Covering the Waterfront:
Innovative State HIV Policy Approaches, from Prevention to Aging in Place

August 15, 2018, 8:30-3:30pm ET

Hyatt Regency Jacksonville Riverfront
225 East Coastline Drive
Jacksonville, Florida

Preconference E-Book

This preconference is supported through a cooperative agreement with the Health Resources & Services Administration
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Table of Contents
For easy access, agenda items below are hyperlinked to the corresponding page(s) in this e-book. To view an agenda item, click directly on the name of the item.

Meeting Materials
Preconference Agenda
Speaker Biographies

Speaker Presentation Slides
Session #1: State Medicaid Financing Models to Support Access and Adherence to PrEP
Michigan: Dr. David Neff
California: Sandra Robinson and Dr. Mike Wofford

Session #2: HIV and SUD: State Strategies to Prevent and Treat SUD Among Medicaid Beneficiaries Living with or at Risk for HIV
North Carolina: Jacquelyn Clymore

Session #3: State Strategies to Effectively Share and Use Data Across Agencies to Improve Health Outcomes
HRSA: Heather Hauck
Washington: Karen Robinson
Louisiana: Kristina Larson

Session #4: Aging with HIV: Implementing Medicaid Long-Term Services and Supports Programs for Beneficiaries Living with HIV
South Carolina: Dr. Peter Liggett
New York: Joseph Kerwin
Covering the Waterfront: Innovative State HIV Policy Approaches, from Prevention to Aging in Place

Join leading state health policymakers participating in the National Academy for State Health Policy’s (NASHP) day-long preconference to learn and engage in discussions about innovative policy solutions to improve health outcomes for Medicaid beneficiaries at risk for and living with HIV across the lifespan.

Learning Objectives: Following this preconference, participants will have a better understanding of state strategies to:

- Develop financing and reimbursement models to support access and adherence to pre-exposure prophylaxis (PrEP);
- Address the complex needs of Medicaid beneficiaries living with HIV and co-occurring substance use disorders (SUD);
- Leverage multiple data sources to address gaps in the HIV care continuum; and
- Develop Medicaid long-term services and supports (LTSS) programs that meet the needs of aging beneficiaries living with HIV.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 am – 8:30 am</td>
<td>Registration</td>
</tr>
<tr>
<td>8:30 am – 8:45 am</td>
<td>Welcome and Opening Remarks</td>
</tr>
</tbody>
</table>
|                      | Moderator: René Mollow  
|                      | Deputy Director, Health Care Benefits and Eligibility, Health Care Programs, California Department of Health Care Services |
| 8:45 am – 10:15 am   | State Medicaid Financing Models to Support Access and Adherence to PrEP  |
|                      | This session will explore promising state strategies to finance PrEP for Medicaid beneficiaries at risk for HIV. Participants will hear from California and Michigan who will describe innovative strategies and lessons learned to address gaps in health insurance coverage for PrEP, Medicaid and the community’s role in PrEP financing and uptake, and sustainability of their statewide PrEP programs. |
|                      | Speakers:  
|                      | Dr. Michael Wofford  
|                      | Chief, Pharmacy Policy Branch, Pharmacy Benefits Division, Health Care Programs, California Department of Health Care Services  
|                      | Sandra Robinson  
|                      | Chief, AIDS Drug Assistance Program Branch, Office of AIDS, California Department of Public Health  
|                      | Dr. David Neff  
<p>|                      | Chief Medical Director, Office of Medical Affairs, Medical Services Administration, Michigan Department of Health and Human Services |
| 10:15 am – 10:30 am  | Break                                                                    |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Description</th>
<th>Speakers</th>
</tr>
</thead>
</table>
| 10:30 am – 11:45 am | **HIV and SUD: State Strategies to Prevent and Treat SUD Among Medicaid Beneficiaries Living with or at Risk for HIV** | People living with HIV in the United States have high rates of substance misuse, frequently in conjunction with complex and high-cost social and healthcare needs. In this session, attendees will hear about Massachusetts’ Office Based Addiction Treatment program and North Carolina’s Safer Syringe Initiative. | Kevin Cranston  
Assistant Commissioner and Director of our Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Health  
Daniel Cohen  
Senior Policy Manager, MassHealth, Massachusetts Executive Office of Health and Human Services  
Jacquelyn Clymore  
HIV/STD/Viral Hepatitis Director, Division of Public Health, Communicable Disease Branch, North Carolina Department of Health and Human Services |
| 11:45 am – 12:00 pm | Break                                                                                              |                                                                                                       |                                                                                             |
| 12:00 pm – 1:30 pm | **State Strategies to Effectively Share and Use Data Across Agencies to Improve Health Outcomes** | Integrating clinical and surveillance data, typically housed in the state health department, with Medicaid claims data is critical to ensuring Medicaid beneficiaries living with HIV are able to access and remain engaged in care. In 2016 and 2017, NASHP worked in partnership with CMS, HRSA, and CDC to convene the HIV Health Improvement Affinity Group, which supported 19 state teams to develop projects aimed at improving health outcomes of Medicaid beneficiaries living with HIV. Following an overview of lessons learned from the Affinity Group by Heather Hauck of HRSA’s HIV/AIDS Bureau, attendees will hear from Louisiana and Washington on how their respective Medicaid and health departments are collaborating to share and use data to better support care for this population. | Heather Hauck  
Deputy Associate Administrator, HIV/AIDS Bureau, Health Resources and Services Administration  
Karen Robinson  
HIV Community Programs Supervisor, Washington State Department of Health  
Kristina Larson  
Data Analyst, STD/HIV Program, Office of Public Health, Louisiana Department of Health |
<p>| 1:30 pm – 1:45 pm | Break                                                                                              |                                                                                                       |                                                                                             |</p>
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
</table>
| 1:45 pm – 3:00 pm | **Aging with HIV: Implementing Medicaid Long-Term Services and Supports Programs for Beneficiaries Living with HIV**  
As HIV care and treatment has evolved, Medicaid beneficiaries living with HIV are living longer. The [Centers for Disease Control and Prevention](https://www.cdc.gov) reports that as of 2014 45 percent of people with diagnosed HIV across the country are over age 50. This population, particularly older adults, often have complex co-morbid physical and mental health conditions. As a result, there is an increased need for Medicaid long-term services and supports (LTSS), which can provide institutional and/or community-based medical care and support services. This session will highlight how New York and South Carolina are structuring their Medicaid LTSS programs to meet the needs of an aging population living with HIV.  
**Speakers:**  
Dr. Peter Liggett  
Deputy Director of Long Term Care and Behavioral Health Services, South Carolina Department of Health and Human Services  
Joseph Kerwin  
Director, Health Homes/DSRIP Unit, Office of Medicaid Policy and Programs, AIDS Institute, New York State Department of Health |
| 3:00 pm – 3:30 pm | **Wrap Up and Closing Remarks**                                           |
|                 | **Moderator:** Ana Novais  
Executive Director, Rhode Island Department of Health |
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Speaker Biographies

Jacquelyn Clymore
HIV/STD/Hepatitis Director, Division of Public Health, Communicable Disease Branch, North Carolina Department of Health and Human Services

Jacquelyn Clymore is North Carolina’s HIV/STD/Viral Hepatitis Director in the Communicable Disease Branch. She oversees the HIV Care Program, the HIV/STD Prevention Program, the North Carolina HIV Medication Assistance Program (HMAP, formerly ADAP), the HIV Health Equity Program and the Viral Hepatitis Program. She currently serves as Chair of the Board of Directors for the National Alliance of State and Territorial AIDS Directors (NASTAD). Ms. Clymore received a degree in English from Vassar College and a Master’s degree in Rehabilitation Counseling Psychology from the University of North Carolina at Chapel Hill.

