Implications of the Affordable Care Act on Access to Effective HIV Services in Rhode Island

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Human immunodeficiency virus (HIV) remains a major public health issue in the United States with over 1.2 million people living with the disease and approximately 50,000 new cases identified annually. Considerable progress has been made in the last few decades in treating the disease but progress still needs to be made in combating transmission of the virus and building the infrastructure necessary to treat prevalent cases going forward.

The Medical Monitoring Project (MMP) is a CDC initiative to assess the health care needs of people who are infected with the HIV virus. Data from this Project have been very useful in understanding the multiple health care needs of the HIV population including comorbid conditions such as hepatitis C and tuberculosis. MMP data also address the psychosocial needs of the HIV/AIDS population and demonstrate the importance of comprehensive health coverage for this vulnerable population.

CDC guidelines recommend that primary care practices and clinics monitor HIV/AIDS services through proactive Counseling, Testing and Referral (CTR) that includes timely diagnosis, immediate referral to treatment, offering Anti-Retroviral (ARV) treatment – with the ultimate goal of viral suppression. All adolescent and adults should be assessed for HIV risk factors and high-risk patients (i.e., men having sex with men [MSM], injecting drug users [IDU] and heterosexuals who have had unprotected sex should all be screened for HIV with appropriate screening tests. In addition to these established high-risk groups, it should be noted that HIV rates are higher in black and Hispanic populations and among men and women between 30 and 39 years of age.

Rhode Island is now considered a moderate-low burden state by CDC with between 1,000 and 3,999 prevalent cases. Today there are approximately 2,200 people living with HIV/AIDS (PLWHA) in the state, and less than 100 new cases have been identified each year since 2011. In addition, the RI Department of Health estimates that there are approximately 400 HIV positive people who are unaware of their HIV status. ‘Unawares’ are at increased risk of transmitting the disease and are a critical population for screening, early diagnosis and referral.

The purpose of this paper is to identify the coverage and treatment options for people living with HIV/AIDS in Rhode Island and the impact of the Affordable Care Act on funding and access to health care services for people with HIV/AIDS. We briefly review general HIV incidence, prevalence and transmission patterns in RI before reporting on quality measures along the HIV Continuum of Care in selected practices in the Ryan White Part B program. We conclude with some recommendations for next steps and suggestions for how the primary care community can continue to assist the state in assertive testing, early diagnosis and treatment efforts.

METHODS

Given the variety of treatment options available to the PLWHA population, data for this study have come from multiple sources. Data on disease occurrence were derived from the Department of Health HIV/AIDS Surveillance System, while data on performance measures associated with quality come from the Executive Office of Health & Human Services (EOHHS) Ryan White Program. Data on risk factor assessment have come from the RI Behavioral Risk Factor Surveillance System. Finally, estimates on the impact of the Medicaid program on services for HIV come from the EOHHS Medicaid Medical Information System (MMIS). National data pertaining to the HIV Continuum of Care are referenced from CDC. In an effort to use the most current data available, we report data from multiple reporting periods.

Coverage/Treatment Options for People Living with HIV/AIDS

The primary sources of public funding for HIV/AIDS come from Medicaid/Medicare insurance coverage or from the Ryan White Program. The Ryan White Program is a key source of HIV care, treatment, and support for individuals who are uninsured and underinsured. Ryan White provides funding for both medical care and non-medical case management services helping individuals living with HIV/AIDS to be engaged and retained in care and treatment. Ryan White has been an important program for patients to overcome some of the barriers associated with medical adherence related to multiple comorbidities. In short, these services provide continued opportunities for access to care including behavioral health services, transportation, housing, and employment. It is important to note that Ryan White is not an insurance program; it offers payment for critical services for PLWHA who are uninsured or underinsured.

Prior to January 2014, full Medicaid coverage for PLWHAs was available to people with incomes below 100% of the federal poverty level (FPL). PLWHAs with incomes below
400% FPL were eligible for limited HIV/AIDS benefits through the Ryan White Program [e.g., support services, case management, home/community-based health services, emergency relief, limited dental, etc.] as well as pharmaceuticals through the AIDS Drug Assistance Program (ADAP).

In states such as Rhode Island that chose to expand Medicaid under the Patient Protection and Affordable Care Act (ACA), full Medicaid benefits are now available to all adults without dependent children with incomes less than 138% FPL. In addition, people with incomes between 138% and 400% of the FPL are eligible for subsidies to purchase full benefit coverage on the state-based or Federal health insurance exchanges. The Ryan White/ADAP programs are still available for HIV/AIDS related services for people under 400% FPL with both public and private coverage. (As such, there is some overlap in coverage among the various programs making unduplicated counts difficult.)

Figure 1 illustrates the population distribution among the various coverage types as of January 2014, after implementation of the ACA. Note that 55% of PLWHAs are covered by some type of public insurance (mostly Medicaid and Medicare) while 28% receive HIV/AIDS-related services through the Ryan White/ADAP Professional Care Program. About 9% have some kind of private insurance (including that purchased on the Exchange - Health Source RI). It is estimated that 8% of the known PLWHA population are uninsured (n=300), 83% of them receive care at Federally Qualified Health Centers (FQHCs) and other sites that receive funding for uncompensated care. About 2% have no insurance and no known site of care. Nationally, almost 30% of PLWHAs have no health insurance coverage.

