

Navigator & In-Person Assistance Programs

On October 1, 2013, health insurance exchanges open for business in every state. However, millions of uninsured Americans who will be able to enroll in affordable coverage through these exchanges do not know about the new benefits or how to enroll. Ensuring that enrollment assistance is available before exchanges open next year will be critical to successfully helping the newly eligible learn about and enroll in coverage.



When told about the new coverage options, **75%** of the newly eligible want in-person assistance to learn about and enroll in coverage. (Enroll America Research, November 2012)

Ways Exchanges Can Help Consumers Enroll

Required Enrollment Assistance Options	{	A consumer-friendly website A toll-free hotline A navigator program
Additional Enrollment Assistance Options	{	An in-person assistance program Health insurance brokers/agents Health care providers Other stakeholders



- Q What is a navigator?**
Navigators are entities that will assist consumers and small employers with the enrollment process. They will conduct public education activities to raise awareness about the exchange, help people apply for and enroll in plans offered through the exchange, and provide referrals.
- Q Who can be a navigator?**
Community and consumer-focused nonprofit groups; trade, industry, and professional associations; commercial fishing industry, ranching, and farming organizations; chambers of commerce; unions; resource partners of the small business administration; licensed producers (i.e., insurance agents and brokers); Indian tribes; state or local human service agencies; and other public or private entities or individuals that are capable of carrying out the required duties and providing information that is fair, accurate, and impartial.
- Q What is the in-person assistance program?**
In the final exchange blueprint, the Center for Consumer Information and Insurance Oversight (CCIIO) outlined an optional in-person assistance program that is distinct from the navigator program. State-based and Consumer Assistance Partnership Exchanges can obtain federal funds to create and operate these programs.
- Q How are the navigator and in-person assistance programs funded?**
Federal exchange establishment grants can be used to plan for and establish a navigator program and to establish and operate an in-person assistance program. It is important to note, however, that federal funds cannot be used to provide grants directly to navigator entities.

	Navigator Program	In-Person Assistance Program
State-Based Exchange		
Will my state's exchange have this program?	Yes. All state-based exchanges are required to have a navigator program.	Maybe. State-based exchanges can choose to have an in-person assistance program distinct from its navigator program.
Is federal funding available?	Yes. States can apply for exchange establishment grants to plan for their navigator program, but navigator grants must come from the exchange's operational budget.	Yes. States can apply for exchange establishment grants to help establish and operate an in-person assistance program.
What does the exchange need to do to establish the program?	<ol style="list-style-type: none"> 1. Select at least two types of entities to serve as navigators, one of which is a community and consumer-focused not-for-profit entity. 2. Develop training, conflict of interest, and privacy and security standards. 3. Budget for navigator grants to come from operational funds of the exchange. 	<ol style="list-style-type: none"> 1. Create a plan for an in-person assistance program that is distinct from the navigator program. 2. Develop timeline for making program fully operational. HHS recommends launching the program in the summer of 2013. 3. Develop conflict of interest and privacy and security standards, and state-specific training modules if desired.
Consumer Assistance Partnership Exchange*		
Will my state's exchange have this program?	Yes. All partnership exchanges are required to have a navigator program.	Yes. HHS will work with your state to establish an in-person assistance program.
What is my state's role in establishing this program?	The state agency that partners with the federal government to manage consumer assistance is responsible for oversight of the navigator entities and may develop additional training modules.	HHS is working with these states to develop in-person assistance programs that are tailored to each state's unique needs. HHS's training program for navigators will also apply to in-person assisters.
What is the federal government's role in establishing this program?	The federal government will establish the program, selecting and providing grants to the entities that will serve as navigators, and will develop and operate the navigator training program.	Federal funding is available to establish and operate an in-person assistance program.
Federally Facilitated Exchange (FFE)		
Will my state's exchange have this program?	Yes. All federally facilitated exchanges are required to have a navigator program.	No. Only State-based and Consumer Assistance Partnership Exchanges will have this program.
What is my state's role in establishing this program?	Miminal. The federal government will select, train, and provide funding to entities participating in the navigator program. HHS plans to release information on the selection process and the various roles that stakeholders can play in their state's navigator program.	Not applicable.

* Partnership Exchanges that only share plan management responsibilities will mirror FFEs with respect to navigator and in-person assistance programs. For more information, see *Guidance on the State Partnership Exchange*, Center for Consumer Information and Insurance Oversight, January 3, 2013, available online at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>.





Dear Ryan White HIV/AIDS Program Colleagues:

The Affordable Care Act (ACA) will benefit People Living with HIV/AIDS (PLWH) in many ways. These benefits include: (1) prohibiting insurers from denying coverage to individuals with pre-existing conditions; (2) stopping insurance companies from dropping coverage just because someone who got sick made a mistake on their application; (3) ending lifetime dollar limits on coverage and phasing out annual limits on essential health benefits by 2014; (4) requiring coverage for inpatient services and other essential health benefit categories; and (5) considering payments from the AIDS Drug Assistance Program (ADAP) as true out-of-pocket expense under Medicare Part D Program. When key parts of the health care law take effect in 2014, there will be a new way for individuals, families, and small business owners to get health coverage through the Health Insurance Marketplace, also known as the Affordable Insurance Exchange.

The HIV/AIDS Bureau recognizes that outreach to and enrollment of Ryan White HIV/AIDS Program (RWHAP) clients into health insurance coverage is critical to ensure that clients fully benefit from the new coverage opportunities created by the health care law. RWHAP grantees and planning bodies are encouraged to review their Fiscal Year 2013 HIV service priorities, allocations, contracts and budgets and consider utilization of RWHAP resources to support Affordable Care Act related outreach and enrollment activities. The attached table highlights RWHAP service categories by Part that can be used to support outreach, benefits counseling and enrollment activities of RWHAP clients into private health insurance plans through the Health Insurance Marketplace and into Medicaid in their jurisdiction.

As more PLWH gain access to health care coverage, it is important to remember that the RWHAP will continue to be the payer of last resort. Grantees and subgrantees must ensure proper use of RWHAP funds and comply with the statutory requirement that RWHAP funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made by another payment source."

Thank you for your continued commitment to RWHAP clients and your efforts to ensure eligible individuals learn about and enroll in new coverage opportunities. If you have additional questions, please contact your project officer.

Sincerely,

Laura W. Cheever, M.D., Sc.M.
Acting Associate Administrator

Attachment: Ryan White and Affordable Care Act Outreach, Enrollment and Benefits Counseling



Ryan White and Affordable Care Act Outreach, Enrollment and Benefits Counseling

This table highlights Ryan White HIV/AIDS Program service categories by Part that can be used to support outreach, benefits counseling and enrollment activities.

Note: Not all Ryan White providers offer all of the service categories listed below. Decisions regarding use of Ryan White Part A and Part B funding for specific services are made by the jurisdiction based on needs assessment data.

	Service Category	Appropriate For	Rationale
Part A/B #1	<p>Early Intervention Services (EIS) that include identification of individuals at points of entry and access to services and provision of:</p> <ul style="list-style-type: none"> • Referral services • Linkage to care • Health education & literacy training that enable clients to navigate the HIV system of care • HIV testing (with prior Project Officer approval) <p>(Core Medical Service)</p>	<p>Benefits Counseling</p> <p>Enrollment</p> <p>Outreach Education</p>	<p>Referrals and linkages to care may include enrollment in Medicaid, Medicare, private insurance plans through the health insurance Marketplaces/ Exchanges and benefits counseling. Services are generally provided to clients who are new to care.</p>
Part A/B #2	<p>Medical Case Management Services (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication.</p> <p>Activities that include at least the following:</p> <ul style="list-style-type: none"> • Initial assessment of service needs • Development of a comprehensive, individualized care plan • Coordination of services required to implement the plan • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, or more frequently, as necessary. <p>(Core Medical Service)</p>	<p>Benefits Counseling</p> <p>Enrollment</p>	<p>Medical Case Management includes a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits/entitlement counseling and referral activities to assist clients with access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other State or local health care and supportive services). It will depend on the local structure of the medical case management model. Services are provided to prevent clients from falling out of care.</p>
Part A/B #3	<p>Case Management (Non-medical) services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services.</p> <ul style="list-style-type: none"> • Benefits/entitlement counseling and referral ac- 	<p>Benefits Counseling</p> <p>Enrollment</p>	<p>The service definition includes benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care.</p>

	Service Category	Appropriate For	Rationale
	<p>tivities to assist eligible clients to obtain access to public and private programs for which they may eligible</p> <ul style="list-style-type: none"> • All types of case management encounters and communications (face-to-face, phone, other) • Transitional case management for incarcerated persons as they prepare to exit the correctional system <p>(Support Service)</p>		
Part A/B #4	<p>Health Education/Risk Reduction services that educate clients living with HIV about HIV transmission and how to reduce the risk of HIV transmission</p> <ul style="list-style-type: none"> • Provision of information about available medical and psychosocial support services • Counseling on how to improve their health status and reduce the risk of HIV transmission to others <p>(Support Service)</p>	Outreach Education	PLWHA who are aware of their status and not in care often cite lack of awareness of health resources. Entry into care is a prevention and risk reduction tool, thus education of clients with regard to the Affordable Care Act and other resources available to them as a key component of health education and risk reduction should occur. Services can be provided to clients who are not in care or who have fallen out of care.
Part A/B #5	<p>Outreach Services designed to identify individuals who do not know their HIV status and/or individuals who know their status and are not in care and help them to learn their status and enter care</p> <p>(Support Service)</p>	Outreach Education	Outreach services can provide additional information on the Affordable Care Act benefits and help clients learn of their status and enter care. Services are generally provided to clients who are not aware of their status and/or not in care.
Part A/B #6	<p>Referral for Health Care/Supportive Services that direct a client to a service in person or through telephone, written, or other types of communication, including the management of such services where they are not provided as part of Ambulatory/ Outpatient Medical Care or Case Management Services May include: benefits/entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs for which they may be eligible, e.g., Medicaid, Medicare Part D, State Pharmacy Assistance Programs, Pharmaceutical Manufacturers' Patient Assistance Programs, and other State or local health care and supportive services.</p> <p>Referrals may be made:</p> <ul style="list-style-type: none"> • Within the Non-medical Case Management system by professional case managers • Informally through community health workers or support staff • As part of an outreach program <p>(Support Service)</p>	Benefits Counseling Enrollment Outreach Education	This service specifically mentions benefits/entitlement counseling and referral to refer or assist eligible clients to obtain access to other public and private programs. It supports retention, adherence to services and assists in clients navigating through available resources. Services are generally provided to clients who have a change in insurance status, new eligibility, or require a change in treatment regimen.
MAI/ Part B	The overall goal of the Ryan White Part B MAI program is to improve minority access to HIV/AIDS medications to treat HIV/AIDS and prevent opportunistic	Benefits Counseling	This service is specifically designed to increase access to medication programs which include Medicaid, Medicare, pri-

	Service Category	Appropriate For	Rationale
	infection through the Part B ADAP and as appropriate to other programs providing prescription drug coverage.	Enrollment Outreach Education	vate insurance through the health insurance Marketplaces/ Exchanges and benefits counseling. Services are generally provided to minority clients.
Part C #1	Medical Case Management including a range of patient-centered services that result in a coordinated care plan, which links patients to medical care, psychosocial, and other services including treatment adherence services. (Core Medical Service)	Benefits Counseling Enrollment	Medical Case Management includes a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits/entitlement counseling and referral activities assisting clients to access other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other State or local health care and supportive services). It will depend on the local structure of the medical case management model. In some cases this may be done by eligibility specialist or benefits advocates. Services are provided to prevent clients from falling out of care.
Part C #2	Case Management (Non-medical) services that provide advice and assistance to clients in obtaining medical, social, community, legal, financial, and other needed services May include: Benefits/entitlement counseling and referral activities to assist eligible clients to obtain access to public and private programs for which they may eligible (Support Service)	Benefits Counseling Enrollment	This service definition includes benefits/entitlement counseling and referral activities as allowable activities. Services are provided to prevent clients from falling out of care.
Part C #3	Outreach to identify people with HIV, or at-risk of contracting HIV, to educate them about the benefits of early intervention and link them into primary care (Support Service)	Outreach Enrollment	Outreach services can provide additional information on the Affordable Care Act benefits and help clients learn of their status and enter care. Services are generally provided to clients who are not aware of their status and/or not in care.
Part D	Medical Case Management Services (including treatment adherence) to ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, provided by trained professionals, including both medically credentialed and other health care staff who are part of the clinical care team, through all types of encounters including face-to-face, phone contact, and any other form of communication. Activities that include at least the following: <ul style="list-style-type: none"> Initial assessment of service needs <ul style="list-style-type: none"> Development of a comprehensive, individualized care plan Coordination of services required to implement 	Benefits Counseling Enrollment	Medical Case Management includes a range of client-centered services that link clients with health care, psychosocial, and other services. This may include benefits/entitlement counseling and referral activities to assist clients with to access to other public and private programs for which they may be eligible (e.g., Medicaid, Marketplaces/Exchanges, Medicare Part D, State Pharmacy Assistance Programs, and other State or local health care and supportive services). It will depend on the local structure of the medical case management model. In some cases this may be left to eligibility specialist or

	Service Category	Appropriate For	Rationale
	<p>the plan</p> <ul style="list-style-type: none"> • Continuous client monitoring to assess the efficacy of the plan • Periodic re-evaluation and adaptation of the plan at least every 6 months, or more frequently, as necessary <p>(Core Medical Service)</p>		benefits advocates. Services are provided to prevent clients from falling out of care.
	<p>Case Management (Non-Medical) services are defined as those services which are needed for individuals with HIV/AIDS to achieve their HIV medical outcomes. Case management which, includes medical, non-medical, and family-centered services.</p> <p>May include:</p> <ul style="list-style-type: none"> • Financial assessment/eligibility counselors (staff whose role is to determine client eligibility for Medicaid and other insurance programs and assist them to apply). • Staff assists clients with linkage, engagement, and retention in HIV care. <p>(Support Service)</p>	Outreach Education Enrollment	This service includes patient and family centered benefits/entitlement counseling and referral activities are allowable as part of this service under Ryan White Part D. Services are provided to prevent clients from falling out of care



Key Provisions of the Affordable Care Act for the Ryan White HIV/AIDS Program

The Affordable Care Act increases access to health insurance coverage and health services for all Americans, including people living with HIV/AIDS (PLWH), through a number of private market reforms, an expansion of Medicaid eligibility, and the establishment of Health Insurance Marketplaces (also referred to as Exchanges). The federal government, states, insurers, and consumers have a number of roles and responsibilities to help with implementation of the Affordable Care Act. This brief provides an overview of the major provisions within the Affordable Care Act that benefit PLWH.

Private Insurance Market Reforms

The Affordable Care Act includes a number of private health insurance market reforms that will benefit PLWH. PLWH cannot be prevented from purchasing most private health insurance plans-- from which they historically have been excluded -- based on having HIV/AIDS as a pre-existing condition. Most reforms will be effective on January 1, 2014, although some provisions have been effective since 2010. These reforms include:

- Guaranteed availability of coverage, which prevents insurers from denying coverage to individuals based on pre-existing conditions
- Fair health insurance premiums, which prohibits discriminatory premium rates by preventing insurers from charging more for individuals based on pre-existing conditions
- Prohibition of pre-existing condition exclusions or other discrimination based on health status
- Prohibitions against imposing annual dollar limits on essential health benefits
- Dependent coverage extension (up to age 26)
- Coverage of specified preventive health services without cost-sharing

Visit <http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html> to learn more about Affordable Care Act private market reforms.

Key Players & Some Core Responsibilities

Federal action: Monitor compliance with and enforce federal laws (except where states are primary regulators of the insurance industry and are substantially enforcing requirements)

State action: Monitor compliance with and enforce state insurance laws

Insurer action: Comply with federal and state laws

Consumer action: Understand the law and sign-up for updates by visiting HealthCare.gov

Medicaid Coverage

The Affordable Care Act establishes a new Medicaid eligibility category for low-income adults between 19-64 years of age with income at or below 133 percent of the Federal Poverty Level (FPL). If a state expands its Medicaid program, low-income people living with HIV who meet the new eligibility criteria will no longer have to wait for an AIDS diagnosis to qualify for Medicaid.

In states that implement this Medicaid expansion, eligibility will be determined using Modified Adjusted Gross Income (MAGI) based methods. If necessary for establishing income eligibility, an income disregard equal to 5 percentage points of the FPL will be applied. Under the law, the “newly eligible” individuals will be enrolled into a Medicaid Alternative Benefit Plan, which must include coverage of the ten statutory essential health benefit categories and comply with state and federal regulations.

Key Players & Some Core Responsibilities

Federal Action: CMS will provide guidance to states on Medicaid expansion, approve state plan amendments for expansion, and regulate inclusion of essential health benefits in Alternative Benefit Plans. CMS will also provide the additional Federal Matching Assistance Percentage (FMAP) for states that choose to expand their Medicaid Program.

State Action: If a state implements Medicaid expansion, it is responsible for establishing Medicaid Alternative Benefit plans for “new eligible” individuals, which must include coverage of essential health benefits. Regardless of its expansion decision, a state must determine income using a Modified Adjusted Gross Income (MAGI) based methodology for non-elderly, non-disabled eligibility groups (except for groups whose eligibility is based on medical need or on receipt of Medicare) covered in each state. States are also responsible for developing a transition strategy and coordinating with the Health Insurance Marketplace in their state.

Health Provider Action: In states that choose to expand and use a managed care model, providers should consider negotiating and contracting with Medicaid managed care plans to ensure alignment with payer of last resort policy.

Consumer Action: Consumers should learn if their state is expanding its Medicaid program and whether they are eligible. If enrolled in a Medicaid managed care plan, the consumer should make sure he/she selects a primary care provider.

Health Insurance Marketplaces

Starting January 2014, PLWH with incomes between 100-400% FPL who are not eligible for other affordable insurance through an employer or other government program may be eligible for federal premium tax credits and/or cost sharing reductions to help pay for private health insurance—specifically qualified health plans—through a Health Insurance Marketplace (or Exchange).

Individuals between 100%-400% FPL may be eligible for premium tax credits distributed on a sliding-income scale and based on the premium of the second lowest cost silver plan offered in a state's Health Insurance Marketplace. Individuals between 100%-250% FPL may also be eligible for cost-sharing reductions if they enroll in a silver level plan. Indians are eligible for additional cost-sharing reductions if their household income is below 300% FPL or for services and items provided by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization, or through referral under contract health services. Other eligibility requirements for this assistance and subsidies apply. To learn more about premium tax credits, visit <http://www.healthcare.gov/marketplace/costs/tax-credits/index.html>.

Health Insurance Marketplaces are designed to make buying health insurance coverage in the individual and small group market easier and more affordable. These Marketplaces will provide a "one-stop shop" for individuals to compare qualified health plan options, get answers to health coverage questions, find out if they are eligible for affordability programs like Medicaid and CHIP or premium tax credits to purchase private insurance, and enroll in a qualified health plan that meets their individual needs. Visit <http://www.healthcare.gov/marketplace/index.html> to learn more about Health Insurance Marketplaces.

States can choose to operate their own Health Insurance Marketplace (State-based Marketplace), participate in one in partnership with HHS (State Partnership Marketplace), or allow HHS to manage and operate a Federally-facilitated Marketplace. Visit <http://cciio.cms.gov/resources/factsheets/state-marketplaces.html> to learn more about what type of Health Insurance Marketplace may be operating in your state.

Key Players & Some Core Responsibilities

Federal Action: HHS approves operating plans for states that choose to establish their own State-based Marketplace. A State Partnership Marketplace enables states to assume primary responsibility for carrying out certain activities related to plan management, consumer assistance and outreach, or both. HHS will carry out all minimum Marketplace functions not performed by states in the State Partnership Marketplace and will oversee operation of the entire Marketplace. In states that do not have a State-based Marketplace or a State Partnership Marketplace, HHS will be responsible for certifying qualified health plans and establishing and monitoring compliance with network adequacy standards and essential community provider requirements. HHS will also administer, oversee, and support in-person application assistance to consumers, including a Navigator Program in Federally-facilitated or State Partnership Marketplaces to assist consumers in understanding their health insurance options and enrolling in a health plan.

State Action: States must decide whether to establish a State-based Marketplace, State Partnership Marketplace, or rely on a Federally-facilitated Marketplace. The deadline for notifying HHS of establishing a State-based Marketplace passed on December 14, 2012. States had until February 15, 2013 to notify HHS and submit an application to participate in a State Partnership Exchange, or cooperate in other ways with HHS with respect to a Marketplace in their State. States operating State-based Marketplaces are responsible for the following: approving and contracting with accredited qualified health plans for State-based Marketplaces

and ensuring they comply with non-discrimination standards and EHB requirements; establishing and monitoring compliance with network adequacy standards and essential community provider requirements for State-based Marketplaces; developing a streamlined eligibility and enrollment process to assess and enroll individuals into Medicaid or the Marketplace and develop a transition strategy for moving individuals from the Pre-Existing Condition Insurance Plan to a qualified health plan in the Marketplace; and administering, overseeing, and supporting in-person application assistance, including a Navigator Program. In states that choose to carry out consumer assistance activities as a partner in a State Partnership Marketplace, the states will support the Navigator program as well as administer and support other in-person assistance programs.

Insurer Action: Insurers may choose to offer coverage--their qualified health plans--through the Marketplaces. They must ensure all health plans offered through the Marketplaces meet qualified health plan standards, including network adequacy standards and inclusion of a sufficient number of essential community providers, as well as other qualified health plan standards. Insurers may choose to market their qualified health plans.

Health Provider Action: Health providers should consider contracting with health plans to ensure they will be included in networks by January 1, 2014 to ensure alignment with payer of last resort policy.

Consumer Action: Initial open enrollment for the Marketplaces begins on October 1, 2013 and ends on March 31, 2014. Consumers should apply before December 15, 2013 to ensure that their new qualified health coverage begins on January 1, 2014. Utilizing consumer assistance programs, such as Navigators, can help consumers understand their Marketplace health plan options. Consumers should also visit <http://www.healthcare.gov/marketplace/get-ready/index.html> to learn about more ways to prepare for enrollment in the Health Insurance Marketplace.

