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Table of Contents

Survey of What Other EMAs are Doing to Prepare for the Affordable Care Act

Executive Summary

The Georgia Health Policy Center (GHPC) was contracted by the Atlanta Eligible Metropolitan Area's (EMA) Metropolitan Atlanta HIV Health Services Planning Council to conduct structured interviews with other EMAs nationwide. The five EMAs, Houston, Los Angeles, Miami, New Orleans, and San Francisco, were chosen based on geography, population size, similar service populations, and operational attributes. The intent of the interviews was to learn what each EMA is doing in preparation for implementation of the Affordable Care Act (ACA), to highlight promising practices currently in place, and to identify lessons learned from their experiences.

Similar to many of the EMAs interviewed, more than half (53%) of all Atlanta EMA clients with known insurance status are uninsured, and approximately 32 percent are covered under Medicaid and/or Medicare. In addition, many EMAs are focusing substantial effort to educate, screen, and treat a growing African American and/or Hispanic HIV+ population. As Atlanta looks to develop a fee-for-service structure and a more integrated data system, lessons learned from Houston, Miami, New Orleans, San Francisco, and Los Angeles may prove useful.

EMAs have begun to outline the implications of health reform on the service needs of people living with HIV and AIDS (PLWHA) through the formation of task forces or other similar groups. Many are waiting for additional guidance from the Health Resources and Service Administration (HRSA). There is concern that health reform may disrupt the systems of care that the EMAs have developed to meet the specific health care needs of PLWHA. To better position themselves for health reform, the EMAs report that it is important to collect and share data with other agencies and providers serving PLWHA and to continue to foster partnerships and opportunities for collaboration.

The EMAs interviewed continue to operate with flat or reduced funding. Like the Atlanta EMA, all are looking to find ways to maximize existing funding and identify other sources to help supplant HRSA funding cuts. Several EMAs, including Houston, Miami, and New Orleans have systems that incorporate fee schedules to help account for care utilization and expenditures. Other EMAs are working to increase adoption of electronic health records (EHRs) and data sharing.

EMAs strive to develop and maintain patient continuity of care through the use of medical homes and centers of excellence. Each adheres to standards of care and has developed unique protocols to help reach underserved populations and those who know their HIV status but are not yet in care. The EMAs are also working to develop and/or improve data collection and exchange among providers and other AIDS service agencies to help maximize efforts, improve outcomes, and reduce duplication of services.

Introduction

The Georgia Health Policy Center (GHPC) was contracted by the Atlanta Eligible Metropolitan Area's (EMA) Metropolitan Atlanta HIV Health Services Planning Council to conduct structured interviews with leaders of up to five of the 24 EMAs in the United States. The intent of the interviews was to learn what each EMA is doing in preparation for implementation of the Affordable Care Act (ACA), to highlight promising practices currently in place, and to identify lessons learned from their experiences. Working with representatives from the Atlanta EMA, an interview instrument was developed to gather information in four main areas:

- demographic and service profiles for each EMA,
- preparation for and implementation of health reform as defined in the ACA,
- strategic and program planning, and
- provision of services for specific populations.

A copy of the interview instrument is included in Appendix A.

Five EMAs were initially identified by the Atlanta EMA for inclusion; however, because two EMAs declined to be interviewed, two additional EMAs were identified. The following EMAs were contacted and/or interviewed:

- Houston
- Los Angeles
- Miami
- New Orleans
- Philadelphia
  (declined participation)
- San Francisco
- Seattle
  (declined participation because they have not begun to prepare for health reform and, due to its small size, indicated that their experience was not applicable to Atlanta's interest).

Participating EMAs

Prior to scheduling interviews, the GHPC project team conducted a web-based review to better understand each EMA in terms of who they serve, how they operate, and how they may be preparing for health reform. During the scheduling process, EMAs were encouraged to share any additional materials they felt might be helpful in understanding their experiences and to allow the interview to be more narrowly tailored to their organization. The following results summarize what was learned from the materials reviewed and interviews conducted by the GHPC project team.

EMA Demographic and Service Profile

The five EMAs that participated in the interviews, Houston, Los Angeles, Miami, New Orleans and San Francisco, represent mid-size to large metropolitan areas across the South and in California. Based on the most recent complete year of data available across the five EMAs, the majority of clients served are men.

Gender	Atlanta	Houston	Los Angeles	Miami	New Orleans	San Francisco
Total Clients (2010)	12,288	11,184	19,139	9,516	7,147	7,660
Male	74%	72%	84%	70%	74%	85%
Female	25%	28%	14%	30%	26%	12%
Transgender	1%	-	2%	-	-	3%
Unknown	-	-	-	-	-	0.1%

- Los Angeles and San Francisco have the greatest portion of male clients (84% and 85% respectively).
- The portion of male clients in Houston, Miami, and New Orleans ranges between 70 percent and 74 percent.

The race/ethnicity of clients served among the EMAs is primarily Black, Non-Hispanic; White, Non-Hispanic; and Hispanic/Latino.

Race/Ethnicity	Atlanta	Houston	Los Angeles	Miami	New Orleans	San Francisco
Total Clients (2010)	12,288	11,184	19,139	9,516	7,147	7,660
Black, Non-Hispanic	75%	54%	23%	35%	60%	21%
White, Non-Hispanic	16%	20%	24%	8%	34%	46%
Hispanic/Latino	6%	25%	48%	45%	5%	22%
Asian/Pacific Islander	1%	1%	3%	0%	-	5%
Multi-Race	-	-	0%	0%	-	2%
Other	2%	1%	3%	12%	-	3%

- More than half of Houston's and New Orleans' clients are Black, Non-Hispanic.
- In New Orleans and San Francisco, 34 percent and 46 percent of clients, respectively, are White, Non-Hispanic.
- In Los Angeles (48%) and Miami (45%) almost half of the clients served in 2010 identified their race/ethnicity as Hispanic/Latino.

The income of the clients served by the five EMAs was also compared. Based on variations in reporting, income levels were combined for some EMAs.

Income as a Percent of FPL	Atlanta	Houston	Los Angeles	Miami	New Orleans	San Francisco
Total Clients (2010)	12,288	11,184	19,139	9,516	7,147	7,660
< 100 FPL	64%	74%	66%	88%*	62%	53%
> 100 but < 200 FPL	25%	21%	25%		23%	31%
> 200 but < 300 FPL	9%	4%	6%	9%	7%	5%
> 300 but < 400 FPL	1%	1%	4%	3%	3%	3%
Unknown	1%	0%	0%	0%	4%	8%

*Income levels of < 138% and <200% FPL combined.

- For all EMAs, the portion of clients earning less than 100 percent of the Federal Poverty Level (FPL) exceeds 50 percent. At 74 percent, Houston's client mix contains the largest proportion in this category.

- Another 21 percent (Houston) to 31 percent (San Francisco) of clients have incomes between 100 and 200 percent of the FPL.

Health insurance status was compiled for the five EMAs.

Coverage (2010)	Atlanta	Houston	Los Angeles	Miami	New Orleans	San Francisco
No Insurance	53%	61%	63%	65%	55%	22%
Medicaid	18%	13%	33%*	19%	18%	43%
Medicare	15%	5%		11%	15%	14%
Private	12%	5%	4%	11%	8%	5%
Other Public	-	2%	-	2%	-	-
Other	-	13%	-	1%	5%**	24%
Unknown	2%	2%	-	-	-	20%

Totals may exceed 100% as clients may have more than one coverage source.
*Reported in the aggregate by the LA EMA.
**New Orleans aggregates "Other" and "Unknown" sources of coverage

- More than 60 percent of clients in Houston, Los Angeles, and Miami have no health insurance coverage.

- In San Francisco, only 22 percent of clients served by the EMA have no health coverage, and 43 percent are covered through a state Medicaid waiver program (implemented as a pilot study that includes San Francisco).

- The portion of clients covered under Medicare ranges from five percent in Houston to 15 percent in New Orleans. In Houston, a majority of clients listed as Other Public are "dual eligible."

- Private coverage among clients ranges from four percent in Los Angeles to 11 percent in Miami.

Average costs per clients served for both core and support services were requested. There is great variation in the core services funded among the four EMAs, and caution should be taken in interpreting the data.

Average Costs per Client Served in 2010	Atlanta	Houston	Miami	New Orleans	San Francisco
Total Clients*	12,288	11,184	9,516	7,147	7,660
Core Services					
Outpatient Medical Care	$1,199	$1,451	$1,607	$826	$876
Medical Case Management/ Early Intervention Services	$718	$455	$547	$325	$502
Oral Health Care	$763	$651	$584	$801	$602
Medications (Local Pharmaceutical Assistance)	$2,326	$925	$470	$861	-
Mental Health	$851	$751	$182	$438	$1,245
Outpatient Substance Abuse	$988	$1,779	$765	$1,658	-
Health Insurance Premium Assistance	-	$1,723	$1,466	$748	-
Hospice	-	$6,129	-	-	$23,647
Medical Nutrition Therapy	-	$246	-	$161	-

*Total clients is per EMA, not per category of service.

- For both Houston and Miami, the average outpatient medical cost per client exceeds $1,000, while New Orleans and San Francisco spend $826 and $876 respectively. The lower average cost per client achieved in San Francisco may be due to the higher proportion of clients who receive Medicaid (43%).

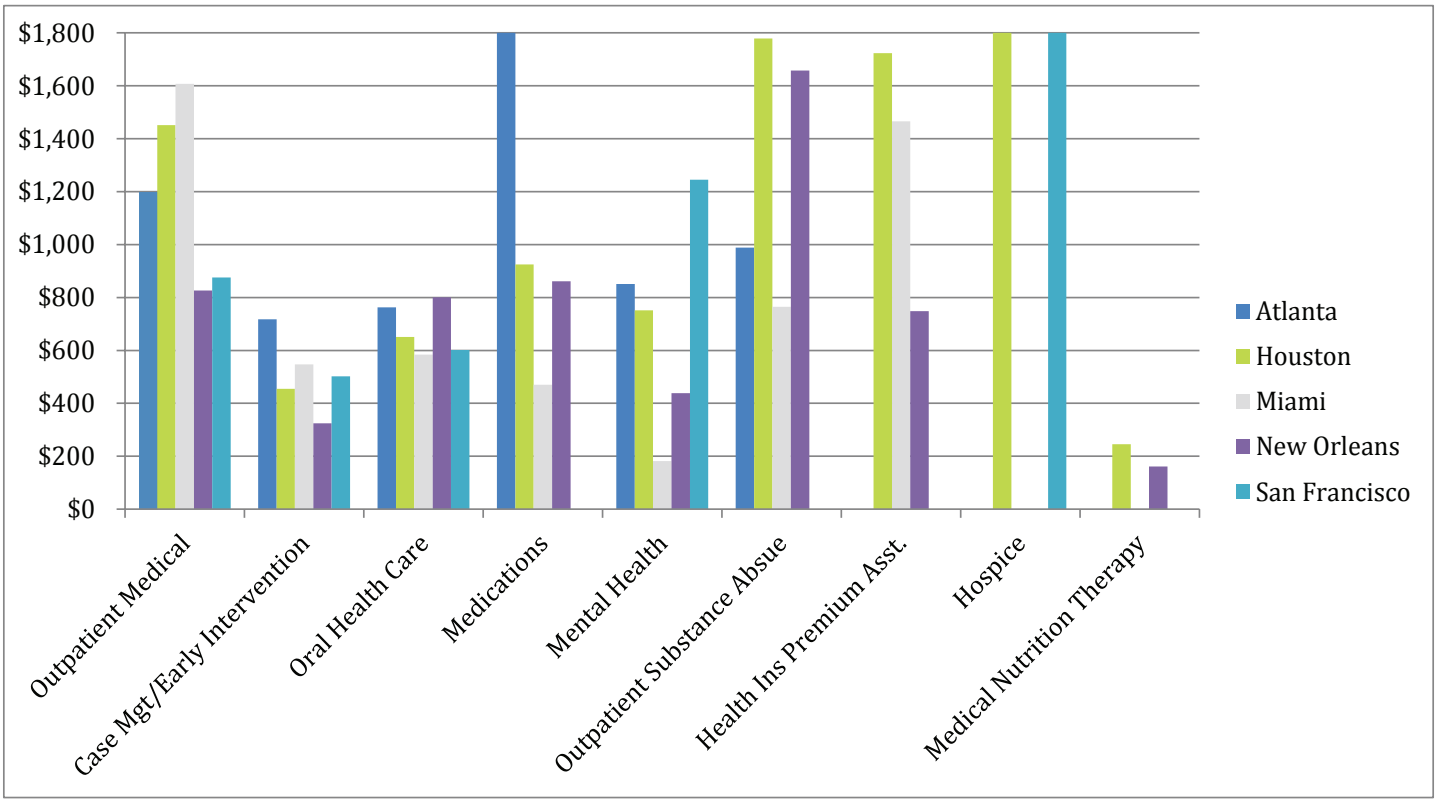
- Average costs per client for case management services ranges from $325 in New Orleans to $547 in Miami.

