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Early Evidence from California on Transitions to a Reformed Health Insurance System for Persons Living With HIV/AIDS

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Abstract

Background—Many uninsured people living with HIV/AIDS (PLWHA) will obtain managed health insurance coverage when the Affordable Care Act (ACA) is implemented in January 2014. Since 2011, California has transitioned PLWHA to Medicaid managed care (MMC) and to the Low Income Health Program (LIHP).

Objectives—To draw lessons for the ACA implementation from the transitions into MMC and the LIHP.

Methods—Surveys about clients and services provided before and after the transition to MMC and the LIHP were sent to 43 HIV service providers. Usable responses were obtained from 18 (42%).

Results—Although total client loads were similar in the pre- (January 2011) and post- transition periods (June 2012), many clients transitioned from fee-for-service (FFS) Medicaid to MMC. Over this period, responding agencies served 43.5% fewer PLWHA in FFS Medicaid while the share of PLWHA covered by MMC rose from 16.9% to 55.5%. Managed care covered a smaller number of services than either FFS Medicaid or Ryan White sites. Ryan White providers reported that 53% of the clients they served in January 2011 had transitioned to the LIHPs. Nonetheless, they continued to provide services to many of these clients and Ryan White cases loads did not decline.

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Conclusions—PLWHA enrolled in Medicaid managed care continue to depend on Ryan White sites to supply the full range of services that will allow them to take full advantage of increased access to care under ACA.

Keywords

HIV/AIDS; Medicaid; health reform; managed care; Ryan White

I. Introduction

People living with HIV/AIDS (PLWHA) and the medical and social service providers who serve them are experiencing a significant period of transition and uncertainty. Since 1991, many PLWHA and their providers have relied on the Ryan White CARE Act, which funds health care, drug treatment and support services for low-income uninsured or underinsured PLWHA [1]. In particular, the Ryan White Program's AIDS Drug Assistance Program (ADAP) has been crucial in providing Anti-Retroviral Therapy (ART) to non-disabled, low income PLWHA who have not been eligible for Medicaid because they are not disabled. Ryan White funds are awarded directly to state and local health jurisdictions and community-based clinics and provide a relatively rich source of reimbursement for the providers who serve this population [2].

The Ryan White Program has been successful in delivering high quality medical care and medication to the uninsured and underinsured population with HIV/AIDS that it serves. In California, data from Los Angeles County document high levels of retention in care and in viral suppression [3]. Despite the prominence of the Ryan White Program in providing treatment to PLWHA, the largest source of funding for HIV/AIDS treatment remains public insurance: Medicaid (Medi-Cal in California) and Medicare cover nearly half of PLWHA [4-6]. The share of California PLWHA who are Medi-Cal beneficiaries will grow further under healthcare reform because California is participating in the Patient Protection and Affordable Care Act's (ACA) extension of Medicaid coverage to all individuals under 133% of the federal poverty level (FPL).

Starting in January 2014, the ACA will extend coverage to a large number of non-disabled Californians living with HIV who previously could not qualify for Medicaid coverage under the categorical eligibility rules then in place. As a result, many current Ryan White clients will become eligible for insurance either through the Medicaid expansion of coverage to everyone under 133% of the federal poverty line, whether or not they are disabled, or through Covered California (the state-operated Health Insurance Exchange for those with incomes too high for Medi-Cal eligibility) [7]. Medi-Cal eligible health insurance beneficiaries will no longer qualify for medical care through the Ryan White program, which is designed to be the payer of last resort. Consequently, significant portions of the Ryan White population will migrate to expanded Medi-Cal coverage with mandatory managed care enrollment, while many more will be eligible for, but not required to enroll into, private insurance coverage available through Covered California.