Essential Health Benefits

PLWH who obtain insurance through non-grandfathered health plans (inside or outside Health Insurance Marketplaces) or through Medicaid in a Medicaid Alternative Benefit Plan will be ensured coverage of “essential health benefits” (EHB). With respect to plan years (small group market) and policy years (individual market) beginning on or after January 1, 2014, non-grandfathered health plans offered in the individual and small group markets (inside and outside the Health Insurance Marketplaces) and Medicaid Alternative Benefit Plans must offer a core package of items and services known as the “essential health benefits” (EHB). EHB must include items and services within at least the following ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

On November 20, 2012, the Center for Medicaid and CHIP services (CMCS) released a letter to State Medicaid Directors to provide guidance to states on the use of Alternative Benefit Plans for

the new eligibility group of low-income adults and the relationship between Alternative Benefit Plans and EHB.¹ CMCS also issued a proposed rule on January 14, 2013 outlining EHB coverage requirements in Medicaid.²

A final rule issued in February 2013 outlines health insurance issuer standards for EHB that non-grandfathered individual and small group health insurance issuers must cover both inside and outside the Health Insurance Marketplace.³ The Affordable Care Act requires that the scope of the EHB be equal to the scope of benefits offered in a “typical employer plan.” To give states the flexibility to define EHB in a way that would best meet the needs of their residents, this rule finalizes a benchmark-based approach. This approach allows states to select a benchmark plan from options offered in the market. If a base-benchmark plan does not cover any benefits in any of the ten required categories of EHB, the base-benchmark plan must be supplemented by adding the entire category of benefits from another of the benchmark plan options to establish the EHB-benchmark plan for that state. Twenty-six states selected a benchmark plan for their state. In the other states and Puerto Rico, the largest small group market plan by enrollment in each state will be the base-benchmark and in the other U.S. territories, the largest Federal Employee Health Benefit Plan by enrollment will be the base-benchmark.⁴ To learn more about a state’s EHB-benchmark plan selection, please visit <http://cciio.cms.gov/resources/data/ehb.html>.

Beginning in 2014, plans that are required to cover EHB also must cover a certain percentage of the total allowed costs of providing benefits, known as actuarial value or “metal levels.” These levels are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Metal levels will allow consumers to compare insurance plans with similar levels of coverage and cost-sharing based on premiums, provider networks, and other factors.

Further, a health plan is not deemed to provide EHB unless it covers at least one drug in every United States Pharmacopeia (USP) category and class, or the same number of prescription drugs in every category and class as the EHB benchmark plan, whichever is greater. Health plans must also have procedures in place to allow enrollees to request and gain access to clinically appropriate drugs not covered by the health plan.

Visit <http://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html> to learn more about the EHB final regulation for non-grandfathered individual and small group market plans.

¹ See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>

² See <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>

³ See http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf

⁴ Appendix A of the final EHB regulation includes the final list of EHB-benchmark plan for coverage years in 2014 and 2015. See http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf.

Key Players & Some Core Responsibilities

Federal action: HHS defined essential health benefits based on a benchmark plan selected by each State. HHS reviews proposed benchmark plan selections submitted by states to ensure compliance with federal law and non-discrimination standards.

State action: States select a benchmark plan for the individual and small group market (both inside and outside the Health Insurance Marketplace) that defines EHB and ensure benchmark plans contain all required benefits and otherwise comply with federal law. States must also ensure that Medicaid Alternative Benefit Plans include coverage of EHB as outlined in the federal regulation.

Insurer action: Under the final rule, non-grandfathered insurers in the individual and small group market must include coverage of EHB using the EHB-benchmark plan as a reference plan. Insurers may set different limitations on coverage so long as they remain substantially equal to the state's benchmark plan and would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. Health plans must also comply with prescription drug formulary minimum requirements as outlined in the final rule.

Consumer action: Although non-grandfathered health plans in the individual and small group market are required to cover EHB, insurers' benefit design may vary. Consumers should review plans' benefits when selecting a health plan.

2013 Proposed New Idea

(Applicant must complete this two-page form as it is. Agency identifying information must be removed or the application will not be reviewed. Please read the attached documents before completing this form: 1.) HRSA HIV-Related Glossary of Service Categories to understand federal restrictions regarding each service category, 2.) Criteria for Reviewing New Ideas, and 3.) Criteria & Principles to Guide Decision Making.)

THIS BOX TO BE COMPLETED BY RWPC SUPPORT STAFF ONLY

1 Control Number Date Received 03/6/13
 Proposal will be reviewed by the: *HTBMN Wnkgoup: 4/15/13 + 4/18/13*
 Quality Assurance Committee on: 03/21/13 (date)
 Priority & Allocation Committee on: 06/12/13 (date)

THIS PAGE IS FOR THE QUALITY ASSURANCE COMMITTEE

(See Glossary of HIV-Related Service Categories & Criteria for Reviewing New Ideas)

1. SERVICE CATEGORY: _____ OR (circle) Navigator Program DATE: 03/06/13
 (The service category must be one of the Ryan White Part A or B service categories as described in the HRSA Glossary of HIV-Related Service Categories unless the idea relates to a Navigator Program.)

Based on how many clients 3 Service Linkage Workers see annually in 15 minutes unit of service increments.

This will provide 750 clients with 15,000 units of service.

2. ADDRESS THE FOLLOWING:
 A. DESCRIPTION OF SERVICE:

With the implementation of the Patient Protection and Affordable Care Act (ACA) on January 1, 2014, many people who were uninsured will become eligible for affordable health care coverage. Using data from the U.S. Census Bureau and estimates of the number of people that will potentially be impacted by the Texas Health and Human Service Commission, the following table includes the estimated number of people who could be impacted by the ACA within the Houston EMA:

County	Currently Uninsured	Marketplace with Tax Credits*	Marketplace without Tax Credits**	Medicaid Expansion ***	Eligible but Not Enrolled Children (CHIP/Medicaid)	Remain Uninsured
Chambers	5,772	2,382	550	1,283	550	1,008
Fort Bend	103,556	42,737	9,862	23,012	9,862	18,081
Harris	1,108,842	457,617	105,604	246,409	105,604	193,607
Liberty	17,474	7,211	1,664	3,883	1,664	3,051
Montgomery	88,754	36,629	8,453	19,723	8,453	15,497
Waller	12,109	4,997	1,153	2,691	1,153	2,114
Houston EMA Totals	1,336,507	551,573	127,286	297,001	127,286	233,358

For people living with HIV and AIDS, based on the income and insurance status of the population, the Texas Department of Health Services estimates that of the approximately 35,000 people who sought Ryan White funded services in 2010, 50% will be eligible for Medicaid in 2014. In addition, there is reason to believe that a significant proportion of the approximately 21,000 people living with HIV and AIDS not currently in care may become eligible for Medicaid

The Marketplace, also known as health insurance exchanges, will begin to function in October 2013. The Marketplace is the program where individuals can apply for healthcare coverage, such as Medicaid and insurance subsidies. Most of the people in the table above will not know about their options through the Marketplace, the new benefits or how to enroll. The proposed new services, **Patient Navigation**, will involve outreach into our community and identify persons living with HIV/AIDS (PLWHA) who are not in care, never established care, dropped out of care, and assisting them with the enrollment into the Marketplace. Patient Navigators will conduct public education activities to raise awareness about the Marketplace, help people apply for and enroll in plans offered through the Marketplace, ensure enrollment is accurate and complete, as well as provide referrals.

Through HIV Counseling, Testing and Referrals (CTR) programs, HIV+ individuals of target populations will be identified and made aware of their serostatus. Patient Navigators will work in tandem with the CTR Health Educators to ensure a relationship embedded with the premise of early identification and linkages to affordable healthcare coverage that will address all core and ancillary medical needs improve access to quality health care and services, build a healthy community and improve Houston's health equity. When a newly diagnosed HIV+ individual is identified, if possible a patient navigator will be introduced at the time of post-test counseling to a Patient Navigator. If a Patient Navigator is not readily accessible, the CTR Health Educator will receive consent from the client to have the Patient Navigator contact them within 24 hours of their post-test counseling. At the initial meeting, the Patient Navigator will initiate a dialog with the client to address their initial concerns regarding their serostatus, assess their emotional wellbeing, and develop a co-dependent relationship and discuss the client's immediate needs. This initial dialog is intended to develop trust, and initiate a rapport between the client and the Patient Navigator. The Patient Navigator will conduct a brief session regarding HIV pathogenesis and disease management, as well as the need for establishing primary care. Furthermore, one of the most essential and vital responsibilities for the Patient Navigator will be to provide the client with information on navigating the Marketplace, including facilitating enrollment, identifying health care providers and support services, as well as assist with making medical appointments.

B. TARGET POPULATION (Race or ethnic group and/or geographic area):

All HIV+ individuals living in the Houston EMA

C. SERVICES TO BE PROVIDED (including goals and objectives):

1. Patient Navigators will link 85% of the newly diagnosed HIV+ individuals that qualify to affordable health coverage through the Marketplace.
2. Patient Navigators will educate 85% of current Ryan White consumers about their options with the Marketplace.
3. Patient Navigators will be an assigned member of each CTR team.
4. Patient Navigators will conduct 50 outreach and public education workshops on the health coverage options and financial assistance that are provided through the Marketplace.
5. Patient Navigators will distribute fair, accurate, and impartial information about the full range of health coverage options that are available through the Marketplace, including public programs.
6. Patient Navigators will facilitate enrollment of 750 clients in qualified health plans (QHPs) through the Marketplace.
7. Patient Navigators will make referrals to health insurance consumer assistance or state agencies for help with grievances, complaints, appeals, and questions about using coverage.
8. Patient Navigators will provide information and services in a manner that is culturally and linguistically appropriate and accessible to people with disabilities.

PLEASE STATE HOW THIS NEW IDEA WILL MEET THE PRIORITY AND ALLOCATIONS CRITERIA AND PRINCIPLES TO GUIDE DECISION MAKING. SITE SPECIFIC STEPS AND ITEMS WITHIN THE STEPS:

This new idea meets the Priority and Allocations Principles A, B, F and G

In addition it meets:

Criteria Step 1 B, D and F

And

Criteria Step 2 A, B, C, E and F

RECOMMENDATION OF PRIORITY AND ALLOCATIONS COMMITTEE:

Recommended for Increased Funding in the Amount of: \$ _____

Not Recommended for Increased Funding

Other:

REASON FOR RECOMMENDATION:

Patients

Donors

Community

News & Media

Public Benefits Navigator

Location: ETMC
 Department: Legal Services
 Job Code: 206PUB
 Pay range: \$38000-\$41000
 Employment duration: Full time
 # of openings: 1

Description

Whitman-Walker Health seeks a **Public Benefits Navigator**, to work primarily at its Elizabeth Taylor Medical Center in Northwest DC and its Max Robinson Center in Southeast DC. These are legal assistant/paralegal-level positions. While the public benefits navigators will be trained and supervised by the Legal Services Department, they are part of a specialized Public Benefits Team that is physically situated as part of the patient flow working closely with reception staff as well as medical, behavioral, and dental staff to ensure health insurance coverage for our patients.

At Whitman-Walker, our commitment to “Community, Caring and Quality” really shines through! Our mission is to be the highest quality, culturally competent community health center serving greater Washington’s diverse urban community, including individuals who face barriers to accessing care, and with a special expertise in LGBT and HIV care. We offer a full line of healthcare services including: (1) Comprehensive outpatient offerings for medical and dental healthcare; (2) an on-site Pharmacy; (3) legal support in the areas of access to health care, public benefits, and private insurance, discrimination and workplace rights, immigration, transgender rights and others; (4) behavioral healthcare provided through individual, group and day treatment means; and (5) confidential and anonymous HIV testing and counseling services.

We are seeking a full-time public benefits navigator to screen all Whitman-Walker Health clients for public benefits eligibility and assist eligible clients to apply for local benefits, including but not limited to Medicaid, Medicare, Medicare Savings Programs, the DC Healthcare Alliance, HIV/AIDS-specific public benefits (including AIDS Drug Assistance Programs and AIDS Insurance Assistance Programs), and any other public health insurance options for our clients. The individual hired for this position will join a team the Public Benefits Team consisting of public benefits navigators at the NW site and a team leader, and will rotate one day a week to the SE site. These navigators meet with new and existing Whitman-Walker clients and counsel them about the range of public benefit programs for which they may be eligible. They assist eligible clients in completing relevant applications, securing necessary supporting documentation, and filing the applications with the appropriate agencies. They track the status of pending applications, advocate for clients with government offices as necessary, and identify matters that should be referred to Whitman-Walker staff attorneys for further action. They also are responsible for cultivating good relationships with staff at the government offices where applications will be filed, and for troubleshooting and advocating on behalf of clients with those offices.

In addition to these responsibilities, the public benefits navigators will assist with collection of documentation for Ryan White and sliding fee scale assignments.

Qualifications:

- A college degree from an accredited school.
- The ability to converse well in Spanish, and to understand written Spanish.
- The ability to quickly learn and stay on top of updates to public benefits programs, specifically eligibility criteria, benefits, application procedures, and how to troubleshoot problems as they arise.

- The ability to work on multiple tasks simultaneously and to handle a large case load of public benefits applications before multiple government agencies in several jurisdictions.
- The ability to grasp complex facts, procedures, and laws.
- The ability to work quickly, independently, and responsibly.
- Strong organizational, record-keeping, and writing skills, and attention to detail.
- Strong interpersonal and customer service skills; the ability to work comfortably with clients, volunteers and staff of diverse backgrounds; and a high level of comfort with HIV/AIDS and with persons of different sexual orientations and gender identities.
- Strong team player required.
- Strong computer skills, including knowledge of Microsoft Office tools and the ability to quickly learn new programs, including electronic medical record and insurance related web programs.
- 40-hour per week position with requirement for Monday through Friday schedule, though early and late coverage is required. Flexibility with regard to hours and work sites. While majority of time will be spend at the health center's Northwest site, at least 20 % of time will be spent at our SE site.

Salary. High \$30s / low \$40's, depending on experience. This is a union position. The health center offers an excellent benefits package.

Application Process: Applicants seeking to apply for this position should go to our website: www.whitman-walker.org and go to Career Center. Within that section, use the 'Apply for this Position' button following the Public benefits navigator posting. New users will be asked to set up an account through the organization's applicant tracking system. Returning users may use the 'Previous Applicants' access. **The submission of interest to a position with Whitman-Walker Health will require each applicant to upload and submit a cover letter and resume through the Employment Opportunities online application.** Only those applicants who submit a cover letter with a resume will be considered. A valid email address is required to apply.

Whitman-Walker Health is an equal employment opportunity employer and does not discriminate against applicants, its employees or former employees on the basis of race, color, religion, gender, marital status, sexual orientation, national origin, age, disability, veteran status and gender identity.

Beck, Diane (County Judge's Office)

From: Krull, Lisa [Lisa.Krull@shelbycountyttn.gov]
Sent: Friday, March 22, 2013 8:51 AM
To: Beck, Diane (County Judge's Office)
Subject: RE: Question re Navigator Programs

Diane,

We are planning to have our Medical Case Managers, Non Medical Case Managers and EIS linkage staff trained through the free on-line navigator training that will be offered through HHS.

Kind regards,

Lisa J. Krull
Program and Quality Manager
Ryan White Program
1075 Mullins Station Road, W275
Memphis, TN 38134
(901) 222-8279 office
(901) 222-8290 fax



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Navigators and In-Person Assistors: Exchanges

October 2012

Support for this resource provided through a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network program.

manatt

Discussion Roadmap – Navigator Program

1

Navigators Defined

State Considerations

- Navigator Roles and Responsibilities
- Navigator Oversight

What States Are Doing

What is a Navigator?

2

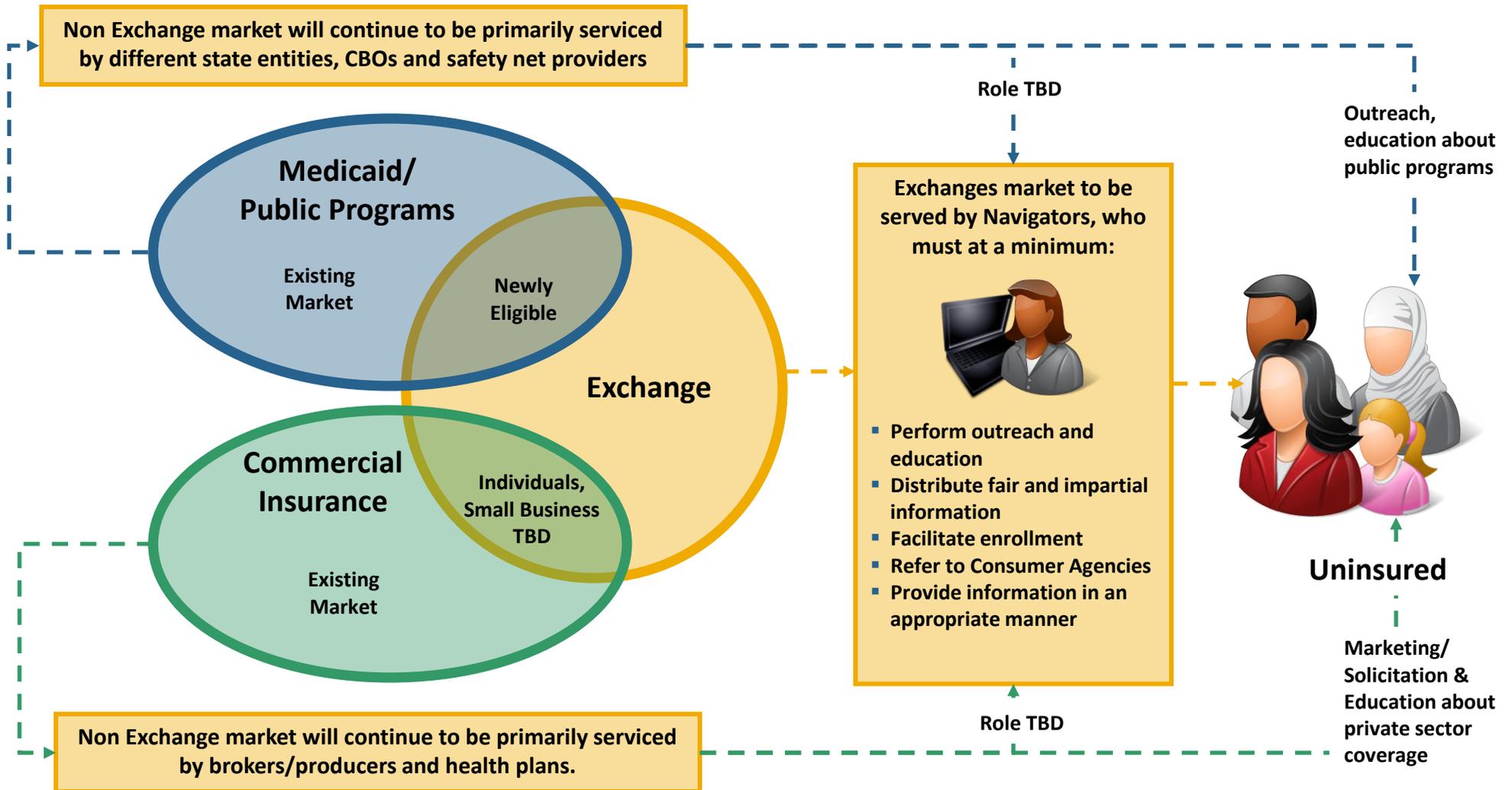
Exchanges must establish a Navigator program to perform the following functions:

- Conduct public education activities to raise awareness of the availability of QHPs;
- Distribute fair and impartial information concerning enrollment in QHPS and the availability of premium tax credits and cost-sharing reductions in accordance with federal laws;
- Facilitate enrollment into QHPs;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or any other appropriate state agency or agencies, of any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan of coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to meet the needs of the population being served by the Exchange

ACA § 1311(i)

Role of Navigator Post-ACA

- The Exchange sits at the intersection of two insurance markets – commercial and public – each with separate mechanisms for outreach/marketing, enrollment and other consumer assistance functions.
- States must contemplate the role and financing of the various consumer assistance providers across markets and programs.



Navigator Duties

4

Navigators must:

45 CFR § 155.210(e)

- ① Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange
- ② Provide information and services in a fair, accurate and impartial manner. Such information must acknowledge other health programs
- ③ Facilitate selection of a QHP
- ④ Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage
- ⑤ Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency

Who Can Serve as a Navigator?

5

Navigators must:

45 CFR § 155.210(c)

- ① Have existing relationships, or could easily establish relationships with target populations
- ② Meet state licensing or other standards
- ③ Not have a conflict of interest
- ④ Comply with the privacy and security standards adopted by the Exchange

Federal regulations require Navigators include at least one community based organization/consumer-focused non-profit as well as at least one of the following:

- Trade, industry, and professional associations;
- Commercial fishing industry organizations, ranching and farming organizations;
- Chambers of commerce
- Unions
- Resource partners of the Small Business Administration
- Licensed agents and brokers; and
- Other public or private entities or individuals that meet the requirements of this section, e.g., Indian tribes, tribal organizations, and State or local human service agencies

Training & Financing

6

Training:

45 CFR § 155.210(b)(2)

States must establish a set of training standards for Navigators to ensure expertise in:

- ① The needs of underserved and vulnerable populations;
- ② Eligibility and enrollment rules and procedures;
- ③ The range of QHP options and insurance affordability programs; and
- ④ The privacy and security standards.

Financing:

45 CFR § 155.210(f)

- The regulations stipulate that Navigators may not be funded from Federal funds received by the State to establish the Exchange
- Navigators may be funded by Medicaid at the State's administrative federal financial participate rate.

Conflict of Interest

7

Navigators must not:

45 CFR § 155.210(d)



- Be a health insurance issuer;
- Be a subsidiary of a health insurance issuer;
- Be an association that includes members of, or lobbies on behalf of, the insurance industry; or,
- Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a QHP or a non-QHP

Exchanges must develop and disseminate conflict of interest standards to ensure appropriate integrity of Navigators. The preamble urges Exchanges to address:

- Financial and nonfinancial considerations
- Family member's employment or activities with potentially conflicted entities
- Monitoring of Navigator-based enrollment patterns
- Legal and financial recourses for consumers that have been adversely affected by a Navigator with a conflict of interest
- Applicable civil and criminal penalties for Navigators that act in a manner inconsistent with the conflict of interest standards set forth by the Exchange.

Navigator Roles and Responsibilities – State Considerations

- Will Navigators support the state's Medicaid program?
- Will Navigators assume other responsibilities (e.g. troubleshooting/dispute resolution, health education?)
- How will the costs of additional services impact the overall costs of the Exchange?
- How will Navigators coordinate with existing enrollment and consumer assistance entities?
- Do all Navigators perform all functions or can there be different levels of Navigators?
 - How should “assisters” be defined or deployed?
- What role do Navigators have in consumer education vs. assistance?
- How can Navigators be used as a feedback mechanism to assess policies and procedures?
- Will Navigators have a different role in the individual market vs. SHOP?
- How should the Exchange ensure that Navigators balance roles and responsibilities during the open enrollment timeframe versus the rest of the year?
- What standard operating practices or metrics should be used to monitor Navigators?

Oversight Considerations

States Must Consider:

- Will the Exchange select, contract with and provide overall compliance oversight for Navigators or are these functions best provided by another entity?
- To the extent Navigators provide Medicaid services, what role will the Medicaid Agency have in providing oversight of Navigators?
- What reporting requirements and mechanisms are needed to track and monitor Navigator activity?
- How will the state track consumer complaints regarding Navigators?
- How do Navigator functions intersect with state licensure requirements?
- What should be the rules for certification/licensing, renewals, revocations, reinstatement, etc.?
- What conflict of interest standards should be established?

