcohol and Other Drug Programs, Mental Health, CHCs, Kaiser, Sutter Medical Group, the County Commission on AIDS, local non-medical AIDS Service Organizations, the local Family Practice Residency, Partnership Health Plan, and consumers from the community.

The group's recommendation was to transition medical services currently provided at the County HIV Center to three local CHCs. The following were the participating health centers: Santa Rosa CHCs wanted to add a robust HIV program; West County Health Centers wanted to expand their existing HIV care system into their new Sebastopol site; Alliance Medical Center wanted to begin providing primary care to people with HIV and use local HIV specialty expertise. Kaiser accepted any insured patients able and willing to transition to a Kaiser Permanente Health Plan.

State and Federal grant funds were awarded to Sonoma County to be reallocated to support services at FQHCs. As of April 2011, among the 604 patients, all but 14 have had medical visits in their new medical homes. Transition outreach work continues through the HIV Health Care Network, a collaboration that was formed to help coordinate HIV medical care services throughout Sonoma County.

Questions & Answers for Local Success Story Presenter

Q: Could you discuss the experience of consumers in the process and whether they became peer advocates/assistants in consumer enrollment/transition?

A: (Netherda). Sonoma County recognized that it was necessary to have consumer presence from the get go. We had high-level executives, consumers, and participants from our board of supervisors. We knew that if the consumers were unhappy or did not understand the process we were not going to get anywhere so we involved them from the beginning. They became champions of the cause. We expected a lot of push-back but we got a lot of positive response.

Q: Can you speak to the importance of your individual transition coordinator to retain people in care?

A: (Netherda). The HIV Center designated one staff member to be the concierge/guide who was bilingual and bicultural. Having him as the point person was key in making the transition as smooth as possible. The previous county HIV manager worked with the health centers and transitioned him into a job with the health centers because they realized that he was key in the capacity building process. He has been an invaluable resource in educating staff at the new facility regarding communicating HIV issues with consumers and providers.

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Appendix E: Background and Supplemental Reading Material

<http://www.cdph.ca.gov/programs/aids/Documents/HCRPreMeetingReadingMaterials.pdf>