Figure 2 illustrates trends in HIV parameters in RI from 1990 to 2012. Prior to 1994, PLWHAs were dying faster than new cases were being added. Since 1994, the prevalence of HIV has increased precipitously while both incidence and deaths have declined. Increased prevalence is the result of more effective treatment along with public and private funding for treatment.\(^5\) Essentially, HIV is now considered a chronic disease with a longer life expectancy. Reduction in incidence is primarily due to better public health control of transmission and compliance with treatment protocols among PLWHA.\(^6\) Still, approximately 100 new cases of HIV are identified annually suggesting that progress needs to be made in controlling transmission.

Figure 3 illustrates the exposure status of new cases of HIV by category. Consistent with national trends, the predominant mode of transmission is through men having sex with men (MSM). Perhaps the most striking result in Figure 3 is the precipitous decline in transmission through injecting drug use (IDU); largely due to the establishment of the state’s syringe exchange program and the repeal of

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Epidemiology of HIV in RI

Figure 2 suggests that PLWHA represents a growing population in Rhode Island with health care needs that will continue to require monitoring and intervention. Therefore, efforts regarding early identification of the disease, early ARV therapy resulting in viral suppression, all bode well for better outcomes and reducing transmission. The State of RI has begun several initiatives with the goal of getting to ‘zero’ native new cases in RI. While 34% of Rhode Island adults have ‘ever’ been screened for HIV, more targeted screening efforts may help identify the ‘unawares.’\(^7\)

The ACA has had a significant impact on both the availability and extent of health coverage for at least 15% of the HIV/AIDS population in the state. First of all, about 260 PLWHAs have transitioned to full Medicaid coverage as a result of expansion provisions of the ACA. These patients were only receiving partial coverage prior to the ACA and now have full medical benefits. In addition, the RI Ryan White Program is making premium assistance payments for 74 PLWHAs to purchase insurance through Health Source RI. As such, about 15% of the HIV/AIDS population is now receiving full medical coverage as a result of the ACA.
the syringe act that required a prescription for the purchase of syringes. Until recently [2010], women were a bit more likely to contract HIV from sexual contact with men than men were to have the virus transmitted from sexual contact with women. However, more recently the transmission rates have been almost identical.

It should be noted that over 60% of PLWHA are sexually active, about 25% have unprotected sex and 13% have unprotected sex with a partner with unknown or negative HIV status. Among men having sex with women, 14.5% are having unprotected sex and 9% are having unprotected sex with a partner with negative or unknown HIV status. Among HIV positive women having sex with men, 14.6% have unprotected sex with a partner of negative or unknown HIV status.

As such, the engaged rates are not exactly comparable to national data. On the other hand, the percent prescribed ART and the percent virally suppressed are comparable from both samples. Over 90% of the patients who are engaged in care are successfully placed on anti-viral therapy and over 80% of them achieve viral suppression. These results suggest that Ryan White agencies are exceeding national performance standards in treating HIV cases.

Figure 4. 2014 Performance Measures for HIV Care Continuum: Selected Practice Sites in RI vs National Rates as Reported to the RI Executive Office of Health and Human Services.

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Performance Measures/HIV Continuum of Care
Nationally monitored performance measures on the HIV Continuum of Care include: 1) the percent of diagnosed cases that are engaged in care (i.e., have at least 2 outpatient visits per year), 2) percent prescribed antiretroviral therapy, and 3) the percent who achieve viral suppression. Figure 4 compares the performance of three RI Ryan White Part B sites with national data from HRSA/HAB. These sites were selected on the basis of the fact they are the only Part B funded entities providing Medical Case Management. The populations sampled represent about 15% of the known PLWHA in RI. Rates are reported as the percent of the diagnosed cases.

In Rhode Island, EOHHS collaborates with Ryan White Part B Funded Medical Case Management Agencies to continuously improve the quality of the care provided to PLWHA. Funded agencies are required to report clinical quality performance measures routinely. EOHHS monitors these measures to identify where gaps may exist in connecting people living with HIV to sustained, quality care, and to implement system improvements and service enhancements that better support individuals through the continuum.

Note that everyone in the Ryan White program has been diagnosed with HIV/AIDS and had at least some contact with the health care system to be included in the sample. While RI is fortunate to be a moderate-low burden state, we still see about 100 new cases per year and the prevalence of the condition is increasing each year. Approximately 15% of the PLWHA population now has full medical coverage – thus reducing the number of uninsured and underinsured.

CONCLUSIONS
Prior to the ACA, only people with incomes below 100% FPL were eligible for full Medicaid coverage for HIV services. PLWHA with incomes below 400% FPL received limited services through the Ryan White Program and/or partial benefits offered through the Medicaid program. Since implementation of the ACA, approximately 15% of the PLWHA population now has full medical coverage – thus reducing the number of uninsured and underinsured.

While RI is fortunate to be a moderate-low burden state, we still see about 100 new cases per year and the prevalence of the condition is increasing each year. Approximately 15% of the PLWHA are unaware of their disease status and many who are aware of their disease status do not comply with recommendations to reduce transmission. Therefore, clinicians should continue to be vigilant in screening high-risk populations and counseling known cases on strategies to prevent transmission.

As HIV/AIDS continues to look more like a chronic disease with a large prevalent population, clinicians and policy makers need to be concerned about the state’s infrastructure available to treat the population. Fortunately, clinical quality measures from the Ryan White Program offer encouraging signs that RI is well poised to meet the HIV/AIDS challenge going forward.
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