Appendix: Notable State Activity

<p>Arkansas</p> 	<ul style="list-style-type: none"> On June 1, 2012, the Arkansas Insurance Department released a Request For Information (RFI) for a solution to meet the technical needs of the Navigator Program Services required under the ACA. The software solution for the Navigator Program in Arkansas must manage three functions concurrently: grant applications, grantee operations and Certified Navigator training/certification. Proposals were due June 22nd and no award has yet been made. Arkansas has previously announced they will pursue a partnership exchange.
<p>California</p> 	<ul style="list-style-type: none"> On June 26, 2012, The California Health Benefit Exchange released a final draft of Phase I and II of the Statewide Assisters Program Design Options, Recommendations and Final Work Plan on June 26, 2012. The report includes two primary components. The first is the Assisters Program recommendations regarding the role of Assisters and Navigators as mandated by the Affordable Care Act. The recommendations also cover training, eligibility and standards, and recruitment and monitoring of Assisters. The second component includes design options for the Exchange to consider with regard to the compensation of the Navigators. The California Health Benefit Exchange, Department of Health Care Services and the Managed Risk Medical Insurance Board commissioned a report on “California Health Benefits Marketplace Assisters Program.” The report: (1) Describes the Assisters Program to include Certified Enrollment Assisters that would be trained, certified and registered with the Exchange in order to enroll consumers in Exchange products and programs. Only those Certified Enrollment Assisters that are designated as Navigators will be compensated by the Exchange and (2) Indicates that Navigators will only be compensated for enrollment of consumers in Qualified Health Plans based on a fixed per application fee of \$58 for a successful enrollment activity. There will be no compensation for renewals.
<p>Colorado</p> 	<ul style="list-style-type: none"> In March 2012, the Colorado Consumer Health Initiative, the Colorado Center on Law and Policy and the Colorado Public Interest Research Group released a report on the consumer perspective on Exchanges, which included survey questions to consumers on Navigators. Of the individuals who responded, 70 percent said they would be extremely likely to use a navigator, and just less than 8 percent said they were not at all likely to use a navigator. The remaining 22 percent were neutral. When asked how they would most like to contact a navigator, the first choice was a phone call to a live person. That was followed by online chat, email and face-to-face
<p>Connecticut</p> 	<ul style="list-style-type: none"> The Brokers, Agents and Navigators Advisory Committee released proposed recommendations on July 10, 2012 on the role of Navigators, Brokers and Agents. The recommendations include two tiers of Navigators for the individual market: <ul style="list-style-type: none"> Tier 1 Educators will focus on raising awareness of the Exchange and Medicaid options, and distribute impartial information about options and enrollment. They would be paid on a grant/lump sum basis. Tier 2 Enrollers will focus on collecting the information needed to determine eligibility for appropriate programs, assisting in enrollment, and following up with consumers as needed. The committee is still discussing how to compensate Tier 2 Navigators. Organizations, not individuals, will be designated as Navigators and can apply for Tier 1, Tier 2 or both functions; individuals carrying out Navigator duties will have to receive the appropriate training and certifications. The committee is still discussing how to certify SHOP Navigators. The committee also discussed providing training/information opportunities for stakeholder organizations and individuals who are not interested in certifying or being paid as Navigators but who want to help in outreach and public education.

Appendix: Notable State Activity

11

<p>Illinois</p> 	<ul style="list-style-type: none"> ▪ The “Illinois Navigator Program Design Final Report” includes the following recommendations: <ul style="list-style-type: none"> ▪ Navigators should be selected competitively. ▪ Navigators should be required to complete training and certification requirements. ▪ Navigators should receive block grant payments. ▪ Navigators should have the opportunity to earn incentive payments, for which standards would be established in advance. ▪ Navigators should initially serve consumers in the individual Exchange (and the Medicaid market) but not the SHOP Exchange. ▪ The current Medicaid outreach and eligibility support program should be fully integrated into the Navigator Program. Rather than continue to operate a separate outreach and consumer assistance program for Medicaid and All Kids, AKAAs should also be able apply to become Navigators.
<p>Maryland</p> 	<ul style="list-style-type: none"> ▪ On August 3, 2012, the Exchange issued a request for information (RFI) seeking input on the design of its Navigator Program. The information collected will help inform the analysis of options by the Exchange’s Navigator Advisory Committee, as well as the solicitation of Navigators by the Exchange in early 2013. Specifically, the RFI asks respondents to provide information related to the following categories: Navigator role and responsibilities in the Individual Exchange; Navigator role and responsibilities in the SHOP Exchange; training; and compensation. Responses were due August 17, 2012. ▪ Under legislation passed in the state, Navigators in the individual exchange are responsible for reaching out to uninsured individuals. Navigators can “sell” only plans inside the Exchange. Certified Navigators (certified by Exchange) are the only ones able to support plan selection. Assistors can support outreach, and anything leading to plan selection and/or individual subsidy discussions. ▪ SHOP Navigators are responsible for reaching out to uninsured groups. Can “sell” only plans inside the Exchange. Licensed (by MIA; different than producer license) Navigators are the only ones able to discuss tax subsidies and support plan selection. Licensure limited to in the exchange, only. Assistors can support outreach and anything leading up to tax subsidy / plan selection discussions.
<p>Nevada</p> 	<ul style="list-style-type: none"> ▪ On June 8, 2012, the Nevada Silver State Exchange’s Consumer Assistance Workgroup discussed Navigators and Brokers. Specifically, their roles and responsibilities, licensing, certification and training, compensation, conflicts of interest and relationship with insurers, and performance metrics. The Workgroup proposed both education Navigators and Enrollment Navigators. Education Navigators are certified by the Exchange and perform all Navigator functions with a focus on outreach to consumers and general health insurance education. Education Navigators can not do enrollment. Enrollment Navigators are licensed and regulated by the DOI and undergo a criminal background check. They are responsible for enrolling consumers into plans offered in the Exchange. Both Navigators will be funded by competitive grants from the Exchange.

Appendix: Notable State Activity

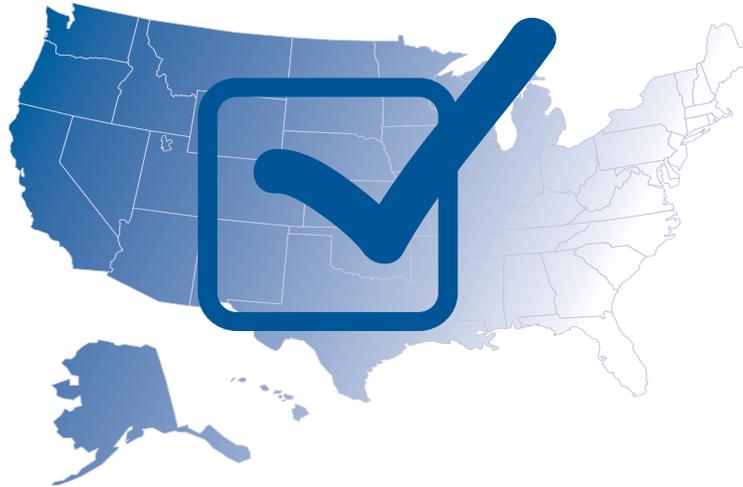
<p>Oregon</p> 	<ul style="list-style-type: none"> ▪ The Oregon Health Insurance Exchange Corporation met to discuss the functions of the Exchange and recommended: <ul style="list-style-type: none"> ▪ The Exchange establishes an Agent Management Program. The Exchange will obtain licensure to become a “Business Entity” which is eligible to affiliate with multiple producers under Oregon Insurance regulation. ▪ As a Business Entity, the Exchange will collect commission from issuers and redistribute commissions to certified agents (as certified by the Exchange). Essentially, the exchange becomes an agent of each participating issuer, eligible to become the single commission payee for all Exchange business for each participating issues. The intent of this model is to remove any incentive for agents to recommend one plan over another. ▪ The Exchange will be tasked with developing a network of agents covering all areas of Oregon. Agents must meet the minimum criteria set forth by the Exchange (including hold a current license, in good standing, has E&O, completes training, etc).
<p>Vermont</p> 	<ul style="list-style-type: none"> ▪ On September 9, 2012, the Medicaid and Exchange Advisory Board met to discuss Exchange updates. On the Navigator, "current progress" includes designing a compensation plan; estimating the needed capacity; developing the certification criteria and process; and creating a training program. Next steps include developing an RFP and model contract and creating an evaluation process ▪ On June 27, 2012, Bailit Health Purchasing provided a report on Proposed Marketing and Outreach Plan; Navigator Proposal to the Vermont Health Benefit Exchange Advisory Committee which presented nine recommendations, including The Navigator Program should play a central role in Vermont’s early efforts to educate and outreach to the public about coverage available through the Exchange; The State will need to determine an overall budget for the Navigator program, without reliance on federal funds, and should provide enhanced funding during the initial Exchange implementation period. Navigators should have the capacity to serve clients over the phone, by email, and in person, as most appropriate; and the Navigator function should be well-coordinated with that of State and call center staff.
<p>Washington</p> 	<ul style="list-style-type: none"> ▪ Conducted a survey and did stakeholder interviews in early 2012 to arrive at recommendations for the Navigator program. Recommendations include that: <ul style="list-style-type: none"> ▪ Navigators be knowledgeable about all aspects of the Exchange, including tax credits, subsidies and Medicaid. Training was mentioned as a “must” and stakeholders were divided between requiring certification for Navigators versus licensure (which was advocated by brokers) ▪ Navigators should be viewed as trustworthy and independent- not part of a government agency and, preferably, part of an existing resource consumers already turn to for guidance ▪ Navigators will need to offer support in a variety of ways- including in-person and online- as well as at the provider’s location ▪ The Exchange is working with Wakely Consulting Group to further develop and refine the structure of the Navigator Program. A forthcoming report will address the program infrastructure, payment model, training program and performance measures. In addition, a newly-formed Technical Advisory Committee devoted to the Navigator Program will conduct its first meeting in July 2012

Melinda Dutton

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212.790.4522



Help Wanted: Preparing Navigators and Other Assisters To Meet New Consumer Needs

As states design their navigator and in-person assistance programs, they will need to consider the barriers consumers face when enrolling in health coverage and think through the issues consumers may need help with when obtaining coverage through an exchange.

This tool kit provides an overview of the requirements for navigator programs and answers some of the key questions states will face as they seek to establish effective navigator programs. The kit also provides lessons learned from State Health Insurance Assistance Programs (SHIPs). SHIPs assist Medicare beneficiaries and have extensive experience in enrollment issues, consumer education, and community outreach.

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Starting on October 1, 2013, millions of Americans who currently lack affordable and adequate health insurance will be eligible to enroll in new private or public coverage under the Affordable Care Act. (This new coverage begins on January 1, 2014). The law established health insurance exchanges, where many individuals and small businesses will be able to buy private coverage, often with financial assistance. In these exchanges, individuals and families will also be able to apply for coverage through Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health program (in states that implement this program). Exchanges will make applying for health coverage easier: In addition to using a single application for both private and public coverage, exchanges will provide help with enrollment through consumer-friendly websites, call centers, and in-person assistance, including new "navigator" programs. Navigators will conduct targeted outreach and will provide one-on-one assistance to help consumers learn about and enroll in new coverage options. The Affordable Care Act also provides states with funding to establish additional in-person assistance programs that can supplement the work of navigator programs.

As states design their navigator and in-person assistance programs, they will need to consider the barriers consumers face when enrolling in health coverage and issues consumers may need help with regarding exchange coverage. The people served by exchanges will need help with many different issues, including assistance in new areas that are unique to the coverage options created by the health care law.

This tool kit begins with an overview of the requirements for navigator programs that were laid out in the Affordable Care Act and in subsequent guidance from the Centers for Medicare and Medicaid Services (CMS, one of the federal agencies responsible for implementing the law). The next section answers some of the key questions facing states as they seek to establish effective navigator programs. These answers are supplemented by lessons that can be learned from State Health Insurance Assistance Programs, or SHIPs, the federally funded programs that help Medicare beneficiaries. SHIPs have extensive experience in conducting community outreach and education and in helping Medicare beneficiaries enroll in public and private coverage, and they are one nationally recognized model for providing consumer assistance.¹

Following the key questions and the lessons from SHIPs, we discuss recommendations advocates can make to help their states implement the best possible navigator programs. In Appendix 1, we offer a useful chart that lists the steps involved in the enrollment process and that shows just what help consumers will need at each stage. And lastly, in Appendix 2, we provide a short list of key resources. *While this tool kit focuses on considerations and lessons for setting up navigator programs, most of these recommendations also apply to setting up other in-person assistance programs.*

Navigator programs will be an essential component of the consumer assistance that is provided by exchanges. These programs can tap and build on existing expertise in serving vulnerable populations—expertise that exchanges will need to help newly eligible consumers get, keep, and use health insurance. Successfully preparing navigators and other assisters to provide effective, high-quality enrollment assistance to the diverse populations exchanges will serve requires providing navigator entities with robust training and support resources. We hope that this tool kit gives state advocates and officials the information and resources they need to ensure that navigator programs and other in-person assistance initiatives achieve their mission of helping consumers find and enroll in appropriate, affordable, high-quality health coverage.



Background

1. What are the federal requirements for navigator programs?²

Navigator programs are a required component of exchange consumer assistance. Exchanges must comply with federal minimum standards in establishing and operating these programs, including the development of state-specific standards and requirements.

■ Duties

At a minimum, each entity that is selected to be a navigator must do the following:

1. Maintain expertise in and conduct outreach and public education on the health coverage options and financial assistance that are provided through the exchange.
2. Distribute fair, accurate, and impartial information about the full range of health coverage options that are available through the exchange, including public programs.
3. Facilitate enrollment in qualified health plans (QHPs) through the exchange.
4. Make referrals to health insurance consumer assistance or ombudsman programs and to state agencies for help with grievances, complaints, appeals, and questions about using coverage.
5. Provide information and services in a manner that is culturally and linguistically appropriate and accessible to people with disabilities.

■ Selecting Navigators

The entities that exchanges select to become navigators must include at least one community-based and consumer-focused nonprofit and at least one other type of public or private entity. These entities cannot be health insurers or have affiliations with health insurers, as this may create a conflict of interest. Each of the entities selected must be able to perform all of the required navigator duties and must demonstrate that it has existing relationships (or the ability to readily establish relationships) with the populations that are likely to be eligible for exchange coverage. Federal guidance states that exchanges should plan to have a sufficient number of navigators to provide assistance to individuals and employers in all of the geographic areas served by the exchange.

■ **Standards of Conduct**

Navigators must comply with the privacy and security standards for exchanges. Each exchange must also establish standards to prevent, minimize, and mitigate conflicts of interest among navigator entities. Federal guidance encourages states to develop methods to ensure that navigators meet these standards and operate with integrity, such as requirements to disclose existing financial and non-financial relationships with other entities, to monitor enrollment patterns, and to impose penalties if standards are violated. The Department of Health and Human Services (HHS) plans to release model conflict of interest standards in forthcoming guidance.

■ **Training**

Navigators must have expertise in all of the following areas:

- the needs of underserved and vulnerable populations
- exchange eligibility and enrollment procedures
- the range of qualified health plans and insurance affordability programs (premium tax credits and cost-sharing reductions) that are available through the exchange
- their state's Medicaid, CHIP, and Basic Health programs
- privacy and security standards for consumer information

Exchanges will develop training and certification requirements for navigators, but exchanges are prohibited from requiring navigators to obtain a producer license or to purchase errors and omissions insurance (a type of liability coverage that provides financial protection for an entity in cases of negligence). HHS plans to issue model training standards, including standards for cultural and linguistic competency, in forthcoming guidance.

■ **Funding**

Navigator programs must be funded through grants from the operating budget that is used to run an exchange. However, federal exchange planning and establishment grants that are available through 2014 can be used for activities involved in *establishing* navigator programs, such as conducting needs assessments, developing training curricula, obtaining technology, and conducting public education to lay the groundwork for navigator outreach.

Navigator entities will also be eligible to receive administrative matching funds for assistance that is provided to individuals who are eligible to enroll in Medicaid and CHIP. Federal guidance states that exchanges should make sure that their navigator programs have sufficient funds to ensure that all potential enrollees have access to assistance.

2. How will navigator programs operate in the different exchange models?

States have three options for structuring exchanges, each of which affects implementation of the navigator program:

1. States may run their own exchange and implement all consumer assistance functions, including the navigator program.
2. States may have a federally facilitated exchange in which the federal government is responsible for implementing all consumer assistance functions, including the navigator program.
3. States may have a federally facilitated exchange but partner with the federal government to operate specific exchange functions, including in-person assistance. This is called a partnership exchange. In a consumer assistance partnership exchange, states will administer the navigator program, including monitoring and providing support to navigators. The federal government will select and award grants to navigator entities, establish standards of conduct, and provide training for navigators. States may provide additional state-specific training.³

3. What are in-person assistance programs?

In its *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges*,⁴ CMS provided a new option for states to receive exchange grant funding to establish and operate “in-person assistance programs” (also known as “assisters”) to supplement and fill gaps in the assistance that is provided by navigators (which may target their services only to specific populations). All states that partner with the federal government to provide consumer assistance must develop and implement in-person assistance programs. States that operate their own exchanges can decide whether to use assisters in addition to navigators. States that have a federally run exchange (including those that partner with the federal government only for health plan management) will not have in-person assistance programs.

This new funding opportunity will be particularly helpful for expanding assistance capacity during the first open enrollment period for exchanges, which begins on October 1, 2013, before exchanges are able to generate sufficient funding to run their navigator program at full capacity.⁵ The recommendations and tips that follow, while focused on navigator programs, also pertain to in-person assister programs.



Key Questions to Consider in Setting Up a Navigator Program

1. How can navigators reach consumers in underserved communities?

The people who will gain coverage under the Affordable Care Act include many individuals and families who have experienced significant barriers to obtaining coverage in the past, including such obstacles as the inability to afford coverage, ineligibility for public programs, being denied coverage based on a pre-existing condition, the complexity of enrollment processes, living in remote areas, low literacy, limited understanding of health insurance, and cultural and linguistic barriers.⁶ Surveys have found that the vast majority—78 percent—of consumers who are currently uninsured do not know about the new coverage options that will be available.⁷

Navigators will be a critical component of efforts to help consumers learn about their coverage options and will provide the targeted outreach, education, and personalized assistance needed to help consumers enroll. Whether navigator programs are successful in reaching those who face the greatest barriers to enrollment will hinge on how well exchanges do in selecting entities that have expertise in working with diverse and underserved constituencies.

- **Whenever possible, navigators should be chosen from groups that have established relationships with the populations that will be eligible to apply for exchange coverage.**

State experiences with similar initiatives to promote enrollment in health coverage show that community-based organizations and local institutions are in the best position to provide outreach and enrollment assistance.⁸ These organizations are trusted resources in their communities, and they are knowledgeable about the unique needs of the vulnerable populations that may be the most difficult for exchanges to reach, such as recent immigrants, seasonal workers or day laborers, the homeless, and individuals with mental health needs. Community-based organizations are therefore well-positioned to identify barriers to enrollment and opportunities to engage the populations they serve, and this information can be used to develop tailored strategies and effective messages for outreach and education.⁹

- **Navigators will have a broader reach if they are located in organizations that provide a range of services.**

Exchanges should be careful to select navigator entities that currently provide a range of services to target populations. Linking enrollment with other services that individuals and families already use, such as free tax preparation assistance, legal services, free or low-cost health care services, and services that help people enroll in public benefits, will help expand a navigator program's reach and foster continued interaction with consumers. This, in turn, will increase the likelihood that those who are newly enrolled in coverage will maintain that coverage over time and get the health care they need.¹⁰

It is important that the navigator entities that are selected and the locations where enrollment assistance is provided be accessible to the populations that the entity will serve. For example, some navigators may target assistance to lower-income adults without dependent children by conducting enrollment assistance at job training programs, community colleges, and organizations that provide free help with food and housing. Other navigators could provide assistance in primary schools and conduct outreach through faith-based networks that are likely to have more interaction with families at all income levels.

- **Navigator programs should provide assistance when and where it is convenient for consumers.**

In order to reach newly eligible populations, enrollment assistance must be available when and where consumers can most easily get that help. Approximately 88 percent of people who will be eligible to receive financial assistance to purchase coverage through exchanges, and more than 70 percent of those who will be newly eligible for Medicaid, will come from working families.¹¹ Therefore, navigators will need to provide assistance outside of typical business hours when potential enrollees will be applying for coverage.

Navigator programs will also need to establish community-based sites to make in-person assistance accessible to all enrollees. Programs must ensure that they meet the needs of applicants who have limited access to transportation and those who need access to computers or assistive technologies. These barriers may be even more problematic for those who live in geographically disparate areas, which typically have fewer health care and social service providers that can serve as entry points for enrollment. Therefore, exchanges should pay special attention to the accessibility of in-person enrollment assistance in rural areas when selecting navigator entities.

■ Navigator selection and outreach efforts should be informed by demographic data.

When designing navigator programs, states should begin by conducting a needs assessment to collect demographic information on uninsured residents or those who are likely to qualify for financial assistance to purchase exchange coverage.¹² Data on where potential enrollees are concentrated geographically, as well as more specific information on such demographics as primary language spoken, disability status, employment status, and family composition, can help an exchange estimate the overall capacity that the program will need and to select navigator entities that can meet the needs identified. Exchanges should regularly collect and share data on the uninsured to help evaluate the effectiveness of their navigator program, refine and update outreach strategies, and fill any gaps in assistance.

SHIP Tips Outreach and Community Education

- Create a community presence by developing relationships with a broad network of local organizations and groups that can refer consumers to the program.¹³
- Inform respected community leaders who are trusted resources for information and advice about your program. This can help you reach consumers who may not otherwise hear about the program or who may not respond to traditional outreach methods.¹⁴
- Conduct surveys to identify what sources of information and media your consumer demographic use most frequently.¹⁵
- Build relationships with local media outlets and take advantage of free opportunities for publicity, such as appearances on local radio shows or ads in community newsletters.¹⁶
- Use program resources efficiently by dedicating some staff and volunteers to outreach and public education work and by developing a specialized training path for this role.¹⁷
- Establish a state-level outreach and publicity team to develop uniform branding for the program; consistent, simple marketing messages; advertisements that can be used statewide; education and outreach materials written at an accessible reading level; and tools for working with the press that can be tailored by local programs.¹⁸
- While it may be too hectic to provide enrollment assistance at outreach events, take advantage of opportunities at these events to collect contact information for follow up and to schedule appointments for one-on-one assistance.¹⁹ Tell consumers what information they should bring to their appointment and identify any language assistance or accessibility needs in advance to make arrangements for providing appropriate services.
- Schedule and publicize opportunities to receive in-person assistance at easily accessible locations, such as libraries, community centers, schools, and universities, especially during open enrollment periods.²⁰
- Provide information on where consumers can get help on state notices, websites, and educational materials.
- Establish a toll-free, statewide number that directs callers to programs in their area.

2. How can navigators provide culturally and linguistically appropriate services?

National surveys have found that the people who are expected to enroll in exchange coverage will have significant language assistance needs, as approximately one in four of these consumers will speak a language other than English at home.²¹ In some states, this percentage will be much higher.