Daniel Cohen
Senior Policy Manager, MassHealth, Massachusetts Executive Office of Health and Human Services

Daniel Cohen is a Senior Policy Manager at MassHealth where his primary focus is developing and implementing policy initiatives related to the health care delivery system, including One Care, Massachusetts’ capitated Financial Alignment Model and Demonstration to Integrate Care for Dual Eligible Beneficiaries and MassHealth’s new 1115 Demonstration, with a particular focus on the intersection between Medicaid and public health. Prior to joining MassHealth in 2014, Daniel managed community and hospital-based programs funded by the Massachusetts Department of Public Health to provide HIV testing and care management through the Ryan White CARE Act. Daniel earned a MBA in Health Care Administration from the Isenberg School of Management at the University of Massachusetts, Amherst.

Kevin Cranston
Assistant Commissioner and Director, Bureau of Infectious Disease and Laboratory Sciences, Massachusetts Department of Health

Kevin Cranston is Assistant Commissioner of the Massachusetts Department of Public Health (MDPH) and Director of the MDPH Bureau of Infectious Disease and Laboratory Sciences. Kevin previously served as HIV/AIDS Program Director at the Massachusetts Department of Education. Prior to government work, Kevin was an adolescent HIV prevention specialist at The Children’s Hospital, Boston. He is past chair of NASTAD and served as a technical advisor to national, state, and provincial AIDS control programs in Nigeria, Brazil, and South Africa. Kevin earned his Master of Divinity degree at Harvard University. Kevin is a member of the Massachusetts Special Legislative Commission on LGBT Aging, the Executive Committee of the Harvard University Center for AIDS Research, and is a past member of the Presidential Advisory Council on HIV/AIDS.
Heather Hauck  
**Deputy Associate Administrator, HIV/AIDS Bureau, Health Resources and Services Administration**  
Heather Hauck is the Deputy Associate Administrator, HIV/AIDS Bureau (HAB), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS). The HIV/AIDS Bureau provides leadership and resources to assure access to and retention in high quality, integrated care and treatment services for vulnerable for people living with HIV and their families. Heather was formerly the Director of the Maryland Department of Health Infectious Disease and Environmental Health Administration (IDEHA). Prior to joining the Maryland Department of Health, She served as the Section Chief, New Hampshire Department of Health and Human Services’ Division of Public Health, STD/HIV Section in Concord, NH. Prior to her work in New Hampshire, Heather was a co-director and a social worker in the Washington Hospital Center Social Work Department in Washington, D.C.

Joseph Kerwin  
**Director, Health Homes/DSRIP Unit, Office of Medicaid Policy and Programs, AIDS Institute, New York State Department of Health**  
Joseph Kerwin is a native of New York State. His educational background is in philosophy, theology, and psychology, and he has worked in community-based agencies in upstate New York in the fields of housing and HIV/AIDS services for almost 20 years. Joseph has also had health care experience as the administrator of a large designated AIDS center hospital and outpatient care program in Albany, NY. His tenure with the AIDS Institute began in the 2012. Over the course of his career, he has worked in New York State, CDC, Ryan White, and Medicaid funded HIV programs.

Kristina Larson  
**Data Analyst, STD/HIV Program, Office of Public Health, Louisiana Department of Health**  
Kristina Larson, MPH, is a Data Analyst with the Louisiana Office of Public Health STD/HIV Program. She works closely with Louisiana’s Ryan White Part B to better understand the clients it serves, service utilization, and effect of these services. Additionally, she works on data sharing projects between the Office of Public Health STD/HIV program and Medicaid that aim to improve health outcomes of people living with HIV in Louisiana. Kristina serves as the Data Liaison for the Louisiana HIV Clinical Quality Group. She earned her MPH from Tulane University.

Dr. Peter Liggett  
**Deputy Director, Long Term Care and Behavioral Health Services, South Carolina Department of Health and Human Services**  
Dr. Peter Liggett serves as the Deputy Director of Long Term Care and Behavioral Health for the South Carolina Department of Health and Human Services (SCDHHs). His focus is guiding long term care and behavioral health policies as SCDHHS transforms these critical services and explores ways to better integrate long term care and behavioral health with primary care services. He joined SCDHHS in August 2012 as Director of Behavioral Health. Dr. Liggett is also a licensed psychologist.
René Mollow
Deputy Director, Health Care Benefits and Eligibility, Health Care Programs, California Department of Health Care Services

René Mollow has been with the California Department of Health Care Services (DHCS) since 1995. In the Medi-Cal program, she serves as the Deputy Director for Health Care Benefits and Eligibility (HCBE). She provides leadership for benefit and eligibility policy planning, development, implementation, and evaluation of health care services and delivery systems under Medi-Cal and for the Children’s Health Insurance Program (CHIP). HCBE is comprised of five divisions and one office: Benefits, Eligibility, Pharmacy Benefits, Primary and Rural Indian Health, Dental, and the Office of Family Planning. René works to ensure that policies, procedures, and related activities in HCBE conform to applicable state and federal policies, statutes, and regulations. She assists the Directorate, Administration and State Legislatures in determining program direction consistent with legislative intent and consults with the Director and State Medicaid Director on issues of significant policy impact.

Dr. David Neff
Chief Medical Director, Office of Medical Affairs, Medical Services Administration, Michigan Department of Health and Human Services

Dr. David Neff is currently the Chief Medical Director in the Office of Medical Affairs in the Medical Services Administration at the Michigan Department of Health and Human Services (MDHHS). In his current role, he has been working with the Medicaid Medical Directors Network, CDC, National Academy of Medicine, AHRQ and the ONC regarding opioids and other chronic conditions. Prior to joining MDHHS, he retired as a medical strategy leader at Merck and Company in Global Medical Affairs. He was involved in developing non-opioid pain medications in the early 2000’s and has been studying the opioid mortality crisis since 2010. He has been involved with large scale planning programs to address population health related issues in the areas of cardiovascular disease, diabetes management and opioid addiction since 2000. He has been a member of the Michigan Osteopathic Association’s Presidential Ad Hoc Committee to address the crisis since it was formed in February 2015.

Ana Novais
Executive Director, Rhode Island Department of Health

Ana Novais holds a master degree in Clinical Psychology, UCLN, Belgium. Ana has worked for the Rhode Island Department of Health since 1998 as an education and outreach coordinator and as the Chief for the Office of Minority Health. In March 2006, as the lead for the Division of Community, Family Health and Equity, Ana oversaw the areas related with health disparities, access to care, maternal and child health, chronic disease management, health promotion, environmental health; and developed and implemented the “Health Equity Zones” initiative. In August 1, 2015, Ana become the Executive Director for the Department.

Karen Robinson
HIV Community Programs Supervisor, Washington State Department of Health

Karen Robinson is the HIV Community Programs Supervisor at Washington State Department of Health. Karen oversees Washington’s Ryan White Part B program, Housing Opportunities for Persons with AIDS, and Medicaid Title XIX Targeted Medical Case Management. These programs provide HIV care management, housing, peer navigation, food services, transportation, and other services for persons living with HIV. Prior to moving to Washington, Karen worked for local health departments in Iowa as the HIV Program Coordinator and in upstate New York as an HIV prevention specialist. Karen has a certificate in public health and 28 years of experience in public health providing HIV care and prevention services.
Sandra Robinson  
**Chief, AIDS Drug Assistance Program Branch, Office of AIDS, California Department of Public Health**

Sandra has an extensive background in the health care delivery system and the public health arena. She currently serves as the AIDS Drug Assistance Program Branch Chief, with the Office of AIDS, California Department of Public Health. Previously, she served as the Chief of Healthy Aging Programs with the Chronic Disease Control Branch in the State California Department of Public Health. Prior to her service with the state, she served as Vice President of Programs with the California Medical Association Foundation. Sandra also worked with the American Cancer Society where she had statewide responsibility as Statewide Director of Health Systems. In both her current position and previous roles, she has worked closely with key stakeholders, informed key policy around major public health issues, and managed large public health programs. Sandra holds a Master of Business Administration and a Bachelor of Science in business administration, with a concentration in strategic management, from California State University, Sacramento.

