FINANCING HIV PREVENTION SERVICES

Collaboration and Innovation between Public Health and Medicaid Agencies

A report prepared by Health Management Associates and the National Alliance of State and Territorial AIDS Directors

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Introduction & Background

The Centers for Disease Control and Prevention (CDC) estimates that, despite ongoing prevention efforts, 50,000 Americans become infected with HIV annually. Nearly 1.2 million individuals are living with HIV in the United States. Continued growth in the population living with HIV will lead to more infections unless prevention, care and treatment efforts are maintained and intensified.*

In July 2010, the Obama Administration released the National HIV/AIDS Strategy (NHAS) to identify priority activities to address the domestic HIV epidemic. In July 2015, the White House released an updated five-year strategy that includes an emphasis on prevention and the following strategy goals, each tied to measurable outcomes:

- Reduce new infections,
- Increase access to care and improve health outcomes for people with HIV,
- Reduce HIV-related health disparities and health inequities,
- Achieve a more coordinated national response to the HIV epidemic.

Funding for prevention, care and treatment services directed towards individuals living with or at risk of acquiring HIV comes from an array of public and private insurance and public health programs. This array of services and programs is undergoing a decidedly complex evolution, as the Affordable Care Act (ACA) expands Medicaid and other insurance coverage options; health care financing and delivery systems are re-designed to emphasize quality and population health; and public health prevention and safety net roles adapt to these developments.

The purpose of this report is to identify emerging opportunities to strengthen and enhance efforts to prevent HIV infection and improve HIV care by forging collaborations between public insurance and public health programs. State health departments are uniquely positioned to develop and lead partnerships with their state Medicaid counterparts.

*Centers for Disease Control and Prevention (CDC), HIV in the United States, available at http://www.cdc.gov/hiv/statistics/overview/ataglance.html

COVERAGE AND FINANCING OF HIV CARE AND PREVENTION

The CDC is the federal agency with primary responsibility for HIV prevention. The CDC supports state and local HIV prevention programs, including health departments and community-based organizations, through funding and technical assistance, surveillance activities, and targeted research efforts. In 2012, the CDC introduced a new "high-impact prevention" approach designed to prioritize proven, cost-effective interventions, including:

- HIV testing
- Behavioral HIV risk reduction interventions (primarily for people living HIV and their partners)
- STD screening and treatment
- Biomedical interventions, particularly pre-exposure prophylaxis (or, PrEP)
- Linkage, reengagement and retention in HIV medical care and treatment
- Partner services
- Condom distribution

In addition, because "treatment as prevention" — ensuring that people living with HIV are virally suppressed and far less likely to transmit the virus — is an effective HIV prevention strategy, the lines between care and prevention have blurred. The close alignment of HIV prevention and care services, particularly around the importance of linkage to and retention in care and treatment, makes new partnerships with health care providers, systems, and payers even more timely and relevant.

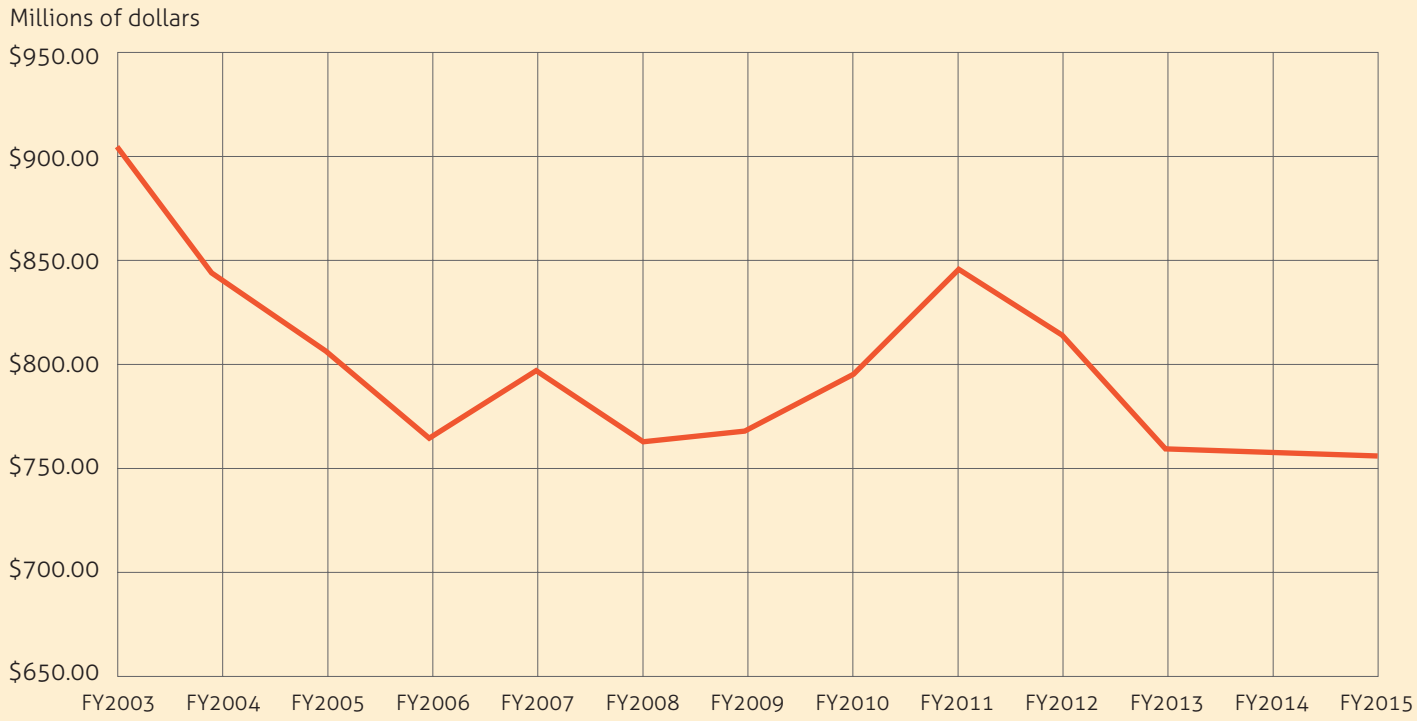
Public health and safety net programs supported through the CDC and Ryan White HIV/AIDS Program have been and continue to be essential to responding to the epidemic. However, given the resource constraints on these programs coupled with the ACA's insurance expansion and federal investments in community health centers and primary care, public health programs are looking to health care systems, providers, and payers as new partners in HIV care and prevention efforts. Even before the ACA, Medicaid was the largest payer of HIV care in the United States.[1] Although Medicaid enrollees with HIV represent less than 1% of the overall Medicaid population, they account for a significant share — 47% — of people with HIV in regular care.[2] Generally speaking, Medicaid coverage for people living with HIV is fairly comprehensive and is a critical source of care and services, including antiretroviral therapy. However, as more people living with and at risk for HIV become eligible for Medicaid through the ACA, HIV programs are assessing how Medicaid delivers and finances preventive services for vulnerable populations. This is true not only for the U.S. Preventive Services Task Force (USPSTF) A and B rated services, which Medicaid expansion benefits must include, but also for the linkage and coordination services that are so important in both HIV prevention and care efforts.[3]

In order to meet the updated HIV prevention goals established in the NHAS, the strategy update calls for public health and health care officials across levels of government and advocates to maximize the opportunities afforded by health care reform. In addition, as **Figure 1** shows, dedicated HIV prevention funding to CDC, when adjusted for inflation, has decreased since FY2003 by approximately $150 million in 2015 dollars.

HEATH CARE DELIVERY SYSTEM REFORMS

Spurred by the recognition that traditional fee-for-service reimbursement incentives are inadequately designed to support patient outcomes population health, the broader health

Figure 1: HIV Prevention Funding Adjusted for Inflation



care system is undergoing significant changes. These changes can be generally characterized by:

- A greater focus on quality measurement and improvement
- An emphasis on the crucial role of primary and preventive care
- Care delivery philosophies that emphasize integration of care across settings and providers
- An acceleration of initiatives to restructure provider payment methodologies to incentivize quality and value over volume
- A shift to Medicaid managed care

These reforms are forcing new interactions between public health and Medicaid programs.[4] With greater emphasis on preventative care in health insurance and in evolving delivery system reforms, there are new opportunities for Medicaid and other payers to cover new services aimed at coordinating care, linking people to appropriate services, and keeping people healthy. This dynamic presents a range of opportunities, some of which are described in this report. At the same time, it creates complexities in grant management for prevention services providers and a need for those same providers to understand the mechanics of health insurance.

