Targeted Policy Resource Series: States Strengthen Medicaid-Ryan White Collaboration to Improve Care Coordination for People Living with HIV

Hannah Dorr

Introduction

People living with HIV (PLWH) who have low viral loads can have better health outcomes and lower risk of transmitting HIV.[1] However, in 2014, half of the 1.1 million people living with HIV in the United States were not virally suppressed. PLWH often have multiple, complex conditions, are more likely to experience homelessness, and have higher rates of mental health and substance use disorders that complicate treatment.[2] **Care coordination can be an important tool for states to increase rates of virologic suppression by helping PLWH access and maintain treatment, stay engaged in care, and address other needs such as housing, nutrition, transportation, and behavioral health services.**[3] Both Medicaid and the Ryan White HIV/AIDS Programs (RWHAP) offer care coordination services, but the type and intensity of these services can vary widely based on how they are delivered, who delivers them, and who can access them. Because the RWHAP is by statute the "payer of last resort,"[4] states must avoid duplication of services to individuals, some of whom may qualify for both programs, or may "churn" between the two programs as they gain and lose eligibility.[5] Collaboration between Medicaid and the RWHAP is key; by working collaboratively across agencies to manage services for PLWH, state policymakers can maximize scarce resources and ensure they are making the best use of available expertise and capacity to address the needs of PLWH.

About This Series

States, through their Medicaid and Ryan White HIV/AIDS programs, play critical roles in supporting access to care for people living with HIV (PLWH). PLWH can be among the most medically complex individuals covered by state health programs, incurring costs up to five-times greater than the average Medicaid beneficiary. Research shows that early, comprehensive treatment can significantly improve health outcomes for PLWH and reduce their overall cost of care. Given increasingly constrained state budgets, state policymakers are working to ensure that care to this population is accessible, well-coordinated, and effective. This series of reports are designed to give Medicaid and RWHAP administrators an understanding of each other's programs, and highlight key opportunities for collaboration.

What are care coordination, care management, and case management?

Care coordination, care management, and case management can mean different things depending on the program or payer source. Definitions vary, but common elements of these services include assessment, person-centered care planning, ensuring linkages to necessary medical, social and other supports, and monitoring and follow up.

Overview of Medicaid Care Coordination Benefits

Care coordination services are provided under a number of state Medicaid options and authorities.[6] Table 1 provides an overview of available services.

Table 1. Medicaid Care Coordination Options

Description	Features/Considerations
Targeted Case Management (TCM)[7]	
Services to assist individuals in accessing medical, social, educational, and other necessary services.	States generally use TCM to support complex populations, including PLWH.
Health Homes[8]	
Supports a team-based approach that includes care management and care coordination as two of six core health home services.	Target populations must have two or more chronic conditions or one chronic condition and be at risk for another. Several states currently include HIV as a qualifying condition in their health home programs.
Home and Community-Based Services (HCBS) Waiver (Section 1915(c))[9]	
Provides a range of services including case management, based on a person-centered care plan.	States may waive certain Medicaid requirements, such as state -wideness, comparability, and rules related to income and resources. HCBS support individuals who would otherwise require nursing home care. State may limit the number of enrollees.
Home and Community-Based Services State Plan Option (Section 1915(i))[10,11]	
Can support a range of services, including case management, based on a person-centered care plan.	States define eligibility for §1915(i) services. States can choose to enroll individuals earning less than 150% of federal poverty levels even if they do not meet institutional levels of care. For both §1915(c) and §1915(i), the state must demonstrate conflict-free case management, which requires independent review of care planning. As a state plan option, the state may not cap enrollment.
Section 1115 Demonstration Waiver[12,13]	
Provides states with flexibility to design and test innovative models and strategies in their Medicaid programs.	States may waive certain Medicaid requirements, such as state-wideness, benefit design, and reimbursement. Waivers must be budget-neutral for the federal government.
Primary Care Case Management (PCCM)[14]	
Physician-based care management that includes provision, location, coordination, and monitoring of primary care services.	PCCM is not limited to specialty or high-needs populations. States may develop enhanced PCCM models to support populations with more intense care coordination needs.
Managed Care Contracting[15]	
States must ensure that Medicaid managed care organizations (MCOs) provide care coordination to enrolled beneficiaries, with additional requirements for enrollees identified by the state as having special health care needs or in need of long-term care.	States may contract with MCOs to provide specialty services and more intensive care coordination for certain populations, such as PLWH.