The state of California jump-started the transition to health reform by making two major changes to the Medi-Cal program. Starting in July 2011, the state required all existing Medi-Cal patients, including the disabled, to enroll into managed care plans [8]. California also obtained a Section 1115 waiver [9] to allow California counties to offer Low Income Health Programs (LIHPs) to a subset of individuals, most of whom will be eligible for coverage under full Medi-Cal expansion in January 2014 [10,11]. The LIHPs, which began enrolling in some counties in July 2011, are intended to serve as a temporary bridge until ACA reforms become operative in 2014, but they operate independently from the existing Medi-

Cal program and from one another, meaning that some subscribers will experience a transition in payer source again in 2014 as they are switched to a Medi-Cal managed care plan.

During the same period, the Center for Disease Control and Prevention's Enhanced Comprehensive HIV Prevention Planning (ECHPP) and Implementation for Metropolitan Statistical Areas Most Affected by HIV/AIDS [12] supported planning efforts in Los Angeles County. Beginning in 2011, CHIPTS investigators used CFAR funding to ECHPP sites to support a series of monthly meetings that brought together staff from the LA County Office of AIDS Programs and Policy (OAPP, now called Division of HIV and STD Programs) and from HIV/AIDS Community Based Organizations with HIV/AIDS researchers in order to help inform and prioritize HIV/AIDS research efforts. Meeting together, we identified the importance of testing, linkage to treatment and maintenance in care as paramount issues, and developed a treatment cascade for Los Angeles County.

A December 2012 meeting convened by the California HIV/AIDS Policy Research Centers at UCLA and at UCSF once again brought together members of the Southern California HIV/AIDS community to help inform priorities for HIV/AIDS policy research. This meeting (and another of Northern California HIV/AIDS community members) set a high priority on examining how the ACA will impact HIV/AIDS treatment in California. The on-going transition to Medi-Cal managed care and to the LIHPS provided an opportunity to forecast the challenges that HIV/AIDS service providers and their clients will face as they negotiate the transition to full ACA implementation in 2014. To harvest the information available from the experience of insurance expansion so far, we fielded a survey between January and March 2013 to health care agencies currently providing services to PLWHA, with a particular focus on how the transitions affected the treatment cascade. These early experiences provide important lessons for smoothing the complex transition to the ACA for PLWHA.

II. Methods

A survey was designed to be answered by agencies providing services to PLWHA financed by Medi-Cal fee-for-service (FFS), Medi-Cal managed care and/or provided at Ryan White sites. The survey was fielded between January and March 2013 and asked respondents to report retrospectively on the numbers of clients with HIV/AIDS who were served under Medi-Cal fee-for-service (FFS) reimbursement, Medi-Cal managed care, and the Ryan White program at three points in time spanning the initial transition period: 1) January 2011, a "baseline:" period prior to most transitions of Medi-Cal beneficiaries into managed care plans and prior to the launching of the LIHPs in July 2011; 2) January 2012, a year following the baseline; and 3) June of 2012, eighteen months following the baseline. In addition to numbers of clients, the survey elicited information on both the range of services available to PLWHA through each financing type and the providers' experience with the transition process.

Forty-three agencies known to provide services to PLWHA in California were identified by HIV/AIDS community partners in northern and southern California (AIDS Project Los Angeles, LA Gay and Lesbian Center, Project Inform, San Francisco AIDS Foundation). Co-authors telephoned the agencies to introduce the survey and to identify the best person within the agency to respond to detailed questions about the numbers of clients seen and the services provided. The surveys could be filled out online through Survey Monkey, by completing a PDF and returning by email or fax, or through a phone interview. Follow-up calls and emails were made to non-respondents, to respondents who provided only partial data, or where clarification was needed.

Logistic regression was used to examine whether the characteristics of agencies that responded to the survey differed significantly from those of non-respondents. A two-sided Fisher's Exact Test was used to examine whether there were significant differences in the percentages of FFS and managed care agencies providing each of eight services. A two sided Fisher's Exact Test was also used to determine whether the percentage of managed care agencies providing each service differed significantly from the percentage among Ryan White agencies. The Wilcoxon Signed Rank test was performed (using Proc Univariate in Version 9.3 of the SAS System for Windows) to determine whether managed care agencies provided significantly fewer services overall than either Medi-Cal FFS or Ryan White agencies.