THIS REPORT

The National Alliance of State & Territorial AIDS Directors (NASTAD) represents the nation's chief state health agency staff administering HIV/AIDS and viral hepatitis health care, prevention, education and support service programs. Given the growing importance of collaboration between Medicaid and public health programs, NASTAD contracted with Health Management Associates

(HMA) to develop a paper to highlight best practices in financing HIV prevention and care services and to identify ongoing challenges. HMA is a national consulting firm specializing in state Medicaid programs, health care system financing, program evaluation and delivery system reform. This report was funded, in part, through a cooperative agreement awarded to NASTAD by the CDC.*

HMA conducted research on national trends and state-specific activities for the purpose of identifying initiatives that represent innovative approaches to HIV treatment and prevention and that exhibit an important connection between public health officials and Medicaid agencies. Four case studies emerged from this research and are presented in the first section of this report. To develop each case study, HMA conducted interviews with the state AIDS Director, representatives of the state Medicaid agency, and other providers or health plans involved with the initiative.

HMA and NASTAD also identified a set of notable trends in financing HIV prevention and treatment, which are addressed in the second section of this report. Based on the report's findings, the final section includes considerations for state public health departments.

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Case Studies

LOUISIANA

Using Medicaid Quality Incentive Payments to Improve Services and Outcomes Across the HIV Care Continuum

OVERVIEW

In recent years, the Louisiana Department of Health and Hospitals' (DHH) Office of Public Health (OPH) STD/HIV Program has successfully implemented innovative programs to improve access to and the utilization of HIV prevention and treatment services. These programs include the Louisiana Public Health Information Exchange (LaPHIE), a bi-directional, electronic information exchange between OPH's HIV surveillance systems and participating health care providers that allows providers to support retention in care for patients with HIV. Another program of the OPH is LA Links, a Care and Prevention in the U.S. (CAPUS) funded initiative which uses regionally located care coordinators to help connect people with HIV care and treatment. Through these and other programs, Louisiana has achieved a viral suppression rate of 50 percent among all people living with HIV — 20 percent higher than the national average of 30 percent.

Most recently, the OPH's STD/HIV Program has demonstrated its commitment to improving the health and well-being of people living with HIV by partnering with the Bureau of Health Services Financing (the state's Medicaid program) to leverage the flexibility of its Medicaid managed care program — Bayou Health — to increase access to and use of HIV care and treatment. Through this combined effort, beginning in 2016, the state's Medicaid managed care plans will be held accountable for helping their members living with HIV to achieve and maintain viral suppression. The new Bayou Health contracts include eight incentive-based performance measures, including one HIV-related measure, HRSA's HIV viral load suppression measure.[5]

Inclusion of this performance measure should lead not only to improved access and use of HIV treatment, including anti-retroviral therapy, but also increased use of other HIV prevention services. While the Managed Care Organizations

Bayou Health managed care plans will be held accountable for helping their members living with HIV to achieve and maintain viral suppression.

The new Bayou Health contracts include HRSA's HIV viral load suppression measure.

(MCOs) are not yet paying for a wide array of HIV prevention services, such as linkage to care services, inclusion of this measure has led the MCOs to think about HIV care and treatment differently. For the first time, the MCOs are developing a direct working relationship with the OPH's STD/HIV Program and learning about its programs and providers. As a result, the MCOs are incorporating these resources into their case and disease management programs and referring members to them, as well as exploring ways to leverage the LA Links program.

While this initiative is in the early phases of implementation, and much remains to be done, the successes and lessons learned from Louisiana's innovative use of Medicaid managed care to improve the health and well-being of people living with HIV provide a valuable model for other states.

PROCESS AND ENGAGEMENT

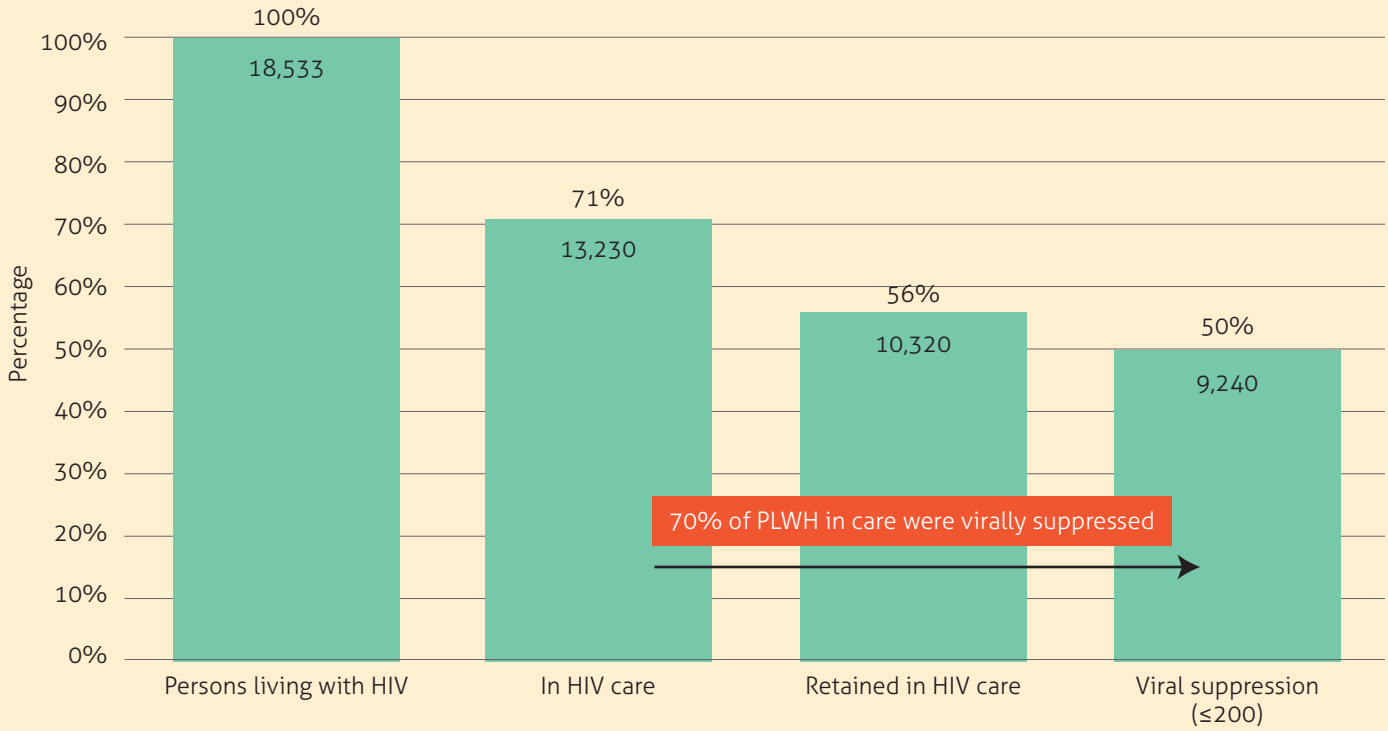
In 2013, the Department of Health and Hospitals — the agency that administers both the OPH and the Bureau of Health Services Financing (Medicaid) — experienced a change in leadership that facilitated greater interaction and data sharing between OPH and the state Medicaid program. Under the new leadership, OPH and Medicaid signed a data sharing agreement in 2014 that allows them to share Medicaid claims and eligibility data and public health data and statistics for the administration and evaluation of the Medicaid program and public health services. Prior to this, the two agencies did not regularly share data. Only a few programs had negotiated individual data sharing agreements for limited data sets. The new data sharing agreement took about six months to negotiate and put in place.

Additionally, OPH and the state Medicaid program began having monthly meetings to discuss joint projects. Staff members from the OPH STD/HIV Program are actively involved in these monthly meetings. This timing coincided with the beginning of the state Medicaid program's re-procurement process for Bayou Health — Louisiana's Medicaid managed care program. As part of this process, the state Medicaid program evaluated the existing quality measures, as well as potentially new quality measures. Given the high HIV prevalence in the state, Medicaid asked OPH whether the HIV viral suppression measure should be included in the MCO contract.

OPH supported inclusion of the viral suppression measure and, using its comprehensive HIV surveillance and continuum of care data, was able to support inclusion of the viral load suppression measure in the Bayou Health contract. (See **Figure 2**: HIV Continuum of Care, Louisiana 2014.) In addition to the data, strong leadership and a champion in the state Medicaid agency were integral to ultimate inclusion of the viral load measure as a value-based performance measure in the MCO contract. Quality improvement in Medicaid is a primary objective of the state Medicaid program, and both the OPH Assistant Secretary and Deputy Assistant Secretary supported inclusion of the HIV viral load measure in the MCO contracts.