- Oral Health ranges from a low of $584 per client in Miami to $801 per client in New Orleans.

- The average cost for mental health ranges from a low of $182 per client in Miami to a high of $1,245 in San Francisco. In San Francisco, mental health and substance abuse services are reported together and may explain why the average cost per person is higher than what is reported by the other EMAs. Houston and New Orleans spend approximately $1,700 for clients who receive outpatient substance abuse services.

- Hospice was included among core services in Houston and San Francisco and cost $6,129 and $23,647 per client, respectively.

Average Cost per Client in 2010 by Service Category



- While the Los Angeles EMA did not report average cost per clients served, they did provide the percent of clients served in each service category.

Service Category	Percent of Clients Served
Outpatient Medical Care	83
Psychosocial Case Management	19
Oral Health Care	18
Psychotherapy	15
Nutrition Support	13
Medical Case Management	12
Psychiatry	10
Medical Specialty	7

- More than 80 percent of clients served by the Los Angeles EMA receive medical outpatient services. Slightly less than 20 percent of clients access psychosocial case management (19%) and oral health (18%) services. Fifteen percent of clients use psychotherapy services, 13 percent nutrition support, and 12 percent medical case management services. Ten percent of clients served in 2010 use psychiatry services, and seven percent use medical specialty services.

The range of support services offered varies across the four reporting EMAs.

Average Costs per Client Served in 2010	Atlanta	Houston	Miami	New Orleans	San Francisco
Total Clients*	12,288	11,184	9,516	7,147	7,660
Support Services					
Non-Medical Case Management	-	$150	-	-	-
Legal Assistance	$678	$996	$1,486	$159	$398
Transportation	$63	$251	$172/$115**	$603	-
Hunger Assistance (Food Pantry, Meal Delivery)	$814	$555	$880/$2,297***	$366	$962
Residential Substance Abuse Treatment	-	-	$7,922	-	-
Psychosocial Support	$151	-	$149	$344	-
Outreach	-	-	$355	$23	-
Housing Assistance	-	-	-	$574	$104
Emergency Financial Assistance	$91	-	-	$178	-
Linguistic Services	$244	-	-	-	-
Child Care Services	$341	-	-	-	-

*Total clients is per EMA, not per category of service.
**Transportation vouchers/transportation services
***Food bank/home delivered meals

- The most common support services offered by the four EMAs are legal and hunger assistance.
- The average cost of legal assistance ranges from $159 in New Orleans to almost $1,500 in Miami.
- Hunger assistance, which may include food pantry and/or meal delivery services, ranges from $366 in New Orleans to $962 in San Francisco.
- Transportation services are offered by three of the four reporting EMAs. In Miami, the average cost per client is $115, while in New Orleans it is $603.

Health Reform Preparation and Implementation

EMAs were asked to describe what they are doing to plan for health reform implementation.

- In Houston, nothing specific is being done directly in preparation for ACA implementation.
- Miami has begun discussions at the state and local levels but is awaiting guidance from the Health Resources and Service Administration (HRSA).
- Los Angeles and San Francisco have created health reform task forces to help monitor and direct the transition.
- New Orleans is awaiting the outcome of the elections to determine a final plan but has begun assisting clients with Pre-Existing Condition Insurance Plan (PCIP) eligibility and enrollment.

EMAs were asked to describe health information technology improvements or health information exchange (HIE) partnerships they have identified, implemented, or entered into in preparation for ACA implementation.

- Houston has not identified or implemented anything specific in preparation for the ACA. However, they were early adopters (early 2000s) of an integrated data system that more recently includes electronic medical records (EMRs) and allows data sharing within the Ryan White program among providers and with state and local agencies.
- In Los Angeles, the information system is fragmented. Providers use over 30 different electronic health records (EHRs). Each provider must enter data into two different systems for reporting purposes. This is an issue that they are working to improve.
- There has been an effort in Miami to increase the number of providers using EHRs. Federally Qualified Health Centers (FQHCs) at the local level are better positioned to upgrade to EHRs. In addition, the Miami EMA has developed a data sharing system that, with signed client consent, allows data to be shared with the Florida Department of Health, Miami-Dade County Health Department, and the AIDS Drug Assistance Program (ADAP).
- New Orleans has partnered with the state to implement a shared Careware database called LACAN, which will allow providers and other agencies to access client information across the state. A primary reason for developing LACAN was due to the dislocation of people from New Orleans after Hurricane Katrina.
- San Francisco is working with the county health department to roll out an EHR that will enable different systems to upload into the AIDS Regional Information and Evaluation System (ARIES), which is managed by the California Department of Health Services, Office of AIDS.

In addition to HIE partners, EMAs were asked to identify other partnerships they have developed in anticipation of health reform.

- Houston began partnering before the ACA to help ensure continuity of care for their patients. Partners include providers, other Ryan White programs and EMAs within the state, and local and state agencies. Houston is also working with non-AIDS service organizations to help them understand the need to develop strong business models that will allow them to bill for services.

- Los Angeles also has long-evolving relationships with providers and other community partners. In addition, they have formed an interagency committee that includes the departments of Health Services, Mental Health, and Public Health to troubleshoot issues at the system, agency, and individual levels. The goal is to design a system that is invisible to patients and provides continuity of care.

- Miami has an active planning council, the Miami-Dade HIV/AIDS Partnership, and related subcommittees that include stakeholders from many areas who meet regularly to address issues of concern that affect them locally, including health care reform. Of special note are the Partnership's Medical Care Subcommittee, Care and Treatment Committee, and Strategic Planning Committee. In addition, Part A funded service providers use a computer network known as Casewatch®. Casewatch®'s Service Delivery Information System (SDIS) is the local client-level data management and billing system. No matter which service provider a client enters the Part A system through, the network tracks their eligibility and service utilization. Clients sign a consent form and choose who is authorized to view their information.

- As part of the LACAN network, New Orleans has partnerships with Ryan White Part A, B, and C providers from across the state.

- Like Houston and Los Angeles, San Francisco continues to focus on increasing collaboration among existing agency partners to plan for ACA implementation.

EMA representatives were asked to share lessons learned as they prepared for implementation of health reform. The following themes were echoed among the group:

- Identify who the players are for implementing health reform. Make sure they are at the table. Coordinate services and communications among these agencies and organizations to reduce duplication of services.

- Map the relationships among Ryan White services and the state's essential benefits packages to find gaps and determine where to allocate funding.

- Ensure data is collected to help inform decision-making, planning, and outcomes monitoring. Monitor utilization data (e.g. clients enrolled in the PCIP) closely in the changing environment so that service allocations can be adjusted accordingly.

Strategic and Program Planning

Representatives from the five EMAs were asked a series of questions about fiscal and programmatic challenges.

When asked to describe the top three fiscal or programmatic challenges that will affect the EMA in the next four years, the most common concern expressed was how to meet the primary care, medication, and other core service needs of patients given flat or reduced funding. While some patients will become eligible for health coverage through Medicaid expansion and the exchanges, the level of primary care may not meet the specialized needs of people living with HIV and AIDS (PLWHA). Other challenges identified included:

- Determining how to supplement funding for all covered services.
- Encouraging and delivering technical assistance to providers to ensure they can bill and receive payments for services under a fee-for-service business model.

EMAs are concerned by the funding uncertainties that loom. Most have not identified other long-term funding sources to supplant what may be cut from the Ryan White program. To maximize existing funding, EMAs are:

- working with other Ryan White agencies and providers to coordinate care and identify opportunities for improvements and efficiencies,
- using data to help inform what services are most critical (primary care versus wraparound services),
- closely monitoring expenditures and reallocating funds (e.g. "carry forward funding") to another service area as needed, and
- ensuring that Ryan White is the payor of last resort.

Two EMAs have partnered with their local governments to secure funding. San Francisco has received $6.6 million in funding from the city to offset cuts in federal funding from Ryan White and the CDC. Houston has benefitted from funding secured by the city health department from the CDC to develop a comprehensive system of care that allows agencies and providers serving PLWHA to follow patients from testing through the continuum of treatment.

Programmatic challenges shared by the EMA representatives include aligning care networks, protecting patient continuity of care, protecting the specialized care needs of PLWHA as they mainstream to other coverage sources through Medicaid expansion and the exchanges, and data collection and exchange. In Los Angeles, the Ryan White Planning Council is working to ensure that HIV+ patients that transition into the low-income insurance plans have access to pharmacy networks that are robust and that the plans cover the same medications offered through AIDS Drug Assistance Programs (ADAP).

EMAs were asked if they experienced clinical space or staffing issues. Only San Francisco indicated that they have clinical space issues due to high real estate costs. In addition, the space that is available is not conducive to team-based care. In terms of staffing:

- Houston indicated they are not experiencing staffing issues.
- Los Angeles reported no new issues, but mentioned that adequate staffing of nurses and psychiatrists is a chronic problem.
- Miami indicated that they have experienced minor provider turnover in the Part A Program that has impacted continuity of care. They also have several Medically Underserved and Physician Shortage Areas. In addition, the small EMA staff can make meeting the Ryan White grantee requirements difficult at times.
- New Orleans reported that they have seen a need for increasingly highly skilled and trained providers.
- While San Francisco does not have problems attracting qualified staff, the program is understaffed due to budget cuts and consolidation within the Department of Public Health, which is experiencing a hiring freeze.

Provision of Care

There is a strong commitment among providers to protect primary and preventive care services and continuity of care for PLWHA. To ensure that the needs of underserved populations are being addressed, EMAs:

- use Minority AIDS Initiative funding,
- conduct regular needs assessments,
- develop primary care medical homes or centers of excellence for special populations, and
- develop and utilize standards of care.

The EMAs described their processes for identifying and providing care to PLWHA who know their status but who are not in care.

- Houston and New Orleans place outreach workers in non-traditional settings frequented by target population(s).
- Houston also has partnered with the City of Houston Department of Health to develop a comprehensive plan that integrates data and services to develop a system or continuum of care that follows patients from testing through treatment.
- Miami conducts targeted outreach activities in accordance with HRSA's limitations and the local service definition, in collaboration with the Florida Department of Health, Miami-Dade County Health Department's HIV counseling and testing sites, and "Take Control Miami" events. This is a collaborative brought together by the ECHHP and EIIHA Initiatives.
- San Francisco uses the CDC-funded LINKS program.

Access to dental care can be problematic for PLWHA. Because state Medicaid programs have various levels of dental benefits, EMA funding for dental services varies as well. Houston and San Francisco have programs readily able to meet demand. Florida Medicaid covers very limited dental care procedures for adults, and the reimbursement rates are very low. Miami provides dental services as the payer of last resort, with a maximum annual per-person allocation and pays providers based on a 3.0 multiplier of Florida Medicaid Dental rates. For patients living in Los Angeles, the state Medicaid program does not provide dental care. Los Angeles anticipates that as more PLWHA become covered through Medicaid expansion and the exchanges under ACA implementation, it will be able to reallocate funds from medical services to dental services.