Exchanges are required to provide oral interpretation and written translations of web and print materials at no cost. They're also required to inform consumers about the availability of these services through the use of tag lines in the most common languages spoken by the exchange-eligible population.²² However, there is still uncertainty about how many languages these resources will be translated into, and about how many languages the taglines will be provided in to inform consumers that oral translation assistance is available. While these basic language services are essential to providing accessible consumer information and assistance in exchanges, these tools alone will not be sufficient to conduct outreach to diverse communities or to meet their consumer assistance needs.

Navigators will be a key component in ensuring that exchange outreach and enrollment assistance is accessible to culturally and linguistically diverse populations. Navigator and assister programs should build language assistance services into program operations by developing policies and procedures for identifying, assessing, and meeting language needs, and by budgeting for language access resources. Regardless of the populations they serve, all navigators and assistors should receive training on how to obtain interpreter services, how to work with in-person and telephone interpreters, and how to respond to calls and written communications and conduct in-person meetings with individuals who have limited English proficiency.²³

Conducting community-based outreach and enrollment using trusted local organizations that can provide culturally appropriate, in-person assistance in multiple languages, including languages that are less commonly spoken, will also be critical in making new coverage options accessible to diverse populations. Beyond leveraging these relationships, it will be important for navigator training in general to make sure that navigators and assistors have or develop the ability to provide assistance in ways that are culturally and linguistically appropriate. It will also be important for individual programs to develop the values, policies, knowledge, and skills necessary to foster effective cross-cultural communication.²⁴

SHIP Tips**Providing Culturally and Linguistically Appropriate Services**

- Build relationships with community groups, cultural institutions, and business communities that may not be well-positioned to provide services themselves but that have strong ties to target communities and can serve as valuable partners in outreach and public education.²⁵
- Translate print and online materials, as well as materials that are used for outreach, using a certified translator.²⁶ Provide counselors with both the English version and the translation to allow those who are working with an interpreter to follow along and help individuals who speak some English to feel more comfortable and confident if they need to communicate in English.²⁷
- Hire trained and competent bilingual staff or staff interpreters, including some who are certified translators. To do this, conduct a rigorous interview process that includes written and oral testing and observation of interactions with consumers.²⁸
- Provide resources and some level of training in the language the counselor will be using when assisting clients. For example, give counselors a translated glossary of key terms to promote consistent use of terminology.
- Be aware that using family and friends as interpreters may not be appropriate, for example, because of privacy concerns or because of the complexity of the information being provided. Ensure that other options to receive oral assistance are available. Also be aware that telephone language interpreters may not be familiar with health care terminology and may provide literal translations that do not accurately convey complex concepts. When working with contracted translators, make sure that they receive training on the information and topics that will be relevant to providing enrollment assistance.

3. How can navigators make services accessible to people with disabilities?

Studies on the demographics of the uninsured show that this population includes vulnerable consumers with a range of disabilities.²⁹ Exchanges are required to make consumer assistance resources and information accessible to people with disabilities by providing websites and telephone assistance in alternative formats for individuals with hearing or vision impairments. It is critical to build on these tools to ensure that in-person assistance is accessible to individuals who use other types of assistive technologies and interpreter services, or who have limited mobility. To do this, secure your program's access to these resources, conduct scheduled home visits, and provide enrollment assistance at sites that are physically accessible. Providing personalized assistance to this population will also require specialized training. For example, this training might include information on how to identify assistance needs, effective approaches to communication, working with authorized representatives, awareness of medical needs that are common among target populations, and how to help consumers with specific health needs connect with certain types of providers.

Outreach to individuals with disabilities may also present other unique challenges. Navigator programs should therefore develop relationships with programs and organizations that serve this population, such as vocational rehabilitation programs; centers for independent living; advocacy organizations for people with disabilities (such as state Family Voices chapters); university centers on disability; state agencies for developmental disability services; and Protection and Advocacy (P&A) programs, which are federally funded to provide legal advocacy services to people with disabilities in every state.³⁰ These programs may provide useful partnerships for delivering services, for training, and for developing resources for navigator and assister programs.

SHIP Tips

Providing Accessible Services

- Develop policies, procedures, and guidelines for providing accessible services, and partner with agencies and organizations that serve individuals with specific needs to establish referral relationships and connect with expert resources.³¹
- Provide sensitivity and skills training on how to effectively communicate with individuals with different disabilities, including respectful language choices and guidance on physical interactions.³²
- Train counselors about the health needs associated with specific disabilities that may be important to consider when individuals are selecting a health plan, such as the accessibility of providers that have appropriate equipment or that provide specific services.³³
- Develop a resource list of sign language interpreters with proficiency in multiple sign language systems, as well as a list of organizations that can provide auxiliary aids, services, and equipment.³⁴
- Provide program, outreach, and educational materials, including materials that are used during counseling, in alternate formats, for example, large-print and Braille versions.
- Ensure that outreach events and sites where enrollment assistance is provided are physically accessible.³⁵

4. What new areas of expertise will navigators need to develop?

The Affordable Care Act's new health coverage options and eligibility and enrollment processes will create new consumer assistance needs. The health care law will make it easier for individuals and families to enroll in health coverage by requiring states to use a single application and streamlining the eligibility determination process for both public and private coverage.³⁶ However, many consumers will need assistance with understanding the new options for coverage and financial assistance, the information they'll need to provide in order to qualify, and their responsibilities after they enroll.

■ Navigators will require specialized training.

Many of the issues consumers will need help with will be complicated, ranging from understanding how premium tax credits work and determining the amount of a premium tax credit to take in advance to providing information about offers of job-based coverage. Providing assistance with these steps in the enrollment process

is a new duty that no existing entity is currently trained to perform. Navigators will therefore need specialized training to develop expertise in new program rules and to learn new skills, such as how to use the exchange's online application portal, plan comparison tools, and cost calculators; how to help consumers choose the health plans that meet their needs in a manner that is impartial; and procedures for safeguarding consumers' financial and private information.

- **Training should include competency testing and require continuing education.**

Navigator programs should conduct competency testing to assess how well their individual navigators have learned and understand the topics and skills taught in initial training to ensure that navigators are prepared to put their new knowledge and skills into practice. States that have begun to develop training for navigators have also proposed requirements for continuing training and education, including yearly refresher courses and testing. States may also develop testing techniques that do not involve written testing that may be better suited to assessing skill level, such as observing a mock counseling session or testing use of online tools. This will help navigators learn about specialized topics and changes in policy, provide opportunities to share best practices across programs, and help ensure that they are providing high-quality assistance.

- **Navigators will need to assist consumers with all the coverage options that are offered through exchanges.**

When applying for coverage, many consumers will not know the type of coverage for which they or a family member may be eligible. These options may include a private plan sold through the exchange, Medicaid, CHIP, or a Basic Health program (where applicable). And many families will have members who are eligible for different coverage options.³⁷

In order to truly achieve a “no wrong door” enrollment system (as required by the health care law), navigators will need to help consumers with the enrollment process from start to finish, regardless of whether they are ultimately determined to be eligible to enroll in a qualified health plan or a public coverage program. Community-based assistance programs for Medicaid and CHIP outreach in California have also found that using an “umbrella strategy,” which makes assistance available for multiple coverage options and all members of a family, helps simplify outreach messages and minimize confusion about where consumers should go for help. This has resulted in higher enrollment.³⁸

- **Navigators must provide assistance with enrollment from start to finish.**

Navigators must be able to assist consumers through the entire enrollment process, from completing an application for coverage to activating that coverage, including selecting a health plan and resolving any issues that may arise as their eligibility is verified. Massachusetts' experience with enrollment in the Connector, the state's exchange, showed that consumers often do not complete the enrollment process when follow-

up actions are required.³⁹ Achieving real-time eligibility determinations through the exchange website is one way to significantly increase enrollment. If online applications cannot be processed in real time, or if a consumer uses a paper application, it will be important for navigators to track consumers' enrollment status and help them take any additional steps needed to complete enrollment.

■ **Some navigators will need training in assisting small employers.**

The Affordable Care Act requires that small businesses and other small employers that buy coverage and apply for tax credits through an exchange also be able to get enrollment assistance from navigators.⁴⁰ Many small employers are expected to continue to work with insurance agents or brokers to buy exchange coverage. However, to ensure that navigators are able to provide meaningful help to any small employers that need it, navigator programs must provide training on assisting small employers with enrollment, with obtaining tax credits, and with helping employees select a health plan.⁴¹

Specific entities, such as trade or business associations and insurance agents or brokers, may be best suited to conducting outreach and providing assistance to certain small employers. In addition, some small employers may have particular needs, such as language assistance. Exchanges should therefore conduct focus groups with diverse small employers to learn about their assistance needs and preferred methods for receiving assistance. Exchanges may also need to evaluate their capacity to adequately serve this population after the first open enrollment period has ended.

SHIP Tips Training

- Certify counselors through an initial multiple day training, followed by competency testing. To reinforce this training, provide counselors with tools for self-study, require them to participate in refresher or continuing education trainings, and require a period of shadowing or mentorship with an experienced counselor before counselors are allowed to provide assistance independently.⁴²
- Include training on ethics, nondiscrimination, privacy and security standards, and providing unbiased information. These standards of conduct should be included in a written agreement that counselors must sign prior to certification.⁴³
- Provide “task-based” training to help new staff and volunteers develop and practice the skills and competencies needed for specific job responsibilities. For example, training could include interactive exercises to model effective approaches to sample case scenarios or specific tasks, such as how to provide objective information about plan options.⁴⁴
- Provide training on how to use online enrollment tools, such as how to complete an online application, how to use plan comparison tools, where to find online resources and information, how to submit documents electronically, and how to record data in the program database.⁴⁵
- Ongoing training and repeat testing are effective ways to reinforce skills and ensure that volunteers and staff keep current on policy and program changes.⁴⁶ Online training modules can help reach assistors in remote geographic areas and supplement in-person training when staff resources are limited.⁴⁷

5. What types of ongoing supervision and support resources will navigators need?

In addition to training, navigators will need ongoing supervision and access to referral resources to ensure that they are able to provide consumers with effective assistance in complex situations and with accurate and impartial information.

- **Navigators will need direct supervision and support.**

All individual navigators must be associated with an organization or entity that can provide direct supervision and oversight. While the exchange will provide oversight of the entire navigator program, direct supervision by senior staff will be an important resource for navigators as they are assisting individuals. Direct supervision will provide opportunities to reinforce skills, identify issues that can be better addressed in training, and help ensure that navigators are providing quality services even in difficult cases.

Two successful supervisory practices that are currently used by consumer assistance programs are 1) pulling a random sample of cases for review, and 2) holding weekly staff meetings to discuss complex cases and share best practices.⁴⁸ These methods will also enable navigator entities to identify systemic issues early and report them to the exchange.

- **Navigators will need a mechanism for communicating with the state and with exchange staff.**

It will be critical for navigators to be able to contact exchange staff or eligibility workers in state Medicaid and CHIP agencies to help consumers resolve problems related to eligibility and enrollment. Exchanges may want to consider providing a technical support line for navigators and a mechanism for exchanges and state agencies to recognize navigators, such as giving navigators unique identification numbers (this would allow information about an individual's application or enrollment status to be shared with the permission of the consumer). Exchanges and state agencies will also need mechanisms to disseminate information and resources to navigator programs and to provide valuable opportunities for communication across local programs.

- **Navigator networks should include programs that provide expert assistance.**

“Expert” programs, such as consumer assistance programs and legal services providers, should be among the entities that are selected as navigators or should be part of a navigator program's extended network. Programs like these are necessary to provide back-up assistance and support when people have complex coverage situations, such as split custody households, households with incarcerated family members, or members

of a family who are estranged due to abandonment or domestic abuse. In cases such as these, consumers may need counseling not just about their coverage options, but also about how they list their family members on tax returns, for example.

In order to make referrals, navigators should have access to a regularly updated directory of other entities that provide assistance on particular issues, as well as established procedures for referral and follow-up to ensure that consumers are able to get the assistance they need.

SHIP Tips

Providing Ongoing Supervision and Access to Resources

- Provide tools that can guide assistance, such as step-by-step guides to helping consumers with applications, checklists of questions to identify consumer needs when helping select plans, reference materials, and a directory of referral resources.⁴⁹
- Ensure that senior staff members are accessible to those providing assistance in the field, for example, by providing all staff with cell phones.⁵⁰
- Schedule regular staff meetings to discuss common consumer assistance issues, reinforce how to effectively spot problems, and identify successful strategies for assisting consumers with complex needs or situations.
- Assign each counselor a unique identification number that is recognized by federal and state entities, and by private health plans, which allows counselors to communicate and share information with the appropriate entities to quickly resolve any problems affecting consumers' enrollment.⁵¹
- Build formal partnerships or strong referral relationships with programs that provide expert assistance with complex consumer problems, legal issues, and access to treatment for particular health conditions.⁵²
- Create strong linkages with county, state, and federal agencies that can help troubleshoot problems in complex cases and resolve eligibility issues quickly.⁵³
- Designate a central hub to provide oversight for program operations, disseminate information statewide, and promote consistent standards for services.⁵⁴
- Organize regularly scheduled opportunities for local programs within and across states to discuss issues faced by consumers, share best practices, recommend helpful partners and resources, and refine marketing and public education strategies.⁵⁵

6. What types of technology will navigators need access to?

Federal agencies predict that the majority of consumers who get coverage through exchanges will apply online.⁵⁶ Navigators will help them do this, and they can also extend the reach of web-based enrollment through the use of portable and community-based access to technology and electronic resources.

- **Navigators will need access to technology and electronic resources in the community.**

Providing assistance with accessing and completing online applications will be an essential service for many consumers who do not have regular access to computers or the Internet, or who have limited experience using technology. Navigators should establish relationships with community-based institutions that can provide publicly accessible computers, scanners, and printers. Navigators should also have their own portable electronic devices, such as laptops or tablets with wireless capability and cell phones that can be used to upload documents.

- **Creating a specialized enrollment portal will enhance navigator efficiency and effectiveness.**

When designing exchange websites and enrollment tools, states should consider creating a specialized portal that would enable navigators to submit coverage applications on behalf of consumers. Such portals would also provide navigators with the capacity to track information on enrollment, eligibility status, and other actions that need to be taken, such as submitting documentation.

The UX 2014 project design for a consumer-friendly exchange interface, which can be used by any state, includes a model enrollment portal for assisters.⁵⁷ This type of portal can help navigators expedite the enrollment process; assist consumers with resolving problems; ensure successful enrollment for consumers whose applications cannot be processed in real time; and provide assistance post-enrollment, for example, with reporting changes or renewing coverage. The portal will also tag applications with information that identifies which assister provided help, allowing exchanges to collect data that will help monitor navigator performance.

An assister portal could work like the database platform used by the HelpLine operated by Health Care for All, a consumer advocacy nonprofit in Massachusetts. HelpLine counselors sign privacy agreements with consumers who call for assistance, which allows the program to receive and track updates in consumers' enrollment status. Counselors collect information using the HelpLine database as they assist individuals with applying for coverage. The database is updated as the program receives new information about a consumer's coverage status (such as changes in

enrollment and eligibility status, pending actions, and requests for documentation or renewal) that the state sends to the program daily in a password-protected spreadsheet and in paper notices. Counselors are then able to follow up with consumers to ensure that they have also received the notices that are sent to the program, understand the information provided, and receive the assistance needed with any action that may be required. When consumers who did not originally apply for coverage through the HelpLine call the program for assistance, counselors are also able to log into a state database, called the Virtual Gateway, to look up information about consumers' coverage status.⁵⁸

■ **Access to consumer information should be integrated for all consumer assistance entities.**

All entities that help consumers enroll in or resolve problems with exchange coverage should be able to look at the data on an individual's eligibility and enrollment status (with the consumer's permission). This will ensure that navigators and other assisters, including exchange call center representatives, can effectively collaborate to quickly and efficiently resolve consumer problems.

SHIP Tips Technology

- Schedule enrollment assistance clinics in places where technology is publicly accessible, such as libraries and schools.
- Equip counselors who are out-stationed at sites in the community, or who are conducting direct outreach, with laptops that have wireless capability.⁵⁹
- Provide online resources and reference tools that counselors can access from any location.⁶⁰
- Use a centralized, web-based data collection system that allows counselors to record and update information while assisting consumers⁶¹ (but be sure to leave consumers a paper record of any enrollment transactions).

7. What type of help will consumers need after enrollment and outside of the annual exchange open enrollment period?

Many consumers will need assistance outside of the annual exchange open enrollment period as they experience changes in circumstance, switch between coverage markets, and/or renew and use their coverage. It is important that navigator programs use staff effectively to ensure that they are able to provide assistance throughout the year while maintaining capacity during open enrollment.

- **Navigators will play a critical role in helping consumers maintain and apply for coverage outside of open enrollment when circumstances change.**

Over the course of a year, it is estimated that as many as 29.4 million consumers could experience changes in circumstance that would result in gaining or losing eligibility for exchange coverage and financial assistance.⁶² This issue is even more acute for individuals with lower incomes, who have the most frequent fluctuations in income. Approximately 50 percent of individuals with incomes below 200 percent of the federal poverty level (\$22,340 for an individual in 2012) are expected to experience changes in income that move them between eligibility for Medicaid and eligibility for financial assistance to purchase coverage through an exchange.⁶³

Navigators will play an important role in educating consumers about their responsibilities to report changes in circumstance and about how changes during the year may affect their eligibility for premium tax credits when they file taxes the following year. For example, when deciding how much of a premium tax credit to take in advance, consumers will need to take into account expected or potential changes in income or family circumstance. Navigators can help individuals report changes and adjust this amount during the course of the year, if necessary.

Navigators will also need to provide assistance with enrollment in new coverage options if a change in circumstance affects eligibility. Part of this work will involve conducting outreach and public education throughout the year to ensure that consumers know about their right to apply for coverage or change health plans during a special enrollment period (if they qualify based on a change in circumstance). Events that may qualify individuals for a special enrollment period include losing job-based coverage, gaining citizenship status, moving to a new state, changes in family size or eligibility for financial assistance, a health plan violation of coverage contract terms, or experiencing exceptional circumstances such as a natural disaster. States may be able to link individuals who are likely to qualify for a special enrollment period to navigators when one of these triggering circumstances is made known to the exchange through data matching or when a change in circumstance is reported by a consumer.

Individuals who become eligible for Medicaid can apply for coverage at any point during the year.

- **Navigators should be able to assist with coverage renewals.**

The Affordable Care Act simplifies coverage renewal procedures by requiring exchanges to pre-populate information on renewal forms for qualified health plans and to conduct administrative renewals for Medicaid and CHIP. However, consumers will still need to report changes that are not captured through data matching, ensure that information on their renewal forms is current, and provide supporting documentation. Massachusetts' experience with enrollment and retention through the Connector revealed that the need to provide information at renewal can be a significant barrier to maintaining coverage and that proactive outreach to consumers is effective in helping them successfully renew coverage.⁶⁴

- **Navigators can play a key role in helping ensure that consumers get the care they need when they need it.**

The ideal time for consumers to understand their benefits, learn how to use their coverage, and connect with providers is when they first enroll. Approximately 65 percent of the individuals who are expected to enroll in coverage through exchanges will be uninsured. Nearly 40 percent of this population will have gone for more than two years without a check-up and will not have a usual source of care.⁶⁵ Navigators can help these individuals find providers, including medical and health homes that offer case management services. If an applicant's family includes members who are undocumented immigrants, navigators can also provide information about low-cost or free health centers and assistance in getting Medicaid coverage for emergency services.

SHIP Tips

Providing Services outside of Open Enrollment

- Provide assistance to consumers who seek help outside of open enrollment when they experience problems with their coverage.
- Offer services that consumers will need year-round, such as counseling on plan benefits, how to find providers, and consumer rights. Navigators may want to give presentations on coverage, for example, as part of community outreach events regarding health and wellness.⁶⁶
- Continue to engage and expand your referral network and outreach partners by educating stakeholders about health insurance issues and by providing public education sessions in forums that are appropriate to your target population.
- Maintain a core year-round staff and recruit highly trained volunteers and additional staff to expand outreach, education, and counseling capacity during open enrollment season.⁶⁷



Key Recommendations for Implementing a Robust Navigator Program

By February 2013, states will have declared whether they will run their exchange, opt for the federal government to operate their exchange, or partner with the federal government to run certain functions of the exchange.⁶⁸ Below are recommendations that advocates can make to help build robust, consumer-focused navigator programs in any of the three exchange models.

- **Secure adequate and sustainable funding for navigator programs.** Navigator programs will require substantial investment if they are to be successful at increasing enrollment and retention rates, expanding the use of online enrollment tools, and ensuring that consumers enroll in the coverage options that best meet their needs. States should use exchange planning and establishment funds to collect data on the populations that will be eligible for coverage to determine the capacity needed in the program. They should also work with stakeholders to develop appropriate payment for navigator entities, and they should take advantage of the opportunity to use federal Medicaid administrative matching funds for assistance that is provided to people who are eligible for Medicaid or CHIP.
- **Create a formal process for engaging stakeholders** in developing grant requirements for navigators and identifying navigator entities that are well suited to meeting the needs of particular constituencies. Provide ample time for entities interested in becoming navigators to prepare for meeting grant requirements and completing their grant applications before the deadline to apply for funding.
- **Establish a central entity to provide technical support for navigators**—this may be the exchange itself, a state agency, or a nonprofit organization. This technical support may include assisting individual navigator programs; communicating with all navigator programs about system-wide issues and policy updates; providing additional training as needed; developing public education and outreach materials; and organizing forums for information sharing among navigators, such as regularly scheduled calls, webinars, or meetings.
- **Provide formal mechanisms for communication and data sharing among navigators, the exchange, and state agencies.** Navigators will need to have formal relationships with both the exchange and the state agencies that determine eligibility for public coverage. Mechanisms for communicating with these entities should enable individual navigators to get real-time data on eligibility and enrollment status for the consumers they are assisting, and these mechanisms should help them work with exchange and state agency staff who have the ability to resolve consumer issues.

- **Create structured opportunities for navigator entities to provide feedback to the exchange and state agencies** on how new systems are working for consumers and opportunities to collaborate with relevant agencies to improve policies and procedures.
- **Create a seamless referral system among the entities that are providing consumer assistance**, including standard procedures for connecting consumers to the appropriate entity, and mechanisms to promote communication, information sharing, and access to consistent information among entities that provide assistance in person, by phone, and online.
- **Ensure that the outreach and public education strategies that are used by the exchange and navigator programs are consistent and coordinated** and that they include consumer-tested materials and marketing messages.
- **Provide contact information for the navigator program in all outreach and public education materials, and through a searchable directory on the exchange website.** This should include hours of operation and the location of all navigator entities. It should also include descriptions of the particular services the program offers, such as bilingual assistors, access to assistive technologies, or whether consumers can make appointments to get assistance at home or in a community setting.
- **Provide oversight of navigator entities.** This may include periodic review of navigator presentations and counseling sessions; monitoring for conflicts of interest, fraud, or steering of consumers into particular insurance options; and establishing a mechanism for consumers to provide feedback, file complaints, and seek recourse (for example, if they believe they have been misled by a navigator).
- **Work with navigator entities to develop data collection requirements that enable the exchange to evaluate navigator performance** overall and for specific entities, and to analyze trends in data in order to refine program strategies.