The state Medicaid program has developed a strong, engaged relationship with the MCOs in the state, with quarterly business meetings and weekly "touch base" meetings with MCO Executive Directors, the state Medicaid Director and Bayou Health Director. However, OPH has not previously had the opportunity to develop similar relationships with the MCOs. As a result of this new initiative, OPH is now engaging with the MCOs through data sharing, as well as educating them about public health programs for people living with HIV, such as the LA Links program. The goal is to develop relationships between the LA Links program and the MCOs. The exact nature of

Figure 2: HIV Continuum of Care and Viral Suppression Rate, Louisiana 2014



Adapted from Public Health in the Era of Health Reform: Developing an HIV Performance Measure with Managed Care Organizations in Louisiana, presented July 20, 2015

these relationships is yet to be determined, but this is an important development in the area of HIV prevention.

While the OPH and state Medicaid staff have actively collaborated in the development of this initiative from the beginning, the MCOs were not involved early in the process. In retrospect, all parties agree that had the MCOs been involved sooner, some of the obstacles encountered could have been prevented. For example, OPH and Medicaid could have learned early that the MCOs do not have the data necessary to calculate the performance measure. Because the plans did not have the necessary data and ability to calculate performance on the quality measure, the accountability component of the quality measure has been delayed until 2016 when the ability to calculate performance on it has been achieved.

QUALITY MEASURE

The Bayou Health HIV viral suppression measure is based on the HRSA HIV/AIDS Bureau Performance Measure, National Quality Forum measure #2082 and is also included in the 2015 Core Set of Adult Health Care Quality Measures for Medicaid. It measures the percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load of less than 200 copies/mL at last HIV viral load test during the measurement year. The Louisiana Medicaid program selected this measure because it is endorsed by the

National Quality Forum (NQF), supported by HHS, and is an outcome-focused measure.

As part of the Core Set of Adult Health Care Quality Measures for Medicaid — which are optional for states — states choose whether to measure and submit the results of these measures to CMS. However, CMS has developed a variety of tools to help states implement collection and reporting of these quality measures, including a Technical Specifications and Resource Manual.[6] Having access to these kinds of resources can be very important. MCOs are used to collecting and reporting on the National Committee for Quality Assurance (NCQA) approved Healthcare Effectiveness Data and Information Set (HEDIS), one of the most widely used sets of health care performance measure in the United States. These quality measures have very detailed technical specifications and are designed for MCOs. One of the MCOs interviewed for this study noted the use of this non-HEDIS measure as a point of concern, because, in their opinion, it lacks the detailed, stringent technical specifications that HEDIS measures have. However, the state Medicaid program sees this as a "growing pain" and that with time, support, and experience, the MCOs will become comfortable with the measure.

CMS has developed a variety of tools to help states implement collection and reporting of these quality measures.

The Louisiana Medicaid program noted that a valuable lesson learned in this process is the important role that piloting the measure could have played to identify obstacles so that solutions could be developed before full implementation. Additionally, the Medicaid program contracts with the University of Louisiana — Monroe, to calculate and validate the viral suppression measure using data provided by OPH and Medicaid and the measure specifications. This has proved very important because the MCOs were not able to calculate the measure results. Medicaid stressed the importance of having an external entity that can calculate and validate the measure results.

Louisiana's Medicaid program set the baseline at 51.34% and the performance improvement target at 54.34%. The first year, 2015, is a reporting year, but beginning in 2016, MCOs will be held accountable for meeting or exceeding the established target. Currently, all of the MCOs in Louisiana are exceeding the target. When setting the target, Medicaid wanted to set something that was achievable. It is likely that the initial target was set too low and will need to be revised to continue incentivizing performance improvement among MCOs. A revision of the performance target will require a contract amendment, which may come as soon as 2016.

DATA SHARING

One of the most valuable lessons learned to date is that timely, reliable, and complete data are critical — but ensuring their availability may require some ingenuity. As a result of the highly collaborative process to implement the viral suppression measure, OPH and Louisiana's Medicaid program have gained a better understanding for the limitations of the data that MCOs have available through claims submitted by providers. For example, while MCOs may receive a claim for a viral load test, the MCO does not necessarily have the results of the test. This means that the MCO cannot determine whether a member meets the measure standard for viral suppression (i.e., viral load less than 200 copies/mL). Additionally, the MCO may not be able to determine which of its members are living with HIV since the MCO may not have received a claim for HIV care.

While OPH and Louisiana's Medicaid program have a fairly broad data sharing agreement in place, determining which agency shares what data with whom has sometimes proven challenging to operationalize. After a year and a half of discussions, OPH and Medicaid have settled on the following approach:

1. Medicaid provides OPH with information about all Bayou Health members who have had a HIV related claim in a set period of time.
2. OPH compares that information to its surveillance data to confirm whether the individual has been diagnosed with HIV; if so, it provides Medicaid individual level information about whether the person is virally suppressed.
3. Medicaid then shares that information with the MCOs via a secure network.

To determine which Medicaid enrollees have been diagnosed with HIV and what their viral loads are, OPH ran a series of data analyses. In July 2014, OPH conducted an initial match between Medicaid claims data and HIV surveillance data. A second match was conducted in January 2015, which included the MCO name and a field "Did recipient have an HIV-related claim in 2014?" In July 2015, a third match was conducted that included a larger set of Medicaid records (1,430,774 enrollees). In the July 2015 data match, OPH identified people living with HIV who were enrolled in Medicaid and found not only matches involving people who had a Medicaid claim for HIV care, but also 2,674 people who did not have a claim for HIV care. Among this latter group, surveillance data indicated that 409 were not virally suppressed and 1,108 had no viral load results. If not for the data shared by OPH, MCOs would have been unaware of those 1,517 members' HIV care needs. Indeed, the data analysis conducted by OPH also found that as many as 3,487 Medicaid enrollees living with HIV could benefit from linkage to care services. (See **Figure 3**: Results of Medicaid and HIV Data Match, July 2015.)

This type of data sharing is important and to have the intended results, it must be performed regularly. Originally, OPH intended to share information with MCOs annually. MCOs requested this data be shared more frequently so that they can act on it in a timely manner. The MCOs prefer monthly data sharing, but no less frequently than quarterly. OPH and the state Medicaid program were responsive to the MCOs' request and OPH will share these data quarterly.

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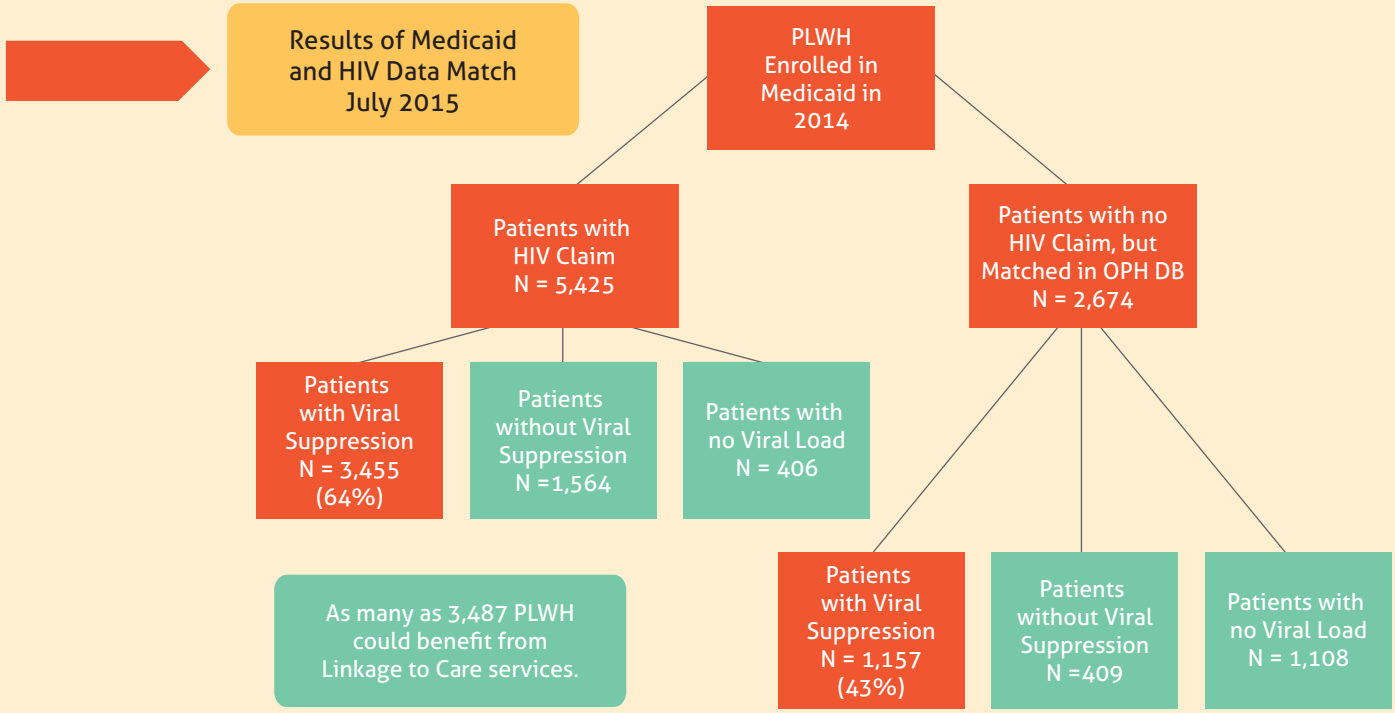
MEDICAL CARE AND SUPPORT SERVICE PROVIDERS