III. Results

Following a description of the characteristics of responding agencies, this section examines the transition from Medi-Cal FFS to Medi-Cal managed care and transitions of clients out of the Ryan White program.

A. Respondents

Responses were received from 23 agencies providing services to PLWHA. Twenty filled in the questionnaires on-line, two provided information by phone, and one completed a PDF and returned it by email. Another 20 organizations did not respond. One of the responding agencies, a county HIV commission, was not included in the analysis because it was not a direct HIV service provider. In addition, four other agencies whose data were missing important components were dropped from this analysis.

The 18 remaining respondents did not differ significantly from non-respondents in terms of metropolitan area/non-metropolitan designation ($p>.34$) or northern or southern California location ($p>.71$). In the majority of the responding agencies, clients with HIV/AIDS accounted for more than 90% of the total client population. All 18 agencies served Ryan White clients in January 2011 and all except four also served Medi-Cal FFS or Medi-Cal Managed Care clients (Table 1). All of the 13 agencies that provided services under FFS arrangements in January 2011 also had either Ryan White or both Ryan White and Medi-Cal managed care contracts.

B. Effects of the Transition from Medi-Cal FFS to Managed Care

Eight of the reporting agencies that served FFS clients in 2011 continued to do so in June 2012; an additional five agencies served Medi-Cal FFS clients, but did not report the number of PLWHA served (Table 2). The number of reporting agencies providing managed care services to HIV/AIDS patients increased by one over the transition period (Table 2). Two agencies reported serving Medi-Cal managed care patients with HIV/AIDS, but did not report number of patients enrolled (Table 2).

The apparent stability in numbers of agencies serving PLWHA obscures the large movement within agencies of patients from FFS arrangements to managed care. The number of clients served under FFS arrangements by reporting agencies fell from an average of 143 in January 2011 to a mean of 80 in June 2012. Thus, over the course of 18 months, the FFS case load of HIV positive patients decreased by 43.5%. Concurrently, the numbers of HIV/AIDS clients covered under Medi-Cal managed care arrangements more than tripled among the reporting agencies providing managed care services, from an average of 44 per agency to an average of 148 per agency (Table 2).

The increases in Medi-Cal managed care caseload varied across respondent agencies. The largest FFS provider in 2011 reported serving 700 clients, and transferred all but 200 of

them to managed care, many apparently at the same agency (see Appendix 1). The Medi-Cal managed care PLWHA caseload of this particular agency grew from 10 clients in January of 2011 to 550 clients in January of 2012. While this single agency was responsible for a significant portion of the increased average caseload across agencies, the average Medi-Cal managed care caseload in the remaining respondent agencies also grew, by 33.7% from January 2011 to June of 2012.

The state allowed clients to delay transferring to managed care if their health was frail, using a process known as a Medical Exemption Request or MER. MERs were designed to allow an individual to be exempted from managed care enrollment until the individual's medical condition stabilized to a point where a transfer to managed care would not adversely affect his or her health. Alternatively, clients could make a Continuity of Care Request in order to complete a current course of treatment initiated with a provider not affiliated with a Medi-Cal managed care plan. Agencies reported that clients who applied for MERs and Continuity of Care Requests experienced high rates of denial for both (80% and 42%, respectively, of all clients who applied).

The transition from Medi-Cal FFS to Medi-Cal managed care did not simply affect service reimbursement; it also affected the types of services enrollees were offered in addition to primary medical care. Table 3 illustrates that smaller proportions of managed care agencies provided non-primary medical care services (with the exception of nutrition counseling) than Medi-Cal FFS agencies ($p<.05$ on the Wilcoxon Signed Rank test). Notably, none of the responding Medi-Cal managed care agencies provided substance abuse treatment, whereas 46% of FFS Medi-Cal agencies did so—a difference significantly different from zero ($p<.05$).