Appendix 1.

Where will consumers need assistance in applying for coverage?⁶⁹

The following chart outlines the steps in the application process (using a single streamlined application) and the issues navigators should be prepared to provide assistance with at each step. These steps apply whether a consumer completes and submits the application in person, over the phone, online, or by mailing in a paper application.

Steps in the Enrollment Process	Areas Where Consumers Will Need Help
1. Learning that coverage is available	<ul style="list-style-type: none"> Getting information about new coverage options, how to apply, and how to obtain assistance.
2. Obtaining an application	<ul style="list-style-type: none"> Finding community-based locations where they can either use computers to apply for coverage online or obtain a paper application.
3. Determining whether to apply for insurance affordability programs	<ul style="list-style-type: none"> Understanding insurance affordability programs (premium tax credits and cost-sharing reductions for qualified health plans, Medicaid, CHIP, and the Basic Health program) to the extent needed to determine whether the applicant or a family member may be eligible for these programs. Gathering the information needed to apply for these programs.
4. Describing household members	<ul style="list-style-type: none"> Providing information on all family members who are part of the household for the purpose of filing taxes. This may be more challenging for consumers who have not filed taxes previously, who live separately from dependents or spouses, who have shared custody arrangements, or who are used to the current application for Medicaid or CHIP.
5. Confirming or reporting correct income information	<ul style="list-style-type: none"> When using an online application, adjusting pre-populated calculations of current and projected household income that appear to be incorrect. Identifying recent or expected changes in income or family size (marriage, divorce, birth, adoption, job change, etc.) to provide the most accurate projection of income and family size for the current tax year.
6. Providing information about an offer of job-based coverage	<ul style="list-style-type: none"> Collecting information on coverage and its affordability for job-based plans using the lowest-cost plan the employer offers. (HHS may develop a template form that employers can use to provide required information to employees.)
7. Submitting supplemental documentation, if needed	<ul style="list-style-type: none"> Gathering and submitting approved forms of documentation within deadlines when information cannot be verified through data matching and when self-attestation is not accepted.

Steps in the Enrollment Process	Areas Where Consumers Will Need Help
8. Reviewing eligibility determinations	<ul style="list-style-type: none"> • Understanding coverage options for which they or their family members have been determined to be eligible. • Appealing an eligibility determination that appears to be incorrect. • Obtaining information about Medicaid coverage for emergency care if a member of the applicant's household is an eligible non-citizen.
9. Enrolling in public coverage, if eligible	<ul style="list-style-type: none"> • Selecting a managed care plan if the state provides Medicaid or CHIP through managed care organizations. • Understanding premium requirements for Medicaid managed care plans. • Completing supplemental sections of the application or supplemental forms to apply for Medicaid under traditional (non-MAGI) rules based on a disability, need for long-term care, or high medical expenses. • Obtaining coverage through the exchange while waiting for a determination of eligibility for traditional Medicaid. • Ensuring successful completion of the enrollment process if applications are transferred to a state Medicaid or CHIP agency for a final eligibility determination. • Coordinating plan choices among individuals in the same household.
10. Deciding the advance amount of premium tax credits to take, if eligible	<ul style="list-style-type: none"> • Understanding the tax credit reconciliation process, the potential tax liability, and the implications for how taxes are filed. • Assessing how much, if any, of the premium tax credit to take in advance monthly payments to minimize the risk of repayment. • Understanding when and how to report changes in income and family size.
11. Selecting a qualified health plan (QHP)	<ul style="list-style-type: none"> • Understanding plan features, such as premiums, cost-sharing, and the differences between plans. • Comparing costs under different coverage tiers based on eligibility for tax credits and cost-sharing reductions. • Comparing the benefits package in each plan to determine which provides needed services, includes current providers, covers certain prescription drugs, or has other features that are important for the individual or family. • Enrolling in supplemental coverage, such as a stand-alone vision or dental plan, if needed. • Coordinating plan choices among individuals in the same household.
12. Obtaining an exemption from the individual responsibility requirement, if eligible	<ul style="list-style-type: none"> • Obtaining exemptions from the individual responsibility requirement if coverage options are unaffordable, or for other allowable reasons.



Appendix 2: Other Resources

Bridging the Enrollment Gap: The Importance of Providing In-Person Assistance (Enroll America, August 2012), available online at <http://www.enrollamerica.org/best-practices-institute/publications-and-resources/2012/bridging-the-enrollment-gap-the-importance-of-providing-in-person-assistance>.

Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP, and Exchanges (Maximizing Enrollment, July 2012), available online at <http://www.maxenroll.org/publication/consumer-assistance-digital-age-new-tools-help-people-enroll-medicaid-chip-and-exchanges>.

Countdown to 2014: Designing Navigator Programs to Meet the Needs of Consumers (Georgetown Center for Children and Families, July 2012), available online at <http://ccf.georgetown.edu/ccf-resources/countdown-2014-designing-navigator-programs-meet-the-consumers/>.

Designing Navigator Programs to Meet the Needs of Consumers: Duties and Competencies (Georgetown Center for Children and Families, September 2012), available online at <http://ccf.georgetown.edu/ccf-resources/designing-navigator-programs-meet-the-consumers-duties-competencies/>.

Filling in Gaps in Consumer Assistance: How Exchanges Can Use Assisters (Families USA, November 2012), available online at <http://familiesusa2.org/assets/pdfs/health-reform/How-Exchanges-Can-Use-Assisters.pdf>.

Navigator and In-Person Assistance Programs (Enroll America, November 2012), available online at http://files.www.enrollamerica.org/best-practices-institute/enroll-america-publications/Navigator_and_In-Person_Assistance_Factsheet.pdf.

Navigators: Guiding People through the Exchange (Community Catalyst, June 2011), available online at http://www.communitycatalyst.org/doc_store/publications/Navigators_June_2011.pdf.

Resources and Guidance from the Federal Government

Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges (Centers for Medicare and Medicaid Services, August 14, 2012), available online at <http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf>.

Cooperative Agreement to Support Establishment of the Affordable Care Act's Health Insurance Exchanges (Center for Consumer Information and Insurance Oversight, June 29, 2012), available online at www.grants.gov by searching for [CFDA 93.525](#) under “find grant opportunities.”

Final Rule and Interim Final Rule on the Establishment of Exchanges (Department of Health and Human Services, March 27, 2012), available online at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>.

Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid (Centers for Medicare and Medicaid Services, December 10, 2012), available online at <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

Guidance on Federally Facilitated Exchanges (Center for Consumer Information and Insurance Oversight, May 16, 2012), available online at <http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf>.

Guidance on the State Partnership Exchange (Center for Consumer Information and Insurance Coverage, January 3, 2013), available online at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>.

Endnotes

- ¹ State Health Insurance Assistance Program (SHIP) counselors assist Medicare beneficiaries with enrollment in Part D drug plans and provide counseling on Medicare, Medicare Advantage, and Medicare supplemental policies. SHIP counselors also regularly assist Medicare beneficiaries with using the medicare.gov online tools to compare, select, and enroll in drug plans, and they help low-income Medicare beneficiaries apply for Medicaid coverage and subsidy programs. Health Assistance Partnership, *Helping State Health Insurance Assistance Programs (SHIPs) Help Medicare Beneficiaries* (Washington: Health Assistance Partnership, October 2009), available online at <http://www.familiesusa.org/assets/hapnetwork/ships-helping-medicare-consumers.pdf>.
- ² 45CFR 155.210 (a-f) and Section II. Subpart C at 18330-18334, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” *Federal Register* 77, no. 59 (March 27, 2012).
- ³ Families USA, *State Responsibilities in a Partnership Exchange* (Washington: Families USA, October 2012), available online at <http://familiesusa2.org/assets/pdfs/health-reform/State-Exchange-Partnership-Responsibilities.pdf>.
- ⁴ Center for Consumer Information and Insurance Oversight, *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges* (Washington: Department of Health and Human Services, August 14, 2012), available online at <http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf>.
- ⁵ Families USA, *Filling In Gaps in Consumer Assistance: How Exchanges Can Use Assistors* (Washington: Families USA, November 2012), available online at <http://familiesusa2.org/assets/pdfs/health-reform/How-Exchanges-Can-Use-Assistors.pdf>.
- ⁶ Kaiser Commission on Medicaid and the Uninsured, *A Profile of Health Insurance Exchange Enrollees* (Washington: Kaiser Family Foundation, March 2011), available online at <http://www.kff.org/healthreform/upload/8147.pdf>.
- ⁷ Deepak Madala, *Bridging the Enrollment Gap: The Importance of Providing In-Person Assistance* (Washington: Enroll America, August 2012), available online at <http://www.enrollamerica.org/best-practices-institute/publications-and-resources/2012/bridging-the-enrollment-gap-the-importance-of-providing-in-person-assistance>.
- ⁸ Kaiser Commission on Medicaid and the Uninsured, *Expanding Medicaid to Low-income Childless Adults under Health Reform: Key Lessons from State Experiences* (Washington: Kaiser Family Foundation, July 2010), available online at <http://www.kff.org/medicaid/upload/8087.pdf>.
- ⁹ California Coverage and Health Initiatives, *A Trusted Voice: Leveraging the Local Experience of Community Based Organizations in Implementing the Affordable Care Act* (Sacramento: California Coverage and Health Initiatives, April 2011), available online at <http://cchi4families.org/cms-assets/documents/30167-92179.cchinewwpoutreachprint-1050411.pdf>.
- ¹⁰ The Colorado Trust, *Trusted Hands: The Role of Community-Based Organizations in Enrolling Children in Public Health Insurance Programs* (Denver: The Colorado Trust, February 2010), available online at http://www.coloradotrust.org/attachments/0001/0489/TrustedHands_021010_FINAL.pdf.
- ¹¹ Unpublished data analysis by the Lewin Group for Families USA. Data are on file at Families USA.
- ¹² The Centers for Medicare and Medicaid Services has posted detailed Census data identifying geographic locations and demographic characteristics of uninsured populations, which may provide a useful starting point for developing state outreach strategies. This data is available online at <http://www.cms.gov/Outreach-and-Education/Outreach/HIMarketplace/Census-Data.html>.
- ¹³ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Mike Klug, consultant and former team leader for the Health Assistance Partnership’s Medicare Education Team, July 20, 2012. SHIPs typically have a central office at the state level that is housed in the office of the insurance commissioner or the state unit on aging that coordinates with local offices at the county level, where most SHIP staff and counselors work in community-based organizations that serve older adults and people with disabilities, such as senior centers and hospitals.
- ¹⁴ For example, the North Carolina SHIP established the “Community Superstars” program to recruit respected community leaders and prepare them to share information about Medicare low-income subsidy programs with potential beneficiaries and to provide referrals to the SHIP. See the Health Assistance Partnership’s best practices in *LIS Outreach Project: “Community Superstars”* online at <http://www.familiesusa.org/assets/hapnetwork/north-carolina-lis-outreach.html>.
- ¹⁵ See a survey developed by the North Carolina SHIP and administered by the Martin Department County of Aging online at <http://www.familiesusa.org/assets/hapnetwork/north-carolina-lis-outreach.html>.
- ¹⁶ See *Simple Ideas for Outreach* online at <http://www.familiesusa.org/assets/hapnetwork/pilot-project-outreach-ideas.html>; *Rural Outreach Strategies—Building Relationships with Small Town Media* for strategies from the Arizona SHIP, available online at <http://www.familiesusa.org/assets/hapnetwork/arizona-rural-outreach.html>; and media tools developed by the Florida SHIP, available online at <http://www.familiesusa.org/assets/hapnetwork/florida-outreach-publicity.html>. Also see Families USA’s tips on media basics, story banking, and online tools, available online at <http://familiesusa2.org/conference/health-action-2012/toolkit/content/skills.html#basics>.
- ¹⁷ SHIP programs develop specialized roles for staff and volunteers that help maximize expertise, provide options for volunteers with different strengths and skill sets, and make responsibilities manageable for new recruits. See the Health Assistance Partnership’s *Guide to Volunteer Program Development* online at <http://familiesusa2.org/hapnetwork/assets/docs/vpd/hap-s-guide-to-volunteer-program-development.doc> and the position descriptions developed by the Virginia SHIP online at <http://www.familiesusa.org/assets/hapnetwork/virginia-2009.html>.

¹⁸ Florida's Department of Elder Affairs established a state-level Outreach and Publicity Team to support promotional efforts for local offices of the Florida SHIP program. See the team's publicity and outreach strategies online at <http://www.familiesusa.org/assets/hapnetwork/florida-outreach-publicity.html>.

¹⁹ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Mike Klug, op. cit.

²⁰ To schedule assistance clinics during open enrollment, SHIPs often develop partnerships with local institutions, such as libraries, community centers, universities, and health care facilities. These clinics are well publicized, and consumers can call to schedule an appointment in advance or come during walk-in hours. Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Alice Ierley, SHIP and SMP Program Director, Colorado Department of Regulatory Agencies, Division of Insurance, August 2, 2012.

²¹ Kaiser Commission on Medicaid and the Uninsured, *A Profile of Health Insurance Exchange Enrollees*, op. cit.

²² 45CFR 155.205 (a-e) in "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," *Federal Register* 77, no. 59 (March 27, 2012).

²³ Training and Advocacy Support Center, National Disability Rights Network, *Effective Communication and Language Access for Individuals with Disabilities* (Washington: National Disability Rights Network, August 2007). The National Disability Rights Network is the nonprofit membership organization for state Protection and Advocacy (P&A) systems and client assistance programs (CAPs), which provide legally based advocacy services for people with disabilities. The network also provides training and technical assistance for P&As and CAPs through its Training and Advocacy Support Center.

²⁴ The Center for Cultural Competence at the Georgetown University Center for Child and Human Development provides conceptual frameworks and practical checklists to help direct service providers assess and develop cultural and linguistic competence. See <http://nccc.georgetown.edu/foundations/frameworks.html> and <http://nccc.georgetown.edu/resources/publicationstype.html#checklists>.

²⁵ Interview between Elaine Saly, Families USA, and Bonnie Burns, Training and Policy Specialist Consultant for California Health Advocates, the lead nonprofit agency for the California SHIP network, November 1, 2012.

²⁶ For a list of what makes a translation good, see Enroll America and Maximus Center for Health Literacy, *Translations that Hit the Mark* (Washington: Enroll America, October 2012).

²⁷ The Department of Health and Human Services translates into 12 languages many documents and fact sheets that are important for Medicare beneficiaries. These fact sheets are used by SHIP counselors. The translated documents are available on the Medicare.gov website at www.medicare.gov/about-us/other-languages/information-in-other-languages.html.

²⁸ Interview between Elaine Saly, Families USA, and Heather Bates, Vice President, Client Services and Program Management, Medicare Rights Center, New York office, former director of the New York SHIP, November 15, 2012.

²⁹ National Council on Disability, *The Current State of Health Care for People with Disabilities* (Washington: National Council on Disability, September 2009), available online at <http://www.ncd.gov/publications/2009/Sept302009>.

³⁰ National Disability Rights Network directory of state Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP), available online at <http://napas.org/en/ndrn-member-agencies.html>. The Association of University Centers on Disabilities directory of programs by state is available online at <http://www.aucd.org/directory/directory.cfm?program=UCEDD>. The National Association of State Directors of Developmental Disabilities Services directory of intellectual/developmental disabilities agencies is available online at <http://www.aucd.org/directory/directory.cfm?program=UCEDD>.

³¹ Training and Advocacy Support Center, National Disability Rights Network, op. cit.

³² See United Spinal Association, *Tips on Interacting with People with Disabilities* (Jackson Heights, New York: United Spinal Association, 2008), available online at <http://www.unitedspinal.org/pdf/DisabilityEtiquette.pdf>; and *Tips: Interacting with People with Disabilities* online at <http://www.familiesusa.org/assets/hapnetwork/interacting-disabilities-1.html>.

³³ Interview among Elaine Saly, Families USA, Elizabeth Priaux, Senior Disability Specialist, and Zach Martin, Disability Advocacy Specialist, the National Disability Rights Network, November 11, 2012.

³⁴ Under the Assistive Technology Act of 1989, each state has an Assistive Technology Act Program that maintains an inventory of assistive technologies, provides training on assistive technology use, and loans assistive technologies to individuals and programs. A directory of Assistive Technology Act programs is available online at <http://ataporg.org/states.html>. The Registry of Interpreters for the Deaf provides an online database of sign language interpreters online at <https://www.rid.org/acct-app/index.cfm?action=search.members>.

³⁵ Allies in Self-Advocacy, *Accessible Meetings and Presentations*, available online at <http://alliesinselfadvocacy.org/accessible-meetings-presentations/>.

³⁶ Centers for Medicare and Medicaid Services, *PRA for Single Streamlined Application Data Elements*, notice and appendices available online in the Medicaid.gov State Resource Center and at <https://federalregister.gov/a/2012-16508>.

³⁷ S. McMorrow, G. Kenney, and C. Coyer, *Addressing Barriers to Health Insurance Coverage among Children: New Estimates for the Nation, California, New York, and Texas* (Washington: Urban Institute, May 2012), available online at http://www.urban.org/url.cfm?id=412561&RSSFeed=UI_ChildrenandYouth.xml.

- ³⁸ California Coverage and Health Initiatives, op. cit.
- ³⁹ Conversation between Elaine Saly, Families USA, and Kate L. Bicego, Consumer Education and Enrollment Manager, Health Care for All, October 26, 2012.
- ⁴⁰ 45CFR 155.705 (a) in “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” *Federal Register* 77, no. 59 (March 27, 2012).
- ⁴¹ Agents and brokers may become navigators in some exchanges, and they may be paid as they are now in others.
- ⁴² As of 2009, about two-thirds of states had established certification programs for SHIP counselors, and more states are in the process of developing such programs. Health Assistance Partnership, *State of the SHIPs: A Summary of Results of the 2009 SHIPs Needs Assessment Survey* (Washington: Families USA, January 2010), available online at <http://www.familiesusa.org/assets/hapnetwork/2010.pdf>. Methods of certification are described online at <http://www.familiesusa.org/assets/hapnetwork/ship-certification-methods.html>.
- ⁴³ See the Volunteer Agreement in the Maryland SHIP volunteer orientation booklet online at <http://www.familiesusa.org/assets/hapnetwork/md-ship-booklet.pdf>.
- ⁴⁴ Washington State’s SHIP program developed a task-based training method that focuses on providing volunteers with hands-on experience in performing the tasks required in their volunteer roles. See *Volunteer Training: Shifting to a Task-Based Training Culture* online at <http://www.familiesusa.org/assets/hapnetwork/washington-volunteer-training.html>. Also see skill-building tools and exercises developed by the Montana SHIP online at <http://www.familiesusa.org/assets/hapnetwork/montana-ship-program.html>.
- ⁴⁵ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Mike Klug, op. cit.
- ⁴⁶ See SHIP best practices for update training and competency testing online at <http://www.familiesusa.org/assets/hapnetwork/ship-certification-methods.html>.
- ⁴⁷ See training and certification best practices from the Maine SHIP online at <http://www.familiesusa.org/assets/hapnetwork/maine-ship-summary.pdf>.
- ⁴⁸ T. de Jung, C. Tracy, and E. Benjamin, *Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York* (New York: New York State Health Foundation, September 2011).
- ⁴⁹ See reference sheets and counseling tools online at <http://www.familiesusa.org/assets/hapnetwork/manage-volunteer-programs.html> and counseling tools developed by the Alabama SHIP and the Health Assistance Partnership online at <http://www.familiesusa.org/assets/hapnetwork/alabama-ship-program.html>.
- ⁵⁰ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Anne Smith, Medicare Rights Advocate, Legal Services for the Elderly, August 24, 2012.
- ⁵¹ SHIP counselors are assigned unique IDs through SHIPtalk.org, the federal technical assistance hub for SHIP programs. These ID numbers allow access to beneficiary information through a direct counselor line to 1-800-MEDICARE, where they are able to use a shorthand menu to reach customer service representatives with the appropriate expertise to resolve particular beneficiary issues. SHIP directors report that the unique ID numbers are the single most helpful tool for counselors, giving them more leverage to help consumers resolve problems with access to coverage. Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Alice Ierley, op. cit.
- ⁵² In addition to providing enrollment assistance, SHIPs help Medicare beneficiaries resolve problems by hiring expert staff and partnering with legal services and consumer assistance programs. In some states, these relationships are formalized through contract agreements with organizations that commit to serving a particular function. Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Alice Ierley, op. cit.; Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Anne Smith, op. cit.
- ⁵³ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Mike Klug, op. cit.
- ⁵⁴ See *Strategies for Success: Motivating Local SHIP Sites* for strategies developed by the Michigan SHIP to help improve local SHIP program performance and promote communication among the state and local SHIP offices, available online at <http://www.familiesusa.org/assets/hapnetwork/michigan-motivating-local.html>.
- ⁵⁵ SHIPs have reported that opportunities to meet with policy experts and programs in other states to discuss common challenges and share best practices are important sources of innovation in their work. Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Alice Ierley, op. cit.
- ⁵⁶ Centers for Medicare and Medicaid Services, *PRA for Single Streamlined Application Data Elements*, op. cit.
- ⁵⁷ Enroll UX 2014, *A New Standard for Public and Private Health Insurance Enrollment: Policy and Implementation Considerations Supplement* (Oakland: California HealthCare Foundation, June 2012), available online at <http://www.ux2014.org/>.
- ⁵⁸ Conversation between Elaine Saly, Families USA, and Kate L. Bicego, op. cit.
- ⁵⁹ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Mike Klug, op. cit. MassHealth is Massachusetts’ Medicaid program, and Commonwealth Care is the state’s subsidized coverage option for adults with family incomes up to 300 percent of the federal poverty level.
- ⁶⁰ SHIP counselors use reference resources, the web-based plan comparison tools on www.medicare.gov/, and state-specific eligibility screening tools for public benefits programs.

⁶¹ A 2007 survey of SHIPs conducted by the Health Assistance Partnership found that use of incompatible local and state-level databases resulted in counselors having to enter data into electronic systems twice, leading to inefficient use of local resources and greater potential for incorrect reporting. See the survey results in *SHIPs' Needs: Summary of Survey Results from SHIP Directors* (Washington: Health Assistance Partnership, April 2007), available online at <http://www.familiesusa.org/assets/hapnetwork/ship-needs-2007.pdf>.

⁶² This number is about 31 percent of the estimated 95.9 million people who are expected to enroll in Medicaid or a qualified health plan with subsidies. Matthew Buettgens, Austin Nichols, and Stan Dorn, *Churning under the ACA and State Policy Options for Mitigation* (Washington: The Urban Institute, June 2012), available online at http://www.urban.org/health_policy/url.cfm?ID=412587.