Each of the five MCOs in Louisiana has disease management or case management programs that provide services to their enrolled members living with HIV. However, these programs differ from the Ryan White-or CAPUS-funded linkage to care services, such as LA Links, in several respects. For example, none of the MCOs have care managers dedicated to providing care management to people living with HIV. Additionally, the programs often rely on telephone and mailings for outreach and engagement. While the programs often include a health risk assessment and some care planning, including referral to services, they do not provide the same comprehensive, in-person care management that Ryan White programs or LA Links provide. Further, not every member who is living with HIV may be enrolled in one of these

Figure 3: Results of Medicaid and OPH HIV Data Match, July 2015



Unpublished data provided by the Department of Health and Hospitals (DHH) Office of Public Health (OPH) STD/HIV Program, September 28, 2015.

programs. For example, the care management program for one of the MCOs interviewed for this project includes the top five percent of members most in need regardless of their HIV status.

However, introduction of the HIV viral suppression measure as a value-based performance measure in the MCO contract has spurred additional activities by the MCOs. These include educating in-network providers and MCO staff about HIV testing, care, and treatment; putting greater focus on meaningfully engaging members who are living with HIV in disease or case management; engaging community-based services and programs for people living with HIV; and providing incentive payments to providers to encourage HIV testing and treatment engagement.

One of the five Bayou Health MCOs, for example, has begun to use its regionally located Clinical Practice Consultants (CPCs) to work with providers whose patients have a HIV viral load greater than 200 copies. The Quality Department for that MCO uses the data provided by OPH to identify members who have not obtained viral suppression and their provider of record. The Quality Department then supplies the CPCs with the list of providers whose patients have not achieved viral suppression. The CPCs works with the provider to identify potential reasons why his/her patient(s) have not achieved viral suppression and helps the provider identify additional local resources that may be able to help his/her patients, such as linkage to care services. This same MCO has begun to explore with OPH how it can better leverage OPH HIV programs, including the LA Links program. The MCO hopes to better understand the services LA Links provides and how the LA Links program and the MCO's care management program can work together to provide comprehensive services to members while avoiding duplication of effort.

However, it is important to note that it is not the MCOs' intention, at this time, to pay for the provision of those services. The MCO hopes to identify community resources to which its care managers can refer members to receive community-based services.

FINANCING

All of the MCOs are risk-bearing and are paid a monthly capitation rate, from which the state withholds two percent. In order to receive the withheld amount, MCOs must meet or exceed the performance targets set for the eight value-based performance measures, including the HIV viral load suppression measure. MCOs that achieve the target for the HIV viral suppression measure will receive $250,000 of the withheld amount. MCOs that do not meet the target will not receive that portion of the withheld amount.

MCO REIMBURSEMENT OF HIV PREVENTION SERVICES

Both the state Medicaid program and OPH hope that the HIV quality measure will result in greater focus on Medicaid members living with and at risk for HIV, as well as a closer collaboration between Medicaid, OPH, and the MCOs. However, the MCOs are largely focused on realizing performance improvements through better delivery and use of the care and support services they are contractually required to provide, as these services are included in the rates that are paid to the MCOs by the state. If an MCO elects to contract with new providers for additional HIV prevention services, such as linkage to care services, it must pay for these services out of its current rate. As a result, MCOs may be interested in helping their members better leverage publicly supported, community-based prevention services, but they are not currently considering contracting for and paying community-based providers for the provision of these services.

When asked if they would consider doing so, MCOs did indicate that if a business and value proposition case is made, it is something they would consider. Nonetheless, it is more likely that if Louisiana wishes to have the MCOs pay for such services, it will need to require that as part of the contract and incorporate it into the MCOs' rate structure.

Lessons Learned

- Quality measurement is technical work and implementing new quality measures requires careful thought to capture necessary data, validate information, and calculate measures.
- Emphasizing performance on a quality measure can lead MCOs to investigate how to coordinate with public health resources and encourage the development of practice-level interventions designed to improve performance.
- Collaboration between MCOs and the state health department to understand available data and data-sharing protocols is crucial and is a specific way to introduce public health agencies and MCOs to the ways that data sharing can be useful to support care delivery improvements.

RHODE ISLAND

Reimagining Medicaid Case Management to Include High-Risk HIV Negative Individuals

OVERVIEW

Targeted case management (TCM) is an established service option under federal Medicaid law. In Medicaid terms, TCM is an optional service, and the process of gaining approval for federal matching funds for the service involves the submission of a state plan amendment[7] that defines a "target group," explains the services to be delivered and the qualifications required of providers, and outlines how the services will be reimbursed. In Rhode Island, HIV-related TCM services were originally delivered through the fee-for-service system, but as the state has shifted to greater reliance on a managed care model for delivering Medicaid services, TCM services have been brought "in plan" as covered services in the MCO contracts. Specifically, when Rhode Island expanded its Medicaid program in 2014, the state used the contract negotiation process as an opportunity to extend TCM to its new coverage population. Incorporating TCM coverage for the Medicaid expansion population into the MCOs for people living with HIV allowed Rhode Island to leverage the expertise and capacity of existing HIV providers to ensure continuity and coordination between the state Medicaid program and the Ryan White HIV/AIDS program, and to maximize federal funding.

Building off of the success of TCM coverage for people living with HIV, the state health department began conversations with the state Medicaid program and Medicaid MCOs to explore a similar set of services for HIV negative individuals.

Building off of the success of TCM coverage for people living with HIV, the state health department began conversations with the state Medicaid program and Medicaid MCOs to explore a similar set of services for HIV-negative individuals. Beginning in January of 2016, the state will build on this structure to include case management services for individuals who are deemed to be at risk of HIV infection, based on defined behaviors or characteristics. The new "at risk" population eligible for case management services is defined as people with any of the following:

- Men who have sex with men (MSM)
- Active substance users and/or those individuals with documented mental illness
- Persons living with hepatitisB or C
- Persons with a documentedhistory of sexually transmitted diseases (STDs)
- People recently released from prison or juvenile detention (TCM services may be delivered within one year post-release)
- Sex workers
- Transgender individuals

- Bisexual men and women
- Adolescents engaging in unprotected sex
- Persons who engage in unprotected sex with HIV+ or high risk individuals

Each person eligible for targeted case management is assessed to determine the severity of need. For people at risk for HIV, TCM services include an intake process, assessments and re-assessments, care planning, and referrals to relevant services, including behavioral health services, medical visits, housing, HIV Testing, STI testing, and vaccinations.

PROCESS AND ENGAGEMENT

The Rhode Island Executive Office of Health and Human Services (EOHHS) is a state umbrella agency that oversees social, public health and human services, and Medicaid. In fact, the HIV Provision of Care and Special Populations Unit, which manages the Ryan White Part B program, resides within the Medicaid Division, and the Principle Investigator for the Ryan White Part B grant reports directly to the State Medicaid Director. This structure has created a channel through which state Ryan White leadership can provide direct policymaking input on how the Medicaid expansion would be implemented.

One challenge with investigating Medicaid coverage options for TCM was funding constraints. The Department of Health, which had been financing case management services, reduced its expenditures for HIV case management, in part, because of a general expectation that, since Rhode Island was expanding its Medicaid program, fewer individuals would be entirely reliant on publicly funded case management services.