Conclusion

To summarize, the five EMAs interviewed serve diverse populations who are primarily poor or near poor and lack access to health insurance coverage. More than 80 percent of all clients served in the five areas have incomes at or below 200 percent of the FPL. For all EMAs except San Francisco, the percent of the population with no health insurance ranged between 55 and 65 percent and Medicare and/or Medicaid coverage ranged between 18 and 57 percent.

Each EMA has begun to outline the implications on the service needs of PLWHA. For states that expand Medicaid eligibility, EMAs may have greater opportunities to reallocate primary care funds to other core services that previously received less funding. In other states, ACA implementation poses challenges in educating and training providers on how to bill for services so that expenditures charged to Ryan White Part A are minimized and the program remains a payor of last resort. EMAs also expressed concerns that health reform may disrupt the systems of care they have developed to meet the specific health care needs of PLWHA. To better position themselves for health reform, the EMAs indicated that it is important to collect and share data with other agencies and providers serving PLWHA and to continue to foster partnerships and opportunities for collaboration.

Ryan White Part A funding is essential to help meet the specialized health care needs of PLWHA, as well as to help minimize transmission. EMAs indicate that funding primary care and other core services is challenging given the reduced or flat funding they continue to receive from HRSA. To help determine where the limited funds must be directed, the EMAs rely on community needs assessments and reviews of client utilization data to develop priorities. Based on these data, outpatient medical and substance abuse services and medication assistance collectively receive the highest allocation of funds for the EMAs interviewed. Without new funding sources, EMAs fear that additional cuts to other core and support services may be necessary. Few have found long-term funding alternatives to supplant the cuts in HRSA Ryan White Part A funding. Many of the EMAs indicated that the funding issues emphasize the importance of Planning Councils to collect and share data with other agencies and providers serving PLWHA and to continue to foster partnerships and opportunities for collaboration.

In spite of the funding inadequacies and the uncertainties that surround health reform, the EMAs strive to maintain and enhance patient continuity of care through the use of medical homes and centers of excellence. Each adheres to standards of care and has developed unique protocols to help reach underserved populations and those PLWHA who are not in care. The EMAs are working to develop and/or improve upon data collection and exchange among providers and other AIDS service agencies to help maximize efforts, improve outcomes, and reduce duplication of services.

Assessment of the Current Continuum of Care's Ability to Receive Third Party Billing

Executive Summary

The Georgia Health Policy Center (GHPC) was contracted by the Atlanta Eligible Metropolitan Area's (EMA) Planning Council to assess the current Continuum of Care's likely capacity to implement or expand third-party billing. GHPC staff conducted telephone interviews with representatives of the 15 Continuum of Care providers between August 13th and August 21st, 2012, using questions developed in collaboration with the Atlanta EMA.

Of the 15 providers, four reported accepting Medicare, Medicaid, and private insurance; five accept Medicare and Medicaid but not private insurance; three accept Medicaid only; and three do not accept any forms of third-party payment. The length of third-party billing experience ranges from two months to more than 20 years; while the portion of clients whose services are paid by third parties ranges from three percent to 46 percent.

Acceptable forms of client payment vary less across agencies. The three that do not accept any insurance offer all of their services at no cost to clients. AID Atlanta does not charge clients except for services they can bill to Medicaid (medical services are provided and billed by a contractor), so they do not handle direct payments or patient billing. Apart from these four agencies, 10 of the remainder accept cash; eight accept personal checks; and nine accept credit cards. Eight agencies have client billing systems in place.

Ten of the providers have staff on-site with bookkeeping, accounting, and/or billing duties. In four other agencies, these functions are performed by external contractors or parent organizations. Three of 15 providers have plans to upgrade or expand their third-party billing capability in the near future; a fourth is stalled in its process of applying to be a Medicaid and Medicare provider due to insufficient capacity to staff the effort.

Just under half of the providers gave some estimate of cost per unit of service. Thirteen collect client outcomes data, of which eight share this information with other providers. Seven have taken steps to prepare for further implementation of the Affordable Care Act (ACA); while others are waiting until the course of implementation in Georgia is clearer. All 15 agencies provide patient advocacy (e.g., navigation) or facilitate their clients' receiving these services from others.

The majority of the Continuum of Care providers could likely accommodate a shift to billing the EMA for Ryan White Part A services; although some may face staffing or data processing challenges. Several could benefit from technical assistance in navigating new and existing requirements and optimizing their collection of third-party payment for eligible services they provide.

Introduction

The Georgia Health Policy Center (GHPC) was contracted by the Atlanta Eligible Metropolitan Area's (EMA) Metropolitan Atlanta HIV Health Services Planning Council to assess the current Continuum of Care's ability to receive third party payments. This information was sought due to possible changes in agencies' payer mix as further provisions of the Affordable Care Act (ACA) are implemented, as well as possible changes in the way Ryan White Part A funds are distributed to the Continuum of Care.

GHPC determined that conducting individual telephone interviews with representatives from the provider agencies would be feasible and more effective than the online survey approach originally planned. An introductory email was drafted for the client to send out to their contact persons in the Continuum of Care agencies. GHPC staff members followed up with emails providing the interview questions and requesting times for the telephone interview. Calls were then conducted at mutually convenient times, with the interviewer taking written notes.

Interview questions were developed in collaboration with representatives of the Atlanta EMA. A copy of the interview script is attached as Appendix B. Calls were conducted between August 13th and August 21st, 2012. All 15 agencies were reached. Results are summarized below.

Third-Party Payments

Of the 15 providers, four reported accepting Medicare, Medicaid, and private insurance; five accept Medicare and Medicaid but not private insurance; three accept Medicaid only; and three do not accept any forms of third-party payment. The latter three, Aniz, Inc., Atlanta Legal Aid Society and Here's To Life, reported that their services are not covered under health insurance plans and are all provided at no cost to their clients. They do not have plans to start accepting third-party payments.

About a year ago, Aniz, Inc. began steps to apply to be a Medicaid and Medicare provider; however, according to their chief operating officer (COO), they have had difficulty dedicating the required staff time for trainings, forms, and other requirements of the process. The COO also believes that, as a mental health and substance abuse treatment provider, their services would not be covered. One Continuum partner that, like Aniz, Inc., is listed in the EMA brochure as providing only support services and mental health and substance abuse treatment, does accept third-party payments: Positive Impact began accepting Medicaid very recently; within the past few months. Fewer than 15 percent of their clients pay through Medicaid.

Another Continuum partner that, like Here's to Life, is listed only as a support services provider, also accepts third-party payment: Project Open Hand began billing Medicaid about ten years ago and currently receives payment for about one-third of their clients this way. In addition, Project Open Hand bills Medicaid for some of their services and plans to begin billing Medicare for covered services in the near future.

All of the remaining Continuum partners provide medical care and medications. Some also provide other services such as case management, dental care, mental health care, substance abuse treatment, or support services. With the exception of AID Atlanta, these agencies all take Medicare, as well as Medicaid. AID Gwinnett and the hospital-affiliated providers also accept private insurance. Clarke County and Clayton County Health Departments have plans underway to begin accepting private insurance.

These findings are summarized in Table 1, along with the length of time respective agencies have been taking third party payments and the portion of clients who pay in this way. Most of the providers that accept insurance have many years of experience doing so. Exceptions are the Clayton and Cobb County Health Departments with roughly two years of experience, and Positive Impact which, as mentioned, began accepting Medicaid only a couple of months ago. Provider representatives reported the percentage of their clients for whom they receive third party payments to be anywhere from three percent for Fulton County Health and Wellness to 46 percent for Clarke County Board of Health and Grady. Emory University Midtown was unable to provide an estimate.

Client Payments

For the three providers whose services are offered at no charge, questions of what forms of payment are accepted from the client and client billing are not applicable. With the exception of AID Atlanta and Project Open Hand, all of the rest accept cash payments, at minimum. AID Atlanta does not charge clients except for services they can bill to Medicaid, so they do not handle direct payments or patient billing. It was noted, however, that this agency subcontracts medical services to an affiliate of Morehouse School of Medicine, which accepts all forms of insurance and bills the small portion of clients over 150 percent of poverty for applicable co-pays. Project Open Hand accepts checks and credit cards and bills clients. Several of the other providers also take checks and/or credit cards; and all of the rest except Clarke, Clayton, and Cobb Health Departments provide billing. Cobb County Health Department noted that although their primary clinic area collects credit card payments, their HIV clinic does not. These findings are summarized in Table 2.

Table 1. Ryan White Part A Funded Agencies: Summary of 3rd Party Payments Accepted

Continuum of Care Agency	Insurance Accepted			Years Accepted	Percent of Clients
	Medicaid	Medicare	Private		
AID Atlanta	✓			>12	~5
AID Gwinnett	✓	✓	✓	9	~30
Aniz, Inc.					
Atlanta Legal Aid Society					
Clarke County Board of Health	✓	✓		10	46
Clayton County Board of Health	✓	✓		~2	~5
Cobb County Public Health	✓	✓		>2	~11
DeKalb County Board of Health	✓	✓		20	21
Emory University Midtown	✓	✓	✓	Many	Unknown
Fulton County Health & Wellness	✓	✓		15	3
Grady Infectious Disease Program	✓	✓	✓	Many	46
Here's to Life					
Positive Impact	✓			~2 mo.	<15
Project Open Hand	✓			~10	~30
St. Joseph's Mercy Care	✓	✓	✓	>20	21

Table 2. Ryan White Part A Funded Agencies: Summary of Client Payments Accepted

Continuum of Care Agency	Cash or Money Order	Personal Check	Credit Card	Client Billing
AID Atlanta				
AID Gwinnett	✓	✓	✓	✓
Aniz, Inc.	n/a	n/a	n/a	n/a
Atlanta Legal Aid Society	n/a	n/a	n/a	n/a
Clarke County Board of Health	✓	✓	✓	
Clayton County Board of Health	✓		✓	
Cobb County Public Health	✓			
DeKalb County Board of Health	✓	✓	✓	✓
Emory University Midtown	✓	✓	✓	✓
Fulton County Health & Wellness	✓	✓	✓	✓
Grady Infectious Disease Program	✓			
Here's to Life	n/a	n/a	n/a	n/a
Positive Impact	✓	✓	✓	✓
Project Open Hand		✓	✓	✓
St. Joseph's Mercy Care	✓	✓	✓	✓

Billing Systems and Staffing

Continuum of Care providers were asked to describe their billing and accounting systems and staffing. Commensurate with their case load, fee structure, and billing practices, they described having from zero to several Full-Time Equivalent (FTE) staff members dedicated to these tasks. Table 3 presents the information provided by agency contacts.

Most agencies described having at least one staff member, a portion of whose duties include reviewing charges, accepting payments, or creating statements. Atlanta Legal Aid Society, whose services are free to clients, has a finance manager to handle income and expenditures. Aniz, Inc. uses an outside contractor for accounting. Emory University Midtown and Grady Infectious Disease Program are part of larger health care systems that handle billing and accounting functions. Positive Impact hired a .75 FTE employee to process the Medicaid billing they recently started. Four interviewees mentioned using proprietary electronic medical records and/or billing systems, and some noted using the Medicaid website.

Table 3. Summary of Billing Systems and Staffing

Continuum of Care Agency	Billing System/Staffing
AID Atlanta	One Medicaid Biller
AID Gwinnett	Two Front office/billing associates supervised by a grants manager. Integrated EMR and specialty practice management software (both Cerner)
Aniz, Inc.	Outside contractor for bookkeeping/accounting
Atlanta Legal Aid Society	Finance manager handles income and expenses according to an accounting manual.
Clarke County Board of Health	One staff member does billing and gives statements to patients when they leave. Use medical billing software (Lytec) and the Medicaid web portal.
Clayton County Board of Health	One program associate reviews charges and determines if patients qualify to pay.
Cobb County Public Health	Front desk receptionist accepts cash and does Medicaid and Medicare billing.
DeKalb County Board of Health	Clerks act as cashiers and collect individual information for Medicaid or patient billing. Office manager oversees billing at the clinic level.
Emory University Midtown	Handled by Emory Healthcare
Fulton County Health & Wellness	Handled by Health Department staff; outside accounting firm.
Grady Infectious Disease Program	Handled by Grady Health System
Here's to Life	None
Positive Impact	Hired 75% FTE employee to handle paperwork for Medicaid. Already had technology system/EMR.
Project Open Hand	Senior director of finance, comptroller, accounting associate and medical biller. Use the Medicaid web portal and a proprietary database for billing.
St. Joseph's Mercy Care	In-house coordinator

Outcomes Data

Thirteen Continuum of Care agencies reported collecting outcome measures. Eight of these said they share these data—in one case only with providers within their health care system; in two cases only for reporting to the Ryan White Program. Providers mentioned using the CareWare system. Two said they only provide information in aggregate without identifying patient information or that they share it only with release authorization.

