AIDS FOUNDATION OF CHICAGO

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Comments on the Draft Medicaid 1115 Waiver
January 22, 2014

Thank you for the opportunity to submit comments on the state's proposed Medicaid 1115 waiver. We appreciate the state's extensive public input process, and urge the state to continue to allow opportunities for input throughout the negotiation process with the federal government.

While we applaud the state for attempting such a massive system redesign as proposed in the draft waiver, we are dismayed that HIV is mentioned just once in the waiver proposal (p 16). **While HIV can be managed as a chronic disease if diagnosed early, HIV is unique in that it remains a communicable disease.** Scaling services in respond to the state's HIV/AIDS epidemic must be viewed as a public health imperative with significant benefits for taxpayers. Every person with HIV who is successfully treated has a dramatically lower risk of transmitting HIV in the community; in fact, new evidence released by the National Institute of Health (NIH) demonstrates that consistent adherence to HIV medications reduces the chance that HIV will be transmitted by 96%.

AFC estimates that by 2017, Illinois Medicaid will cover 24,000 people with HIV, or nearly two-thirds of people with HIV in the state, making it the largest single payer source for HIV care services. If Illinois is to reduce new HIV cases and improve health outcomes for people with HIV, Medicaid must be at the center of the state's strategy for fighting HIV and must take a leadership role. We believe Illinois has an opportunity to make the state a model for Medicaid leadership in HIV care.

Our specific comments follow.

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PATHWAY 1: TRANSFORM THE HEALTH CARE DELIVERY SYSTEM

Link HIV-positive individuals with supportive services through targeted case management state plan option: If ending AIDS was as simple as giving people pills, we would have ended the epidemic a decade ago. Medicaid recipients with HIV often have chaotic lives that can make managing HIV a challenge. AFC's decades of experience coordinating the HIV case management system in the Chicago area demonstrates that case management is essential to connecting people with social services, behavioral health treatment, and stable housing that helps them to stabilize their lives and remain adherent to HIV care.

We urge the state to implement the targeted case management (TCM) state plan option to provide case management for people with HIV, behavioral health needs, a history of incarceration, and other complex needs. With oversight from the Illinois Department of Public Health that has led similar service models as the state's recipient of federal Ryan White HIV Program dollars, the TCM option should be leveraged to incentivize managed care organizations (MCOs) and managed care community networks (MCCNs) to provide case management on a more intensive basis to vulnerable populations, including people with HIV. Medicaid funding for TCM will allow Illinois to expand these service broadly as TCM would be covered as a Medicaid-reimbursable service. MCOs must be further incentivized to partner with community-based organizations that have deep knowledge of vulnerable client populations and long histories building trust within their communities.

We also urge the state to institute integrated delivery system contract requirements that stipulate that systems must provide case management services for people with HIV that meet specific requirements, including hours of HIV-specific training, access to services that will be funded only by the Ryan White Program (such as emergency rent and utility assistance, legal assistance, food and nutrition, and transportation to non-medical services), low client-to-case manager ratios to meet health-outcome metrics, and services geared toward the unique health needs of

populations disproportionately affected by HIV/AIDS (gay and bisexual men, transgender women, people with histories of substance use, homeless or unstably housed populations, and those affected by the criminal justice system). Because HIV disproportionately affects African-American and Latino men and women, these service strategies must aim to provide culturally competent care for racial/ethnic minorities as well as their subgroups previously listed.

Health home for people with HIV: An opportunity to improve HIV care is the health home state option, similar to the health homes for adults with serious mental illness proposed on p. 38 of the waiver draft. The health home state option gives states the flexibility to propose health conditions which can be included in health homes. Federal guidance specifically name HIV as one of those conditions.[1] Four states – New York, Oregon, Florida, Washington and Wisconsin – are implementing health homes for people with HIV. The health home state plan option would provide additional funding to promote care coordination for people with HIV, including linkages to essential community-based services. Health home models seek to improve the health of people with chronic medical conditions with comprehensive service strategies and management of specific performance indicators for the two or more chronic disease conditions faced by their patient populations.