Overview of the Ryan White HIV/AIDS Program (RWHAP) Case Management

The RWHAP is a federal program that provides states with funding for medical care and support services, such as case management, for eligible PLWH.[16] Unlike Medicaid, the RWHAP is not an entitlement program. Both medical and non-medical case management are allowable services under the RWHAP Parts A-D.[17] Eligibility, as well as the scope of case management services offered by each state, can vary based on state priorities and available federal and state funding.[18]

- Medical case management helps PLWH:
    - Access services that help support their adherence to complex HIV treatments, and
    - Improves their clinical outcomes.[19]
- Non-medical case management helps PLWH access necessary social services, such as financial assistance and legal aid.[20]

As the payer of last resort, RWHAP resources can only be used if a RWHAP client is not eligible for coordination services under Medicaid or another payer.[21]

Key Policy Issues

State policymakers from Medicaid and the RWHAP share an interest in working together to ensure that PLWH have access to physical and behavioral health care and other supports necessary to improve health outcomes. By leveraging the expertise of a state's specialized HIV providers, developing processes to avoid duplication of services, and training providers to meet the specialized needs of PLWH, states can make the most of limited resources. Outlined below are strategies states are using to align Medicaid and RWHAP care coordination programs.

Facilitate cross-agency care and service delivery by specialized HIV providers and service organizations. Medicaid and RWHAP can benefit from using the same providers to serve PLWH enrolled in these programs:

- ***Managed care contracting:*** States, including New York, have created specialty managed care plans for Medicaid beneficiaries living with HIV. New York's HIV Special Needs managed care plans (SNPs) exclusively serve New York City and are required to coordinate care among the state's RWHAP, specialized providers, social service agencies, and other service organizations.[22]

- ***Health homes:*** Wisconsin was the first state to implement a health home model designed exclusively for PLWH in 2012, after state legislation required the Medicaid agency to implement a care coordination program for beneficiaries living with HIV.[23] AIDS service organizations may serve as health home providers under Wisconsin's model, using their capacity and experience serving PLWH.[24] Alabama, New York, and Washington also have health homes that include HIV as a qualifying condition, and work closely with RWHAP partners to ensure adequate care coordination through these models.[25]

- ***1915(c) waivers:*** California's §1915(c) waiver, AIDS Medi-Cal Waiver Program (MCWP), provides home- and community-based services, including case management, to PLWH who would otherwise require

institutional care, nursing facility care, or hospitalization. MCWP and RWHAP utilize the state's specialized care providers in a number of ways. The California Department of Public Health, which administers the state's RWHAP, also operates the MCWP. Case managers help PLWH enroll in RWHAP or other qualifying services if they no longer qualify for waiver services in order to maintain the health of the participant. In certain counties, the same providers serve PLWH enrolled in either program.[26,27,28]

Use data to link individuals to services and reduce duplication. Data can help states target care coordination services to PLWH who are not engaged in care and increase rates of virologic suppression; but data is often siloed in separate departments or agencies. Clinical and surveillance data is typically housed within public health agencies, while claims data is held within the state Medicaid agency.[29] State and federal restrictions on how and what data on PLWH can be shared[30] may also create barriers to the flow of information between state Medicaid programs and RWHAP. To address these challenges, the RWHAP and state Medicaid programs can:

- ***Reduce duplication of care coordination services through interagency data sharing.*** States can develop an interagency data-sharing strategy, such as a data-sharing agreement, a memorandum of understanding or a data-sharing policy.[31] The Washington Department of Health administers a HIV/AIDS case management program for Medicaid beneficiaries living with HIV. To reduce duplication of care coordination services, the HIV/AIDS case management program's daily operations are managed by the Department of Health, but the Health Care Authority (Medicaid) pays for case management services. To achieve coordination of services, the two agencies have an interagency agreement, which allows them to share the names of beneficiaries receiving case management.[32] Several of California's HIV care programs, including the RWHAP and MCWP, utilize the AIDS Regional Information and Evaluation System (ARIES), a shared data system that allows state program staff and providers to monitor and coordinate medical care and support services for PLWH across programs.[33]

Align training for care coordinators across the Medicaid and RWHAP programs. To better address the needs of PLWH, the New York Department of Health's AIDS Institute established standards of HIV care and program standards for managed care plans to ensure quality medical care for PLWH or those at risk of HIV.[34] The AIDS Institute conducts quality-of-care reviews and provides technical assistance to managed care plans to help them meet the specific health care needs of Medicaid beneficiaries living with HIV.[35]

Conclusion

States can use resources efficiently and effectively by aligning care coordination services between Medicaid and the RWHAP. Medicaid has a number of different authorities available to support care coordination for PLWH and these services and systems can be enhanced through close collaboration with the state RWHAP. These state innovations demonstrate several ways that Medicaid and the RWHAP can work together to keep PLWH connected to necessary services, make the most of existing expertise, and avoid duplication of services.

For additional resources detailing how state agencies can improve care for PLWH, read National Academy for State Health Policy, Toolkit: State Strategies to Improve Health Outcomes for People Living with HIV

Endnotes

1. Centers for Disease Control and Prevention. "HIV Treatment as Prevention." Retrieved from: https://www.cdc.gov/hiv/risk/art/index.html Accessed on 6/18/2018.
2. Health Resources and Services Administration. *Impact of Mental Illness on People Living with HIV*. (Washington, DC: U.S. Department of Health and Human Services, 2015).
3. Mary K. Irvine, et. al., "Improvements in HIV Care Engagement and Viral Load Suppression Following Enrollment in a Comprehensive HIV Care Coordination Program," *Clinical Infectious Diseases Society of America* 60 no. 2 (Jan. 2015): 298-310
4. While Medicaid typically pays a claim only after other liable third parties have made payment, Section 2617(b)(7)(F) of the Public Health Service Act mandates that the RWHAP be the payer of last resort – after Medicaid and other state and federal programs.
5. For more information on eligibility requirements for PLWH in Medicaid and Ryan White, please read NASHP's Targeted State Policy Resource: Coordinating Program Eligibility Across Medicaid and Ryan White HIV/AIDS Programs. [LINK TO PRIMER]
6. 81 Fed. Reg. 27498-27901 (May 6, 2016), available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
7. Social Security Act, §1905(a) and §1915(g); 42 U.S.C §440.169(b)
8. Social Security Act §1945, 42 U.S.C. 1396(w-4).
9. Social Security Act §1915(c), 42 U.S.C 1396n
10. Social Security Act §1915(i), 42 U.S.C 1396n
11. Centers for Medicare & Medicaid Services. "Home & Community-Based Services 1915(i)." Retrieved July 12, 2018. https://www.medicaid.gov/medicaid/hcbs/authorities/1915-i/index.html.
12. Centers for Medicare & Medicaid Services. "About Section 1115 Demonstrations." Retrieved July 20, 2018. https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html
13. Social Security Act § 1115A, 42 U.S.C 1315a
14. Social Security Act § 1905(t), 42 U.S.C. §1396(d).
15. 81 Fed. Reg. 27498-27901 (May 6, 2016), available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
16. TITLE XXVI—HIV HEALTH CARE SERVICES PROGRAM https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/legislationtitlexxvi.pdf
17. TITLE XXVI—HIV HEALTH CARE SERVICES PROGRAM https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/habpartbmanual2013.pdf
18. Health Resources and Services Administration. *Ryan White HIV/AIDS Program: Part B Manual.* (Washington, DC: U.S. Department of Health and Human Services, 2015). https://hab.hrsa.gov/sites/default/files/hab/About/RyanWhite/habpartbmanual2013.pdf
19. Health Resources and Services Administration. "HAB HIV Performance Measures: Medical Case Management". Retrieved from: https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/archivedmcm.pdf
20. Health Resources and Services Administration. "Policy Clarification Notice (PCN) #16-02" https://hab.hrsa.gov/sites/default/files/hab/program-grants-management/ServiceCategoryPCN_16-02Final.pdf
21. Public Health Service Act, 42 U.S.C §§ 300ff - 300ff-140.
22. Division of Health Plan Contracting and Oversight. *Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan/Health and Recovery Plan Model Contract*. (Albany, NY: New York State Department of Health, 2015). https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
23. State of Wisconsin, 2009 Senate Bill 647, 2009 Wisconsin Act 221, published May 19, 2010, https://docs.legis.wisconsin.gov/2009/related/acts/221.pdf.
24. U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. *Health Homes for Individuals with Chronic Conditions: State Plan Amendment*. (Wisconsin, 2013). https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/4-19h.pdf
25. National Academy for State Health Policy. "State Delivery System and Payment Reform Map" Retrieved May 25, 2018. https://nashp.org/state-delivery-system-payment-reform-map/