Preparation for Health Reform Implementation

When asked if they had begun planning for a possible increase in the number of Medicaid patients they might serve as a result of ACA-related changes, seven described specific steps they had taken. These ranged from hiring additional clinical or administrative staff, to planning for implementation of electronic medical records (EMRs), to anticipating what changes might mean for their clients. Positive Impact's move to accept Medicaid was made for this reason. AID Gwinnett indicated that they are fully prepared and capable of doing whatever is required going forward. Like Aniz, Inc., they are waiting to see what materializes through the political and regulatory processes. Atlanta Legal Aid Society expects an increase in the number of clients they see who need legal assistance in connection with ACA requirements. Clarke County Health Department surmised that they will not serve more patients if Medicaid is expanded, only that some of those they currently serve will become Medicaid eligible.

Unit Cost for Service

Over half of the Continuum of Care agencies were unable to give an estimate for the unit cost of their services. Atlanta Legal Aid referenced private attorneys' fees for comparable services as $200 to $300 per hour. Project Open Hand estimated $6 as the average cost per meal served, depending on delivery area. Five others gave the following responses:

- AID Gwinnett – Their accounting staff is in the process of determining unit costs using the HRSA toolkit. Rough estimates are $2,775 per year for an established, male patient; $3,000 per year for an established female patient; $3,100 per year for a patient with hepatitis C; and $3,500 per year for a progressed AIDS patient.

- DeKalb County Board of Health – A basic calculation of average cost per patient yielded $1,996.25 for 2010.

- Fulton County Health and Wellness – From their accounting system, annual cost for a primary care patient is $1,075.

- Here's to Life – The cost to provide all services, including intake and counseling, is approximately $4,300 for eight weeks.

- Positive Impact – Using the SeaTec system, their cost is roughly $100 per hour; however, individual services vary in unit cost.

Patient Advocacy

Representatives were asked whether their agency provides advocacy, such as navigation services. Only one reported that it does not: the DeKalb County Board of Health contact said they do not do advocacy work in-house, but work with community advocates to ensure that patients receive these services.

Conclusion

On the whole, since 11 of 15 providers have at least a Medicaid billing system in place, most of the Continuum probably has the technical capacity to shift to billing the Atlanta EMA for services covered under Ryan White Part A. Some cited challenges with staffing, particularly administrative staffing, which might impede their implementation of such a change. These agencies may have the capacity to increase their Medicaid billing if the Medicaid population grows; it is unclear whether they have the program or the administrative capacity to meet an overall increase in clients if that should occur. However, one agency representative predicted that a Medicaid expansion would not produce more clients for them; it would only increase the proportion insured.

The three agencies that currently provide all services for free to clients may need technical assistance or new resources to implement billing systems if Ryan White Part A funds require billing. These and other providers may also need assistance in determining what, if any, services can be billed to third parties as regulations implementing the health reform law continue to roll out. For example, some have questions now about some of the mental health and addiction services they offer. Finally, agencies that are newer to Medicaid billing or have not yet become Medicaid providers might benefit from technical assistance in completing the application process and optimizing their bookkeeping and data management systems.

Evaluation of Non-Ryan White Programs and Their Networks

Executive Summary

Fulton County, Georgia's Ryan White Part A Program, through the Atlanta Eligible Metropolitan Area's (EMA) Metropolitan Atlanta HIV Health Services Planning Council, requested the assistance of the Georgia Health Policy Center (GHPC) in describing the potential impact of the Patient Protection and Affordable Care Act (ACA) on the HIV/AIDS Service Delivery System in the 20-County Atlanta EMA, especially drawing on the experiences to date of non-Ryan White providers.

Though the Ryan White CARE Act is not specifically cited in the ACA, the implementation of health reform has multiple implications for people living with HIV/AIDS (PLWHA) and their providers. Changes to both public and private sources of insurance coverage, as well as new funding available to encourage collaboration across the health care sector and support the expansion of public health outreach and patient support, will have a direct impact on how and where patients access care and how it is paid for.

Health care reform presents many opportunities, but Ryan White providers must first address certain challenges before they can take full advantage of these opportunities. People tend to think about challenges from a technical framework. For example people might ask, "Will I have money for this program next year?" "Will we still provide this service?" when, in fact, what is needed is a more adaptive perspective in order to plan under the type of uncertainty health reform is likely to create.

The health reform law presents many adaptive challenges for Ryan White providers and others providing care and support to PLWHA. By their very nature, these challenges have no ready answer or response. Providers must learn as they go, making sense of what is happening as it unfolds, and adjusting accordingly.

The GHPC has been studying the law's implications for state and local entities, community-based organizations, health providers, and businesses. As part of this work, the GHPC conducted a series of strategic consultations of the likely impact of health reform on 15 Georgia stakeholder groups representing a diversity of sectors, both public and private (rural, urban, government entities, providers, employers, local and state government agencies, community-based organizations, etc.). GHPC staff conducted an analysis of the findings from the consultations and identified eight strategic actions related primarily to the adaptive challenges of health reform.

Influencing Decisions: Many of the required decisions for implementing the ACA have not yet been made, creating a tremendous opportunity for Ryan White providers to influence decisions, particularly at the state level. Decisions can be influenced through conversations with legislators, contributions to community forums, through social media, responding to government requests for comments, being networked to information, and convening diverse stakeholder groups. There may be opportunities for the Atlanta EMA and Ryan White providers to inform the local and state planning process for health reform.

Educating Others: Providers and public health professionals understand the ACA to varying degrees, and at different levels, and those who do understand more about the law and its potential impact on health and public health have the opportunity to educate others at the state and local levels. There may be opportunities for the EMA to translate frameworks for planning for health reform (e.g. the Georgia Health Policy Center's Eight Strategic Actions) for providers and other key stakeholders that serve PLWHA. The EMA might identify key messages about the health and social support needs of PLWHA that need to be communicated to policy makers at the local, state, and national levels. Finally, there could be opportunities for the Atlanta EMA to use providers' experience in working with vulnerable and underserved populations to inform the design of enrollment strategies for expanded insurance options.

Planning Under Uncertainty: Because the changes in the health reform law will take place over several years, providers are faced with the daunting prospect of making decisions without complete information. In addition, they are acutely aware that in the process of rule-making, there are many decisions still yet to be made that will have direct impact on what the law looks like. Some ideas to help plan under uncertainty include identifying the most likely scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of reform; building good information systems to track progress and identify needed adjustments; and looking for win-win opportunities that can be created through collaboration with multiple partners.

Staying Abreast of New Information: Given the length and complexity of the ACA, it is challenging to stay on top of all the regulations, administrative decisions, and guidance that has been, and will continue to be, issued from various sources. Even more difficult is sorting out what this information means and how it should be used. Still, adaptive thinkers must seek out the latest information related to the challenges they are facing. The EMA might look to other stakeholder groups that have similar concerns (e.g. safety net hospitals, free clinic associations, public health departments, Federally Qualified Health Centers, mental health agencies, and provider associations) and learn from their strategic planning and preparation.

Creating New Partnerships: New collaborations are critical to the success of health reform. Some of the partnerships needed to implement health reform may involve coalitions among public health, community health centers, provider communities, hospitals, businesses, universities, social service organizations, community-based organizations, faith-based communities, state and local government authorities, senior centers, and others. Effectively forging such partnerships requires a neutral, respected convener who is ideally not an entity that stands to directly benefit from the partnership. Safety net providers will likely play a key role in insuring that the newly insured are connected to care. These providers are preparing for health reform by building new partnerships to expand their ability to outreach to key populations that will require education and navigational assistance.

Building Workforce Capacity: The elimination of co-pays, deductibles, and coinsurance for many preventive services will likely increase the demand for primary care and other health providers when health reform is fully implemented. Meeting the workforce shortfall may require incentives to retain providers in needed locations; educational initiatives to ensure the pipeline produces providers that match workforce needs; and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers. This also means training a workforce that is culturally competent and aware of and able to effectively provide care to PLWHA with complex health care and social service needs. One concern of particular importance for service organizations and safety net providers is the need to actively engage with patients accessing the healthcare system for the first time. Community health workers, patient navigators, and others in a clinic extender role will be key to ensuring that traditionally underserved and vulnerable populations get an appropriate source of coverage and are connected to the care that they need.

Building Information Technology Capacity: The ACA will stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. Institutional information technology needs and requirements vary and reflect the idiosyncratic and unique nature of organizations. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient management and clinical management systems, sharing data among systems, building systems that can accommodate the increase in anticipated volume of claims and provider information, and developing data system standards for health. Additional data collection and monitoring functions will be needed to ensure that PLWHA receive appropriate and quality care.

Building Capacity for Care Coordination: The ACA includes a number of features for improving coordination of care, including a requirement that health insurance exchanges contract with professional associations and local organizations to provide exchange navigator services; funding to support improved care transition services for high-risk Medicare beneficiaries; establishment of community-based, interdisciplinary care teams; and grants to support comprehensive, coordinated, and integrated health care services for low-income populations. The law specifically provides funding for outreach and enrollment assistance for underserved and vulnerable populations, including PLWHA. To build capacity for care coordination, organizations will need to understand the administrative requirements; be able to link different types of care; influence decisions about health reform; assist health networks in obtaining pertinent information (perhaps surveillance information); and obtain the technical ability to collect information.

The providers participating in the Ryan White Program in the Atlanta EMA will be presented with challenges and opportunities as they prepare for changes brought about through the ACA. Thinking adaptively about questions related to health reform will help providers position themselves for sustainability as the health care landscape shifts and will ensure continuity of care for Ryan White clients.

Introduction

Fulton County, Georgia's Ryan White Part A Program, through the Atlanta Eligible Metropolitan Area's (EMA) Metropolitan Atlanta HIV Health Services Planning Council, requested the assistance of the Georgia Health Policy Center (GHPC) in describing the potential impact of the Patient Protection and Affordable Care Act (ACA) on the HIV/AIDS Service Delivery System in the 20-County Atlanta EMA, especially drawing on the experiences to date of non-Ryan White providers. This report, prepared for the Atlanta EMA's Health Services Planning Council, is divided into four sections. The first section provides a general overview of the ACA and its major change components. The second section describes some of the anticipated direct and potential indirect impacts of the implementation of health reform on people living with HIV/AIDS (PLWHA) and providers. The third section presents the findings from a series of strategic consultations conducted by the GHPC to explore the likely impacts of health reform on a diverse group of stakeholders, provider organizations, rural and urban community-based groups, businesses, professional associations and government entities. Building on the findings from those consultations, case examples are provided to illustrate the strategies and processes being undertaken by a variety of non-Ryan White organizations and entities to prepare for changes coming as a result of the ACA. The fourth section presents a series of questions aligned with key areas for strategic action meant to help guide the EMA in planning for the implementation of health reform.

Overview of the Patient Protection and Affordable Care Act

The ACA, also known as health reform, was signed into law on March 23, 2010. One of the driving concepts of health reform was to provide more Americans with health insurance coverage.