Dr. Michael Wofford  
**Chief, Pharmacy Policy Branch, Pharmacy Benefits Division, Health Care Programs, California Department of Health Care Services**

Dr. Michael Wofford is the Chief of Pharmacy Policy for the California Department of Health Care Services, the state agency tasked with development and oversight of the pharmacy benefit for 13.5 million Californians covered by the state Medicaid program (Medi-Cal). Michael is a 1978 graduate of the University of the Pacific School of Pharmacy, where he obtained a Doctor of Pharmacy degree. During his studies, he spent a winter semester studying health care in the Palestinian refugee camps throughout several Middle Eastern countries. That experience changed the course of his future career and demonstrated to him the need for health care service dedicated to the marginalized members of society. He currently participates in the California Integrated HIV Surveillance, Prevention, and Care Planning Group and sits on the PrEP Stakeholder workgroup, which coordinates the California PrEP Assistance Program.
Speaker Presentation Slides
Expanding PrEP Uptake in Michigan Through Collaborations

David R. Neff, DO
Chief Medical Director
Office of Medical Affairs
Medical Services Administration
Overview

• Patient Education
• Provider Resources
  • Website
  • Training
  • Outreach
• Measuring Uptake
• Measuring Barriers
• Next Steps
• Future Collaborations
Patient Education

- Media
  - CAB input
- Provider Directory
- Provider Finder
- Linkages
  - PrEPcost.org
Provider Resources

- Website Resources
  - PrEP Provider Toolkit with billing codes
  - Risk and Readiness Assessments
  - Practice/Clinical Guidelines
- Training
  - Henry Ford Health System 24 hour NP consult line
  - MATEC Clinical Preceptorship and PrEP Provider Network
  - MPCA PrEP Modules
- Outreach
  - Academic Detailing
    - Using HIV and STD surveillance data to target providers
Measuring Uptake

• Referrals and Continuum of Care
  • Measured in public health databases—HIV testing and STD case management
• Client Surveys at LGBT events—roughly 200 a year in SE MI
• Insurance Claims
  • Collaboration with Medicaid and Blue Cross
Measuring Barriers

- Sampled SE MI providers who diagnosed at least 1 case of gonorrhea or syphilis in the past 2 years
- 227/551 surveys
- 19% discuss PrEP with all of their MSM patients
- 64% have heard of PrEP before
- 42% feel comfortable prescribing PrEP but only 28% would be willing to oversee care
- 67% say their practice cannot provide information on PrEP payment programs
- 59% of their clients are insurance by Medicaid
- 23% have concerns about staff time
- 48% have concerns about prior authorization
Next Steps

• Using claims data to identify and outreach to vulnerable population
  • Collaboration with a Medicaid Health Plan and a University to mine local data to look for HIV- men with rectal gonorrhea or syphilis who could receive an active PrEP referral and education
• Community Health Worker billing for peer support
• MTM model for pharmacy reimbursement
• RN billing for local health department STD nurses
Future Collaborations

• Public Health Presentation to Medicaid Policy Division
• Public Health Meeting with Medicaid EOB Division to discuss confidentiality provisions
• Public Health Presentation to Medicaid Health Plans Pharmacy and Medical Directors
• Public Health Presentation to Clinical Advisory Steering Committee
• Public Health Presentation to Pharmacy Liaisons
Thank you for your time....

- David Neff, DO - Chief Medical Director, Office of Medical Affairs, MI Medicaid
  - Neffd2@Michigan.gov

- Katie Macomber, Director, Division of HIV/STD Programs
  - macomberk@Michigan.gov
State Medicaid Financing Models to Support Access and Adherence to Pre-Exposure Prophylaxis (PrEP)

MICHAEL WOFFORD, PHARM.D.- CHIEF, MEDI-CAL PHARMACY POLICY
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
SANDRA ROBINSON, MBA- CHIEF, ADAP BRANCH- OFFICE OF AIDS
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
Goal for the Session

To describe California state strategies and programs designed to finance PrEP for people at risk for HIV

Discussion will include innovative programs that address gaps in health insurance coverage for PrEP
Objectives

• Discuss cost-effectiveness of providing a PrEP drug benefit
• Describe PrEP financing and reimbursement through Medicaid
• Discuss other PrEP assistance programs with California state administrative oversight
• Discuss manufacturer patient assistance programs
Cost Effectiveness of PrEP

• 2015 study showed undiscounted lifetime HIV treatment costs ranged from approximately $1,440,000 to $1,480,000

• The annual cost of PrEP was approximately $12,000 per participant, and $621,400 per infection prevented (In California, without insurance, PrEP costs approximately $1,250 a month or $15,000 a year)

• The PrEP strategy was cost-saving in all scenarios for undiscounted and 3% discounting rates

Cost Effectiveness of PrEP

• Failures of daily oral HIV pre-exposure prophylaxis (PrEP) with Truvada are rare

(Redefining Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis Failures: Clinical Infectious Diseases, Volume 65, Issue 10, 30 October 2017, Pages 1768–1769)

• Study of HIV infections among individuals receiving PrEP within the Kaiser Permanente Northern California (KPNC) healthcare system: Among those who started PrEP, the mean duration of use, estimated from the time a first Truvada prescription was filled until the last filled prescription ran out, was 12.4 months. No new HIV infections occurred during more than 5000 person-years of Truvada use

(Marcus JL et al. Redefining HIV preexposure prophylaxis failures. Clinical Infectious Diseases, 2017.)
Medi-Cal: PrEP Benefit Overview

• PrEP medication is noncapitated (carved-out) from Managed Care Plans (MCPs) and is paid via a Fee-for-Service (FFS) claim

• Provider outreach and education - State Drug Utilization Review (DUR) process

• MCP outreach and directives related to patient assessment of risk, testing for HIV, and PrEP prescribing considerations

• Academic detailing Programs-Pacific AIDS Education and Training Center (PAETC)
Medi-Cal Benefit- Reimbursement

- Medication cost is a 50:50 shared cost split with the federal government
- Provider reimbursement established in statute and State Plan: National Average Drug Acquisition Cost plus dispensing fee
- Net cost to state is the provider reimbursed amount minus all rebates (state and federal)
Medi-Cal Benefit - Rebates

• Federal rebates
  ▪ Mandatory
  ▪ Collected for both MCP and FFS beneficiary utilization
• Manufacturer state supplemental rebate contract
  ▪ FFS claims only
  ▪ Negotiated with manufacturer on a drug by drug basis using 5 criteria in state statute: Safety, Effectiveness, Essential Need, Misuse Potential, Net Cost to the State
Other State Funded PrEP Programs

- California HIV/AIDS Research Program
- PrEP Assistance Program
- Project PrIDE
- State Funded Strategic HIV Prevention Programs
The California HIV/AIDS Research Program (CHRP) fosters outstanding and innovative research that responds to the needs of all people of California, especially those who are often under served, by accelerating progress in prevention, education, care, treatment, and a cure for HIV/AIDS.

Since 1983, CHRP has invested over $250 million to sponsor more than 2,000 research projects on HIV/AIDS in California.

CHRP’s 2016 budget is $8.75 million.

Since its founding, the program has funded over 2,000 research projects and allocated more than $275 million in grants.

In 2012 partnership with Gilead Sciences, which agreed to provide the drug free of charge for the research, CHRP researchers at UCLA, UC San Diego and UCSF teamed with public health departments and HIV/AIDS community programs to provide Truvada to at risk individuals and monitor compliance and effectiveness.
CHRP Targeted Outreach Pilots

- Young Gay and Bisexual Men of Color
- Transgender
- Homeless Youth
- Women of Color
Manufacturer’s Assistance Program and Covered California Plans

The Gilead Medication Assistance Program provides Truvada to qualified individuals (income below 500% of the FPL and no other sources for health insurance or prescription coverage) free of charge.

Gilead, also offers an “Advancing Access” co-pay coupon card which covers up to $4,800 in co-pays per year with no monthly limit.

Most Covered California plan’s drug benefit, in conjunction with the Gilead co-pay card, potentially reduces a person’s out-of-pocket spending for Truvada® to zero.

Patients may have to pay copay amounts over $400/annually if enrolled in Bronze plans.
North Carolina Strategies to Reduce HIV Infections and Manage SUD

Covering the Waterfront: Innovative State HIV Policy Approaches, from Prevention to Aging in Place.