26. California Department of Health Care Services. "HIV/AIDS Waiver." https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8168
27. California Department of Public Health. "HIV Care Program Providers." Retrieved July 26, 2018. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/HCPProviderList-ADA.pdf
28. California Department of Public Health. "Medi-Cal Waiver Program Providers." Retrieved July 26, 2018. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/MCWP%20Provider%20List.pdf
29. Lyndsay Sanborn, Erin Kim, *Better Together: How Cross-Agency Data Sharing Can Improve the Care Continuum for People Living with HIV/AIDS* (Portland, ME: National Academy for State Health Policy, 2017). https://nashp.org/better-together-how-cross-agency-data-sharing-can-improve-the-care-continuum-for-people-living-with-hivaids/
30. Katherine Witgert, Jennifer Dolatshahi, and Rachel Yalowich, *Strategies for Coordination Between Medicaid and Ryan White HIV/AIDS Programs* (Portland, Maine: National Academy for State Health Policy, 2013). https://nashp.org/wp-content/uploads/2017/09/ryanwhite.medicaid.coordination.pdf
31. Kelsey Donnellan. "Building Bridges: Data Sharing Agreements." National Alliance of State & Territorial AIDS Directors. https://www.nastad.org/sites/default/files/TA-Meeting-Data-Sharing-Agreements-NASTAD-IL.pdf
32. Interview with the Washington State Department of Health, February 16, 2018.
33. California Department of Public Health. "HIV Care Branch." Retrieved July 20, 2018. https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAcare.aspx
34. New York State Department of Health AIDS Institute. "Clinical Guidelines Program." Retrieved from: https://www.hivguidelines.org/ Accessed on 6/22/18.
35. New York Department of Health. "Community Support Services." Retrieved from: https://www.health.ny.gov/diseases/aids/general/about/comm_support_services.htm Accessed on 6/12/18.

Acknowledgements:

The National Academy for State Health Policy (NASHP) wishes to thank the following states' Medicaid and health departments for their time and insights, which helped make this report possible: Alabama, California, New York, and Wisconsin.

The author also wishes to thank Trish Riley, Kitty Purington, and Rachel Donlon for their contributions to this paper. Finally, the author would like to thank her Health Resources and Services Administration (HRSA) project officer, Lynnette Araki, and her HRSA colleagues for their review and input.

This project was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) under grant number UD3OA22891, National Organizations of State and Local Officials. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the US Government.