The state engaged its two Medicaid MCOs in advance of the implementation of the ACA's Medicaid expansion, with discussion originally focused on the planned contract amendment that would include TCM services for people living with HIV as MCO-covered services. The state expanded those discussions to include TCM services for HIV negative individuals.

NETWORK PROVIDERS, CLAIMS, AND REPORTING

Under the fee-for-service TCM program, the target group was defined, in part, as individuals "receiving case management services from providers who are licensed by the Department of Health and provide service under contract to the Department of Health." In effect, approved Ryan White providers were able to bill the Medicaid program for fee for service (FFS) enrollees. The new MCO contract requires MCOs to develop a network of HIV-related TCM providers. In order to streamline the development process, the state provided the MCOs with a list of existing Ryan White providers and also communicated its expectation that all of those Ryan White providers should become MCO network providers. About half of the existing providers also offered other medical services and were already enrolled providers in each MCO's network. The MCOs also developed contracts directly with all Ryan White TCM providers that were not already included in their networks.

The new MCO contract requires MCOs to develop a network of HIV-related TCM providers.

Under the MCO contracts, MCOs negotiate rates independently with the provider agencies. Those negotiations were initially informed by the established state TCM rate and by information from local providers about their costs. In both health plans, the services are billed on a unit basis, in 15-minute increments. Both plans conveyed that billing processes were new but did not result in significant disruption or issues for Ryan White providers. In advance of the

implementation of the new coverage, plans provided technical support to providers — either one-on-one training or visits to provider sites.

The state health department also played a role in encouraging the development of infrastructure and capacity at the provider level to manage and monitor HIV clinical and supportive care. This has been important to the MCO expansion of TCM because the state has set expectations of significant quality reporting for the MCOs. Beginning this year, and over the coming years, the state is collecting a set of performance measures associated with the service, including patient participation measures, patient process measures, quality of care measures, and patient outcome measures. These measures are required reporting elements under the MCO contracts and represent an interest on the state's part to be able to analyze over time the population receiving services and identify outcome variables. While the detail included in these reporting requirements has caused initial concern on the part of the MCOs, the state has worked with the MCOs to help them understand that they should be able to gather the data from their network because providers are obligated, as Ryan White HIV/AIDS Program providers, to have the reporting capacity.

Just as important, there are challenges related to the advocacy-based culture of some community-based provider organizations and their perceptions of Medicaid and managed care as bureaucratic or finance-focused entities. Technical assistance and support at the provider level is necessary — and one state interviewee suggested that such support needs to address not only staff practices and provider operations, but also governance and organizational culture. This general point may take on greater importance as the state moves toward TCM for HIV negative (at risk) individuals — when the state anticipates that the pool of participating providers could expand given the expanded potential client base.

COMBINING MEDICAID CASE MANAGEMENT AND PREVENTION SERVICES

As prevention services are prioritized for both individuals with HIV or at risk individuals, the operation of case management can support prevention but must be structured carefully to comply with federal and state rules. Indeed, the regulatory structure of the TCM program reflects the challenges of distinguishing between traditional case management services and prevention services. Because of the importance of demonstrating compliance with Medicaid rules, covered services in Rhode Island are documented as traditional case management services, including intake screening, assessment and re-assessment, and care plan development. The state's provider manual explicitly states that "Case management provides access to services but does not include the actual provision of the needed services."

Nevertheless, the case management program is designed to support the provision of high-impact prevention services. For example, the state's collection of performance measures requires that case management providers report viral suppression trends for HIV positive individuals, and case managers need to be aware through the assessment and care planning process of any risk factors and ongoing need for medical or behavioral services. Moreover, once the program is expanded to high-risk HIV negative individuals, case management providers will be required to refer such individuals for HIV testing and STD testing and help link consumers to those services.

COMBINING PUBLIC HEALTH AND MANAGED CARE APPROACHES

In interviews, both state officials and health plan representatives identified important cultural and operational differences between the state's publicly funded HIV care and prevention programs and Medicaid managed care. From the

state's perspective, it was important for the health plans to engage meaningfully with the community of TCM providers. As the state AIDS Director stated, health plans should be encouraged to move away from acting as a traditional "payer" to engaging with community providers as a "player."

By contrast, from the health plan perspective, the state's regulatory and contract management approach to the TCM service failed to adequately recognize necessary differences in the organization and operation of case management available through managed care plans and those offered by stand-alone, disease specific programs. The health plans were universally impressed with the infrastructure and organization of the existing Ryan White program in Rhode Island, but they felt that some program elements—like reporting and monitoring requirements— were ill-suited to (and therefore, should not be applied to service provided within) a managed care context. As one plan representative stated, the state has to "make a transition from being a program [operator] to being an overseer."

For practical reasons — namely, that the state already had an established TCM service for individuals with HIV — the services initially brought into managed care were traditional HIV case management services. Looking ahead, the state is planning to expand the target group entitled to the services to those at risk of HIV infection. The point emphasized repeatedly by state officials is that their strategy has been to start small and build toward broader engagement between community-based providers and the established Medicaid delivery systems.

As the state AIDS Director stated,health plans should be encouraged to move away from acting as a traditional "payer" to engaging with community providers as a "player."

Indeed, as the state has begun discussions about expanding TCM through the MCOs to include individuals who are HIV-negative but are demonstrably at risk of HIV infection, it has found that MCO care managers have expressed an interest in being involved in the development process. The state intends to work with the MCOs to determine how best to identify at-risk members and to support providers as they plan for this new service model focused on case management to prevent HIV infection.

Lessons Learned

- **Coordination between plan-based care managers and community-based care management and prevention providers can provide mutual benefits and improve integration of care.**
- **Starting with a smaller managed care initiative provides a way for MCOs and providers to develop relationships and mutual respect, paving the way for broader and more comprehensive initiatives.**
- **Medicaid coverage for HIV care-related services, such as TCM, can provide a foundation for MCO engagement with public health programs and providers and open the door to opportunities for coverage of other HIV prevention services.**

CHICAGO

Making the Case for Inclusion of Community-Based Organizations in Medicaid Managed Care Payment and Delivery Systems

AFC is working to establish new partnerships in care and prevention, built on their 30 years of serving the community with prevention, care, housing and advocacy.

OVERVIEW

In the post-ACA environment, expanded insurance coverage and experimentation with new delivery and payment models have produced significant new revenue-generating opportunities for HIV prevention and care services. In particular, new emphasis in Medicaid on population health and care coordination for people with complex conditions has created opportunities for services provided by non-clinical community-based organizations.

The AIDS Foundation of Chicago (AFC) has secured two contracts directly with Medicaid MCOs to date, and an additional four contracts are under discussion. While a majority of the work being conducted is focused on PLWH and those at risk, AFC services under contract reflect AFC parlaying its experience serving those populations to stretch beyond an established HIV-specific service track record. Prior to engaging with health plans for contracting services, AFC's funding mix consisted of grants from the public (federal, state and local governments) and private sectors, as well as donations from foundations and community supporters.

Health plan contracting with CBOs can address needs and provide benefits to both sides, but unless the state Medicaid office actively encourages MCOs to contract with community providers, the onus is generally on the CBO to initiate dialogue and propose partnership opportunities. This case study leverages AFC's experience working with Aetna Better Health of Illinois to illustrate how CBOs can articulate *and demonstrate* their potential value as part of a managed care network.

INTERNAL ASSESSMENT, POSITIONING AND VALUE-PROPOSITION

AFC conducted extensive preparation to market a range of services to MCOs, including those based on its expertise in linking and re-engaging back into care hard to reach health plan members, by developing a business case focused on supporting the MCO to achieve high-quality, cost-effective care.

A premise put forward by AFC for the services marketed to MCOs is that established, well-governed CBOs such as AFC know the communities,

populations, navigation pathways for treatment and care and the cultural contexts in which clients live their lives. Accordingly, AFC explicitly built its business case around data from key outcome indicators that demonstrated its track record of service delivery to hard-to-reach populations. In the interviews conducted for this report, senior MCO administrators repeatedly cited AFC's solid reputation and track record as two key factors in deciding whether to pursue a partnership with AFC.

CATALOGUE OF SERVICES AND CROSSWALK

Before engaging MCOs, AFC conducted an internal assessment of the "actual" cost of providing each unit of service. This analysis proved essential in the initial determination of whether the agency should pursue this line of work, and subsequently provided important benchmarks throughout the initial negotiating process. AFC then assessed its existing service mix and developed service packages to highlight key functions aimed at addressing emerging MCO and population health needs. The result of this effort, branded "CommunityLinks," is a suite of service packages—including those that address prevention, linkage and treatment —that can be marketed and sold to health plans. The catalogue became a marketing tool around which AFC constructed a business case demonstrating it could perform at the level that the MCO expected of a business partner.[8]

While AFC thus markets services across the HIV prevention and care continuum, this case study focuses on the "Reach and Engage" service package, which is described in greater detail below.