August 15, 2018

DPH Communicable Disease Branch
Background on North Carolina

The 9th largest state, by population
• High growth (ranked 13th) in the US

Mountains to the coast
• 5 of top 100 most populous cities
• Substantial rurality
• 2 Different Barbecue Styles

Have not expanded Medicaid:
* using managed care model
* Carolina Cares of NC

HIV in North Carolina
• High Incidence State (16.4 cases/100,000)
• Approx. 1400 new diagnoses in 2016
• Approx. 34k reported HIV clients currently living in North Carolina
North Carolina HIV Infection Rates by Year of Diagnosis, 2000-2016

*Based on most recent address in eHARS as of December 31 of the given year.

**New cases are only among adults and adolescents (13 years and older).


North Carolina DHHS HIV/STD/Hepatitis Surveillance Unit
Newly Diagnosed HIV Cases among Adults/Adolescents (13 years and older) by Race/Ethnicity

HIV Cases: 1,399
- White/Caucasian*: 62%
- Black/African American*: 24%
- Hispanic/Latino: 10%
- Multiple Race: 1%
- American Indian/Alaska Native*: 1%
- Asian and Pacific Islander*: 1%

North Carolina Population: 8,507,543*
- White/Caucasian*: 67%
- Black/African American*: 22%
- Hispanic/Latino: 8%
- Multiple Race: 3%
- Asian and Pacific Islander*: 1%
- American Indian/Alaska Native*: 1%

**US Census Bureau North Carolina 2016 Adult and Adolescent population estimate

*Non-Hispanic/Latino.
Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 27, 2017).

North Carolina DHHS HIV/STD/Hepatitis Surveillance Unit
Newly Diagnosed HIV among Adults and Adolescents (13 years and older) Exposed through Injection Drug Use (IDU)\(^*\) by Gender and Race/Ethnicity, North Carolina 2016

\(^*\)Unknown risk has been redistributed. This includes people classified as MSM/IDU.

\(^*\)Non-Hispanic/Latino.

\(^*\)Includes American Indian/Alaska Native, Asian/Pacific Islander, and Multiple Race.

Data Source: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 27, 2017).

North Carolina DHHS

HIV/STD/Hepatitis Surveillance Unit
North Carolina HIV Continuum of Care 2009 and 2016*

NHAS goal by 2020: 90%

- Diagnosed & Reported: 76% (2009-eHARS only), 90% (2016-eHARS, CW, ADAP, Medicaid*)
- At Least 1 Care Visit **: 42% (2009-eHARS only), 71% (2016-eHARS, CW, ADAP, Medicaid*)
- Retained in Care***: 29% (2009-eHARS only), 67% (2016-eHARS, CW, ADAP, Medicaid*)
- Virally Suppressed: 26% (2009-eHARS only), 62% (2016-eHARS, CW, ADAP, Medicaid*)

*2016 data are preliminary (do not include vital records or national death matches). 2016 data includes labs and services from CAREWare (all Ryan White services excluding Part A), AIDS Drug Assistance Program (ADAP), and Medicaid data sources.

**At least 1 care marker in a given year.

***Retained in care is defined as having 2 or more care visit (VL or CD4 test) at least 90 days apart in a given year. In 2016, this definition also includes if they were virally suppressed during the given year.

Legend: year shown refers to the year in which care measures were evaluated; cases were diagnosed and reported between the year prior. For example, the data labeled "2016" represent all cases diagnosed and reported through 12/31/2015, and had care markers or were virally suppressed during calendar year 2016.

Data Sources: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 2013 and June 27, 2017), CAREWare, ADAP, and Medicaid claims (data for calendar year 2016).

Diagnosed & Reported

Linked to Care within 1 Month

Linked to Care within 3 Months

Linked to Care within 6 Months

Virally Suppressed

NHAS goal by 2020: 85%

NHAS goal by 2020: 80%

NHAS goal by 2020: 72%

NHAS goal by 2020: 74%

*2016 data includes labs and services from CAREWare (all Ryan White services excluding Part A), AIDS Drug Assistance Program (ADAP), and Medicaid data sources.

Data Sources: enhanced HIV/AIDS Reporting System (eHARS) (data as of June 27, 2017), CAREWare, ADAP, and Medicaid (data for calendar year 2016).
NHAS Goal #1

Reduce the number of New HIV Infections

- Re-engage those lost to care
- Probabilistic matching with Medicaid data
- State Bridge Counselors
- Needle Exchange
- HIV Control Measures
- Efforts around the opioid crisis
NCECHO:
Data to find the Lost to Care

• NC ECHO enables NC to sync the care “state” of clients from 5 data systems

• Includes HIV Surveillance, RW Programs, and NC Medicaid

• Linking to External Data is straightforward (via probabilistic linkage)

• Construction of standardized HIV care outcomes measurements greatly facilitated for various subpopulations
Goals of our work:

Develop a claims / utilization-based definition of HIV care
  • Develop a 3-way relationship to execute a data use agreement
  • Match Combined HIV Surveillance/HIV Care data with Medicaid data to identify common cohort
  • Generate a “Medicaid HIV Continuum of Care” to better understand Care in this population (situational awareness!)

• Data Use Agreement Between CCNC/DMA/DPH
  • Person-Level Line list format:
    • Identifiers
    • HIV Care Utilization type
    • Utilization count
    • Managed Care Status
Improvement in Medicaid HIV Care Outcomes

This compares to:

- 85% Viral Suppression in Core-Funded Ryan White B Clients in 2017
- 82% Viral Suppression in All Ryan White B Clients in 2017
- 86% Viral Suppression in HMAP at the end of 2017
- 83% Virally Suppressed among PLWH in NC with HIV Care in 2017
- 59% Virally Suppressed among PLWH in NC (eHARS)
State Bridge Counselors:
DIS in a New Way

• Expanded traditional DIS work to address Data to Care and Linkage issues

• Two functions:
  • Follow up if a newly diagnosed person misses first medical visit
  • Act on the out of care list produced by NCECHO to re-engage clients

• All State Bridge Counselors are DIS-trained
  • Work with any existing DIS at regional or clinic level
  • Partner service testing in the field

Now replicating this model for Hepatitis C in light of the opioid crisis affecting NC and the number of people living with SUD
HIV Control Measure Changes
How did we do what we did?!

UPDATED BASED ON SCIENTIFIC FACT

As of January 1, 2018, PLWH who are:

• In care
• Adherent to provider’s treatment regime
• Reliably virally suppressed for at least 6 months

No longer required to tell sexual partners their HIV status

Condoms are still encouraged in order to prevent other STIs
Open and honest conversations within a relationship are always important
HIV Control Measures
Con’t.

EVIDENCE: Undetectable=Untransmittable

- HPTN 052 Study

- PARTNER Study
  https://jamanetwork.com/journals/jama/fullarticle/2533066

- Opposites Attract Study
  http://i-base.info/htb/32190

Control measures must be founded in science
Modernized HIV control measures assist LHDs

• Incentivize PLWH to get in and remain engaged in care

• Allows Public Health to focus time and resources on PLWH who need our assistance getting into care

• Provides LHDs with tools to maximize success of intervention efforts

• Provides clear guidance on how to handle common community issues (i.e. bites in schools)

• Reported HIV data allows us to see health status and focus interventions at the individual and community level.

• Efforts focused on getting people into care and treatment, and keeping them there, encourage trust, and are a better fit with our public health mission. Collaboration is earned. Partnership required.
Syringe Exchange: At Long Last!

• Pursued initially to protect law enforcement
• First legislative change: Good Samaritan law protecting people calling for 911 help
• Second legislative change: pilot project to allow for safe disposal of used syringes
• In light of opioid epidemic, new interest in exchanges

• Became law July 2016
• Must register site with state office
  • 35 programs have registered
3,983 people received services during the first year of legalization

- Participants made 14,997 total contacts with syringe exchange services (average 3.77 contacts per person).
- Programs distributed 1,154,420 sterile syringes.
- 489,301 used syringes were returned to syringe exchange programs for safe disposal (42.4% return).
- 5,682 naloxone kits were distributed to people directly impacted by drug use.
- Programs made an additional 1,311 referrals for naloxone at pharmacies and health departments.
- More than 2,187 overdose reversals reported.
- Over 3,766 treatment referrals to substance use disorder and mental health services (combined)
- 2,599 HIV tests reported five positive results (.19% positivity).
- 738 hepatitis C tests reported 138 positive results (18.7% positivity).
North Carolina’s Opioid Action Plan: under Secretary Cohen’s leadership

- Coordinate the state’s infrastructure to tackle the opioid crisis.
- Reduce the oversupply of prescription opioids.
- Reduce the diversion of prescription drugs and the flow of illicit drugs.
- Increase community awareness and prevention.
- Make naloxone widely available.
- Expand treatment and recovery systems of care.
- Measure the effectiveness of these strategies based on results.

