NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

2018 ACA Enrollment: Market Madness in Virginia

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Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Identify the challenges in Virginia's marketplace leading up to and during 2018 coverage ACA open enrollment;
2. Describe the process Virginia used to address each challenge and development of a hybrid model to assure continuity of care for underinsured clients; and
3. Identify the objective criteria developed for use of the hybrid model for underinsured clients.

Introduction

- Virginia ADAP (VA ADAP) provides medication access through several options for eligible clients:
  - Purchase directly and distribute through local health departments
  - Pay for insurance premiums and cost-shares (medication co-pays, coinsurance, deductibles) for plans on the federal Marketplace.
  - In the insurance option, medications are distributed through retail pharmacy network of PBM
- Insurance cost-effective in the aggregate
- VDH reviews and approves the plan offerings of the carriers on the Marketplace it will support based on HRSA guidance

Open Enrollment Preparation

- VDH and RWHAP B provider education with ACE TA webinars
- Encouraged client tune-ups and provider preparation for enrollment (CACs, training, etc.)
- Client and provider communications
- RWHAP B Provider first time initiatives:
  - Procured enrollment assistance from 3rd party payer for insurance
  - Some providers made binder payments; contracts modified

Open Enrollment Preparation (cont.)

- Client level data system ACA module to document enrollment and premium amounts
- Daily uploads into separate ADAP database for insurance premium processing by quality assurance team
- Extensive data and communication exchanges with 3rd party payer for premium payments and corrections/reinstatements

Quality Improvement for Premium Payments

- Received very high amounts of credits historically from premium overpayments
- Reviewed entire payment process using Plan-Do-Study-Act (PDSA)
- Developed improvement process:
  - To improve accuracy of payments to carriers
  - To reduce the volume and amounts of credits to VDH either through 3rd party payer or directly to clients
- Developed more robust relationships with carriers:
  - To create positive changes in payment process and schedule
  - To reduce client terminations/need for reinstatement

Open Enrollment Successes

- Historic client enrollments
- Insurance enrollment vendor + 25 other prevention and care stakeholders participated
- Limited # of providers paid binder payments
- Outreach to insurance brokers to research off-Marketplace plans and understand changes in Special Enrollment Period criteria
- Extensive review of provider status for in- and out-of-network for each carrier
- Notified and assisted providers to change network status where possible

Challenges and Solutions

- Carriers withdrew from Marketplace; some areas of state would have had no coverage
- Some areas of state had only one carrier option
- Some carriers made inappropriate requests related to RWHAP B funding and riders to exclude ADAP clients from coverage
- VA Executive Leadership intervened on carrier withdrawal; mapped plan coverage for all of state for clients and providers
- Required clients to sign up for insurance regardless
- VDH wrote denial to carrier and explained disallowance by law; researched and wrote rebuttal to VA Bureau of Insurance to explain disallowance by law

Challenges and Solutions (cont.)

- Inconsistencies in premium amounts from Marketplace and carriers
- Carriers tried to change or limit payment options by 3rd party payer
- Carriers willingness to terminate coverage for as little as $0.01

- Implement quality improvement process from PDSA to address all issues
- Created three new contractual positions to become payment quality assurance team
- Knowledge and skill training for team
- Electronic check payments and client reinstatements by 3rd party payer

Challenges and Solutions (cont.)

- Greatest challenges resulted from carrier decisions to:
  - Exclude RWHAP HIV specialty care providers from in-network status
  - Disallow out-of-network benefits (exception was emergency care for one carrier)
  - Structure plans as managed care plans to reduce cost and requiring clients to have referral from Primary Care Provider for HIV specialty care
  - Make off-Marketplace plans mirror the same benefit structure and networks as on-Marketplace plans; flexibility to use plans was moot
  - Allow only specific hospitals or facilities for care in large geographic areas

Virginia's Hybrid Model

- Developed HRSA-approved model using insurance coverage for medication access and RWHAP B funds to out-of-network providers for HIV-related Outpatient Ambulatory Health Services and laboratory testing service to clients ***underinsured*** by carrier
- Clients had to meet ***at least one*** of the following objective criteria:
  1. Available HIV specialty care providers could not accept new clients
  2. New patient appointment wait time exceeded two weeks
  3. Public transportation > 60 minutes and personal transportation> 45 minutes to appointment
  4. Structural barriers to new provider location may affect retention in care e.g. tunnel, tolls, etc

Virginia's Hybrid Model

- VDH staff used 2018 CMS non-facility physician rates including level of client care and fees for all labs recommended in HHS' HIV treatment guidelines for adults and adolescents
- Required VDH to establish new contracts with some HIV specialty care providers
- VDH will employ again if similar circumstances arise in Virginia's ACA Marketplace

Thank you/Questions?

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