REACH & ENGAGE

Description: Our Mobile Engagement Team is designed to find and engage health insurance members to inform them about health plan benefits and provide a brief health assessment.

Targeted members: "Unable to locate" health insurance plan members.

Benefits: By rapidly connecting and re-engaging those who are not yet connected with their primary care provider or have fallen out of care, members will be able to begin accessing services and appropriate treatment on a timely basis.

ESTABLISHING CONTACTS, BUILDING RELATIONSHIPS AND NEGOTIATING

With their services catalogued and business case for pitching partnerships honed, AFC established a logo, web page and phone line specifically for CommunityLinks. AFC then began reaching out to health plan contacts as broadly as possible. Outreach to health plans was prioritized based on corporate reputation, relationships and responsiveness. The approach was undertaken as a long-term relationship-building effort and AFC was mindful not to overwhelm the health plans with information and proposals. Initial targets for engagement included the health plan CEO, the executive responsible for Medicaid plans, or the company's government affairs representative. Beyond these systematic, strategic steps, AFC reported casting as wide a net as possible for business development contacts, including a cold call approach: "at a certain point we just picked up the phone and started dialing," when a health plan was not responsive and other approaches had failed.

Our Mobile Engagement Team is designed to find and engage health insurance members.

Once initial contact was established and as a precursor to discussing the service details, AFC and the plan established a Business Associate Agreement, which includes HIPAA provisions, in order to share information. Despite having packaged its services in a manner expected to align with what health plans would need to fulfill demands and requirements on them, significant additional discussion and customization was typically necessary to set contract terms and reimbursement methods.

To further attract interest from health plans unaccustomed to working with CBOs, AFC approached MCOs with the idea of starting small and then growing contract volume and services over time after AFC had fine-tuned its operations and demonstrated its value as a partner. Both of the MCOs with which AFC originally contracted were receptive to this idea, and initial contracts were executed for a one-year term, with a six-month re-evaluation built into the contract. In terms of authorized caseloads for the network, both contracts limit caseloads to fewer than 100 members. By starting small, AFC is able to essentially pilot a new payment and delivery model. However, for statewide policy and coverage reforms that ensure that all Medicaid MCOs are inclusive of HIV services and providers, a broader approach that addresses state MCO contracts and includes the state health department and state Medicaid program may be necessary.

REIMBURSEMENT AND CONTRACTING STRUCTURES

AFC proposed to operate on a monthly flat rate payment basis, which provides set revenue and allows for simplicity in administration of billing and payments. However, AFC has had to adapt to the unique preferences of its partner health plans. Currently, one contract is reimbursed at a flat monthly rate for services provided and the other is a per-member per-month (PMPM) structure, based on the preference of the health plan. Furthermore, interviews with MCO executives suggest that they are increasingly favoring payment and partnership models that shift more of the risk to providers, including community-based entities like AFC. One executive noted that this is consistent with the health care system's evolution towards reimbursement structures that favor payment for performance.

AFC embarked on this initiative despite some uncertainty as to whether the payments it secured from MCOs would ultimately cover both the large upfront investment costs associated with developing its new business lines and the ongoing costs associated with providing high quality, often intensive services. In part, AFC was able to take this risk because it was well-capitalized: it secured special private and grant funding to support the transitional work, and it had a solid foundation of categorical HIV care and prevention funding. This stability has allowed AFC to be innovative and creative in designing service suites specifically tailored to the unique needs associated with new service populations.

AETNA AND *REACH & ENGAGE*

In March 2015, AFC finalized a contract with Aetna and began providing its Reach & Engage services to members that the health plan had been unable to locate. AFC maintains a monthly minimum case load of 83 health plan members, which the health plan identifies by holding internal interdisciplinary staff discussions, as well as reviewing claims data and Aetna case manager referrals. In assigning AFC's case load, the health plan takes into consideration factors such as whether the member is at high risk for HIV acquisition, whether the member is HIV-positive and out of care and whether the health plan has been able to "reach" the member, but not able to "engage" that individual.

AFC uses various data sources — including publicly available information (e.g., Cook County Jail and the Illinois Department of Corrections) and the agency's internal housing database — to locate members for engagement. In addition, Aetna has been fine tuning a system whereby claims data for Emergency Department utilization and pharmacy usage would trigger immediate notifications to provide additional information on hard to reach members. Once a client is successfully contacted, AFC conducts Aetna's required state risk assessments and provides the client with information about the health plan's benefits. As part of their services to health plan members, AFC offers HIV and HCV screening to every health plan member contacted, where appropriate. To date, this screening has occurred in people's homes during a face-to-face reach and engage visit. AFC provides linkage to HIV medical care for individuals with a reactive test and re-engagement services for previously diagnosed clients who are out-of-care.

Lessons Learned

- CBOs interested in establishing new relationships with health plans must be prepared to articulate a value proposition; this may include evaluating the cost to the CBO of providing each service unit; establishing the CBO's capacity to deliver services as contracted; and demonstrating to the MCO that the service will result in cost savings and better health outcomes.
- Contracts should be as specific as possible about all terms; however, they should also offer sufficient flexibility to allow fine-tuning as the relationship and the specific service categories evolve.
- Even partnerships grounded in a well-developed business case and support from leadership and staff on both sides will require patience and flexibility, as program requirements evolve and as the partners identify and strive to overcome technical and programmatic barriers.
- By partnering with state HIV programs and other state agencies in these contracting processes, providers and state health programs can maximize opportunities to ensure the long-term sustainability of pilot projects like this and foster state-wide approaches.

HOUSTON

Leveraging Medicaid Delivery System Reform Incentive Payment (DSRIP) Projects to Improve HIV Linkage and Reengagement

OVERVIEW

The City of Houston's Department of Health and Human Services Bureau of HIV/STD & Viral Hepatitis Prevention leadership has leveraged new financing opportunities through a statewide Delivery System Reform Incentive Payment Program (DSRIP) Medicaid 1115 waiver. Specifically, the DSRIP process in Texas has opened up a substantial new source of funds to support expansion of the Department's use of patient navigators to link newly HIV diagnosed and HIV diagnosed out-of-care patients to care and treatment with DSRIP funds.

The City of Houston is using Medicaid 1115 waiver DSRIP funding to support patient navigators to link newly HIV diagnosed and out-of-care patients to care and treatment.

Section 1115 waivers are approved by CMS and are vehicles that states can use to test new ways to deliver and pay for health care services in Medicaid. For example, Section 1115 waivers may be used by states to evaluate policy approaches such as expanding eligibility or services or using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Across the country, DSRIP waivers have been designed to support state delivery system reform goals to improve integration and coordination of Medicaid services. Typically a Section 1115 DSRIP waiver articulates state-specific goals and sets specific milestones that are measureable improvements in quality and overall population health.[9]

Eligible providers and the process for applying for funding may differ substantially across DSRIP states. While some states have been fairly prescriptive about eligibility for funding, the process for designing programs, and the metrics providers are permitted to select, Texas set up a regional system in which providers had flexibility to choose specific projects and select the metrics for delivery system reform. Specifically, Texas divided itself into geographic regions, known as Regional Healthcare Partnerships (RHPs), under which all applicants for DSRIP-funded services are organized. Each RHP is led by an anchor organization, generally the organization with the strongest leadership capacity and experience with safety net services in the area, and all public and private hospitals and non-hospital providers in a given region are eligible to participate. RHP #3 covers the entire Houston metropolitan area and is led by Harris Health Systems (HHS), which takes responsibility for coordinating the 25 other providers, overseeing the several hundred

waiver-funded projects currently underway, and providing a single point of contact for interaction with the state.

While DSRIP implementation varies broadly, on a national level, the point of DSRIP funding is to provide a source of funding to permit planning and implementation of projects that further the state's delivery system reform goals.[10]

Houston has had an HIV linkage program since the early 2000s; prior to DSRIP, the city had primarily relied on Ryan White HIV/AIDS Program funding, and, more recently, additional funds from private sources. Houston had applied for, but did not receive CDC PS 12-1201 Category C funding for a re-engagement data-to-care project. With the advent of the DSRIP waiver, the city's Department of Health was able to incorporate some of the activities that were not funded under Category C into its DSRIP linkage project. In addition, the city has not only been able to plug gaps created by reductions in traditional funding streams, but also to incrementally expand the overall capacity of the operation. In fact, DSRIP funds have helped put the department on track to double the number of people served through its linkage programs. The target population is Medicaid recipients, living with HIV as well those with syphilis infection (the syphilis-related focus was added as a result of a state Medicaid program requirement to identify additional related objectives to HIV linkage from a list of approved objectives), with an ultimate goal of increasing the number of people stable in care with viral suppression beyond the short-term intervention.