There are four major health reform components:

- **Changes in public coverage**: Eligibility for Medicaid programs will be expanded to include all Americans up to 133% of the Federal Poverty Level (FPL) in states that choose to expand Medicaid coverage. The June 28, 2012 Supreme Court decision made the Medicaid expansion optional for states. The expansion could potentially increase the number eligible for Medicaid by approximately 16 million Americans, with the largest increase being childless adults who are not currently eligible. The full cost of this expansion will be paid by the federal government beginning in 2014, with a phase-in of state share starting in 2017 (up to 10% of expansion costs). The federal government retains 90% of new and ongoing expansion costs beginning in 2020.

- **Changes in private coverage**: Modifications in current insurance regulation practices include: community rating rather than risk-adjusted premiums, no pre-existing condition exclusions, no lifetime and very limited annual benefits caps, prior approval of rate increases, and a mandatory medical loss ratio of 80 or 85 percent (by group size). The legislation also creates a high-risk pool as a bridge to provide a way to obtain coverage until other insurance market reforms are fully implemented in 2014. In addition, it allows for the creation of health insurance exchanges, with the structure either determined by each state alone, states in partnership with the federal government, or the federal government alone depending on what states decide to do or their readiness to act. The exchanges will establish common rules for benefits and pricing; offer consumers a choice of plans; provide consumers information about their choices; facilitate plan enrollment; and administer the subsidies for people who earn less than 400 percent of the FPL. Because many states were waiting for the Supreme Court decision on the ACA, and some for the 2012 presidential election, it is likely that not all states that want to operate their own exchanges by 2014 will be ready to do so without federal assistance.

- **Changes in health care quality**: A variety of strategies address the need for improved quality of care: incorporating best practices and systemically collecting and analyzing health care data; streamlining and coordinating care, as well as encouraging interdisciplinary treatments; instituting a series of quality-driven incentives and penalties for providers; and funding to study and implement evidence-based practices related to the financing and delivery of Medicare. Many of these strategies focus on decreasing the overall cost of health care, while maintaining or improving quality

- **Changes in health**: Efforts to improve health and well-being will be coordinated by a national council, supported by research and innovation, and implemented through insurance coverage requirements, as well as state and community programs. Wellness and prevention services and research will be expanded to focus on physical activity, nutrition, emotional wellness, smoking cessation, and other chronic disease priorities. Public and private insurers will be required to provide preventive and wellness services in their qualified health plans, and employers will be permitted to incentivize employee participation in wellness programs. State and local agencies will be given opportunities to apply for federal funds to implement programs to create healthier communities.

The ACA and HIV/AIDS Care

The Ryan White CARE act is not specifically cited in the ACA. There are, however, four sections of the law that mention programs and health care services for PLWHA:

Section 2201 of Subtitle C (Medicaid and SCHIP Enrollment Simplification) of Title II (Role of Public Programs) - Enrollment Simplification and Coordination with State Health Insurance Exchanges
The law calls for targeted outreach and enrollment of vulnerable and underserved populations eligible for medical assistance (e.g. enrollment in health insurance exchange plans, Medicaid, etc.), including individuals with HIV/AIDS.

Section 2953 of Subtitle L (Maternal and Child Health Services) of Title II: Personal Responsibility Education
This section details the state allotment program designed to educate adolescents in abstinence and contraception use for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS. In order to access the allotment, States are required in their applications to describe how the goal will be achieved, especially among higher risk or vulnerable populations, including youth with HIV/AIDS. Under this section, the Secretary reserves $10,000,000 in grants to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally underrepresented youth populations, including youth with HIV/AIDS.

Section 3314 of Subtitle D (Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans) of Title III (Improving the Quality and Efficiency of Health Care)
Under this section, the costs incurred by AIDS drug assistance programs and Indian Health Services in providing prescription drugs are applied towards the annual out-off-pocket threshold under the Medicare Part-D prescription drug plan.

Sections 5301-03 of Subtitle D (Enhancing Health Care Workforce Education and Training) of Title V (Health Care Workforce)
These sections give power to the Secretary to provide funding for education and training programs (internships, residencies, fellowships, etc.) in public health, dentistry, primary care, direct care, etc. It is stated that funding preference will be given to entities that provide training in the care of vulnerable populations, including individuals with HIV/AIDS.

The ACA will have direct and indirect implications for PLWHA. Perhaps the change that has the greatest potential impact is the expansion of health care coverage (both private and public). Almost one-fourth of PLWHA are uninsured, less than one-fifth (17%) have private health insurance (Department of Health and Human Services, 2011), and approximately 40 percent of PLWHA are recipients of Medicaid (Henry J. Kaiser Family Foundation, 2011).

Private Coverage

The regulations addressing private insurance coverage provide patient protections that are important for PLWHA. Already in effect are regulations that bar insurance companies from denying coverage to children because of their HIV or AIDS status (or any other pre-existing condition). In addition, the ACA eliminates lifetime spending limits on essential health benefits and coverage rescission for adults or children (unless there is fraud or intentional misrepresentation) (Department of Health and Human Services, 2011). These changes will likely improve access to coverage for PLWHA who already have or will seek private insurance coverage.

Under the ACA, the ability for young adults to remain on their parents' insurance until the age of 26 may be an important new source of coverage for PLWHA, given that the highest rates of new HIV diagnoses are among young adults aged 20-24 and 25-29 (Centers for Disease Control and Prevention, 2011). Even though Pre-existing Condition Insurance Plans (PCIPs) have been made available to PLWHA who had been denied private insurance coverage because of their illness, uptake has been low nationally. Just 56,257 individuals had signed up as of February 2012 (Department of Health and Human Services, 2012), and few PLWHA have purchased PCIPs (Martin and Schackman, 2012).

Beginning in 2014, Health Insurance Exchanges will be established in each state. Of importance to PLWHA are the requirements set forth in the ACA that no plan offered through exchanges can contain pre-existing exclusions for adults, no lifetime or annual caps on coverage can be imposed, and plans must cover routine costs associated with participation in clinical trials (Department of Health and Human Services, 2011; McKay, 2011).

Public Coverage

Medicaid Expansion: The Kaiser Family Foundation published a report in 2011 that uses data from all states to analyze the enrollment and service utilization patterns of PLWHA enrolled in Medicaid. Medicaid is currently an important source of coverage for PLWHA and will likely become even more so after 2014. Twenty-three percent of people with an HIV diagnosis were enrolled in Medicaid in Fiscal Year 2007. Of those PLWHA who are in regular care for their disease, it is estimated that almost half are enrolled in Medicaid (Henry J. Kaiser Family Foundation, 2011). Under current law, a person must be low-income, as well as meet criteria for "categorical" eligibility (children, pregnant women, individuals with disabilities who receive Supplemental Security Income, etc.). For PLWHA, the disability category is the principle category through which they qualify for Medicaid coverage.

For states that opt in to the expansion of Medicaid under the ACA, Medicaid coverage will be significantly expanded to include any legal resident under the age of 65 with income below 133 percent FPL. This expansion removes what the Kaiser report terms the "Catch-22 for many people with HIV" – under current eligibility rules for Medicaid, most adults cannot enroll in the program and access anti-retroviral treatments that would keep them healthy, instead they are forced to wait for an AIDS diagnosis in order to become eligible for Medicaid and receive care (Department of Health and Human Services, 2011).

The Medicaid expansion to people with incomes below 133 percent FPL without the additional categorical eligibility requirements (for those states that do expand Medicaid) is likely to improve access to care for a sizable population of PLWHA. There is a disproportionate burden of HIV/AIDS among low-income individuals. Approximately one-third of Ryan White clients are uninsured and over half (52%) of Ryan White clients come from households with incomes below the poverty level (Health Resources and Services Administration, 2009). Many of these individuals will be newly eligible for Medicaid in states that expand eligibility (Martin and Schackman, 2011; National Alliance of State and Territorial AIDS Directors, 2011). The Ryan White Part A program in Los Angeles, CA estimates that up to 70% of their Ryan White clients may receive medical care through new sources of coverage outside the Ryan White Program (McKay, 2011).

This movement of PLWHA to Medicaid will impact providers currently providing care through the Ryan White program. In some states, Medicaid reimbursement rates are below the reimbursement levels provided through the Ryan White program. This may be especially true for private practice physicians and for clinics that are not Federally Qualified Health Centers. It is possible that those providers could experience a reduction in income as PLWHA transition from the Ryan White program to Medicaid as the payor for medical services (McKay, 2011).

Medicare Changes: Changes to Medicare through the ACA are focused in two areas – expansion of benefits and better integration of care and changes to the Medicare Part D prescription drug program.

Almost one-third of PLWHA who are enrolled in Medicaid are dually eligible for Medicare. For these individuals, Medicaid provides assistance to low-income Medicare enrollees by helping with long-term care and other services not covered under Medicare and through assistance with premiums and cost sharing (Henry J. Kaiser Family Foundation, 2011). Under the ACA, a new office at the federal level, the Medicare-Medicaid Coordination Office, was set up to determine ways in which Medicaid and Medicare can better coordinate care between the two programs (Prindiville and Burke, 2011). To further encourage more integrated health care, Medicare providers and hospitals are authorized under the ACA to form Accountable Care Organizations (ACOs) that will facilitate patient care coordination among different providers and across care settings (Martin and Schackman, 2012). PLWHA who are covered under Medicare

will also gain additional coverage for preventive services. Co-pays and deductibles are eliminated for many preventive care services and annual wellness visits (Project Inform, 2011).

Perhaps the most significant change for PLWHA currently covered by the Medicare program is the change in the requirements for out-of-pocket expenses under the Medicare Part D prescription drug program. The ACA will eventually eliminate the Medicare Part D donut hole. Beginning in 2010, Medicare enrollees who reached the donut hole received a rebate of $250. In 2011, beneficiaries who reached the donut hole received a 50% discount on certain brand-name drugs (Martin and Schackman, 2012). In 2020, the donut hole will be completely phased out, and beneficiaries will be responsible for 25% of the cost of drugs in the coverage gap (Henry J. Kaiser Family Foundation, 2011). In addition, benefits paid out by state AIDS Drug Assistance Programs (ADAP) are now counted towards Medicare beneficiaries' true out-of-pocket spending limits for drug coverage (Department of Health and Human Services, 2011). As a result, once a patient moves out of the donut hole, they are able to revert from ADAP back to Medicare Part D for drug coverage (Martin and Shackman, 2012).

The high cost of anti-retroviral drugs and other HIV/AIDS therapies has posed a significant barrier for PLWHA seeking treatment. For many PLWHA, the donut hole amounted to over $3,000 in uncovered prescription drug assistance (Hoadley, Summer, et al. 2011). With the changes to Medicare Part D under the ACA, this barrier will be minimized for beneficiaries. There is a possibility that with more patients reverting to Medicare Part D for drug coverage and off of the state ADAP, ADAP funds could cover more PLWHA in need of assistance, potentially reducing the ADAP waiting list (Martin and Schackman, 2012).

Despite expansions in coverage (public and private), not all current Ryan White patients will have a source of health insurance coverage after 2014. Some individuals may have incomes that are too high to qualify for Medicaid or for subsidies in the health insurance exchange (Buettgens and Hall, 2011). The ACA does not extend Medicaid coverage to undocumented immigrants, and the five-year waiting period for Medicaid and Children's Health Insurance Program (CHIP) eligibility is still in effect for legal permanent residents.

Even those PLWHA who gain access to insurance coverage may experience discontinuity in coverage and care. Those with fluctuating incomes may move in and out of eligibility for Medicaid and the health insurance exchanges. It is estimated that at least 35 percent of adults with incomes below 200 percent FPL will have changes in eligibility for health insurance coverage within six months (Sommers and Rosenbaum, 2011). Though there is no penalty for moving between the two sources of coverage, frequent "churning" will likely pose a threat to continuity of care, as some providers may accept private insurance but not Medicaid. In addition, different plans may cover different benefits, and cost sharing differences may make care less accessible as individuals move between different sources of coverage (Sommers and Rosenbaum, 2011; Jost, 2010). The potential for churning among PLWHA means that health care providers, care managers and coordinators, and patient navigators will likely play an important role in helping patients navigate between the two programs and ensuring continuity of care.