Data Dashboard
- 1,056: unintentional opioid overdose deaths in 2017 (through Q3)
Conquering the Syndemic: The Impact of HCV, HIV, and Opioid Overdoses in North Carolina

HCV

- Reported acute HCV, 2016\(^1\) = 185 (3-fold increase from 2010)
- Estimated people living with chronic HCV in U.S., 2015\(^2\) = 3.5 million
- Average lifetime treatment cost of chronic HCV\(^3\) = $100,000/person

Syndemic

- Estimate 7-13% of HIV-infected people in NC are co-infected with HCV (CDC estimates 25%)\(^4,5\)
- At least 6% of people diagnosed with HIV in NC in 2016 were exposed through injection drug use\(^1\)
  - An estimated 50%–90% of HIV-infected injection drug users are co-infected with HCV\(^6\)
  - Around 43% of people with acute HCV in 2016 reported injection drug use\(^1\)

Opioid Overdoses

- Prescription opioid deaths in NC, 2015\(^7\) = 1,370
- Heroin deaths, 2015\(^7\) = 364
- CDC estimates the cost of drug overdose deaths in NC, 2015\(^8\) = $1.8 billion

HIV Infections

- Newly reported HIV, 2016\(^1\) = 1,399
- People living with HIV, 2016\(^1\) = 34,187
- Average lifetime treatment cost of HIV\(^9\) = >$370,000/person

Notes:

Drug-associated endocarditis incidence in NC, 2008-2017
Addressing the Opioid Crisis
Con’t.

**Multidisciplinary approach to treat patients with injection related infections**

- Psychiatric services
- Inpatient peer-support specialists
- Linkage to Outpatient addiction care
- Emergency Department involvement
- Harm reduction involvement
- Community role
Released Testing Recommendations

• Substance users should test for HIV, HCV and HBV every year (sometimes 6 months) as long as risk exists

• Funding all local health departments to test substance users and Baby Boomers, including Eastern Band of Cherokee Indian (EBCI)

• Prioritize Substance Users into treatment when identified but…
  • Insufficient number of treatment facilities
  • Usually uninsured
Where to find HIV/STD Information?

http://epi.publichealth.nc.gov/cd/stds/figures.html
QUESTIONS?

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Integration for No New Infections: HIV Health Improvement Affinity Group (HHIAG)

Heather Hauck, Deputy Associate Administrator, HRSA/HAB
Introduction to the Affinity Group Concept

- **Voluntary, state-to-state learning and enhanced technical assistance model, organized under the Medicaid Prevention Learning Network**
- **6 launched since 2015**
  - Hepatitis C, in partnership with CDC, HRSA, and HHS – Launched December 2017
  - School Based Health (SBH) – Launched Fall 2017
  - HIV Health Improvement, in partnership with CDC, HRSA and HHS – Launched Fall 2016
  - Antipsychotic Drug Use in Children (ADC) – Launched Spring 2016
  - Diabetes Prevention and Management – Spring 2016-Summer 2017
  - Tobacco Cessation – Summer 2015-Summer 2016
- **State teams include Medicaid staff and other partners as appropriate**
  - Examples: public health, behavioral health, education, and social services agencies
Goals of the HHIAG

• **Primary Goal:** Support state collaborations between public health and Medicaid programs to improve rates of sustained virologic suppression among Medicaid and CHIP enrollees who are living with HIV.

• **Secondary Goals:**
  – Durable, sustainable relationships
  – Better, more efficient use of available resources
  – Continuous quality improvement
Partners and Partnership Structure of the HHIAG

Lead Federal Agencies: CDC, CMS, HRSA, OHAIDP

National Academy for State Health Policy

Data Linkage and Outcomes Evaluation: CA, GA, IA, MD, NC, WI

Data for Delivery System Improvement: IL, LA, MA, NY, RI, WA

Provider Engagement and Quality Improvement: AK, CT, MI, MS, NH, NV, VA
HIV Health Improvement Affinity Group States
• Each state focused on a project to improve viral suppression among PLWH in Medicaid and RWHAP
• To be successful, the performance improvement projects all needed to establish relationships at the structural level
  – State public health agencies
  – Medicaid agencies
  – Other state agencies
• Relationships led to bi-directional exchange/use of data to measure
  – Health outcomes
  – Outreach
  – Engagement
  – Accountability
  – Clinical Quality Improvement
HIV Health Improvement Affinity Group Learning Communities – Data Focus

• **Data Linkage and Outcome Learning Community**
  – Institute/expand current data-sharing activities
  – Identify performance improvement targets with data analysis
  – Analyze laws, regulations, policies, and procedures for barriers

• **Data Analysis and Utilization for Delivery System Improvement Learning Community**
  – Use Medicaid authority to expand access to evidence-based HIV services
  – Integrate Medicaid and RWHAP services
  – Accelerate value-based purchasing
  – Encourage on interdisciplinary care teams

HIV Health Improvement Affinity Group Learning Community – Provider Focus

• Provider Engagement and Quality Improvement Learning Community
  – Engage providers to improve clinical outcomes and quality of care
  – Share data between state public health agencies and Medicaid agencies
  – Identify people who should be in care but are not – then get them into care and on treatment
Plan Snapshots—What States Accomplished

• Alaska
  – Established data sharing agreement between HIV Program & Medicaid
  – HIV Program gained access to Medicaid claims data

• California
  – Matched Medi-Cal data with public health HIV surveillance data to determine the number of Medi-Cal beneficiaries living with HIV, and examined HIV viral load suppression in this population.
Plan Snapshots—What States Accomplished

• Massachusetts
  – Formalized communication process between DPH and MassHealth resulting in more frequent communication and ability to triage and address potential issues early
  – Included MassHealth staff in DPH repprocurement process to encourage information sharing and alignment between MassHealth restructuring and DPH contracting

• North Carolina
  – Completed a Data Use Agreement between: NC Division of Public Health, NC Division of Medicaid, and NC Medicaid Managed Care Agency
  – Developed HIV Continuum of Care for matched NC Medicaid Clients, Calendar Year 2016
    • Results are comparable to recipients receiving Ryan White Part-B services
How Sustainable are Accomplishments?

“This type of work is going to continue, it’s iterative and we are going to keep at it. Our partnership is strong with Medicaid right now” (Public Health)
What Aspects were Useful?

• Peer-to-peer discussions and in-person meetings

• Structure to meet regularly and have deadlines

• Encouragement by seeing examples as to how other states are succeeding (It can be done!)

“Look what Louisiana is doing. Look what Rhode Island is doing . . . it normalizes some of the changes that we’re proposing . . . certainly we’re moving the system beyond . . . the historic limits that we have been operating under. (Public Health)
What Aspects were Useful?