C. Effects of the Transition from Ryan White to the County-Administered Low Income Health Programs (LIHPs)

The Ryan White clients who moved into LIHPs no longer were entitled to obtain most primary medical care from Ryan White providers. Nonetheless, the number of clients receiving some services from the Ryan White Program remained nearly constant over the 18 month period, increasing from 4,724 to 4,935, despite the fact that agencies reported that 53% of those who were receiving care through the Ryan White Program in January 2011 were screened and enrolled in their county's LIHP. Average Ryan White caseloads among the agencies reporting client numbers remained nearly steady, averaging 363 clients in January 2011 and 380 in June 2012.

An explanation for this paradox lies in Ryan White agencies' provision of a broader range of services than are available through managed care providers. Comparing Ryan White agencies to Medi-Cal managed care agencies reveals that a greater percentage of the Ryan White agencies provided services than managed care agencies ($p< .01$ on the Wilcoxon Signed Rank test). However, given the small numbers of agencies represented, none of these paired service-specific differences was statistically significant at conventional levels.

Sixteen of the 18 Ryan White agencies reported that they continued to provide some Ryan White services to clients who transitioned into their county's LIHP (Table 4). Half the agencies reported that they continued to provide mental health care to clients who had enrolled in the LIHP. Agencies that provided housing and food services, benefits counseling and case management to current Ryan White clients reported that they continued to supply these services for clients who had obtained LIHP coverage.

IV. Discussion

The total number of clients with HIV/AIDS served by the responding agencies increased by only 4.4% between January 2011 and June 2012, (Appendix 1). However, within the Medi-Cal program, there was significant movement from FFS plans to managed care plans. Many of these payment transitions occurred within the same agencies, increasing the chance that PLWHA could maintain their existing provider relationships.

California's efforts to move seniors and persons with disabilities (SPDs) from Medi-Cal FFS to Medi-Cal managed care are nearly complete. By 2013, 380,000 California seniors and persons with disability had transitioned from Medi-Cal FFS plans into managed care [13, 14]. This growth in managed care enrollment is echoed in our survey of HIV/AIDS providers, who reported that the number of clients they served under Medi-Cal FFS arrangements declined by 559, while the number of clients served under Medi-Cal managed care payment increased by 625. In the reporting agencies, the proportion of Medi-Cal beneficiaries with HIV/AIDS served under managed care increased from 16.9% to 55.5%.

LIHP enrollment also increased substantially over the period. By July 2013 nearly 700,000 individuals were enrolled in LIHP plans [15]. Despite the transition of many PLWHA from Ryan White sites to LIHP coverage for their primary medical care, survey respondents reported that many LIHP enrollees continued to rely upon Ryan White providers for a variety of essential services.

The findings of this survey are consistent with those reported by Hazelton, et al. [16], whose qualitative study of providers of HIV services to low income Californians during the transition to Medi-Cal managed care and the implementation of the LIHPs found provider concerns with the limited scope of benefits, particularly for case management within the managed care and LIHP plans. Our survey documents that Medi-Cal managed care providers offer a more limited range of services than either Ryan White providers or Medi-Cal FFS agencies. Thus, as many FFS Medi-Cal beneficiaries were moved into managed care, they may have visited Ryan White sites to replace services -- such as substance abuse treatment-- that they had formerly accessed through Medi-Cal FFS providers. Medi-Cal managed care providers are not financially responsible for specialty mental health services, which are "carved out" of the managed care capitation [17]. Rather than seeking mental health care through county mental health departments, many PLWHA may use Ryan White mental health providers.

The care completion services provided by Ryan White providers play a key role in ensuring that clients are maintained in treatment [18]. For people living with HIV/AIDS, maintaining a stable regime of anti-retrovirals and minimizing interruption in other health services are vitally important to continued viral suppression and long-term treatment success [19-22]. The ACA recognizes the need to encourage "medical homes" that provide the full range of needed treatment and supportive services. For PLWHA, such a medical home already exists in the Ryan White Program [23].