⁶³ Ibid.

⁶⁴ Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage* (Washington: The Urban Institute and the Robert Wood Johnson Foundation, November 2009), available online at http://www.urban.org/UploadedPDF/411987_massachusetts_success.pdf; conversation between Elaine Saly, Families USA, and Kate L. Bicego, op. cit.

⁶⁵ Kaiser Commission on Medicaid and the Uninsured, *A Profile of Health Insurance Exchange Enrollees*, op. cit.

⁶⁶ Interview among Cheryl Fish-Parcham and Elaine Saly, Families USA, and Mike Klug, op. cit.

⁶⁷ SHIPs depend on a highly trained volunteer workforce to develop the capacity to meet consumer needs during open enrollment season. See the Health Assistance Partnership's *Guide to Volunteer Program Development* online at <http://familiesusa2.org/hapnetwork/assets/docs/vpd/hap-s-guide-to-volunteer-program-development.doc> and program development tools online at <http://www.familiesusa.org/assets/hapnetwork/program-development.html>.

⁶⁸ Department of Health and Human Services, *Letter from Secretary Kathleen Sebelius to Governors*, November 9, 2012, available online at <http://www.modernhealthcare.com/assets/pdf/CH83821119.PDF>.

⁶⁹ Center for Consumer Information and Insurance Oversight, *The Consumer-Mediated, Dynamic Eligibility and Enrollment Process*, presentation for the Health Insurance Exchange System-Wide Meeting (May 21-23, 2012), available online at <http://ccio.cms.gov/resources/files/hie-cmdeep.pdf>.

For nearly 10 years (from 2001 to 2010), Families USA provided technical assistance to State Health Insurance Assistance Programs (SHIPs) through a special project called the Health Assistance Partnership. During this time, because Medicare Part D was just going into effect, SHIPs were dealing with enrollment and outreach issues that are similar to the challenges navigators will encounter. In response, we helped SHIPs develop outreach campaigns and training materials, and we helped them build their capacity to address these issues more generally. Many of the lessons described in this tool kit are drawn from our joint work with SHIPs.

Acknowledgments

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**Help Wanted:
Preparing Navigators and Other Assisters to
Meet New Consumer Needs**

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STATE HEALTH REFORM IMPACT MODELING PROJECT

Texas

January 2013

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) will dramatically change how people living with HIV access healthcare.¹ In states that fully implement the law (including expanding Medicaid), thousands of uninsured people living with HIV—many of whom currently receive care and treatment through Ryan White program—will have access to healthcare through Medicaid or subsidized private health insurance.

The State Health Reform Impact Modeling Project (the Modeling Project) assesses the impact that healthcare reform will have on people living with HIV by compiling and analyzing Ryan White program and AIDS Drug Assistance Program (ADAP) data to predict the shift of uninsured people living with HIV from these discretionary programs to Medicaid or private insurance in all 50 states pursuant to the ACA. In addition, for 21 states and the District of Columbia (DC), the Modeling Project compiles and analyzes detailed budgets and benefit guidelines to assess the services provided by the Ryan White program, ADAP, Medicaid, and plans sold on an exchange, in order to estimate the impact that a transition into Medicaid or private subsidized insurance will have on low-income people living with HIV.²

Information on the methodology used to model numerical results for each state and DC are available in Appendix A. See Appendix B for additional

methodology, notes, and a summary of the limitations of the modeling process.

In Texas, the Modeling Project focuses on four state-specific inquiries:

1. What demographic information is available about Ryan White program and ADAP clients?
2. How many ADAP clients will be newly eligible for Medicaid or private insurance subsidies in 2014?
3. What services are currently available to people living with HIV under the Ryan White program versus Medicaid or plans to be sold on an exchange, and what gaps in services currently exist?
4. Given the current Ryan White, Medicaid, and benchmark plans, what are the likely outcomes of a transition from one program to another in 2014?

TEXAS

TEXANS LIVING WITH HIV OR AIDS

UNMET NEED

As of 2011, 27% of people diagnosed with HIV (18,784 individuals) were not receiving any HIV-related medical care.³ Need is met if a patient receives at least one of four services: a viral load test, a CD4 test, an HIV related prescription, or a medical visit.^{3*} In 2011, 17% of newly diagnosed individuals (553 individuals) were not linked to care.³ Over the past 5 years, 44% of individuals were retained in care, 38% were in and out of care, while 18% had no record of care at all.³ Because untreated patients are

not part of the Ryan White program or ADAP, they are not counted in the Modeling Project's estimation of newly eligibles for Medicaid or private subsidized insurance in 2014. It is likely that most of these individuals will also be newly eligible for Medicaid in 2014 (ie, are living under 133% of the federal poverty level (FPL), as those least likely to be in care are low-income minorities and intravenous drug users).³

THE RYAN WHITE PROGRAM IN TEXAS

The Ryan White program is a discretionary, federally funded program providing HIV-related services across the United States to those who do not have other means of accessing treatment and care. In other words, it serves as a critical payer of last resort, filling gaps in healthcare and ancillary support services that are unmet by all other charitable or funded healthcare services. In 2010, Texas received

\$153,515,213 of Ryan White funding,⁴ and served 58,092 duplicated clients.^{3,5} About 58.4% of the state's Ryan White funds were Part B grants, assigned based on prevalence of HIV in the state.⁶ Of these, approximately 24.1% covered core medical services, 63.9% went toward the AIDS Drug Assistance Program (ADAP), and 9.7% provided ADAP supplemental funding.⁵

ADAP IN TEXAS

ADAP is a component of Ryan White (within Part B), which is also funded with matching state appropriations and covers the cost of antiretroviral treatment (ART) for enrollees. To be eligible for ADAP in Texas (also referred to as the Texas HIV Medication Program, or THMP), one must:

- › Be a Texas resident diagnosed with HIV;
- › Meet drug-specific eligibility criteria of one or more of the drugs listed on the THMP/ADAP formulary;
- › Be under the care of a Texas-licensed physician who prescribes the medication(s); and
- › Meet financial eligibility criteria.⁷

To be financially eligible, one must:

- › Not be covered for the medication(s) under the Texas Medicaid Program, or, if covered, have met the Medicaid pharmacy benefit monthly maximum;

- › Not be covered for the medication(s) by any other third-party payer; and
- › Have an adjusted gross income that does not exceed 200% of the federal poverty level (FPL) (including spousal income).⁶

As of June 2011, 14,123 Texans were enrolled in ADAP.⁸ The state's fiscal year 2011 ADAP budget was \$96,383,814 (\$64,245,687 in federal funds).⁹ Approximately 87.1% of these funds were used to cover the cost of prescription drugs, 5.4% was used to provide insurance assistance to cover copayments and deductibles, and the remaining 7.5% was used for program administration.^{10,†}

State contributions to ADAP have been growing as a result of the increasing number of people living with HIV, the rising cost of HIV medications, and the increasingly complex drug regimens that some patients require.¹¹ As a way to contain costs, the Texas Department of State Health Services (TDSHS) has considered purchasing insurance for some

*This definition of met need is a technical definition used by the Texas Department of State Health Services to track HIV patients in care. Some patients may fall within this definition even if their medical needs are not met (eg, a patient who has been tested and diagnosed with HIV, but never receives ART when clinically appropriate).

†In fiscal year 2010, Texas spent \$106,814,957 on ADAP, of which \$93,009,354 was used to cover the cost of prescription drugs, \$5,805,624 was used for insurance copayments and deductibles, and \$8,000,000 was used for program administration.

ADAP clients, as well as limiting new enrollment into the program.¹⁰ Three eligibility changes are being considered:

- › Requiring new applicants to present with a CD4 count of less than 500 cells/ μ L;
- › Switching from using adjusted gross income to gross income when determining eligibility; or
- › Requiring new applicants to present with a CD4 count of less than 350 cells/ μ L.¹⁰

Such policies are unlikely to save money and may adversely affect the health of individuals and the public. Early initiation of ART results in a 96% reduction in HIV transmission to sexual partners,¹² meaning that requiring patients to present with lower CD4 counts before qualifying for ADAP-funded ART would result in avoidable transmission of HIV. Moreover, patients who do not receive treatment until their HIV has progressed to AIDS or their CD4 count has dropped below 200 cells/ μ L incur care costs that are 1.5 to 3.7 times higher than the costs incurred by patients who initiate treatment earlier.¹¹

CURRENT RYAN WHITE AND ADAP SPENDING AND RECIPIENT POOL

In 2010, the Ryan White program served 58,092 duplicated clients in the state; 90% will be eligible for Medicaid or a Basic Health Plan (BHP) under the Patient Protection and Affordable Care Act (ACA) (excluding those otherwise eligible for insurance).⁴ Between 12,662³ and 16,501¹⁴ residents received assistance from the AIDS Drug Assistance Program (ADAP) in 2010.⁵ In June 2011, ADAP served 10,959 Texans.¹⁵ Of these individuals, 65% would be eligible for Medicaid under the expansion (see Appendix A) and 35% would be eligible for a BHP, if one is created.¹⁴

These numbers are significant; because the majority of individuals receiving support from these programs are African-American (42% of Ryan White recipients⁵ and 30-34% of ADAP beneficiaries in 2010),^{13,16} implementing Medicaid in a way that ensures continuity in access to services will be critical to reducing health disparities. Moreover, an increasing proportion of these individuals are uninsured, making them perfect candidates for Medicaid or subsidized private insurance (41% of Ryan White clients were uninsured in 2010⁴ and 93% of ADAP beneficiaries were uninsured in 2011).¹⁶

THE ACA AND ITS IMPACT ON HIV+ TEXANS

THE MEDICAID EXPANSION

Beginning in January 2014, the Patient Protection and Affordable Care Act (ACA) will expand Medicaid eligibility to most individuals under 65 years of age living below 133% of the federal poverty level (FPL).^{17**} Although the Department of Health and Human Services (HHS) cannot force states to comply with the expansion (by withdrawing existing federal

medical funding), the federal government will cover 100% of the cost of newly eligible beneficiaries until 2016, and at least 90% thereafter. Newly eligible enrollees will receive a benchmark benefit package that must include at least ten categories of essential health benefits, described in the following section.¹⁹

SUBSIDIES FOR PRIVATE INSURANCE PREMIUMS, AND STATE-BASED INSURANCE EXCHANGES

The ACA extends insurance premium credits to individuals and families living below 400% FPL, to ensure that premiums do not exceed 2.0-9.8% of household income.²⁰ Eligible individuals and families can employ these credits to purchase a private health insurance plan on a state or federally operated insurance exchange.

Exchanges will be operational January 1, 2014.²¹ States can elect to set up state-run exchanges, partner with the federal government to set up a hybrid state-federal exchange, or default into federally facilitated exchanges. Each exchange will provide individuals and families with a choice of plans, tiered by actuarial value of coverage (bronze, silver, gold, and platinum). Each plan available on an exchange

³The data from the federal Health Resources and Services Administration (HRSA) and the National Alliance of State and Territorial AIDS Directors (NASTAD) are slightly inconsistent, because HRSA provided data for 2010, whereas NASTAD provided data for fiscal year 2010

**Undocumented immigrants and lawfully residing immigrant adults who have been in the country 5 years or less will not be eligible for Medicaid coverage.

DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, THE AFFORDABLE CARE ACT: COVERAGE IMPLICATIONS AND ISSUES FOR IMMIGRANT FAMILIES, 7, available at <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/lib.pdf>

must, at a minimum, adhere to a state-defined and federally approved list of essential health benefits:

these benefits are discussed in the following section.

THE BASIC HEALTH PLAN

The ACA also provides additional federal medical funding to states that create a Basic Health Plan (BHP), covering most individuals under 65 years of age living between 133-200% FPL as well as legal residents who do not qualify for Medicaid because of the 5-year residency requirement.²² BHPs must cover at least the essential health benefits and have

the same actuarial value of coverage as a bronze plan the individual might otherwise purchase on an exchange.²³ Cost sharing on BHPs can be subsidized, either for all beneficiaries or for those with specific chronic conditions (eg, HIV/AIDS).²⁴ The federal government is expected to pay up to 95% of the premium credits for individuals enrolled in a BHP.²⁵

ESSENTIAL HEALTH BENEFITS

The ACA requires both Medicaid plans and private health insurance plans sold on state-based insurance exchanges to provide a minimum of essential health benefits (EHB), to be defined by the Secretary of HHS.²⁶ EHB must include items and services within the following ten benefit categories:²⁷

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;

8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

HHS released a proposed rule that will define the scope of EHB on the private market, and will accept public comments before drafting final guidance.²⁰ The Centers for Medicare and Medicaid Services has indicated that the HHS rule on EHB will also apply to newly eligible Medicaid beneficiaries, in addition to the protections provided under the Social Security Act.²¹ This means that benefits provided by Medicaid will likely be more robust than on the private market. For example, the Social Security Act requires that a Medicaid benchmark plan cover any US Food and Drug Administration-approved drugs with significant clinically meaningful therapeutic advantage over another.²²

AN ESTIMATE OF CURRENT RYAN WHITE AND ADAP CLIENTS WHO WILL BE ELIGIBLE FOR MEDICAID OR INSURANCE CREDITS IN 2014

Given the ACA-instituted reforms, a large number of HIV+ Texans are expected to become eligible for Medicaid or a BHP in 2014, provided that Texas expands Medicaid and institutes a BHP. An estimated 90% of the state's Ryan White program clients in 2010 were at 200% FPL or lower, making them potentially eligible for either Medicaid or a BHP.⁴ More specifically, approximately 65% of Texas AIDS Drug Assistance Program (ADAP) clients will be eligible for Medicaid following its expansion (see Appendix A), and 35% will be eligible for a BHP. Finally, many of the estimated 24,006 Texans living with HIV/AIDS and who have not received HIV-related medical care are likely to become eligible for Medicaid in 2014, given the assumption that a significant number of these individuals are living near the FPL.

The percentage of Texas' ADAP clients who will be newly eligible for Medicaid (53%) is higher than the

total proportion of Americans who will be newly eligible, which stands at approximately 29% (see Appendix A). This is primarily because Texas' ADAP primarily serves individuals with incomes below 133% FPL (as many as 65% of the state's ADAP clients were living below 133% FPL in 2011),¹⁴ but also because the state's ADAP clients are almost entirely uninsured (approximately 85% of ADAP clients served in 2011).¹⁶

Similarly, the percentage of Texas' ADAP clients who will be newly eligible for private insurance subsidies (26%) is higher than the total proportion of Americans who will be newly eligible for subsidies, which stands at approximately 15% (see Appendix A). This is due to the sizable group of ADAP clients served who are just above 133% FPL (approximately 35% of ADAP clients served in 2011 were living between 134-200% FPL, many of whom are also uninsured).¹⁶

A COMPARISON OF SERVICES PROVIDED BY RYAN WHITE, ADAP, MEDICAID, AND THE EXCHANGE TO HIV+ TEXANS

Since a significant number of HIV + individuals in Texas who are currently served by the Ryan White program or the AIDS Drug Assistance Program (ADAP) are likely to be eligible for Medicaid in 2014, it is important to assess the outcome of transitioning from the former programs to Medicaid. This assessment compares and contrasts the services

and treatments that the Ryan White program, ADAP, and Medicaid currently provide to HIV + Texans. Forthcoming federal guidance on the essential health benefits that newly eligible Medicaid beneficiaries are guaranteed under the Patient Protection and Affordable Care Act (ACA) will affect the scope of coverage provided in 2014.

COMPARING RYAN WHITE, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN TEXAS

The Ryan White program funds both core medical services and support services for patients living with HIV (see Appendix C for a breakdown of core medical services versus support services). Both medical and ancillary services are critical to maintaining the health of low-income individuals who may not have access to many necessities that facilitate effective HIV treatment and care (eg, transportation, child care, nutrition). However, Medicaid and Texas's benchmark plan, which will determine essential health benefits (EHB) for private insurance sold on the state's exchange, do not cover ancillary services (although they cover a broader range of medical services). Accounting for the gaps between the Ryan White program and Medicaid or private insurance sold on the exchange will be critical in transitioning Ryan White beneficiaries onto Medicaid and private insurance while ensuring that health status does not deteriorate (eg, due to lack of proper nutrition, access to transportation to a health clinic, or stable housing). For example, oral health care, housing, and transportation are already a few of the most severe

gaps in care in most Health Service Delivery Areas (HSDAs) in Texas.³²

Texas currently has three different types of managed care Medicaid programs: STAR, STAR + PLUS, and STAR Health. Most standard Medicaid managed care programs are STAR programs, whereas the STAR + PLUS plan combines acute care with long-term care services for people aged 65 years and older, and STAR Health covers children. Currently, there are 18 different STAR programs to choose from, which vary depending on geographic location.³² While the managed care programs cover many services, there are certain services that are considered carve-out services, which are still provided by Texas Medicaid and not the client's managed care program.³⁴

Table 1 provides a comparison of covered services between Texas' Ryan White and Medicaid programs, as well as the largest small-group market plan in the state (the default benchmark plan used for purposes of defining EHB).

Table 1. Ryan White Versus Medicaid and the Benchmark Plan: Covered Services

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

Covered Service	Ryan White ³⁴	Medicaid ³⁵	Blue Cross Blue Shield of Texas – BestChoice PPO ³⁶
Home Health Care	X	X	X
Mental Health	X	X	X
Substance Abuse (outpatient)	X	X ³⁸	X

Continued on next page

³⁴Texas Medicaid managed care programs must at a minimum cover the same services that the Texas fee-for-service Medicaid program covers. TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Texas Medicaid Provider Procedures Manual*, November 2012, Volume 2, 8 (Nov. 2012) available at http://www.tmhpc.com/TMPPM/TMPPM_Living_Manual_Current/Vol2_Medicaid_Managed_Care_Handbook.pdf.

³⁵Some Medicaid patients on managed care may have additional healthcare benefits such as limited adult dental benefits, additional vision benefits, or additional transportation. TEXAS HEALTH AND HUMAN SERVICES COMMISSION (HHSC), CHAPTER 6 - MEDICAID MANAGED CARE, <http://www.hhsc.state.tx.us/medicaid/reports/PB8/PDF/Chp-5.pdf> (last visited September 26, 2012)

Table 1. (continued)

Substance Abuse (inpatient)	X	X	X
Medical Case Management	X	X	
Community Based Care	X	X	
Ambulatory/Outpatient Care	X	X	X
Oral Health Care	X	X	
Early Intervention Clinic	X		
Nonmedical Case Management Services	X		
Child Care	X		
Emergency Financial Assistance	X		
Food Bank/Home-Delivered Meals	X		
Housing Services	X		
Health Education/Risk Reduction	X		
Legal Services	X		
Linguistic Services	X		
Nonemergency Medical Transportation	X		
Outreach Services	X		
Psychosocial Support	X		
Referral Agencies	X		
Treatment Adherence Counseling	X		
Intermediate Care Facilities for the Mentally Retarded		X	
Family Planning Services and Supplies		X	X
Hospital Services (outpatient)		X	X
Hospital Services (inpatient)		X	X
Rural Health Clinic Services		X	
Hospice Services		X	X
Lab and X-ray Services		X ⁵⁵	X
Prescription Drugs	X	X	X
Vision Care (including contacts and eyeglasses)		X	X (routine eye exam only)
Nursing Facility		X	X
Midwife/NP Services		X	
Private Duty Nursing			
Physician Services		X	X
Licensed Marriage and Family Therapists		X	
Licensed Clinical Social Workers		X	
Chiropractor		X	X
Podiatry		X	
Mental Health Rehabilitation		X	X
PT, OT, and Speech Therapy		X	X
Renal Dialysis		X	
Hearing Instruments and Related Audiology		X	X

⁵⁵ HIV testing is covered by Medicaid if it is considered medically necessary; it is not part of routine treatment. KAISER FAMILY FOUNDATION, *50 State Comparisons, Medicaid Coverage of HIV Testing, 2010*, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=1013&cat=11> (last visited September 13, 2012).

As Table 1 indicates, the Ryan White program covers critical services for low-income people living with HIV/AIDS, many of whom are not available to Medicaid beneficiaries or people covered by Texas' benchmark plan (eg, nonmedical case management, legal services, food bank and home delivered meals, linguistic services, housing services, and emergency financial assistance). Since these ancillary services

are important for the well-being of people living with HIV/AIDS, in fact there has been evidence to suggest that HIV patients using Ryan White program services have higher care-retention rates than HIV patients not in the program. The individuals who transition from the Ryan White program on to Medicaid or private insurance plans are likely to be at a disadvantage.

COMPARING ADAP, MEDICAID, AND THE BENCHMARK PLAN FOR THE EXCHANGE IN TEXAS

ADAP provides funding for a robust drug formulary that is necessary to afford low-income individuals access to a combination of drugs to treat HIV. All states participating in ADAP must cover at least one drug in every class of antiretroviral treatment (ART); most cover almost all drugs in each class. The Texas Medicaid Vendor Drug Program defines the drug formulary for the Medicaid STAR plans differently (and its formulary for newly eligible individuals has yet to be defined). Ensuring that Medicaid STAR plans

and plans sold on the exchange provide coverage for a sufficient number of antiretroviral medications will also be critical to maintaining the health of Texans living with HIV.

Table 2 provides a comparison of the antiretroviral drug formularies included in the state's ADAP and Medicaid programs, as well as the largest small-group market plan in the state (the benchmark plan used for purposes of defining EHB for plans sold on an exchange).

Table 2: ADAP Versus Medicaid and the Benchmark Plan: Covered Drugs³⁹

Benefits applying only to beneficiaries under 21 years of age are not assessed in this report.