To apply for funding under the Texas DSRIP waiver, which began in 2012, RHPs were required to conduct a comprehensive community health needs assessment. In Houston, this assessment identified high rates of HIV and inadequate access to HIV treatment and services, as well as lack of patient navigation and information programs. The member organizations then developed and proposed projects for funding that each fall under any or all of the four categories established by CMS for this funding program: Category I, Infrastructure Development; Category II, Program Innovation and Design; Category III, Quality Improvement; or Category IV, Population Health Improvement.

The first two years of funding were planning years. The third through fifth year of funding are program operation years. Each year has specific outcome measures for the categories under which they proposed and are measuring the progress and impact of work. For receipt of DSRIP payment — which is a set amount of funding rather than service-based — certain milestones need to be met. For example, a certain number of clients served under the waiver must have a dual diagnosis of syphilis with evidence of treatment for satisfaction of metrics selected under the program's Category III milestones. Payments are made three months after submission directly to the Houston Health Department.

To apply for funding, RHPs needed to conduct a comprehensive community health needs assessment.

For the linkage program, the approved total of milestone payments the second year for all Category I and II goals was $2,061,713. Houston accomplished 100% of its milestone goals and therefore was paid in full following completion and satisfactory reporting. Category III milestones, which were also accomplished, totaled $108,511. An important component of the program is that the DSRIP funds are reimbursed only after the work has been done and successfully documented and reported. Therefore from an operational standpoint, the agency must make a large investment in

floating the costs of the program. This pressure is particularly high for Category I and II milestone payments, which are "all or nothing," in the sense that their payments and can only be received when full achievement is achieved. Category III milestones, by contrast, can be paid out in quartiles for partial achievement. If milestones had not been achieved, they can be moved forward into the following year for future accomplishment and payment.

THE SERVICE LINKAGE PROGRAM IN HOUSTON

The service linkage program in Houston uses data from multiple sources to identify: newly HIV diagnosed patients; HIV-diagnosed out of care patients; and HIV-diagnosed patients in care who need additional supportive services to achieve medical stabilization and treatment adherence. The sources of client referral include reported cases through city surveillance data, local clinic primary care sites, disease intervention staff, and less frequently, local CBOs and self-referrals. Once an intake is conducted by linkage staff, the interviewer is allowed three days to complete all documents and then a 180 day period begins, during which time it is the goal of the program staff to get the client in care and linked to other relevant services. Success requires extensive knowledge of community resources and advocacy by the program staff on behalf of the client to connect them to available (separately funded) support services and medical care. Often an appointment for medical intake can take 90 days and the linkage staff are required to be tenacious champions to accomplish their goals. Discharge occurs when the client is stable in care, or at the end of the 180 day period, whichever comes first.

The department created its own data system for tracking DSRIP-funded program clients, as there are multiple sources of data and unique tracking and reporting requirements. They also use this independently maintained system to generate all of their internal monthly reports and biannual reports to the state. Multiple sources provide data used to operate the services of the program, such as the Centralized Patient Care Data Management System (CPCDMS), which is operated by Harris County and used to track Ryan White clients; the Sexually Transmitted Diseases Management Information System (STDMIS) operated by the state; the city health department's surveillance database; and an internal access database the department created to capture and track other information not housed elsewhere. Importantly, use of the CPCDMS to track DSRIP clients (although they are of course not reimbursable through Ryan White/AIDS Program funds) required a special agreement with the city's Ryan White Program. This arrangement, which was implemented during the DSRIP planning years, has proven to be critical for the program to be compliant with data use and funding restrictions.

A BROADER FRAMEWORK OF GOALS, AND SPECIFIC DSRIP MILESTONES AND PAYMENTS

The Houston health department has effectively "braided" multiple funding sources (including those available through the Ryan White and DSRIP programs) to better support its linkage to care activities. This has allowed the Department to create a framework of short, intermediate and long-term goals, combined with quantifiable objectives, which would not have been possible with any single funding stream. In that larger framework, outcomes include:

Short-term: Improved capacity for service delivery, caseload optimization, and increased number of referrals.

Intermediate-term: Enhanced capacity to prevent spread of HIV/AIDS; increased ongoing access to medical care among people living with HIV; increased ongoing access to non-medical services among

people living with HIV; reduction in people living with HIV who use ED, urgent care and/or hospital services; and decreased morbidity among people living with HIV.

Long-term: Appropriate utilization of ED among people living with HIV; improved quality of life among people living with HIV; and reduction of health disparities.

Although the specificity of the milestones and data capture requirements have proven challenging (see above), the DSRIP program complements the Department's overall framework by requiring very specific clinical and process measures. The program's category-specific milestones for the two remaining years of the program, which are broken down into specific milestones and metrics for each year, are as follows:

- **Category I or II Expected Patient Benefits:** Increase number of primary care physician referrals for indigent or Medicaid patients without a medical home who use the ED, urgent care, and/or hospital services by 5% over the baseline (baseline of 275 patients) in Y4 and by 10% over baseline in Y5.
- **Category III Expected Outcome:** Reduce by 5% each the number of ED visits among program participants in HIV Linkage Program and number of patients from specific zip codes over baseline in Y4 and by 10% over baseline in Y5.

Now in its fourth year of operation, the program has a strong track record of accomplishing its milestones and significantly expanding linkage resources for its HIV out-of-care population. Houston has been paid a total of $4,696,814 through the end of year three of the project. The Department characterizes the initiative as a challenging one from an operational and managerial perspective, but also one that has resulted in meaningful program expansion.

Lessons Learned

- Designing appropriate metrics for a milestone-based reimbursement program requires great attention and flexibility to adjust according to external state and federal frameworks and priorities. Even with two years of planning preparation it was extremely challenging to get this program fully up and running.
- The reimbursement process for DSRIP, which requires an organization to "float" operating costs is a compelling reason for an organization to carefully consider their capacity prior to delving into DSRIP as a new funding opportunity.
- Service providers and program managers should be as involved and vocal as possible in goal setting, in discussion of specific program metrics, and in assessing what will be required to collect data.
- For a program that is bound by a period of time for linkage services, ongoing training and workforce development efforts are needed to ensure consumer retention in care after the required time allotted to service linkage workers has expired.

Notable Trends in Financing HIV Prevention

In addition to the approaches featured in the case studies, there are other innovative payment and delivery system reforms that present opportunities for public health departments and providers to partner with Medicaid to increase access to HIV prevention services. The table below describes some of these emerging opportunities in detail.

Medicaid Delivery System and Payment Reforms: Notable Trends

Payment and Delivery Model	States Implementing the Reform	Approval Process	Provider Reimbursement Mechanism	Federal Guidance/ Resources
Medicaid Health Home	As of May 2015, 19 states have approved SPAs with a total of 26 approved unique Health Home models. Of these, four states (AL, WA, WI, NY) expressly include people living with HIV or AIDS in the target population.	Medicaid agency in the state must obtain a Medicaid State Plan Amendment (SPA). As part of the SPA process, states must consult with the Substance Abuse and Mental Health Services Agency (SAMHSA) to assure that Health Homes meet the needs of people with behavioral health needs — a priority population for Health Home services.	States have flexibility in determining the way in which providers are reimbursed for providing Health Home services. Examples include: **Wisconsin:** Monthly Case Rate, **Rhode Island:** Weekly, bundled rate per enrollee, **Iowa:** Per Member Per Month patient management fee	CMS Medicaid Health Home Resource Page