The survey of HIV/AIDS provider agencies reported here documents that the transition to Medi-Cal managed care and LIHPs has opened a potentially serious gap in providing the full spectrum of services needed to effectively manage HIV/AIDS, particularly for mental health and substance abuse treatment. The fact that PLWHA who have "transitioned" to other delivery systems continue to rely on Ryan White providers to supply these services attests to the difficulty of obtaining the full spectrum of needed care under the new financial arrangements. These findings highlight important considerations in defining the future roles of the Ryan White Program [24] and the development of medical homes under the ACA. The welcome expansion of insurance under the ACA is complementary to, not a substitute

for, the care completion services historically delivered by the Ryan White Program. There is a continuing need for the Ryan White Program to provide the services that will allow PLWHA to take full advantage of the increased access made newly available by the ACA.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Payer Sources of Agencies Providing HIV/AIDS Services in January 2011

Payer Source	N	Percent
Ryan White only	4	22%
Ryan White and Medi-Cal FFS	6	33%
Ryan White and Medi-Cal Managed Care	1	6%
Ryan White, Medi-Cal FFS, and Medi-Cal Managed Care	7	39%
TOTAL	18	

Table 2

Numbers of Agencies and Clients by Medi-Cal FFS, Managed Care and Ryan White Program Funding: January 2011, January 2012 and June 2012

	Jan. 2011	Jan. 2012	Jun. 2012
Medi-Cal FFS			
Agencies Delivering FFS Care and Reporting Client Numbers	8	8	8
Agencies Delivering FFS Care but Not Reporting Client Numbers	5	5	5
Total Numbers of FFS HIV/AIDS Clients Reported	1285	794	726
Average FFS clients/agency reporting	143	88	80
Range	0 – 700	0 – 350	0 – 325
Medi-Cal Managed Care HIV/AIDS Clients			
Agencies Delivering Managed Care and Reporting Client Numbers	5	5	6
Agencies Delivering Managed Care but Not Reporting Client Numbers	2	2	2
Total Numbers of Managed Care HIV/AIDS Clients Reported	262	838	887
Average Managed Care Clients/Agency reporting	44	140	148
Range	0 – 125	0 – 550	18 – 550
Ryan White HIV/AIDS Clients			
Agencies Delivering Ryan White Services and Reporting Client Numbers	13	13	13
Number of Agencies Delivering Ryan White Services but Not Reporting Client Numbers	5	5	5
Total Numbers of Ryan White HIV/AIDS Clients Reported	4,724	5,249	4,935
Average Ryan White Clients/Agency reporting	363	404	380

Table 3

Services Supported by Medi-Cal FFS and Medi-Cal Managed Payment since January 2011

	FFS [1]		Managed Care	
Service	**N**	**%**	**N**	**%**
Mental Health Care	10	77%	6	75%
Substance Abuse Treatment[2]	6	46%	0	0%
Housing/Food Services	6	46%	3	38%
Benefits Counseling	6	46%	3	38%
ADAP Enrollment	9	69%	3	38%
Case Management	2	15%	1	13%
Nutrition Counseling	1	8%	1	13%
Adherence Support	1	8%	0	0%
Total	**13**		**8**	

Notes:

[1] Proportions of Medi-Cal FFS agencies providing all services are significantly greater than proportions of Medi-Cal managed care agencies ($p<.05$ on Wilcoxon Signed Rank test)

Proportions of Medi-Cal FFS agencies providing substance abuse treatment are significantly greater than proportions of Medi-Cal managed care agencies ($p<.05$)

Table 4

Services Offered to Ryan White Clients. June 2012

	Services Provided Since January 2001 to			
	Current Ryan White Clients[1]		To former Ryan White Clients After LIHP Enrollment	
Service	**N**	**%**	**N**	**%**
Primary Medical Care	15	83%	6	38%
Mental Health Care	17	94%	8	50%
Substance Abuse Treatment	3	17%	1	6%
Housing/Food Services	10	56%	7	44%
Benefits Counseling	12	67%	6	38%
ADAP Enrollment	15	83%	6	38%
Case Management	4	22%	4	25%
Nutrition Counseling	3	17%	1	6%
Adherence Support	1	6%	0	0%
Total	**18**		**16**	

Notes:

[1] – Proportions of Ryan White agencies providing all services are significantly greater than proportions of Medi-Cal managed care agencies ($p<.01$ on Wilcoxon Signed Rank test)