Drugs (ART class indicated in bold; brand name in normal type; generic in italics)	ADAP ³⁹	Medicaid ⁴⁰	Blue Cross Blue Shield of Texas – BestChoice PPO ⁴¹
Multiclass Combination Drugs	2 Drugs Covered	2 Drugs Covered	1 Drug Covered
Atripla; <i>efavirenz + emtricitabine + tenofovir DF</i> (counted as 3 medications)	X	X	X
Complera; <i>emtricitabine + rilpivirine + tenofovir</i> (counted as 3 medications)	X	X	
Stribild; <i>elvitegravir + cobicistat + emtricitabine + tenofovir</i>			
Nucleoside Reverse Transcriptase Inhibitors	11 Drugs Covered	11 Drugs Covered	11 Drugs Covered
Combivir; <i>lamivudine, zidovudine</i> (counted as 2 medications)	X	X	X
Emtriva; <i>emtricitabine</i>	X	X	X
Epivir; <i>lamivudine</i>	X	X	X
Epzicom; <i>abacavir, lamivudine</i> (counted as 2 medications)	X	X	X
Retrovir; <i>zidovudine</i>	X	X	X
Trizivir; <i>abacavir + zidovudine + lamivudine</i> (counted as 3 medications)	X	X	X
Truvada; <i>tenofovir DF + emtricitabine</i> (counted as 2 medications)	X	X	X
Videx EC; <i>didanosine (delayed-release capsules)</i>	X	X	X
Viread; <i>tenofovir disoproxil fumarate DF</i>	X	X	X
Zerit; <i>stavudine</i>	X	X	X
Ziagen; <i>abacavir</i>	X	X	X

Continued on next page

Table 2. (continued)

NNRTIs	5 Drugs Covered	5 Drugs Covered	4 Drugs Covered
Edurant; <i>rilpivirine</i>	X	X	
Intelence; <i>etravirine</i>	X	X	X
Rescriptor; <i>delavirdine mesylate</i>	X	X	X
Sustiva; <i>efavirenz</i>	X	X	X
Viramune; <i>nevirapine</i>	X	X	X
Protease Inhibitors	9 Drugs Covered	9 Drugs Covered	9 Drugs Covered
Agenerase; <i>amprenavir</i>			
Aptivus; <i>tipranavir</i>	X	X	X
Crixivan; <i>indinavir sulfate</i>	X	X	X
Invirase; <i>saquinavir mesylate</i>	X	X	X
Kaletra; <i>lopinavir + ritonavir</i>	X	X	X
Lexiva; <i>fosamprenavir</i>	X	X	X
Norvir; <i>ritonavir</i>	X	X	X
Prezista; <i>darunavir</i>	X	X	X
Reyataz; <i>atazanavir sulfate</i>	X	X	X
Viracept; <i>nelfinavir sulfate</i>	X	X	X
Fusion Inhibitors	1 Drug Covered	1 Drug Covered	1 Drug Covered
Fuzeon; <i>enfuvirtide</i>	X	X	X (PA)
Entry Inhibitors – CCR-5 Coreceptor Antagonist	1 Drug Covered	1 Drug Covered	1 Drug Covered
Selzentry; <i>maraviroc</i>	X	X	X
HIV Integrase Strand Transfer Inhibitors	1 Drug Covered	1 Drug Covered	1 Drug Covered
Isentress; <i>raltegravir</i>	X	X	X
"A1" Opportunistic Infection Medications	14 Drugs Covered	30 Drugs Covered	21 Drugs Covered
Ancobon; <i>flucytosine</i>		X (Ancobon only)	X
Bactrim; <i>sulfamethoxazole/trimethoprim DS</i>	X	X	X (generic only)
Biaxin; <i>clarithromycin</i>	X <small>(current or previous diagnosis of mycobacterium avium complex required)</small>	X	X (generic only)
Cleocin; <i>clindamycin</i>		X	X (generic only)
Dapsone	X <small>(CD4 count of ≤ 200, or symptoms such as thrush, unexplained fever $> 100^{\circ}\text{F}$ for over 2 weeks, or a child aged under 13 years with ACTG clinical indicators required)</small>	X	X
Daraprim; <i>pyrimethamine</i>		X (Daraprim only)	X
Deltasone; <i>prednisone</i>		X (generic only)	
Diffucan; <i>fluconazole</i>	X <small>(cryptococcal meningitis or esophageal candidiasis)</small>	X	X
Famvir; <i>famciclovir</i>		X	X (generic only)
Foscavir; <i>foscarnet</i>		X (generic only)	

Continued on next page

Table 2. (continued)

Fungizone; amphotericin B		X (generic only)	
INH; isoniazid		X (generic only)	X
Megace; megestrol	X (AIDS diagnosis and anorexia or anorexia with acute or chronic weight loss)	X (Megace only)	X (generic only)
Mepron; atovaquone	X (acute, mild-to-moderate pneumocystis carinii pneumonia and intolerance to sulfamethoxazole-trimethoprim)	X	
Myambutol; ethambutol	X (current or previous diagnosis of mycobacterium avium complex required)	X (generic only)	X (generic only)
Mycobutin; rifabutin	X (CD4 count ≤ 100 required)	X (Mycobutin only)	X
NebuPent; pentamidine	X	X (Nebupent only)	
Nydrazid; isoniazid, INH			
Probenecid		X	X
Procrit; erythropoietin		X (Procrit only)	
Pyrazinamide (PZA)		X	X
Rifadin, Rimactane; rifampin		X	X
Sporanox; itraconazole	X (histoplasmosis, blastomycosis, or esophageal candidiasis diagnosis required)	X	X
Sulfadiazine – Oral		X	
Valcyte; valganciclovir	X (CMV disease that has resulted in retinitis or infections of other major organs required)	X (Valcyte only)	X
Valtrex; valacyclovir	X (acute or chronic herpetic infections required)	X	X (generic only)
VFEND; voriconazole		X	X (generic only)
Vistide; cidofovir		X (Vistide only)	
Wellcovorin; leucovorin		X (generic only)	
Zithromax; azithromycin	X (current or previous diagnosis of mycobacterium avium complex required; failed therapy on clarithromycin)	X	X
Zovirax; acyclovir	X (acute or chronic herpetic infections required)	X	X (generic only)

Currently there are over 400 pharmacies participating in the Texas ADAP.⁴² Patients can only obtain their medication from the Texas ADAP pharmacy to which they are assigned, but they can ask to be reassigned to a different participating pharmacy at any time.⁷ Patients who wish to receive their medication from a nonparticipating pharmacy need to prove hardship exists with their current arrangement before they can switch pharmacies.⁷ ADAP beneficiaries not eligible for Medicaid are subject to \$5 copays per month, unlike Medicaid beneficiaries also receiving ADAP assistance.⁷ Further, ADAP clients are limited to receiving a maximum of four antiretroviral drugs per month (as the table indicates, some drugs are counted as more than one).⁷ In order to receive certain drugs, ADAP clients need to meet further medical criteria as indicated in Table 2.⁷

Medicaid's pharmacy services are better than ADAP's for people living with HIV, as the drug coverage indicated in Table 2 is more generous and Medicaid recipients in STAR managed care plans may obtain an unlimited number of prescriptions.³⁵ Texas has a preferred drug list (PDL) and a prescriber must receive prior authorization to prescribe a reimbursable nonpreferred drug.³⁵ Medicaid

formularies available to newly eligibles will be just as, if not more, robust (newly eligible beneficiaries will be guaranteed access to any FDA-approved drugs with significant clinically meaningful therapeutic advantage over another).⁵⁴

As Table 2 indicates, Texas's benchmark plan—BlueCross BlueShield of Texas Best Choice PPO—has a slightly more limited formulary than the ADAP or Medicaid formulary for the core HIV treatment drugs, but has more “A1” opportunistic infection medications than ADAP but less than Medicaid. On this plan, people with HIV/AIDS do not face the same limits as they would under Medicaid's formulary, but they do not have access to all the same drugs covered under ADAP. A proposed federal rule defining EHB provides that plans sold on exchanges must cover at least the same number of drugs in each category and class as the benchmark plan (or one drug per class if the benchmark plan does not cover any). Thus, assuming the proposed rule is adopted, plans in Texas must cover at least the number of drugs in each class listed above for the BlueCross BlueShield BestChoice PPO plan (although not necessarily the same drugs).⁵⁵

COMMUNITY HEALTH CENTERS

The ACA has provided Texas with \$162.3 million to fund new and existing community health centers.⁴⁴ Additionally, six centers in five cities (Houston, Plano, Gatesville, Fort Worth, Tyler) have each been awarded \$80,000 in health center planning grants.⁴⁵ A seventh center in Houston was awarded \$79,780.⁴⁴ All community health centers in Texas (337 as of 2010) provide primary care services, and 83% provide HIV preventive care.⁴⁵ There are also three designated AIDS education and training centers in Texas—all are National Centers for HIV

Care in Minority Communities (NCHCMC).⁴⁶ Some Texas community health centers, such as Legacy, are leaders in providing comprehensive healthcare to people living HIV/AIDS. For example, Legacy provides primary care, assistance with social services, financial assistance, eye care, and counseling on medication adherence and prevention services.⁴⁷ Community health centers can go beyond providing basic healthcare to people living with HIV/AIDS to help ensure successful case management and treatment.

CONCLUSIONS AND NEXT STEPS

This report provides analyses of the Ryan White program, the AIDS Drug Assistance Program (ADAP), Medicaid, and essential health benefits (EHB) under the Patient Protection and Affordable Care Act (ACA), enumerating the benefits covered under each, and the implications of transitioning individuals living with HIV onto Medicaid or private insurance. This report is intended to assist state legislators in implementing the ACA in a manner that serves the needs of Texans.

While much of the ACA has yet to be implemented, it is certain that large numbers of people living with HIV will be newly eligible for Medicaid. Given that a significant proportion of uninsured ADAP

clients would transition into Medicaid in Texas, implementing the ACA's expansion provision is crucial to ensuring access to care and reducing transmission of HIV across the state. In other words, expanding Medicaid is the state's only currently available option to provide access to treatment for the thousands of HIV+ individuals in the state who currently lack access to care. Without Medicaid expansion it will be the Texas counties that will assume a substantial cost for providing services to indigent HIV+ individuals who were previously covered by the Ryan White program.

In that vein, the Medicaid system must be ready and able to handle the needs of low-income people who

have HIV. Should Texas elect to expand its Medicaid program, this report provides an initial analysis of the capacity of the program to handle the needs of this influx of individuals living with HIV. An analysis of the barriers to care that this population is likely to face (based upon the existing Medicaid program) is timely as states prepare for the transition to Medicaid. Comparing current Ryan White and ADAP programs with existing Medicaid formularies allows for a baseline analysis of the needs of individuals living with HIV moving into the Medicaid system.

This report identified a number of services currently provided by the Ryan White program that are not available under the state's current Medicaid program, and may reduce the ability of those living with HIV to access services. For instance, the Ryan White program, unlike Medicaid, covers nonmedical case management, food bank services, and nonemergency medical transportation services. Initial federal guidance indicates that Medicaid benchmark plans (those for newly eligible beneficiaries) will not be required to cover these services.⁵⁶ The Ryan White program will continue to be a critical payer of last resort to ensure that all individuals living with HIV have access to comprehensive antiretroviral therapy (ART).

While more Texas ADAP clients will transition to subsidized private insurance in 2014 (compared with national numbers), it remains essential that private insurance plans provide a level and scope of services sufficient to meet the needs of these individuals. In particular, there are a number of services that are currently provided by the Ryan White program which are not available under Texas' default benchmark plan and will not be requisite EHB on the exchange.⁵⁵ HIV+ individuals who shift from the Ryan White

program to private insurance plans on the exchange are therefore likely to have trouble accessing a number of services currently available to them.

There will remain an ongoing demand for Ryan White and ADAP services to fill the gaps left by Medicaid coverage for low-income people living with HIV. Identifying these gaps and structuring these programs to efficiently work together from the start is not only fiscally prudent but also necessary to secure the health of Texans and slow the spread of HIV.

In conclusion, this report makes clear three factors that will be essential to successfully implementing the ACA in a way that reduces the burden of HIV on the state:

1. Texas must adopt the Medicaid expansion, pursuant to the ACA, extending eligibility to most individuals living under 133% FPL in order to slow the transmission of HIV and make treatment accessible to thousands of individuals who currently lack care.
2. Effectively defining the EHB, patient navigation, and outreach systems, and opting into prevention and health home program resources will maximize the potential for the state to meet the care and service needs of individuals living with HIV.
3. Texas must ensure that Ryan White and ADAP services are available where Medicaid or private insurance coverage gaps exist (eg, nonemergency medical transportation, nonmedical case management, food and nutrition, childcare) or where cost sharing makes meaningful coverage prohibitive.

APPENDIX A

2014 STATE-SPECIFIC ESTIMATES

Medicaid Estimates

The Patient Protection and Affordable Care Act (ACA) directs states to extend Medicaid eligibility to all individuals living below 133% of the federal poverty level (FPL), and offers a 100% federal matching rate for these newly eligible individuals (those who would not otherwise be eligible for Medicaid but for the new law).

To estimate the number of individuals currently using the AIDS Drug Assistance Program (ADAP) who will be newly eligible for Medicaid in 2014, the following formula was used:

	Total #	ADAP clients served in 2010 ¹³
—	est. #	ADAP clients with income above 133% FPL ^{14,15}
—	est. #	insured ADAP clients with income below 133% FPL ^{16,17}
—	est. #	ADAP clients who are uninsured undocumented immigrants with incomes below 133% FPL ^{18,19}
=	Total #	ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014 ^{20,21,22}

In Texas, 16,501 individuals were served by ADAP in fiscal year 2010. Of those, it is estimated that 35% (5,775) of ADAP clients have incomes above 133% FPL. Additionally, an estimated 8% (1,325) of individuals living below 133% FPL are currently insured and approximately 5.6% of the state population was undocumented immigrants in 2008 (603 ADAP individuals). Thus, the calculation for Texas is:

	16,501	ADAP clients in fiscal year 2010
—	5,775.35	ADAP clients living above 133% FPL
—	1,325.46	insured ADAP clients living below 133% FPL
—	603.34	uninsured undocumented Texas living below 133% FPL on ADAP
=	8,797	(53%) of ADAP clients served in fiscal year 2010 who will be newly eligible for Medicaid in 2014

The calculation above was done similarly for all 21 states and the District of Columbia (DC). The results of the calculations are below:

State	#ADAP Clients Newly Eligible for Medicaid	%ADAP Clients Newly Eligible for Medicaid
Alabama	1,345	76%
Arkansas	299	53%
California	12,274	31%
DC	1,124	41%
Florida	7,321	51%
Georgia	3,075	52%
Illinois	4,374	68%
Kentucky	619	42%
Louisiana	No data available	No data available
Maryland	1,394	22%
Massachusetts	1,400	21%
Mississippi	1,008	68%
New Jersey	2,101	29%
New York	4,233	20%
North Carolina	3,476	62%
Ohio	1,287	37%
Pennsylvania	1,334	22%
South Carolina	1,428	39%
Tennessee	2,505	60%
Texas	8,797	53%
Virginia	2,690	66%
Wisconsin	696	40%
United States	62,971	29%

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.⁵ (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

¹³ In order to estimate the number of ADAP clients in any income group, we apply the percentage of clients served in each income group (acquired from Table 13 of the 2012 NASTAD Report) to the number of clients served in fiscal year 2010 (acquired from Table 8 of the same report)

¹⁴ See Appendix A for a description of the method used to estimate the distribution of insured ADAP clients in Texas by income group

¹⁵ The final estimate provided is likely to be somewhat higher than the actual number of ADAP clients who will be newly eligible for Medicaid, since the formula does not account for insured ADAP clients whose incomes fall below 133% FPL—these clients will not be newly eligible for Medicaid in 2014. The number of insured clients with incomes below 133% FPL is likely to vary by state

¹⁶ The final number is an estimate based largely on figures taken from 2010-2011

The percentages of ADAP clients who will be newly eligible for Medicaid in 2014 vary considerably from state to state. These differences can be explained by the different eligibility standards currently in place for ADAP eligibility within each state, as well as by the differences in estimated percentages of undocumented immigrants in each state. For instance, states with higher-than-average newly eligible Medicaid beneficiaries may currently require that ADAP recipients have no other sources of insurance (eg, Virginia). On the other hand, states with lower-than-average newly eligibles have higher insurance rates all around (eg, Massachusetts) or other public assistance programs that supplement ADAP. In sum, NASTAD's data do not capture all groups of people living with HIV who may be eligible for Medicaid in 2014.

Private Insurance Subsidy Estimates

To estimate the number of people currently using ADAP who will be eligible for private insurance subsidies through health insurance exchanges, the following formula was used:

Total #	ADAP clients served in fiscal year 2010 ¹³
— est. #	ADAP clients living below 133% FPL or above 400% FPL ¹⁴
— est. #	insured ADAP clients living between 133-400% FPL ¹⁴
— est. #	of insured ADAP clients living between 133-400% FPL ^{14,15}
— est. #	uninsured undocumented ADAP clients living between 133-400% FPL ¹⁶
= Total #	ADAP clients served in fiscal year 2010 who will be newly eligible for subsidized private insurance in 2014

In Texas, 16,501 individuals were served by ADAP in fiscal year 2010. Of those, approximately 65% (10,726) are living below 133% or above 400% FPL. We estimate that 7% (1,150) of individuals with incomes between 133% and 400% FPL are currently insured. About 5.6% of the state's population was undocumented in 2008. Applying this percentage to the individuals enrolled in the Texas ADAP program, we estimate that 325 Texas ADAP clients are uninsured and undocumented, living between 133% and 400% FPL. Thus, completing the calculation above for Texas ADAP program yields:

16,501	ADAP clients served in fiscal year 2010
— 10,725.65	ADAP clients with incomes below 133% or above 400% FPL
— 1,149.69	insured ADAP clients with incomes between 133% and 400% FPL
— 324.87	estimated uninsured undocumented immigrants with incomes between 133% and 400% FPL
= 4,301	(26%) of ADAP clients served in fiscal year 2010 who will be newly eligible for subsidized private insurance in 2014

The calculation above was done similarly for all 21 states and the District of Columbia (DC). The results of the calculations are below:

State	#ADAP Clients Eligible for Insurance Subsidies	%ADAP Clients Eligible for Insurance Subsidies
Alabama	305	17%
Arkansas	147	26%
California	8,580	22%
DC	829	30%
Florida	4,134	29%
Georgia	1,404	24%
Illinois	1,127	17%
Kentucky	269	18%
Louisiana	No data available	No data available
Maryland	1,726	28%
Massachusetts	932	14%
Mississippi	384	26%
New Jersey	1,879	26%
New York	4,502	21%
North Carolina	621	11%
Ohio	901	26%
Pennsylvania	1,567	26%
South Carolina	1,091	30%
Tennessee	1,531	37%
Texas	4,301	26%
Virginia	896	22%
Wisconsin	401	23%
United States	32,758	15%

Note: Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.¹³ (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of insured clients exceed 100% for Maryland and Ohio.)

METHODOLOGY FOR DISTRIBUTION OF INSURED ADAP CLIENTS BY INCOME

Estimating the proportion of insured ADAP clients falling into each income bracket required several steps:

1. The percentage of adults living below 133%, between 133% and 400%, and above 400% of the FPL in each state who are insured was determined using data available at the Kaiser Family Foundation's STATEHEALTHFACTS.ORG website. The website lists insurance status for people beginning at 139% of the FPL instead of 133% of the FPL, but because of the ACA's 5% income disregard, the Medicaid expansion applies to all individuals living below 138% FPL, making this distinction irrelevant. The website also divides the 133-400% FPL income group into two groups: 133-250% FPL and 250-399% FPL. The number of insured adults, and the total number of adults in these two groups were pooled together in order to determine the percentage of adults living between 133-400% FPL who are insured.

In Texas, for example, 42% of adults living below 133% FPL are insured; 68% of adults living between 133-400% FPL are insured; and 91% living above 400% FPL are insured.

2. Next, we determined the likelihood of an adult in each of the three income groups being insured, relative to the likelihood of being insured in the other income groups. To do this, we gave the figure for the insurance rate for adults living below 133% FPL the baseline number 1, and the insurance rates for the other income groups were calculated to be multiples of this baseline.

In Texas, we gave the figure 42% the baseline number 1; 68% is 1.62 times 42%, and 88% is 2.10 times 42%. Thus, in other words, an adult in Texas with income between 133-400% FPL is 1.62 times more likely to be insured than an adult with income below 133% FPL, while an adult with income above 400% FPL is 2.10 times more likely to be insured.

3. Next, we calculated the number of insured ADAP clients in each state, by referring to Tables 8 and 14 of the 2012 NASTAD National ADAP Monitoring Project Report.⁵⁴ Table 8 lists the total number of ADAP clients served in each state in 2010. Using this number, and applying to it the percentage of ADAP clients who are insured in each state (Table 14), we attempted to estimate the number of insured ADAP clients in each state.⁵⁵

In Texas, we estimated that about 2,475 of the state's 16,501 ADAP clients served in 2010 were insured. The insurance rate for ADAP clients in that state stood at 15% in 2011.

4. In order to proportionately divide the number of insured ADAP clients among the three income groups listed previously, the percentage of a state's ADAP clients who fall in each income group was required. Table 13 of the 2012 NASTAD Report shows the percentage of ADAP clients in most states who have income below 133%, income between 133-400%, and income above 400% FPL.

In Texas, 65% of ADAP clients have income below 133% FPL, 35% are living between 133-400% FPL, and none are living above 400% FPL.

5. We then treated the number of insured ADAP clients in each income group as a product of the relative likelihood of being insured (determined previously), and compared it with the relative proportion of clients in that income group among the total clients (based on the percentage of ADAP clients in each income group), along with a weighing factor called a .

We relied on two formulas:

Formula 1:

$$\begin{aligned} & \text{Number of insured clients in each group} \\ = & \text{(relative likelihood of being insured)} \\ \times & \text{(proportion of income group)} \\ \times & a \end{aligned}$$

Formula 2:

$$\begin{aligned} & \text{Total number of insured ADAP clients} \\ = & \text{(number of insured clients living below 133\% FPL)} \\ + & \text{(number of insured clients living between} \\ & \text{133-400\% FPL)} \\ + & \text{(number of insured clients living above 400\% FPL)} \end{aligned}$$

⁵⁵ The 2011 and 2012 NASTAD National ADAP Monitoring Project Reports list the percentage of ADAP clients in each state covered by various kinds of insurance. We added the different insurance percentages to estimate the number of ADAP clients in each state who were insured. This leads to an overestimation of the number of insured people in each state since a single ADAP client may be enrolled in multiple insurance plans (eg. Medicare and private insurance), adding up the insurance percentages may often result in double-counting a number of ADAP clients.

Thus, for Texas:

2,475

$= (1 \times 0.65 \times a)$

$+ (1.62 \times 0.35 \times a)$

$+ (2.10 \times 0.00 \times a)$

Solving for a ,

$a = 2,033.69$

Applying the value of a determined above to Formula 1:

The estimated number of insured ADAP clients in Texas with:

Income below 133% FPL = 1,325

Income between 133-400% FPL = 1,150

Income above 400% FPL = 0

These figures were applied to the general calculations estimating the number of ADAP clients who will be eligible for Medicaid or private insurance subsidies.

APPENDIX B

DATA COLLECTION METHODOLOGY

In the interest of consistency between state profiles, and to ensure that data between states is comparable, data sources that provide information for all 21 states and the District of Columbia (DC) are prioritized. More recent or detailed data available for a particular state, have also been included.

Ryan White Program Data

Demographic information about Ryan White program clients was culled from a number of sources. For the sake of continuity, the federal Health Resources and Services Administration (HRSA) 2010 State Profiles were used for data about the Ryan White program. Income, race/ethnicity, gender, and insurance status for 2008 are available from HRSA and have been provided for each state. Where available, information from state departments of health has also been included. Demographic information for AIDS Drug Assistance Program (ADAP) clients is most thoroughly documented by the National Alliance of State and Territorial AIDS Directors (NASTAD), and information from that organization has been provided for income and insurance status of ADAP clients. NASTAD's data for fiscal year 2010, fiscal year 2011, and June 2011 was used (fiscal year 2010 was necessary for states that did not report data in 2011). Because ADAP data compiled by NASTAD is unduplicated (ie, patients are not double-counted by multiple providers), it is one of the most reliable sources of demographic information for people living with HIV. Data from June 2011 provide information on how many people living with HIV currently enrolled in ADAP were living between 100-133% of the federal poverty level (FPL). Since the expansion of Medicaid eligibility to those living under 133% FPL is a new development, there is a relative dearth of data regarding the number of HIV+ individuals currently living between 100-133% FPL. NASTAD provides the only reliable source of this data to date. NASTAD's ADAP information was used for estimates regarding people living with HIV who are newly eligible for Medicaid in 2014 at the end of this report. Where information is also available from state departments of health or HRSA, it has been provided.