Medicaid Delivery System and Payment Reforms: Notable Trends				
Payment and Delivery Model	States Implementing the Reform	Approval Process	Provider Reimbursement Mechanism	Federal Guidance/ Resources
Community Health Workers	A number of states are implementing models using Community Health Workers to expand access to preventive services. Some states, such as New Mexico and Oregon, mandate use of CHWs.	There are several ways to allow peers or CHWs to provide Medicaid services, including through a State Plan Amendment expanding the types of providers who may provide preventive services. States may file a State Plan Amendment that describes what services will be covered; who will provide them and any required education, training, experience, credentialing or registration of these providers; the state's process for qualifying providers; and the reimbursement methodology.	Reimbursement for CHW services varies by program. In some cases, MCOs are hiring CHWs directly and paying them a salary. In others, MCOs or state agencies are contracting with community-based organizations, in which case reimbursement is often a per-member per-month payment.	Center for Medicaid and CHIP Services Informational Bulletin Medicaid Reimbursement for Community-Based Prevention
Delivery System Reform Incentive Plan (DSRIP)	As of June 2015, six states have implemented or are implementing DSRIP as part of a comprehensive 1115 wavier program. Other states, such as Alabama, Illinois, and New Hampshire are developing DSRIP waivers.	Included as part of a broader Section 1115 Medicaid waiver. States must apply for and obtain approval for the 1115 waiver program.	Performance-based incentive programs; not grant programs. DSIRP funding allocation methodology varies by state, but in all cases providers must meet certain process and/or outcome measures before receiving any DSRIP funding.	Using Medicaid Supplemental Payments to Drive Delivery System Reform An Overview of Delivery System Reform Incentive Payment Waivers
State Innovation Model (SIM)	As of November 2015, over half of states representing 61 percent of the U.S. population (38 total SIM awardees, including 34 states, three territories and the District of Columbia) are working toward comprehensive state-based innovation in health system transformation.	CMMI has issued two rounds of funding for SIM. To be awarded funs, states had to submit a letter of intent to apply, along with a formal application. CMMI selected and awarded Model Design and Model Test grants.	States are pursuing broad system reform through SIM, with a focus on community, public, and whole-person health. Many SIMs include some form of value based payment, such as shared savings or risk-based payment methods, for providers.	State Innovation Models Initiative: General Information State Innovation Models Initiative: Round Two The State Innovation Models (SIM) Program: An Overview

Considerations for State Health Departments

State Health Departments should consider working with their Medicaid counter-parts to include HIV-specific quality requirements in MCO contracts.

State Medicaid agencies can use program monitoring authority and different incentive arrangements to encourage MCOs to focus on HIV prevention and quality of care. States are required under federal Medicaid managed care regulations to implement a minimum number of performance improvement projects (PIPs) each year. Some states also impose additional PIP requirements. Public health agencies or departments can work with their Medicaid counterparts to incorporate HIV-prevention focused PIPs in the Medicaid managed care contracts, or can follow Louisiana's lead and include quality measures that focus on HIV care and treatment. Quality improvement efforts can be further encouraged by linking performance to payments to the MCOs.

State Health Departments should consider establishing relationships with Medicaid Managed Care Organizations (MCOs).

Medicaid MCOs have the ability to provide value-added benefits to members, as well as to contract with non-traditional providers, such as non-clinical community-based organizations. State public health agencies or departments can help foster direct connections between community-based organizations that provide care and services to people with HIV and MCOs. The goal is to include HIV prevention care and services to support health plan enrollees. Forging this connection between MCOs and CBOs can happen because a state has required it (as in Rhode Island), because a state has put in place a specific contract requirement that encourages it (as in Louisiana), or because a provider and health plan determined that the partnership could have mutual benefits (as in Illinois). In all cases, it is worthwhile to first construct the business case for why an MCO program or company should focus on HIV services and/or providers. Whether directed at state Medicaid decision makers or at the MCO itself, this business case should illustrate how the HIV programs can help the MCO achieve one or more of its contract requirements, improve health outcomes for its members, and/or contain costs by reducing unnecessary utilization.

States should consider exploring ways to establish mechanisms to support community providers in developing MCO relationships.

Comprehensive networks of providers are a significant value to MCOs, particularly those with strong ties to disproportionately impacted communities. However, community-based non-clinical providers may face capacity and infrastructure challenges in developing relationships with MCOs and implementing financing arrangements that allow for reimbursement for prevention services. State health department and Medicaid programs can help by encouraging MCOs to work directly with community-based providers, and by providing "translation services": helping MCOs and CBOs better understand and appreciate the state or federal requirements under which each operates.

All parties should acknowledge differences of "culture and capacity" between public health organizations and health plans and work together to identify opportunities that leverage the unique strengths of both sets of stakeholders.

When establishing ongoing initiatives that involve MCOs and CBOs, it is important to recognize that these participants in the health system have evolved separately, with different orientations toward state agencies and different financial incentives. Creating new initiatives to align incentives can encourage collaboration, but the fact remains that CBOs operate in an advocacy-based culture and MCOs operate in a business-driven insurance-based culture. Moreover, these entities will have very different capacities and orientations to data collection and systems.

Experience has shown that working together on data issues is both essential to operationalize a partnership, and can help to illuminate that both public health systems and MCOs have data that can strengthen collaboration.

State public health and state Medicaid agencies should consider working together to eliminate barriers to community-based collaboration.

Issues of data access and Ryan White "payer of last resort" standards can be complex barriers for health plans and individual service providers to resolve, and the state health department can provide leadership and facilitate dialogue to move collaborations forward. Regardless of the specific operational context, issues of identifying eligibility and monitoring service provision cross multiple funding streams will remain important both to appropriately manage resources and to create methods to monitor progress and track clinical outcomes.

New Medicaid demonstration projects present HIV care and prevention programs with opportunities to fund public health programs and services not typically covered by Medicaid.

A central element of the Texas DSRIP program and of DSRIP nationally is achievement of quantifiable goals, so the design of DSRIP-funded programs across the country may offer opportunities to assess the challenges and possibilities of identifying specific clinical or process measures that capture how well an HIV linkage or prevention program is working. The establishment of these types of measures holds promise for creating ways to assess how public health and Medicaid programs are supporting public health.

Conclusion

This paper offers a snapshot of how states are working to bridge public health and Medicaid in ways that improve HIV services and to finance HIV prevention efforts. Much of this promising work is in its infancy, however the programs and trends described here help to provide a set of potential options to engender more collaboration across state agencies and with providers.

This report describes strategies to reform the delivery of health care that, in different ways and using different mechanisms, all emphasize the importance of care coordination, prevention and the need to address barriers to healthy lifestyles. Taken together, these new innovations represent a critique of the current health care delivery system, which is generally not adequately designed to emphasize or finance preventive services. Whether creating new incentives for managed care companies, designing specific initiatives through a state DSRIP program, experimenting with Medicaid health homes, or exploring new uses for community health workers, Medicaid programs and state public health agencies represent opportunities to collaborate on efforts to reform health care delivery so that it prioritizes proven HIV prevention strategies.

Notes

[1]Assessing the Impact of the Affordable Care Act on Health Insurance Coverage for People with HIV, Kaiser Family Foundation, Publication #8535, January 2014, available at http://kff.org/hivaids/issue-brief/assessing-the-impact-of-the-affordable-care-act-on-health-insurance-coverage-of-people-with-hiv/

[2]Medicaid and HIV: A National Analysis, Kaiser Family Foundation, Publication #8218, October 2011, available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8218.pdf

[3]In April 2013, the USPTF gave routine HIV screening of all adolescents and adults, ages 15 to 65, an "A" rating.As a result, individuals eligible for Medicaid expansion coverage (and most individuals covered through private insurance) now receive HIV screening without any cost sharing. Coupled with USPSTF grades for STD screening and counseling and viral hepatitis screening, these coverage requirements present new opportunities for Medicaid to deliver and pay for prevention services.

[4]See generally The Critical Role of Public Health Departments in Health Care Delivery System Reform, Health Management Associates Accountable Care Institute, April 2014, available at https://www.healthmanagement.com/assets/Publications/The-Critical-Role-of-Public-Health-Departments-in-Health-Care-Delivery-System-Reform.pdf

[5]U.S. Department of Health and Human Services, Health Resources and Services Administration, *HIV Viral Load Suppression*, November 2013, available at http://hab.hrsa.gov/deliverhivaidscare/coremeasures.pdf.

[6]Centers for Medicare and Medicaid Services, *Adult Health Care Quality Measures*, available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html

[7]A Medicaid State Plan is a continually evolving agreement between a state and the Federal government describing how that state administers its Medicaid program. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities that are underway in the state, to assure the state that it's program activities will be federally reimbursable and to assure the federal government that federal rules will be complied with. When a state is planning to make a change to its program policies or operational approach, it proposes a state plan amendment to CMS for review and approval.

[8]AIDS Foundation of Chicago, Community Links, available at http://www.aidschicago.org/page/our-work/community-links

[9]An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers, Kaiser Commission on Medicaid and the Uninsured, Oct. 2014 Issue Brief, available at http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/

[10]Ibid.

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