• States led the way. There were no imposed outcomes from federal partners

• Federally backed work helped states justify the time and resources needed

“There's no mandate for this. We’re not going to fail. We may succeed but we're going to attempt to do something that increases care for patients and it's our own goal with Medicaid.” (Health Department)
State AND Federal Partnerships Can Work

• A shared focus and meaningful objective – improving viral suppression among PLWH – contributes to the success
  – Understanding of what each program ‘brings to the table’
  – Learning from other state models
  – Learning about the data

• Structural change (regulation or policy change) facilitates collaboration
  – Data sharing agreements and exchanges
  – Data quality assessments and analyses

• Successful partnerships are sustainable, even beyond a project period
  – Context matters (e.g., managed care reform)
  – Change is inevitable - leverage those changes when possible
  – Persistence pays off
  – Find common ground (existing relationships, champions)
Beyond the HHIAG—Extending the Model and Lessons Learned

• **NASHP Toolkit**

• **Hepatitis C Medicaid Affinity Group**
  – Goal: Increase the number and percentage of Medicaid patients diagnosed, treated, and cured of HCV infection

• **Revised Reporting Guidance for VLS Medicaid Core Measure**
  – Specific allowance for matching Medicaid and HIV surveillance data to support reporting in FFY18
Questions?
END AIDS Washington

- 50% decrease in new HIV diagnoses
- 80% suppression of viral load
- 25% decrease in HIV mortality
- Decrease in HIV health disparities
- Increase in quality of life with HIV
Affinity
Objectives
- Identify and analyze data for persons living with HIV (PLWH) who are Medicaid clients and NOT virally suppressed
- Increase number of Medicaid PLWH clients receiving optimal medical care or case management services

Outcomes
- Collaborative data analysis
- Increase number of Medicaid HIV Positive clients with viral suppression
Affinity Project: Work Flow
HIV Care among People Living with Diagnosed HIV, Medicaid, 2016

Based on HIV surveillance data reported through October 2017

- Late Diagnoses (New Cases in 2016): 27% (52/196)
- Linked to Care in 30 days (New Cases in 2016): 83% (163/196)
- Ever Diagnosed (Living Cases): 100% (4,775/4,775)
- Engaged in Any Care (Living Cases): 92% (4,413/4,775)
- Suppressed Viral Load (Living Cases): 79% (3,781/4,775)
- Among Engaged in Care: 86%

Robinson
HIV Care among People Living with Diagnosed HIV, Medicaid and WA State, 2016

- Late Diagnoses (New Cases in 2016): 27% (Medicaid), 25% (WA State)
- Linked to Care in 30 days (New Cases in 2016): 83% (Medicaid), 83% (WA State)
- Ever Diagnosed (Living Cases): 100% (Medicaid), 100% (WA State)
- Engaged in Any Care (Living Cases): 92% (Medicaid), 90% (WA State)
- Suppressed Viral Load (Living Cases): 79% (Medicaid), 79% (WA State)

Legend:
- Red: Medicaid
- Blue: WA State
Beyond
Case Management Dashboards

Percentage of clients engaged in medical care

Percentage of clients with a viral load test

Percentage of clients virally suppressed

Percentage of Black clients virally suppressed who had any service

Percentage of Latinx clients virally suppressed who had any service

Percentage of white clients virally suppressed who had any service

Percentage of unstably housed clients virally suppressed who had any service

Percentage of clients who did not have a case management visit in the last 6 months

Demographics
Black
Latinx
White non-Hispanic

Robinson
Engagement in Care (EIC)
EIC – Integration Across Projects
Bree Collaborative

• Public and private health care stakeholders work together to improve quality, health outcomes, and cost effectiveness of care in Washington State

• Washington State Public Payers must implement the recommendations
Bree Collaborative Project

LGBTQ Health Care Standards Work Group

• Screening and taking a social history
• Appropriate next steps
• Communication and language
• Inclusive environment
Lessons Learned - Future Projects

• Lessons Learned
  • Data Share Agreements
  • Legislative Support
    • Bree Collaborative
  • Stakeholders
  • Relationship Building
    • Key Contacts
      • Department of Health
      • Health Care Authority
  • Planning Groups
  • Medicaid MCO’s
  • RW Partners

• Future Projects
  • Hepatitis C
  • PrEP
synergy
ˈsɪnərjē/ Noun

The interaction of two or more agents to produce a combined effect greater than the sum of their separate parts.
Contact

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Utilizing Medicaid Claims Data to Improve HIV Outcomes

Kristina Larson
Louisiana Office of Public Health
Bureau of Infectious Diseases, STD/HIV Program
HIV Continuum of Care
Louisiana, 2017

- Persons living with HIV: 20,418 (100%)
- In HIV care: 15,235 (75%)
- Retained in HIV care: 11,917 (58%)
- Virally suppressed (<200): 12,698 (62%)
HIV Continuum of Care
Louisiana, 2017

- 100% of persons living with HIV
- 75% in HIV care
- 58% retained in HIV care
- 62% virally suppressed (<200)

83% of PLWH in care were virally suppressed.
Louisiana Medicaid

- Both Office of Public Health (OPH) and Bureau of Health Services Financing (Medicaid) under Louisiana Department of Health
- 5 Managed Care Organizations (MCOs)
- Medicaid program – new Governor and new name in 2016

Healthy Louisiana

- Expanded Medicaid on July 1, 2016
Historically, a few OPH Programs had individually negotiated data sharing agreements with Medicaid, but many programs had no access to Medicaid data.

Change in leadership at Medicaid and OPH in 2012-2013 facilitated process to establish an agency-wide data sharing agreement.

Staff had moved from Medicaid to OPH and had established relationships.

Process took only 6 months.
OPH/Medicaid Data Sharing Agreement

- Signed data sharing agreement in Feb 2014
- All users complete an annual “Data Sharing User Agreement”

DATA SHARING AGREEMENT
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS (DHH),
BUREAU OF HEALTH SERVICES FINANCING (BHSF),
AND
OFFICE OF PUBLIC HEALTH (OPH)

I) PURPOSE

The Department of Health and Hospitals (DHH), through both the Bureau of Health Services Financing (BHSF) and the Office of Public Health (OPH), will exchange Medicaid claims and eligibility data and public health data and statistics. This exchange of information will assist in the administration and evaluation of Louisiana Medicaid and public health services. The data will only be used for program planning, implementation, administration, research, and analytical purposes and will not be used to determine eligibility. This agreement will define and permit the reporting exchange between BHSF and OPH to address the provision of personal health services, as well as other core public health functions.
HIV Viral Suppression Measure

- From 2015 – 2017, Louisiana Medicaid had an incentivized viral suppression measure for MCOs.
- Based on HRSA performance measure:
  - Percentage of patients with an HIV viral load of <200 copies/mL at last HIV viral load test during the measurement year.
  - Target was low: 54.5%.
  - Incentive: $250,000.
Data Sharing/Linking

• OPH STD/HIV Program (SHP) receives quarterly files of all Medicaid enrollees during the previous 12 month period
  • Data are transferred through a secure VPN connection with very limited access

• Medicaid file includes:
  • name, DOB, SSN, parish, number of months enrolled in Medicaid during the 12 month period, plan name, and an indicator for whether the enrollee had an HIV diagnosis in the measurement year (based on ICD-10 codes)

• SHP exports a file from the HIV surveillance database (eHARS) that includes:
  • all persons living with HIV during the same 12 month period as the Medicaid file. All possible name, date of birth and SSN combinations, including aliases, are exported
Results of Medicaid and HIV Match – April 2017-March 2018

All People Enrolled in Medicaid N=1,832,910

Persons with HIV Claim n=10,312

- Matched in OPH Database n=9,711 (94%)
- No Match in OPH Database n=601 (6%)

Persons with no HIV Claim n=1,822,598

- Persons with Viral Suppression n=6,929 (71%)
- Persons without Viral Suppression n=2,227 (23%)
- No Viral Load n=555 (6%)
Results of Medicaid and HIV Match – April 2017-March 2018

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  - No Viral Load n=555 (6%)
- No Match in OPH Database n=601 (6%)

Persons with no HIV Claim n=1,822,598
- Matched in OPH Database n=2,973
  - Persons with Viral Suppression n=1,137 (38%)
  - Persons without Viral Suppression N=293 (10%)
  - No Viral Load n=1,543 (52%)
Results of Medicaid and HIV Match – April 2017-March 2018

How can we improve linkage to HIV medical care, retention in care and viral suppression for these Medicaid enrollees?

All People Enrolled in Medicaid N=1,832,910

Persons with HIV Claim n=10,312
- Matched in OPH Database n=9,711 (94%)
  - Persons with Viral Suppression n=6,929 (71%)
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No Viral Load n=555 (6%)

Persons without Viral Suppression N=293 (10%)

No Viral Load n=1,543 (52%)
Data Provided to MCOs

- Individual-level data are provided back to each MCO for their clients only

- Data provided by SHP:
  1. Was the client virally suppressed (i.e., VL <200 copies/mL) at the most recent test in the last 12 month period?
  2. Was the client confirmed to be HIV positive in the SHP HIV Surveillance database?

