FINANCING HIV PREVENTION SERVICES

Collaboration and Innovation between Public Health and Medicaid Agencies

CASE STUDIES

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NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

This case study is a part of a white paper published by the National Alliance of State & Territorial AIDS Directors (NASTAD) in collaboration with Health Management Associates (HMA), "Financing HIV Prevention Services: Collaboration and Innovation between Public Health and Medicaid Agencies." The full paper highlights four case studies:

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

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

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

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

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.

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. The case study highlighted below is one example of a promising model bridging public health and health care systems and payers.

Download the complete report at: **https://www.NASTAD.org/Financing-HIV-Prevention**

CHICAGO

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

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.

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.

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.

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

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.[1]

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.

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.

NOTE

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

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.

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