Increased Coverage for Preventive Services

The ACA will also expand access to important preventive care services by eventually requiring that Medicare, Medicaid, and new private insurance plans cover preventive services recommended by the U.S. Preventive Services Task Force (those services that receive an A or B rating from the Task Force). These services will be covered without cost sharing and will likely expand important services for PLWHA and people at risk for contracting HIV, including: screening for substance abuse, depression, sexually transmitted infections (STIs), and cervical cancer (U.S. Preventive Services Taskforce, 2011). In addition, the ACA requires that these plans provide coverage for HIV and STI counseling for sexually active women without co-pays or deductibles (Department of Health and Human Services, 2011).

Increased Funding for Patient Education and Navigation

The ACA includes several provisions meant to expand the role of community health workers (CHWs) in education, patient navigation, and as part of the health care team in a patient-centered medical home model. Recent trends in the prevention and treatment of HIV/AIDS align with this focus on patient navigation and better integrated care. The U.S. has experienced an increased use of CHWs/peer support approaches in HIV prevention and care. The HIV/AIDS Bureau has funded several projects to incorporate peer CHWs (lay health workers who are HIV positive) into HIV/AIDS care. In addition, providers and administrators are increasingly approaching HIV as a chronic disease. As such, models have been developed that front-load interventions with self-management education and patient navigation support, similar to the approach used with diabetics (McKay, 2011).

The ACA provides funding for patient navigators and CHWs in the following program areas:

- Health insurance exchanges will establish patient navigator programs to help educate people about plans and assist in enrollment.
- The Centers for Disease Control and Prevention will make grants to train CHWs to improve health outcomes and promote healthy behaviors in medically underserved areas.
- Health Resources and Service Administration (HRSA) is reauthorized to continue a grant program that uses patient navigators to improve the health outcomes of people with chronic diseases.

Because many AIDS Service Organizations and health care providers already have close contact to uninsured PLWHA, these same organizations will likely play an important role in linking individuals with appropriate sources of coverage, both public and private. There may also be opportunities for providers and AIDS Service Organizations to provide patient self-management education and care coordination as part of an ACO or a patient-centered medical home (McKay, 2011; Martin and Schackman, 2012).

Increased Funding for Federally-Funded Clinics and Incentives for Providers

The ACA increased the level of funding for providers and clinics that currently serve underserved communities and large numbers of PLWHA. Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs) experienced an original authorization of $11 billion over five years. Though Congress cut those funds in 2011, FQHC/CHC capacity is anticipated to continue to increase through expansion of existing community health centers and the funding of new start FQHCs over the next five years as the ACA is implemented (McKay, 2011). In addition, the ACA provides for payment incentives for Medicare primary care physician practices in underserved areas where many PLWHA reside. Finally, the ACA provides additional funding to develop the health care workforce through investments in the National Health Service Corps program to encourage residents to train and practice in underserved areas (Martin and Schackman, 2012).

Planning for Health Reform: Lessons from Non-Ryan White Organizations

Upon the passage of the ACA, the GHPC formed a health reform team that has been studying the law's implications for state and local entities, community-based organizations, health providers, and businesses. The aim is to translate the ACA so that stakeholders can understand the components of the law and make informed decisions about how to best prepare for its implementation. As part of this work, the GHPC conducted a series of strategic consultations on the likely impact of health reform on 15 diverse Georgia stakeholder groups. The objectives of the consultations were to better understand the issues that individuals and organizations are grappling with related to health reform and to assist them in thinking strategically about how to best respond to potential changes. The groups included providers and provider organizations, rural and urban community-based groups, businesses, professional associations, and local and state government entities.

The Strategic Consultation Process

The GHPC conducted strategic health reform consultations for 15 interested groups representing a diversity of sectors, both public and private (rural, urban, government entities, providers, employers, local and state government agencies, community-based organizations, etc.). GHPC staff contacted each group for a telephone interview to gather contextual information and identify a question or series of questions that the group was interested in exploring as it related to planning for health reform. Staff then conducted background research and analysis with input from policy analysts and subject matter experts on the GHPC health reform team. Once the analysis was completed, GHPC staff met onsite with the stakeholder group to present their analyses and facilitate a two- to three-hour strategic consultation session on understanding and adapting to health reform. The groups began to explore the issues that were of most concern to them related to health reform and what their next steps would be. Once all 15 site visits had been completed, staff convened to identify key themes that emerged among the 15 consultations. The following section highlights the key findings from the strategic consultations.

Strategic Consultation Findings: A Framework for Looking at Health Reform through an Adaptive Lens

The changes inherent in health reform have extensive implications for all aspects of the U.S. health system: financing, service delivery, coverage and access, quality, and ultimately, well-being. Broad transformations such as health reform have implications for providers on an individual level, as members of an organization or trade, and as part of the larger health system or community. Such large scale change is very difficult to navigate and requires a framework that considers the issue in its full complexity.

Health care reform presents many opportunities, but Ryan White providers must first address certain challenges before they can take full advantage of these opportunities. People tend to think about challenges from a technical framework. For example, people might ask, "Will I have money for this program next year?" "Will we still provide this service?" when, in fact, what is needed is a more adaptive perspective in order to plan under the type of uncertainty health reform is likely to create.

Marty Linsky and Ronald Heifetz, leaders in the field of management consulting, talk extensively about the differences between technical and adaptive challenges. (Heifetz and Linsky, 2002). While their teachings have not previously been used in the context of health reform, the GHPC has employed Linsky and Heifetz' theory on adaptive leadership to provide a framework for the role providers might take in this environment.

According to Linsky and Heifetz, technical challenges, while not simple, are solvable. Through research and practice, effective approaches have been designed and adopted even if they require intense skill and expertise (such as brain surgery). Adaptive challenges, on the other hand, are quite different. They are often being seen for the first time. There is no expert. Solutions require both experimentation and innovation.

The table below provides examples of technical and adaptive challenges.

Types of Challenges*	
Technical Challenges	Adaptive Challenges
Ready-made solutions exists	Never solved issue; perhaps new, never seen before
Can be resolved through Standard Operating Procedures (SOPs)	No one's got *The Answer*
Someone has *The Answer*	Resolved by changes in people's priorities, beliefs, habits and loyalties
Even if they require intense skills, some expert knows exactly what to do...	Requires collaboration
Examples:	**Examples:**
Building a hospital	Decreasing poverty
Fixing a broken computer	Reforming public education
Implementing health reform	Implementing health reform

*Adapted from Heifetz and Linsky, 2002.

Health reform presents both types of challenges. Some are routine and technical, while others are adaptive and require planning, building partnerships, gathering information, and building capacity. To navigate through this uncharted territory, leaders must be able to deviate from their plans as learning takes place.

According to Linsky and Heifetz in *When Leadership Spells Danger*, "a challenge for adaptive leadership is to engage people in distinguishing what is essential to preserve from their organization's heritage from what is expendable. Successful adaptations are thus both conservative and progressive. They make the best possible use of previous wisdom and know-how. The most effective leadership anchors change in the values, competencies, and strategic orientations that should endure in the organization" (Heifetz and Linsky, 2004). Leadership requires a diagnostic capacity that identifies the forces at play that constantly shape health reform. These forces include legal (changing or repealing legislation), administrative (enforcing regulations), and financial (providing funding).

Eight Strategic Actions

The health reform law presents dozens of adaptive challenges for Ryan White providers and others providing care and support to PLWHA and their clients. By their very nature, these challenges have no ready answer or response. Providers must learn as they go, making sense of what is happening as it unfolds, and adjusting accordingly. Eight strategic actions emerged from the 15 consultations related primarily to the adaptive challenges of health reform. These eight actions are described below, with accompanying case examples to illustrate strategies for preparing for health reform.

Influencing Decisions

Many of the required decisions for implementing the ACA have not yet been made, creating a tremendous opportunity for Ryan White providers to influence decisions, particularly at the state level. Decisions can be influenced through conversations with legislators, contributions to community forums, through social media, responding to government requests for comments, being networked to information, and convening diverse stakeholder groups.

One area where there is potential to inform the decision-making process that would greatly impact PLWHA and their partners is around the definition of essential health benefits (EHB). EHB are a set of health benefits that must be included in health plans offered through the Health Insurance Exchanges, Medicaid programs for new beneficiaries, and basic health plans (for people between 133% and 200% FPL). The Department of Health and Human Services has defined the 10 basic service areas that must be covered as essential health benefits, but has granted states some latitude in implementing the benefits through the selection of a benchmark plan that serves as the model for all plans offered in the state.

AIDS Service Organizations, advocacy groups, and provider organizations are working in their states to inform the conversation by providing information about the coverage needs of PLWHA. In Illinois, the AIDS Legal Council of Chicago prepared a document that assessed small group health insurance plans that the state could select as a benchmark plan for the health insurance exchange. In the document, the authors assess three small group plans to determine if their benefits are suitable for PLWHA (Miller, 2012).

Professional associations and other groups are providing guidance to states as administrators begin the process of designing user-friendly enrollment processes for expanded Medicaid plans and plans offered through the exchanges. The National Council for Community Behavioral Healthcare published an issue brief outlining their suggestions to states for how to create an enrollment strategy for insurance expansion that will meet the needs of the consumer community. Recommendations in the report include encouraging state agencies to partner with community-based organizations and providers to do targeted outreach and education for enrollment and looking at existing enrollment strategies, like SCHIP's Express Lane Eligibility, as a model for enrollment under insurance expansion. (National Council for Community Behavioral Healthcare, 2010).

Educating Others

Providers and public health professionals understand the ACA to varying degrees and at different levels, and those who do understand more about the law and its potential impact on health and public health have the opportunity to educate others at the state and local levels. There are multiple resources about health care reform and implications for PLWHA and providers. The blog *HIV and Health Reform* hosts webinars and posts articles presenting the experiences of states like Massachusetts, Texas, and California in preparing providers, advocates, and service organizations who serve PLWHA. The Treatment Access Expansion Project provides fact sheets and webinars on information pertinent to the provider community on the ACA and implications for PLWHA. Beyond these resources, opportunities exist at the local and state levels for the EMA to play a role in convening stakeholders in order to understand better how the ACA will impact providers, current and potential partners, and clients. In this role, the EMA can share what is known about the opportunities the ACA creates for improving the health of PLWHA. In the process of educating others, information should be neutral, simple, accurate, and accessible to all.

Another way that leaders in the field are providing information and capacity-building support to their constituents and partners is through the development of readiness assessment tools that guide providers, organizations, and other entities through an assessment of key competencies that may be necessary to be successful under health reform. The National Council for Community Behavioral Healthcare is a national member organization for behavioral health organizations. The National Council advocates for policies that expand access to care and provides technical assistance and resources to providers to deliver more effective and efficient services to consumers. The National Council developed the Mental Health and Substance Use Provider Readiness Assessment for success in the new "healthcare ecosystem." The tool is meant to raise awareness of the preparation, key actions, and areas for capacity building necessary for providers to successfully navigate health reform. This assessment sets forth 23 strategies and competencies with descriptions of each and guidance on how to put the change plan into action (National Council for Community Behavioral Healthcare, 2011). Tools like this readiness assessment and the Georgia Health Policy Center's Eight Strategic Actions provide organizations with a framework from which to approach health reform preparedness.

Planning Under Uncertainty

Because the changes in the health reform law will take place over several years, providers are faced with the daunting prospect of making decisions without complete information. In addition, they are acutely aware that in the process of rule-making, there are many decisions still yet to be made that will have direct impact on what the law looks like. It is often said that jazz musicians listen to what is being played and play what is missing. Like jazz musicians, strategic thinkers must be improvisational in their thinking and planning. Some ideas to help plan under uncertainty include identifying the most likely scenarios and then using them as a foundation for planning; pursuing good ideas, even in the absence of reform; building good information systems to track progress and identify needed adjustments; and looking for win-win opportunities that can be created through collaboration with multiple partners.