- MCOs calculate their own VS rates based on the HRSA measure
  - Medicaid Quality Improvement Team provides technical support
Challenges

• In the 2018 contract extensions with the MCOs, the viral suppression measure was changed to a monitored measure
  • MCOs must measure and report viral suppression, but there is not a penalty if viral suppression target is not achieved
• Finding staff with expertise to analyze Medicaid claims data
  • Helpful to partner with a university
• MCOs have limited data analysis capacity
• Medicaid has many competing public health priorities in addition to HIV
Monitoring Ryan White ADAP Clients

• Monthly matches between ADAP client population and Medicaid enrollment data
  • Tracked movement of clients from ADAP to Medicaid after July 1, 2016 expansion
  • Targeted outreach to clients
  • Batch disenrollment
  • Ensure payer-of-last-resort requirement met

• Match of providers between major Louisiana insurer (BCBS) and Medicaid providers
  • Identified regions with scarce advanced nursing specialties and Infectious Disease physicians
Monitoring Ryan White ADAP Clients

- 3,692 PLWH transitioned from Ryan White ADAP onto Medicaid between July 2016 and January 2017
- SHP followed these clients to monitor viral suppression and engagement in care
  - Matched to SHP surveillance database to monitor viral suppression
  - Viral suppression was 81% pre-transition and 83% post-transition
Activities in Process

• Analyze Medicaid pharmacy claims data
  • Analyze ART prescription claims to create a treatment adherence measure; ensure clients continue to pick up HIV medications; review ART regimens
  • Create the Medication Possession Ratio (MPR) for each person and compare pre-/post-expansion
    
    \[
    \text{MPR} = \left( \frac{\text{Sum of days' supply for all fills in period}}{\text{Number of days in period}} \right) \times 100\%
    \]

• Analyze PrEP prescription claims to monitor PrEP uptake statewide

• Monitor HIV and STI screening during first and third trimesters among pregnant women enrolled in Medicaid
HIV Continuum of Care
Louisiana, 2017

- 100% of 20,418 persons living with HIV
- 75% of 15,235 in HIV care
- 58% of 11,917 retained in HIV care
- 62% of 12,698 virally suppressed (<200)

83% of PLWH in care were virally suppressed.
Percent Virally Suppressed among All PLWH and PLWH in Care by Year, Louisiana

Viral suppression = viral load < 200 copies/ml
For more information:

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Louisiana Office of Public Health
Bureau of Infectious Diseases, STD/HIV Program
South Carolina Department of Health & Human Services
HIV/AIDS 1915(c) HCBS Waiver

Peter D. Liggett, Ph.D.
Deputy Director, Behavioral Health & Long Term Living
August 15, 2018
To provide cost-effective alternatives to institutional placement for individuals with long-term care needs, allowing them to remain in community environments.
Community Long Term Care (CLTC) Timeline

- **1984**: Elderly and Disabled waiver (2006, *Community Choices*)
- **1988**: HIV/AIDS waiver
- **1989**: Palmetto SeniorCare (2003, *became a SC Medicaid State Plan service*)
- **1990**: Children’s Personal Care Aide (CPCA)
- **1991**: Intellectually Disabled/Related Disabilities (ID/RD)
- **1994**: Mechanical Ventilator Dependent waiver
- **1995**: Head and Spinal Cord Injuries (H ASCI)
South Carolina’s Current Landscape

- SC’s population = 5 million
- Medicaid enrollment = 1.1 million
- Approximately 20,000 residents living with HIV
  - 71% are male
  - 29% are female
  - 47% are 50 and older
  - 24% are 40-49 years of age
  - 17% are 30-39 years of age
  - 12% are 20-29 years of age
  - 171 individuals are 0-19 years of age
- African-Americans make up 70% of HIV population; 20% are white men
Admission into the HIV/AIDS Waiver requires individuals to:

- Be at-risk for hospitalization certified by the patient’s physician.
- Have a diagnosis of HIV or AIDS.
- Have a CD4 count below 500 or a history of a CD4 count below 500.
- Be currently located in SC or intend to locate in SC.

Exceptions to criteria may be granted by the state with certification of risk for hospitalization by physician.

There is no age requirement or functional needs (i.e., activities of daily living) dependencies.
Cluster of Differentiation 4 (CD4) Considerations

• Early in the waiver’s history, CD4 counts among participants were very low (below 500) for most. It was rare to have a patient that did not meet the CD4 count requirement for the program.

• As medications were developed and widely used, applicants’ CD4 values were consistently above the minimum (500) required for entry.

• Consideration was given to using viral load lab values rather than CD4 counts but no changes were made.

• Developed a process for level of care exceptions when the participant did not meet all the required criteria.

• The exception is mainly based on need and if the participant specifically needs a CLTC waiver service. This includes waiver enrollment to receive Medicaid benefits.
30 Years of the SCDHHS HIV/AIDS 1915(c) Waiver
First Decade: 1988-1997

- Waiver focused on psycho-social support.
- Enrollment increased ~19% per year.
- Six-month average length of stay.
- Agency involved in HIV/AIDS advocacy & support groups for recruitment.
- Average age at enrollment was 36, with 67 children under age 18.
- Not intended to be a disease management approach.
Waiver Services

• **High Utilization Services**
  - Counseling
  - Case Management

• **Low Utilization Services**
  - Adult Foster Care
  - Chore/Home Maintenance
  - Environmental Adaptations/Home Modifications
  - Home Delivered Meals
  - Mental Health Services
  - Personal Care
  - Skilled Nursing

First Decade: 1988-1997
First Decade: 1988-1997

- Average per-person per-year (PPPY) spending was $1,400 over the decade, peaking in 1995 at $1,600.
- Counseling had the lowest PPPY spending at $430 with 100% utilization.
- Personal Care PPPY spending averaged $2,315 with 8% utilization.

- Waiver shifted to medical and in-home support.
- After initial increases, enrollment flattened and then declined.
- Length of stay increased to 10 months.
- Involvement in HIV/AIDS groups declined.
- Average age is 41 at enrollment, with 38 children under age 18.

Waiver Services

- **High Utilization Services**
  - Case Management
  - Prescribed Drugs
  - Home Adaptation (Pest Control)

- **Low Utilization Services**
  - Adult Foster Care
  - Attendant Care
  - Chore/Home Maintenance
  - Counseling
  - Home Delivered Meals
  - Medical Equipment/Supplies (IS & Nutritional Supplements)
  - Nutritional Counseling/Assistance
  - Personal Care
  - Psychologist Services
  - Skilled Nursing
Waiver Changes

• 1998
  • Added extra prescription drug coverage
  • Removed counseling in favor of in-home services

• 2000
  • Added Attendant Care, a self-directed in-home service

• 2001-2006
  • Fine-tuned the in-home service offerings, breaking out Personal Care I & II
• Average per-person per-year (PPPY) spending was $3,300 over the decade, peaking in 2005 at $4,200.

• *Case Management* had 100% utilization with a PPPY average of $670.

• *Prescribed drugs* had 85% utilization with a PPPY average of $1,900.

• *Personal Care* PPPY spending averaged $2,600 with 12% utilization.
Third Decade: 2008-2017

- Enrollment declined an average of 4% per year.
- Length of stay increased to 11 months.
- Average age at enrollment was 48, with only six children under the age of 18.
Waiver Services

• **High Utilization Services**
  - Case Management
  - Prescribed Drugs
  - Personal Care

• **Low Utilization Services**
  - Attendant Care
  - Companion Services
  - Environmental Adaptations/Home Modifications
  - Home Delivered Meals
  - Private Duty Nursing
  - Specialized Medical Equipment and Supplies
• After being fine-tuned in the previous years, the service package is virtually unchanged.
• Level of Care exceptions granted related to CD4 counts increased because of the efficacy of drugs.
• Extra prescription coverage has been moved to the SC Medicaid State Plan in 2017.
• Utilization of Personal Care services grows every year.
Third Decade: 2008-2017

- Average per-person per-year (PPPY) spending is $4,500 over the decade, peaking in 2016 at $5,500.
- *Case Management* has 100% utilization with a PPPY average of $744.
- *Prescribed drugs* has 25% utilization with a PPPY average of $4,000. There were sharp increases in PPPY in 2010, 2012 and 2016.
- *Personal Care* PPPY spending averages $4,800 with 22% utilization.
The Future?