Estimates of unmet need for people living with HIV are available in each state's Statewide Coordinated Statement of Need (SCSN). SCSNs must be provided by all states receiving Ryan White program funding, but different states provide SCSNs in different years, so comparability among states is limited. Where information about unmet need is available from other sources, it has also been included.

Information on current services covered by the Ryan White program is available from HRSA and the SCSNs, and this data has been included in each state profile. Where more detailed information is available, it has been included in the profiles.

Income thresholds for ADAP eligibility, cost-containment measures in each state, and ADAP formularies are available from a variety of sources. The most common sources for this information are MEDI.CARE.GOV, the Kaiser Family Foundation, and NASTAD's *ADAP Watch* publication. This information has been included for every state and standardized to the extent possible among states.

Ryan White program budget allocations are also available from a number of sources, and information from the Kaiser Family Foundation has been included in every profile for the sake of consistency among states. ADAP budget information is available from NASTAD, including the fiscal year 2011 total budget, and a breakdown of expenditures. This information is provided in each state profile. Kaiser Family Foundation's information on ADAP expenditures has also been included for information on the amount spent by ADAP programs on insurance assistance and full prescription coverage.

Medicaid Coverage Data

Services currently covered by Medicaid and their limitations are detailed by state departments of health and state Medicaid manuals. Amounts of information available and levels of detail differ among states, and detailed information is provided in the profiles where available. The focus in each profile is on services most relevant to people living with HIV as well as limitations that may impede access to needed services.

NOTES

Data for certain states were incomplete in the 2012 National ADAP Monitoring Project Annual Report; missing data were obtained from alternate sources:

- › Data on the insurance status of ADAP clients in Maryland, North Carolina, Ohio, and Kentucky came from the 2011 NASTAD Report instead of the 2012 NASTAD Report.⁵⁵ (The 2012 NASTAD Report is missing data for North Carolina and Kentucky, and the percentages of the insured exceed 100% for Maryland and Ohio.)

- › Data on the number of clients served by Mississippi's ADAP program appear to be incorrect in NASTAD's Monitoring Report, as the number of clients served is listed as larger than the number of eligible ADAP clients in the state. The number listed was used in these calculations, and while the specific number of ADAP clients eligible for Medicaid and private insurance subsidies in Mississippi may not be reliable, the proportion of clients eligible for both programs was obtained in the same way as for other states, for interstate comparability reasons.

CAVEATS AND ASSUMPTIONS

The estimates provided require a number of caveats and assumptions:

1. ADAP data (as opposed to Ryan White data) were used both to account for insurance status and to avoid double-counting individuals who may be enrolled in multiple Ryan White programs (ie, seeing multiple providers). The estimates presented here, therefore, are only for the proportion of ADAP clients who will be eligible for Medicaid and private insurance subsidies;
2. Data for ADAP clients served were used rather than data for clients enrolled, because the number of individuals enrolled may exceed the actual number of clients actually accessing ADAP services. Potential clients who are currently on ADAP waiting lists in several states are also not included in these calculations. Thus, the numbers provide a conservative estimate of ADAP beneficiaries who will transition onto Medicaid or into subsidized private insurance;
3. National data (NASTAD and HRSA) were used in calculations instead of state-specific data to ensure that these estimates could be compared across the states surveyed; and

4. The number of undocumented immigrants on ADAP is a rough estimate extrapolated from estimates of the overall number of undocumented immigrants in the state as a whole as of 2008. It is possible that this estimate either overestimates or underestimates the actual number of undocumented immigrants currently served by ADAP.

With these caveats and assumptions in mind, the figures above are our best estimates of the number and percentage of ADAP clients who will be newly eligible for Medicaid in 2014 (assuming full implementation of the ACA), and the number and percentage of ADAP clients who will be eligible for private insurance subsidies.

These estimates are for ADAP recipients only, and are of limited analytical assistance in determining percentages of all people living with HIV who will be newly eligible for Medicaid and insurance subsidies in 2014. While the percentages provided could be extrapolated to apply to the broader HIV population in states, given the number of caveats and assumptions needed to arrive at this rough estimate, it would be better to obtain further information about the unmet need within states before attempting to make such calculations.

APPENDIX C

Part A of the Ryan White program funds both medical and support services, allowing states to provide HIV+ individuals with a continuum of care. States are required to spend 75% of Part A awards on core medical services, which include:

- › Outpatient and ambulatory care;
- › AIDS Drug Assistance Program (ADAP) (full coverage of drugs or insurance assistance);
- › Oral health;
- › Early intervention services;
- › Health insurance premiums and cost-sharing assistance;
- › Medical nutrition therapy;
- › Hospice services;
- › Home- and community-based health services;
- › Mental health services;
- › Substance abuse outpatient care;
- › Home healthcare; and
- › Medical case management (including treatment adherence services).

States may spend up to 25% on support (ancillary) services that are linked to medical outcomes (eg, patient outreach, medical transportation, linguistic services, respite care for caregivers of people living with HIV/AIDS, healthcare or other support service referrals, case management, and substance abuse residential services).

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Prepared by the Center for Health Law and Policy Innovation of Harvard Law School
and the Treatment Access Expansion Project



Center for
Health Law
and Policy
Innovation

HARVARD LAW SCHOOL



A collaboration between the Harvard Law School
and the Treatment Access Expansion Project

Potential Impact of the Affordable Care Act on the Ryan White HIV/AIDS Program

November 27, 2012

All Grantee Meeting Presentation: HIV/AIDS Bureau, HRSA
Margaret Hargreaves and Charles Henley

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Study Goals

- Assess the potential impact of the Affordable Care Act (ACA) on the Ryan White HIV/AIDS Program (RWHAP)
- How can the Health Resources and Services Administration help the RWHAP community with the ACA transition?

Comprehensive Literature Scan

- Identified topics in six broad areas
- Reviewed ACA-related reports
- Reviewed more than 250 documents
- February 2012 preliminary report
- Findings updated in final report

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Expert Consultations

- Scan informed discussions with topic experts in the ACA, HIV/AIDS, Medicaid, and RWHAP
- Discussions with 15 experts in April and May 2012
- Experts asked to prioritize issues and identify innovative ACA implementation practices

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State Medicaid Program Interviews

- Seven state Medicaid programs selected
- States represented a range of early ACA implementation experiences, HIV/AIDS demographics, and Medicaid policies
- Group interviews conducted in July and August
- States: Colorado, Iowa, Maryland, Massachusetts, New York, Oregon, and Texas

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Findings and Recommendations

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Six Topic Areas

- Eligibility
- Exchanges
- Benefits
- Costs
- Services
- Payments

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Eligibility Reforms

- Guaranteed issue and pre-existing condition insurance plans (PCIPs):
 - ACA prohibits denial of coverage based on pre-existing conditions (takes effect for adults in 2014)
 - Created PCIPs to provide temporary coverage
- People living with HIV/AIDS (PLWHA) have faced barriers accessing PCIPs
- RWHAP can help PLWHA access PCIPs and transition to other health insurance in 2014

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Eligibility Reforms, cont.

- Individual insurance mandate and exemptions:
 - Most legal residents required to purchase insurance or pay a penalty
 - Two types of exemptions:
 - Requirement to purchase insurance
 - Requirement to pay penalty
- Requirement upheld by Supreme Court

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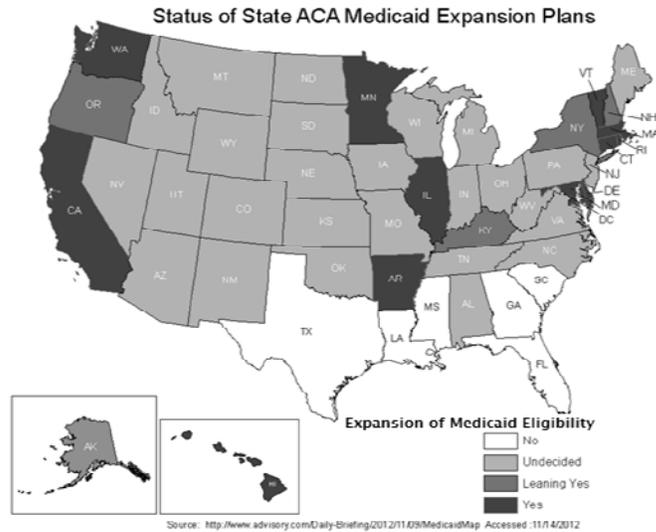
Eligibility Reforms, cont.

- Expansion of Medicaid eligibility:
 - National Medicaid income eligibility threshold of 133% of the federal poverty level (FPL)
 - Effective rate is 138% due to standardized 5% income disregard
- Challenged and struck down by the Supreme Court
 - Expansion is now effectively optional for states

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State ACA Medicaid Expansion Plans



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Eligibility Reform Recommendations

- Work with states on Medicaid expansion policy
- Maintain and increase outreach to ineligible groups

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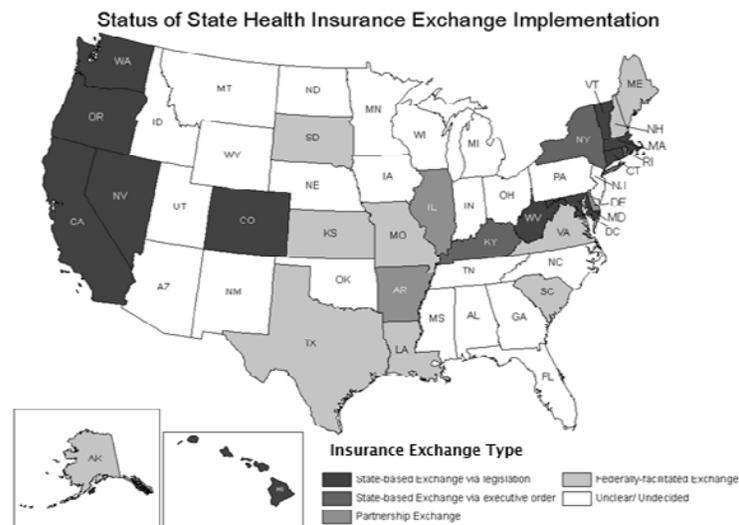
Health Insurance Exchanges

- Creation of affordable insurance exchanges:
 - Those with incomes from 100 to 400% of the FPL (if ineligible for Medicaid) can receive assistance to purchase private insurance
 - November deadline to submit plans for state-based exchanges
 - Exchanges open for enrollment in October 2013
 - Coverage starts in January 2014
- Exchanges will provide new source of coverage for PLWHA
 - Might face more cost-sharing requirements (e.g., for drugs)
 - Some needed services might not be covered
- Need to improve exchange navigation and streamline enrollment for PLWHA

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State Health Exchange Plans



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Health Insurance Exchanges, cont.

- ACA citizenship requirements:
 - Undocumented immigrants and “lawfully present” immigrants within 5 years of residency barred from receipt of federal benefits
 - Under ACA, lawfully present immigrants
 - Still barred from Medicaid for first five years
 - Can purchase insurance in Exchanges
 - Can qualify for private insurance tax credits and cost sharing reductions
- PLWHA who do not meet eligibility requirements will still need services from RWHAP
 - Other groups are also likely to require RWHAP services

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Exchange Reform Recommendations

- Help PLWHA through the eligibility and enrollment process, and make informed Medicaid and private insurance choices
- Train RWHAP case managers to serve as Exchange patient navigators and transition coordinators for RWHAP clients
- Carefully plan the transition of newly eligible PLWHA into expanded Medicaid and private insurance

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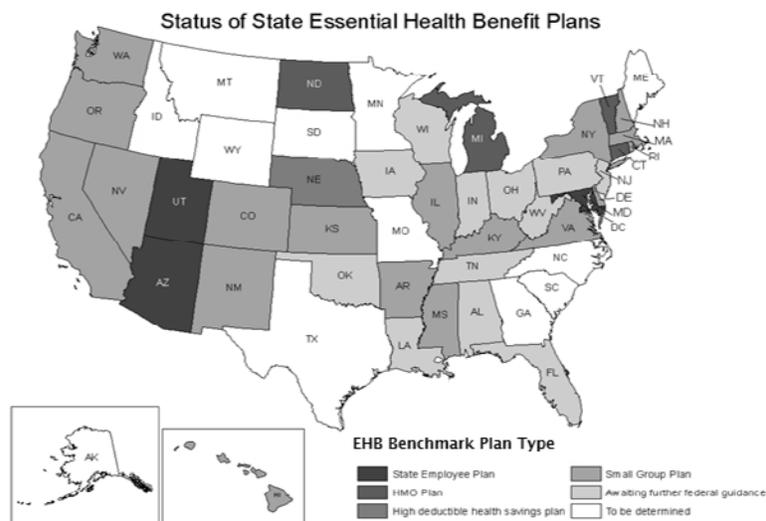
Insurance Benefits

- Essential health benefits (EHBs) and benchmark plans:
 - EHBs are 10 categories of “items and services” specified in the ACA
 - Insurance offered through Medicaid expansion, Exchanges, and state Basic Health Plans (BHPs) must meet EHB requirements
- States given right to define state-specific EHBs
 - Will result in significant state variation in benefits
 - Could lead to
 - Inadequate coverage for PLWHA in some states
 - Service disruptions for PLWHA moving across states

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State Essential Health Benefit Plans



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Insurance Benefits, cont.

- **Basic Health Plan:**
 - State plan option for people with incomes from 133 to 200% of the FPL
 - Otherwise eligible for premium tax subsidies
 - Benefits must be at least as generous as state's EHBs
- **Potential BHP benefits:**
 - Provide lower costs for consumers who cannot afford other qualified health plans
 - Prevent churning between Medicaid and private insurance for PLWHA with income fluctuations in this range

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Benefit Reform Recommendations

- Comprehensive EHBs that meets the complex health care needs of PLWHA
- Continuity of access to ART medications
- Identification of state-specific service gaps for reallocating Part A and B funding from direct medical care to premium supports and services not covered by Medicaid or private insurance

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Insurance Costs

- Private health insurance subsidies:
 - Citizens and lawfully present residents (with incomes from 100 to 400% of the FPL if otherwise ineligible for Medicaid) are eligible for advance tax credits
 - Cost-sharing reductions are available for people with incomes from 100 to 250% of the FPL
 - Will cover copayments, deductibles, and co-insurance
 - Available to low-income people with high out-of-pocket costs
- Not clear what assistance, if any, will be available to PLWHA with incomes less than 100% of the FPL in non-Medicaid expansion states

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Insurance Costs, cont.

- Preventive service cost-sharing:
 - ACA covers preventive care without cost-sharing for services graded A or B by the U.S. Preventive Services Task Force (USPSTF)
 - Currently covers HIV testing in high-risk settings
 - In Medicaid, HIV testing without cost sharing will be available as a state plan option on January 1, 2013
- USPSTF issued draft recommendation for routine HIV testing for teens and adults in November 2012
- HIV testing is not always included in bundled payments to providers, which could limit provider uptake

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Insurance Costs, cont.

- Medicare Part D prescription drug coverage gap:
 - Donut hole to be phased out by 2020, until then
 - AIDS Drug Assistance program (ADAP) payments count toward true-out-of-pocket costs
 - Beneficiaries also receive a 50% discount on name-brand drugs
 - Medicare cost-sharing requirements still apply (25% cost of medications)
- Reform could reduce costs for HIV medications and reliance on ADAP for medication coverage
- PLWHA on Medicare will still need cost-sharing subsidies to help cover their out-of-pocket costs

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Cost Reform Recommendations

- Allocate RWHAP funds to cover cost-sharing
- Educate RWHAP community about tax credits, cost-sharing reductions and out-of-pocket expense limits

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Service Delivery

- Medicaid managed care:
 - More than 70% of Medicaid enrollees served through managed care
 - Aged, blind, and disabled enrollees traditionally exempted, but states have started mandating managed care for them
- Expansion of Medicaid means more people covered through managed care organizations (MCOs)
 - MCOs might not have capacity to provide HIV care for PLWHA newly covered by Medicaid
 - Lack of experienced HIV providers within networks
 - Inadequate pharmacy coverage
- Potential for care disruptions

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Service Delivery, cont.

- Patient Centered Medical Homes (PCMH):
 - ACA provisions promote expansion of PCMH model
- Medicaid health homes:
 - New state plan option (1/1/12) to develop Medicaid health home programs for people with complex health needs
 - At least 2 chronic conditions
 - One condition and at risk for developing second
 - At least one serious and persistent mental health condition
 - Conditions covered include HIV
- Potential for incorporating comprehensive HIV care into PCMH and Medicaid health home models

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Service Delivery, cont.

- HIV workforce capacity:
 - Increased demand for HIV care under ACA
 - Many community-based providers do not have HIV expertise
 - Health plans have limited access to HIV pharmacies
 - RWHAP clients might have to transfer to new clinics
- ACA reforms
 - Expand initiatives to increase cultural competency of providers
 - Include essential community providers in qualified health plans
 - Double community health center capacity
- AIDS Education and Training Centers (AETCs) can help train PCPs in HIV care

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Service Delivery Reform Recommendations

- Ensure that experienced HIV providers are included as HIV primary care providers (PCPs) in provider networks
- Tailor PCMH and health home program models to address HIV care needs
- Provide more AETC training for primary care providers working in community health centers and other settings to build their expertise providing HIV treatment and care to PLWHA

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Payment Reforms

- **Provider reimbursement rate:**
 - Medicaid reimbursement rate for PCPs up to 100% of Medicare reimbursement rate in 2013 and 2014
 - Includes HIV specialists
 - Applies to both fee-for-service (FFS) and managed care plans
 - Set to expire after 2014
- **Some RWHAP providers will need help getting third-party payments**
 - Have to be certified as Medicaid providers and in managed care provider networks
 - Lack internal systems to manage the documentation and reporting associated with billing multiple insurance plans

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Payment Reforms, cont.

- **Other integrated payment reforms**
 - ACA funds accountable care organizations (ACOs), bundled payment reforms, and demonstration programs for duals
 - ACOs change financial incentives for how doctors and hospitals work together
 - Bundled payments designed to minimize patient cost while improving care
 - The Centers for Medicare & Medicaid Services (CMS) is working on integrated payment models for dual-eligible beneficiaries
- **Potential for RWHAP to share its comprehensive HIV care expertise to help create new Medicaid models**

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Payment Recommendations

- Work with stakeholders on permanent Medicaid reimbursement rate increase issue
- Provide information about new non-FFS payment models
- Help medical providers and community-based organizations build insurance screening, eligibility and enrollment, billing, and reporting capacity to manage increased volume of clients on Medicaid or private insurance

State/Local ACA Experiences

State/Local Experiences: Houston EMA

TX has highest rate of uninsured persons (24%)

- 25% of all Houston residents are uninsured
- 62% of Houston EMA RW clients are uninsured
- 87% of Houston EMA RW clients earn <100% of FPL.
- 76% of PLWHA in Houston EMA are unemployed

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State/Local Experiences: Eligibility

- Houston EMA
 - So far Texas has not committed to expansion
 - Difficult for PLWHA to qualify under existing state rules
 - Consumers & others joining Statewide advocacy efforts
 - State Healthcare Access Research Project (SHARP)
 - Texas HIV/AIDS Coalition
 - Policy Development
 - National Academy of State Health Policy (NASHP)
Medicaid Safety Net Learning Collaborative
 - 1115 Transformation Waiver

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State/Local Experiences: Exchanges

- Houston EMA
 - Texas has not elected to implement its own Exchange
 - Approximately 20% of Houston EMA PLWHA may be eligible to purchase coverage through an Exchange
 - Nurture & develop capacity to assist Exchange-eligible consumers in choosing best plan for their needs
 - RW-funded agencies offering core services must be Providers with all plans PLWHA may enroll in

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State/Local Experiences: Benefits

- Houston EMA
 - Essential Health Benefit (EHB) remains work in progress
 - Houston EMA has “bundled” RW-funded Primary Care, Medications, Medical Case Management and Service Linkage (non-medical CM) into a single local category
 - Will assist Planning Council, Grantee and Providers in quickly retooling RW-funded services to best wrap-around EHB to ensure access to and retention in care
 - Local Pharmacy Assistance Program (LPAP) may be able to wrap-around expanded benefits as with ADAP
 - Ongoing training for CMs, patient navigators & eligibility workers on new benefits available to PLWHA

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State/Local Experiences: Costs

- Houston EMA
 - RW-eligible PLWHA will likely need more assistance with premiums, co-insurance and co-payments
 - RW Health Insurance Assistance allocation may need increase to meet the needs of Exchange-eligible PLWHA (now receives 5th largest allocation of funds in EMA)
 - Increased need for wrap-around services
 - Linkage to care, system navigation, case management
 - Dental, medications & other services not fully covered under expanded Medicaid or insurance policies available via the Insurance Exchange

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State/Local Experiences: Services

- Houston EMA
 - Texas Medicaid program already in transition from Traditional to Managed Care Organizations (MCO)
 - Grantees must ensure RW-funded core medical service agencies are enrolled with multiple MCOs
 - RW agencies often need increased capacity in back-office operations to integrate new benefits into RW continuum of care
 - Electronic benefit eligibility/verification systems
 - *HealthHIV* Fiscal Sustainability T/A
 - NASHP Medicaid-Safety Net Learning Collaborative

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State/Local Experiences: Payments

- Houston EMA
 - Fee-for-Service reimbursement model
 - Aligns with enhanced Medicaid rates (FQHC rate)
 - Includes HIV specialists and Sub-specialty providers
 - Local continuum of care includes most wrap-around services needed by PLWHA including
 - Medical & Non-medical case management*
 - HIV and HIV-related medications*
 - Oral Health
 - Mental Health and Substance Abuse Treatment
 - Medical Nutritional Assessment & Therapy*
- *bundled with Primary Care services – 1 Stop Shopping

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Conclusions

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National Transition Leadership

- Address anxiety about RWHAP's future
- Provide more transparent and visible HAB leadership in transition process
- Offer clear guidance to support the transition
- Tailor RWHAP to operate in divided Medicaid expansion environment – “tale of two cities”
 - Expansion and non-expansion states
 - States on track or delayed in ACA implementation

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Collaborative Transition Planning

- Engage the RWHAP community now in state-level ACA planning and implementation
- Identify critical state agencies, decision makers, and decision points, and deadlines
- Gain a seat at the state policy table to develop or revisit policy decisions

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Education and Technical Assistance

- Recognize the significant change in billing practices for RWHAP providers
- Recognize the significant change in Medicaid and insurance status for RWHAP clients
- Implement outreach and enrollment of PLWHA
- Increase coordination among states, medical providers, insurance plans, and MCOs

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