Safety net hospitals provide an example of this type of strategic planning when the future is uncertain. These hospitals have long relied on subsidies and write-offs to provide care for the uninsured in their communities. After health reform, many of their current patients will be insured, some through the insurance exchanges, but many more through expanded Medicaid. Though millions of Americans will gain coverage under the ACA, there will still be a significant number of uninsured after 2014. National estimates put the number of future uninsured at around 26 million (Congressional Budget Office, 2012). In addition, funding streams like the Medicaid Disproportionate Share Hospital (DSH) program, which provides funding to subsidize hospitals for the unreimbursed costs they incur treating uninsured and Medicaid patients, will be phased out starting in 2014 (Academy Health, 2011.) Total caseloads, the patient mix, reimbursement sources, and funding streams will shift for safety net hospitals, but at this point, it is unclear how.

A safety net hospital in an urban area in Northern California has begun to plan for a change to their payer structure, considering multiple scenarios in patient mix and payer sources. Hospital leadership recognizes the need to be competitive with other hospital facilities in the area for insured patients. Many safety net hospitals, like this one, have a reputation in the region for being the place people go when they have been shot or stabbed, not for other types of care outside of the emergency room (ER). The hospital is working to reposition itself as a provider of quality care and rehabilitating its image by hiring a public relations firm. It is also beginning to plan for ways to improve performance and patient outcomes rather than continuing with the mindset of charging for the beds occupied in the facility. The hospital's current patients often use the hospital ER for chronic disease care, something that they could potentially receive care for in clinics once they are insured. This hospital, like many other safety net hospitals, has experience in providing culturally competent care to the most underserved populations in the community and has recognized the need to engage their patient population in education around more effective use of the health care system. The safety net hospital is looking for ways to expand its clinic system to meet the needs of the population who will have new sources of coverage and will need to seek care in the clinic system rather than at the ER. The hospital must also consider how they will continue to meet the demand for care for those who remain uninsured (Woodhall, 2011).

Staying Abreast of New Information

Given the length and complexity of the ACA, it is challenging to stay on top of all the regulations, administrative decisions, and guidance that has been, and will continue to be, issued from various sources. Even more difficult is sorting out what this information means and how it should be used. Still, adaptive thinkers must seek out the latest information related to the challenges they are facing. Some sources of new information related to the ACA include the Federal Register, national association Web publications, healthcare.gov, listservs, and information clearinghouses at the state level. To better utilize these sources, dedicated staff is sometimes needed for research opportunities, supportive infrastructure, grant writing capacity, and the ability to benchmark progress. Since most organizations cannot dedicate staff to all of these functions, partnership is all the more important.

One important source of information to aid providers, service organizations, and other key stakeholders in preparing for health reform is to look to early adopters of some aspects of reform and analyze the data coming from their experience (e.g. patterns in coverage uptake and utilization, patient/client support needs, costs, etc.). Counties across California are participating in the Low-Income Health Program, a short-term program that seeks to insure tens of thousands of uninsured residents until the ACA coverage expansions are rolled out in 2014. This program allows California counties to expand eligibility requirements for Medicaid. For these counties' governments and health care providers, this is an opportunity to work out some of the kinks on a smaller level before larger and more complicated changes take place in less than two years. During this year and a half of participation in the temporary program, county officials and health care leaders are monitoring patient and provider data to answer key questions: Who exactly are the uninsured? What are the barriers to getting them enrolled in coverage? Will connecting them with regular, preventive care cut down on costly, unnecessary trips to the emergency room? They plan to use the information to plan for the full roll out of the ACA in 2014. (Rubenstein, 2012).

Other provider organizations are looking to the experience in Massachusetts to aid in their own planning processes. Associations for health care providers and public health and medical journals are analyzing the experiences of patients and providers in the state after Massachusetts implemented its own health care reform in 2006. For example, the National Association for Community Health Centers is highlighting data that shows that CHC patients who became newly insured under Massachusetts' health reform program tended to remain patients of their CHC, and that CHCs saw client loads grow. Data from patient interviews show that patients did not see the CHC as the provider of last resort and opted to receive care at the clinic because it was convenient and affordable (Leighton, Jones, et al., 2011).

The New Orleans EMA reports that they are closely monitoring enrollment and utilization patterns of clients in the state's PCIP to see how enrollment in the PCIP is going to impact primary care provision and medication reimbursement. The EMA is monitoring those Ryan White clients enrolled in the PCIP who now get their prescriptions and medical care covered by insurance to see if that will free up monies in other areas of the Ryan White Program. Having access to this information prior to full implementation of health reform will help the EMA better allocate their resources to address the unmet need of their clients.

Creating New Partnerships

New collaborations are critical to the success of health reform. Some of the partnerships needed to implement health reform may involve coalitions among public health, community health centers, provider communities, hospitals, businesses, universities, social service organizations, community-based organizations, the faith-based community, state and local government authorities, senior centers, and others. Effectively forging such partnerships requires a neutral, respected convener who is ideally not an entity that stands to directly benefit from the partnership.

The early work that Local Health Departments are doing to build partnerships with CHCs and FQHCs illustrates the importance of creating new ways of collaborating to ensure coordinated care for populations that have been traditionally underserved.

According to a 2010 fact sheet by the National Association of County and City Health Officials (NACCHO), 13 percent of local health departments nationwide directly provided comprehensive primary care services. Twenty-seven percent provided oral health services, and 10 percent provided behavioral health services. In many jurisdictions, reimbursement by third party payers is not sought. For those local health departments that do provide direct services, reimbursement might improve overall financial sustainability (NACCHO, 2011). Local Health Departments across the state and country are exploring ways to build new partnerships to expand their capacity to accept third party payments and stay financially viable after health reform. In its health reform planning, the Laurens County, Georgia Health Department realized it needed to begin to think about doing business differently under health reform, including exploring a fee-for-service business model and building capacity to invoice third party payers. It is likely more providers will be needed to serve the population enrolled in the programs operated by the department. Improving collaboration among the health department, primary care providers, and the local community is seen as a priority.

In a position paper published in 2010, the National Association of Community Health Centers details different collaborative models that FQHCs/CHCs and health departments can consider and evaluate for local implementation. The paper cites the passage of the ACA and an emphasis on the coordination of care across the health care system as the impetus for the push for members to actively seek out partnerships with their local health departments. The paper proposes models such as co-location agreements, purchase of services agreements, or referral agreements as opportunities for both entities to engage in a partnership drawing from the traditional areas of strength of each and a way to minimize duplication of efforts and turfism. For example, FQHCs could look to their local health department to conduct the required community needs assessment because health departments are charged with monitoring population level health status to identify and address community health problems. (National Association of Community Health Centers, 2010).

Safety net providers will likely play a key role in ensuring that the newly insured are connected to care. These providers are preparing for health reform by building new partnerships to expand their ability to outreach to key populations that will require education and navigational assistance. A network of providers in North Carolina provides an example of how a safety net provider is seeking out new partnerships in preparation for the full implementation of health reform. The Western Carolina Medical Society is an association of over 900 physicians that runs a safety net program that provides physician office-based charity care and partners with local hospitals for free lab and imaging services and hospitalizations. The group recognizes that many of their patients receiving care after 2014 may become insured but will require assistance in making a smooth transition to Medicaid and other sources of coverage. The society is looking to partner with a network of primary care providers that provide case management and care coordination to chronically ill patients, recognizing that the newly insured patients will need more care and navigation support because they are new to the health care system (Currie, 2011).

Building Workforce Capacity

The elimination of co-pays, deductibles, and coinsurance for many preventive services will likely increase the demand for primary care and other health providers when health reform is fully implemented. Meeting the workforce shortfall may require incentives to retain providers in needed locations, educational initiatives to ensure the pipeline produces providers that match workforce needs, and better utilization of the current workforce, including reorganizing provider teams and considering new types of providers. This also means training a workforce that is culturally competent and aware of and able to effectively provide care to PLWHA with complex health care and social service needs.

> One concern of particular importance for service organizations and safety net providers is the need to actively engage with patients accessing the healthcare system for the first time. Community health workers, patient navigators, and others in a clinic extender role will be key to ensuring that traditionally underserved and vulnerable populations get an appropriate source of coverage and are connected to the care that they need. They may require transportation support, health literacy assistance, health coaching, and other navigational support to ensure that they utilize the health care system efficiently and are compliant with their treatment plan.

An Area Health Education Center (AHEC) in East Texas is working to build local capacity for patient navigation and care coordination ahead of the full implementation of the ACA by training and certifying Community Health Workers to work in multiple settings: community health clinics, hospitals, family support organizations, etc. Of equal importance is their work with local health care organizations (FQHCs, hospitals), provider organizations (Head Start, Health Department), and local businesses to develop organizational capacity to hire and effectively engage CHWs at their agencies. The focus of the AHEC's workforce initiative is educating administrators, managers, and human resource staff on the proper scope of work for certified CHWs and providing guidance on how to utilize CHWs at the top of their skill set. The AHEC is assisting these organizations in planning for the long-term sustainability of the position at the placement organization.

Safety net providers, because of their experience with serving the uninsured, may be uniquely positioned to be a part of the local solution to workforce shortages. For one free clinic on the coast of Georgia, workforce shortage problems are currently an issue in the three counties that it serves, and the shortage will likely get worse due to the anticipated increased demand under the ACA. The clinic board is positioning the free clinic as a key player in the community's work to build primary care capacity. They are working to turn the clinic into a training site for physicians and nurse practitioners and are building partnerships with area educational institutions.

Building Information Technology Capacity

The ACA will stimulate demand for electronic records and other health data and increasingly require complex data sharing systems. Institutional information technology needs and requirements vary and reflect the idiosyncratic and unique nature of organizations. The most likely information technology capacity needs related to the ACA will involve designing or purchasing patient management and clinical management systems, sharing data among systems, building systems that can accommodate the increase in anticipated volume of claims and provider information, and developing data system standards for health.

In preparation for the full implementation of Medicaid expansion under the ACA, some states are improving their data collection and monitoring capacity. The Robert Wood Johnson Foundation's (RWJF) Maximizing Enrollment program worked with eight states to increase their capacity to use data to monitor enrollment and retention in public insurance programs like SCHIP and Medicaid with the goal of improving outreach efforts and coverage for eligible individuals. These states are using those lessons learned to prepare for insurance expansion under the ACA. A brief published by RWJF and Mathematica Policy Research, Inc. outlines a key early learning from the capacity-building program – the need for states to develop core performance measures for effective monitoring of enrollment in public insurance programs. The measures are meant to be applicable across public benefits programs and aid state policy makers in tracking individuals as they move in and out of those programs (Trenholm, Harrington, et al., 2012).

Other communities are taking advantage of state and federal funding opportunities available to build their health information capacity in preparation for a more integrated and collaborative health care delivery system. The Beacon Community Collaborative program of HHS' Office of the National Coordinator for Health Information Technology provides funds to communities across the country to demonstrate how effective use of health information technology (HIT) results in improved quality of care, better health outcomes, and lower costs. Lessons learned from the 17 funded communities that participated in this pilot program can help guide other communities and health care systems in their planning around HIT development. Of particular interest to systems of care serving medically underserved populations with complex health and support needs are the experiences of Beacon communities related to testing models for community-wide health information exchange capability. The Crescent City Beacon Community Initiative in New Orleans is using patient registries to track patient outcomes and test the efficacy of interventions (The Office of the National Coordinator for Health Information Technology, 2011a). The San Diego Beacon Community (SDBC) is working to build the capacity of the county's providers to share health information through improved electronic communication. The goal is to improve care coordination and management of patients across health care settings by creating electronic interfaces and data sharing. The program is building connections among the public health system, medical centers, and labs in order to more quickly identify emerging epidemics. The SDBC is also working with inpatient facilities and outpatient medical centers to make sure that all the providers on a patient's care team have access to the patient's medication list and discharge follow-up instructions (The Office of National Coordinator for Health Information Technology, 2011b).