Incentivize MCOs/MCCNs to improve HIV outcomes by instituting one HIV-specific pay-for-performance measure: The best measure of whether people with HIV are receiving quality care is viral load suppression. To incentivize MCOs/MCCNs to focus on HIV quality, viral load suppression (National Quality Forum #2080) should be included as pay-for-performance measure. This measure has been adopted uniformly by the NQF, the Medicare Physician Quality Reporting

[1]CMS State Medicaid Director Letter 10-024 Re: Health Homes for Enrollees with Chronic Conditions., downloaded 1/22/14 from http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

System (PQRS), the Electronic Health Record Meaningful Use Programs, and the federal Core Set of Health Quality Measures for Medicaid-Eligible Adults and HHS Secretary's Core HIV Measures Set.[2]

PATHWAY 4: LTSS INFRASTRUCTURE, CHOICE AND COORDINATION

Home and community-based waiver consolidation: AFC has coordinated the AIDS home and community-based care waiver since the late 1980s. Through a network of community-based case managers employed by 21 agencies, the AIDS waiver has coordinated and provided culturally-competent, HIV-specific case management that helps people with HIV successfully remain in the community instead of being institutionalized.

As waiver services have transitioned to MCOs in the suburbs, we have already experienced that some HMO case mangers lack knowledge about HIV and community-based, HIV-specific resources. AFC is concerned that waiver consolidation would worsen this trend. Waiver consolidation should improve services for every waiver population, not just give the state more flexibility.

As waiver consolidation proceeds, we urge the state to preserve disease-specific training practices. AFC, for example, has implemented a five-day training program that ensures case managers are highly knowledgeable. Such practices should be continued after waiver consolidation. We also urge the state to maintain condition-specific case managers to ensure they are best able to help clients thrive. A case manager should not have to be expert in traumatic brain injury, HIV, and senior services, but should focus on better medical and home-assistance management for similar clients experiencing similar needs related to their disabling conditions.

Supportive Housing: AFC strongly agrees that supportive housing is essential to improving health outcomes for people with chronic diseases, including HIV, and particularly if they are also

[2]For more information, see Strategies for HIV Medical Providers Contracting with Health Insurers, HIV Medicine Association, January 2014, downloaded from http://www.hivhealthreform.org/wp-content/uploads/2014/01/Tools_for_Monitoring_Issue_Brief_final_Jan2014.pdf

diagnosed with behavioral health needs. We strongly support the state's efforts to increase availability of supportive housing services.

However, it is not enough to encourage MCOs/MCCNs to employ "flexible services" (p. 41) to fund housing. Although we support this effort, there are tens of thousands of *current* supportive housing residents who are enrolled in Medicaid or will soon enroll.

In addition to incentivizing MCOs to provide housing services, Illinois should seek Medicaid funding for services that are currently not matchable, but could be if Illinois selected the appropriate Medicaid options. Current supportive housing providers should be able to bill Medicaid or DHS for supportive services without a managed care organization as an intermediary. Organizations that receive federal housing funding would be able to reallocate to rent dollars that are now spent on supportive services, allowing more people to be housed. For example, case management provided to supportive housing residents could be funded through Medicaid if Medicaid adopted the 1905 (a) targeted case management (TCM) state option, (1905 (a)(13) rehab option, 1915 (i) home and community based care option, 1915 (k) Community First Choice option, or health home state plan option. Many services, such as needs assessment, services planning development, referral and linkage, crisis intervention, could be paid for by Medicaid under these and other state plan options. A 2011 report, "Implementation of the Affordable Care Act and Medicaid Reform in Illinois to Incorporate Permanent Supportive Housing," specifically outlines these options.[3]

Thank you for accepting our comments regarding Illinois's proposed 1115 waiver application to CMS, which offers low-income HIV-affected Illinoisans unprecedented opportunities to improve their health and lives but only if the waiver application is calibrated to deliver expanded benefits to our vulnerable clients affected by HIV/AIDS. We look forward to working with you to shape a cogent and responsive waiver application to federal officials.

[3] Downloaded 1/21/14 from http://www.csh.org/wp-content/uploads/2011/12/Report_CrosswalkMedicaidIL.pdf