• Enrollment expected to continue to decline for this waiver.

• Moving prescription drug coverage to the SC Medicaid State Plan may decrease participation or need for the waiver altogether.

• People with HIV are living longer and healthier lives than in previous decades; as they become older and frailer, they may become eligible for the Community Choices waiver.

• The name...if you’re in this waiver, your diagnosis can be known.
Medicaid Long-Term Care Services and Support Programs for People Living with HIV/AIDS in New York State
Presentation Outline

• “Ending the Epidemic”
• Living Longer with HIV: New York State Epi Data
• NYSDOH AIDS Institute Medicaid Initiatives
  – Designated AIDS Centers
  – HIV Special Needs Plans
  – Adult Day Health Care Program
  – Medicaid Health Homes
• Conclusion
GET TESTED.
TREAT EARLY.
STAY SAFE.
End AIDS.

health.ny.gov/ete
Ending the AIDS Epidemic

Goal: Reduce new HIV infections to 750 annually by the end of 2020.

Three Point Plan

1. Identify all persons with HIV who remain undiagnosed and link them to health care.

2. Link and retain those with HIV in health care, to treat them with anti-HIV therapy to maximize virus suppression so they remain healthy and prevent further transmission.

3. Provide Pre-Exposure Prophylaxis for persons who engage in high risk behaviors to keep them HIV negative.

Governor Andrew Cuomo announcing his new initiative to combat the AIDS epidemic before the 2014 NYC Gay Pride Parade.

Credit: Michael Appleton for The New York Times
Epi Data: An Aging Epidemic
“The examination of PLWDHI by current age shows that HIV infection should no longer be thought of as a young persons' disease. While most new HIV diagnoses (64%) occur before age 40, 75% of persons living with diagnosed HIV infection are at least 40 years of age and 52% are age 50 years or older.”

Persons Living with Diagnosed HIV (non-AIDS and AIDS) as of Dec. 2016 by Age

NYS Case Numbers

- 19 & under: 7
- 20-29: 10,052
- 30-39: 22,244
- 40-49: 36,567
- 50-59: 25,286
- 60+: 18,092
- Unk: 671
Persons Living with HIV and AIDS (PLWHA’s) in the Medicaid Program

- NYS PLWHA’s Medicaid Population: 65,120
- Dual Medicaid/Medicare Recipients: 16,582 (25%)
- Medicaid Spending on PLWHA’s: $2.26 Billion

Source: NYS AI MDW FFY2017
Medicaid Initiatives for PLWHA in New York State
Continuum of HIV Care

AIDS Institute Program Initiatives:

Clinical risk adjusted reimbursement models have replaced HIV specific rates.

1986 Designated AIDS Centers
1988 AIDS Nursing Facilities
1989 Pediatric Maternal AIDS Centers
1989 AIDS Home Care Programs
1990 Community Follow-up Program
   (HIV COBRA Targeted Case Management)
1990 HIV Primary Care Medicaid Program
1991 Enhanced Fees for Physicians Program
1993 AIDS Adult Day Health Care Program
Designated AIDS Centers (DACs)
Why Designated AIDS Centers?

- Rapid increase of AIDS in NYC in early 80’s
- Lack of specialized services
- High costs of care
- Reluctance of some staff and facilities to serve persons with HIV

1986—Spellman Center (St. Clare’s Hospital) in NYC first DAC
DAC Program

- State-certified, hospital-based programs
- Provide state-of-the-art, multi-disciplinary inpatient and outpatient care
- DAC programs with pediatric and obstetrical departments also provide specialized HIV care to infants, children, and pregnant women
- Developed and remains a patient-centered program model
- Provide a primary care home for the person with HIV
- Patient outcomes improve when care is seamless, coordinated by a care manager utilizing multi-agency, multi-disciplinary health care teams
DAC Program (2)

- HIV-specific care standards developed for DACs are intended to ensure uniformly high quality care for persons with HIV

- Enhance coordination with their community-based partners to identify patients at risk, help patients access and remain in care, and understand and adhere to their complicated regimens
HIV Special Needs Plans (SNPs)
Background

- HIV Special Needs Plans (SNP’s) are a comprehensive managed care option in New York City designed to meet the health care needs of persons living with HIV/AIDS and other identified populations at high risk for HIV transmission.
- As widespread transition to managed care expanded, DOH continued to work with SNP to support enrollee outreach and the provision of evidence based quality primary care and social services.
- Currently there are three operational SNPs serving the five boroughs of New York City.
Eligibility

• SNP eligibility expansion
  • Homeless and transgender individuals regardless of HIV status

• HIV SNP enrollment is voluntary.

• 12 month “lock-in” exemption
SNP Features

- HIV SNP Case Management
- Coordinated Care
- Networks that include HIV program models of care
- Primary Care Provider Ratios
- Treatment Adherence Services
Features (2)

- Access standards appropriate to persons with HIV
- HIV prevention and risk-reduction education
- Established standards of care
- Monitor clinical quality based on a QI model
- SNP-specific QARRs
Adult Day Health Care Programs
Adult Day Health Care Program Summary

- Adult Day Health Care Programs (ADHCP) provide a comprehensive range of services in a community-based, non-institutional setting.

- General medical care.

- The intent of the ADHCPs is to complement or enhance the existing continuum of medical services.
ADHC Program Summary (2)

- Recently amended regulations (effective September 2017) enable programs to expand the population served to include high need, high risk HIV-negative individuals.
  - High need, high risk associated with
    - Unstable mental health condition
    - Active substance use disorder
    - Condomless sex
  - Significant portion of high risk population also have health care service needs which require assistance with monitoring/developing self-management skills for other chronic conditions (e.g. diabetes, hypertension, asthma, hepatitis C, etc.).

- 10 programs in operation
  - 9 programs in NYC
  - 1 program in Rochester
Health Homes
Health Homes

• The goal of Health Homes is to manage the utilization of health care services by Medicaid beneficiaries who have complex, chronic, high-cost conditions.

• Health Home member eligibility:
  • Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes, etc.) OR
  • One single qualifying chronic condition:
    • HIV/AIDS or
    • Serious Mental Illness (SMI) (Adults) or
    • Serious Emotional Disturbance (SED) or
    • Complex Trauma (Children)
Health Homes (2)

- Health Home “lead agencies” establish contractual relationships with other organizations (Care Management Agencies) to provide care management services to members.

- Health Home CMA services include comprehensive care coordination, care management, health promotion, transitional care, including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and the use of health information technology (HIT) to link services.

- Require strong ties to social service providers in the community to address the social barriers to health care that Medicaid enrollees may encounter.

- Transition to Managed Care, July 1, 2018
Health Homes (3)

- May 1, 2018: Health Home rate restructuring for care management services providing the highest payment rate to CMA’s for services provided to members with the most intensive needs.
Importance of Health Homes

- Critical to the State’s effort to reduce emergency room and inpatient visits.

- 59% of hospital readmissions in NYS are related to chronic medical conditions in persons with a Substance Use Disorder (SUD) or Severe Mental Illness (SMI).
  - High rate of members with co-morbid HIV, SMI, and/or SUD

- Health Homes provide care management services to the high-utilizing, chronically ill population of Medicaid members who are driving more than 50% of avoidable costs.
Conclusions
Ending the Epidemic

GET TESTED. TREAT EARLY. STAY SAFE. End AIDS in NYS.

UNDETECTABLE = UNTRANSMISSIBLE

Naloxone Co-payment Assistance Program

Take Control

End the AIDS Epidemic

NEW YORK STATE DEPARTMENT OF HEALTH

PREP

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