Building Capacity for Care Coordination

The ACA includes a number of features for improving coordination of care, including a requirement that health insurance exchanges contract with professional associations and local organizations to provide exchange navigator services; funding to support improved care transition services for high-risk Medicare beneficiaries; establishment of community-based, interdisciplinary care teams; and grants to support comprehensive, coordinated, and integrated health care services for low-income populations. The law specifically provides funding for outreach and enrollment assistance for underserved and vulnerable populations, including PLWHA. To build capacity for care coordination, organizations will need to understand the administrative requirements, be able to link different types of care, influence decisions about health reform, assist health networks in obtaining pertinent information (perhaps surveillance information), and obtain the technical ability to collect information.

One of the key components of improving coordination of care is strengthening the links between primary care and community-based services (VanLandeghem and Schor, 2012). The ACA provides opportunities for agencies to assume a lead role in assuring access to clinical preventive services. One such initiative, the SPARC program (Sickness Prevention Achieved through Regional Collaboration) has had success in broadening the use of recommended preventive services among older adults. An evaluation found increases in immunizations for influenza and pneumococcal disease and screening for breast, cervical, and colorectal cancers, as well as screening for elevated cholesterol and high blood pressure. SPARC's approach is to establish collaboration and coordination among a wide variety of community agencies and organizations (e.g., local health departments, area agencies on aging, health care providers, etc.) with a vested interest in improving the health of community residents. SPARC does not directly deliver services, rather, it creates, facilitates, and monitors community-wide strategies that make it easier for individuals to get their screenings and immunizations in places convenient for them. One particularly successful strategy has been SPARC's Vote & Vax, a program that makes vaccines and appointments for cancer screenings available at polling places on election days. (Centers for Disease Control and Prevention, 2012).

The ACA presents opportunities for current safety net providers to expand their role in their local community by leading the conversation and planning process for care coordination and patient navigation for the underserved. Free clinics are an important aspect of the safety net system in Georgia and across the country. During the GHPC's strategic consultation process, three free clinics from different areas of the state engaged GHPC to strategize about how to best adapt their current clinic model through health reform implementation. As current providers for some of the most underserved in their communities, these free clinics, like others in the safety net system, are uniquely positioned to help ensure that clients entering the health care system with a payment source for the first time experience an appropriate continuum of care. The boards of the three clinics focused on this strong connection with the most underserved in their communities to strategize about their clinics' roles in shaping how health reform will play out at the local level and to identify what opportunities may be available to free clinics through health reform. Because they are aware of the health and support needs of the uninsured in their communities, they feel like they are best positioned to develop and operate patient navigation and education services for patients during enrollment, interpreting the different insurance options, and determining the appropriate providers to address healthcare needs. The free clinics see the funding opportunities under ACA for patient navigation assistance and for the growth of the patient centered medical home model as important for their long-term viability in the community. In addition, they are well-positioned to describe the needs of the newly insured (and those who remain uninsured after 2014) to other stakeholders in the community and to help shape a plan to meet the needs of all patients.

The Atlanta EMA and Ryan White Providers: Positioning for Success Under Health Reform

The providers participating in the Ryan White Program in the Atlanta EMA will be presented with challenges and opportunities as they prepare for changes brought about through the ACA. Thinking adaptively about questions related to health reform will help providers position themselves for sustainability as the health care landscape shifts and will ensure continuity of care for Ryan White clients.

The previous section described eight strategic actions that providers and organizations can consider as they prepare for health reform. Ryan White providers are uniquely positioned within the local healthcare system to guide their patients and other providers in the system through these times of uncertainty and transition. As it plans for health reform, the Atlanta EMA might consider the following questions, among others:

Influencing Decisions

- What are the opportunities for the Atlanta EMA and Ryan White providers to inform the local and state planning process for health reform? What input and guidance could the EMA provide related to:
    - Essential health benefits?
    - Metrics for quality of care for ACOs, Medicaid, and the plans offered through the health insurance exchange?
    - Development of work force capacity to meet the service and support needs of PLWHA and other vulnerable populations?
    - The implications of Georgia's decision to opt in or out of the Medicaid expansion on the health care and support needs of PLWHA?
    - The design of enrollment strategies for expanded insurance options?

Educating Others

- What can the EMA do to translate frameworks for planning for health reform (e.g. the National Council for Community Behavioral Healthcare Readiness Assessment Tool and The Georgia Health Policy Center's Eight Strategic Actions) for providers and other key stakeholders that serve PLWHA?
- What key messages about the health and social support needs of PLWHA must be communicated to policy makers at the local, state, and national levels?

Planning Under Uncertainty

- What are the potential new needs for Ryan White funding following the implementation of the ACA? How might the EMA and providers approach the following emerging needs:
    - Assisting people with HIV to find new health care coverage;
    - Supporting individuals who experience churning (gaps in their coverage due to changes in income or other circumstances); and,
    - Providing adequate reimbursement for HIV providers whose services may not be fully covered under new reimbursement models?
- What are the most likely scenarios facing providers (funding, type, and level of service needed)? What additional information is needed to more fully flesh out those scenarios for planning purposes?
- How can the Atlanta EMA use current demographic and utilization data to engage in scenario-based planning for the movement of some portion of the current client base into health insurance coverage?
- Given the uncertainty surrounding the state of Georgia's decision whether to opt in or out of the Medicaid expansion, what are the different scenarios for program planning and resource allocation for the uninsured population?

Staying Abreast of New Information

- What information sources on the ACA (websites, blogs, webinar series, policy briefs, etc.) provide information most pertinent to current Ryan White providers and their patients?
- What other stakeholder groups might have similar concerns (e.g. safety net hospitals, free clinic associations, public health departments, FQHCS and CHCs, mental health agencies and provider associations, etc.)? How can the EMA learn from their experiences and planning processes?
- What role might the EMA play in collecting, analyzing, and disseminating information about the ACA to the provider and patient communities?

Creating New Partnerships

- How might Ryan White providers build new partnerships with other healthcare organizations that may become part of the system of care for PLWHA under expanded health insurance coverage?

- Where are the opportunities for Ryan White providers to partner with other health care organizations to ensure that the unique needs of PLWHA are being met?

    - What are the key strengths that Ryan White providers bring to bear in the provision of clinical and support services to PLWHA and other vulnerable populations?

    - How do Ryan White providers frame these partnerships as a win-win (i.e. providers offer culturally competent and medically appropriate care for PLWHA)?

    - What role might Ryan White providers play in the provision of wrap-around services offered through Medicaid, patient-centered medical homes, and ACOs?

Building Workforce Capacity

- How can Ryan White providers help shape the local and state strategies around workforce development?

    - What are the opportunities to serve as training sites?

- How can the EMA and Ryan White providers build the capacity of the system at the local and state levels to meet the needs of PLWHA and other vulnerable populations?

- What capacity development/training needs do current Ryan White providers have to help position them for viability post-health reform? What would a training and technical assistance program look like? Are there existing resources (professional associations, HRSA, advocacy groups) from which to draw?

Building Information Technology Capacity

- What health information technology capacity do providers need to develop in order to move into an integrated care model with new partners?

- What additional data collection and monitoring functions might the EMA perform in order to:

    - better inform the development of quality of care metrics;

    - inform program planning for the Ryan White program, especially as it relates to support service needs that will likely not be available under new sources of coverage for Ryan White patients; and,

    - forecast who might be eligible for various coverage options?

Building Capacity for Care Coordination

- How might Ryan White providers translate their experience coordinating care for people with highly complicated medical needs across multiple health care settings to other vulnerable populations who may be entering the health care system for the first time?

- Is there a role that the EMA or Ryan White providers might play in the coordination of services? How might providers add coordination to their existing services?

- What role might current care coordinators and case managers play in educating and enrolling people in new insurance programs, connecting them to appropriate care, and ensuring an appropriate continuum of care as people move between sources of coverage? What additional training might they need to serve in this role?

The ACA is complex and will present multiple technical and adaptive challenges moving forward. The Act also presents new opportunities for providers who have positioned themselves to take advantage of them through early planning and partnership development. The framework presented above will help providers begin planning for health reform, support the continued viability of Ryan White providers, and increase access to high quality care for clients.

Appendix A
EMA Interview Instrument

EMA Interview Instrument Tool

ACA Preparation and Implementation

1. What are you doing to plan for health reform?

2. What health information technology updates has your EMA identified and/or implemented in preparation for the ACA? What health data partnerships (HIE) has your EMA identified or entered into?

3. What partnerships and/or collaborations has your EMA identified or entered into to help prepare for and implement the ACA (e.g. PCMH, ACO, and Community Benefit Partners)?

4. What promising practices or lessons learned has your EMA identified in preparing for ACA implementation?

Strategic and Programmatic Planning

5. What are the top 3 fiscal and/or programmatic challenges that your EMA has identified that will affect your EMA over the next four years?

6. What programs do you have in place to help meet the health and support service needs of underserved and disproportionately affected sub-populations?

7. What plan(s) has/ (have) your EMA developed and/or implemented to treat more patients if funding does not increase?

8. Please describe the funding issues your EMA is experiencing? What other resources, if any, has your EMA identified to address this? What has worked well? What challenges have you experienced?

9. Is your EMA experiencing staffing issues? If yes, please describe the problem(s) and how your EMA is managing the problem(s). What has worked well? What challenges have you experienced?

10. Is your EMA experiencing clinical space problem(s)? If yes, please describe the problem(s) and how your EMA is managing the problem(s)? What has worked well? What challenges have you experienced?

EMA Characteristics for HIV+ Population

11. Payor/funding profile

    a. For FFY2012, please list the percent of population served by payor/funder and total amount paid/ received for each of the following:

        i. Medicaid

ii. SCHIP

iii. Fee-for-service (FFS)

iv. Ryan White

v. Other grant funds (please list)

vi. Uncompensated/charity care.

b. Does your EMA reimburse on a fee-for-service basis? If so, how were fees established? What types of agencies are included in your FFS structure (health care, mental health, legal, housing, etc.)? What has worked well? What challenges have you experienced?

12. Services and Cost
    a. For FFY2012, please list the core services your EMA provides and the average cost per core service.

    b. What processes does your EMA utilize to identify and provide HIV-related primary health care services to those individuals who know their HIV status but who are not receiving care?

    c. Does your EMA provide adult dentistry services? Is this service also covered under your state Medicaid program and if so, to what degree? Does your EMA have enough capacity to meet the dental needs of the population you serve? If no, what resources has your EMA identified to meet demand?

13. Please list the EMA planning council members.

14. For FFY2012, please list the following demographic information for your HIV+ service population:

    a. Gender

    b. Race/ethnicity

    c. Age cohorts

    d. Income

    e. Education

    f. Undocumented patients

    g. Number of patients enrolled in Health Insurance Continuation Program (HICP)

    h. Number of patients enrolled in AIDS Drug Assistance Program (ADAP).

Appendix B
Ryan White Continuum of Care Agencies
Survey for Atlanta EMA Regarding Third Party Payments
Telephone Interview Script

The Affordable Care Act is expected to reduce the number of people who are uninsured. While we don't know yet the exact number of people in Georgia who might become insured through its various provisions, it is possible that you might serve more clients who have coverage for some or all of your services.

1. Do you currently accept 3rd-party payments for any of your services?
    - Do you accept Medicaid, in particular? What about Medicare?
    - For how long have you been accepting 3rd party payments?
    - What portion of your clients pay this way?
2. If you don't accept 3rd party payments now, do you have plans to begin doing so in the future?
3. What forms of payment by the client do you currently accept?
    - Cash/money order
    - Personal check
    - Credit card
    - Client billing – e-mail; US mail
4. Do you collect any patient outcomes data?
    - If so, do you share these data with other providers?
5. Tell me about the current staff and systems you have in place to manage billing and accounting.
6. The recent Supreme Court ruling made the Affordable Care Act's Medicaid Expansion optional for states. Have you begun any planning for a potential increase in the number of Medicaid clients you see?
7. Do you have an idea of the cost per unit of service you provide? (i.e., cost to you; not fee charged) If so, how did you determine your costs?
8. Do you provide patient advocacy? (e.g., navigation; assistance determining eligibility and connecting to services)

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