Webinar Transcript
February 14, 2023

Medicaid 101 for RWHAP Recipients and Providers

Molly Tasso: Thank you so much for joining us today, and welcome to today's webinar on Medicaid 101 for the Ryan White Program Recipients and Providers.

My name is Molly Tasso. I'm the project director and a consultant at JSI and I'm excited to be kicking off the third presentation in our four part webinar series, which is focused on all things Medicare, Medicaid and Medicare Medicaid dual eligibility. So today's session will focus on Medicaid eligibility and enrollment, the services that the Medicaid program covers and how to ensure clients can access the services they need that are not covered by Medicaid.

Before we get started, just a few technical details. So attendees are in listen-only mode, but you are welcome to ask questions using the chat feature. So you can submit your questions at any time during the presentation today via the chat, and we will take as many of them as possible at the end of the session today. If any additional questions that maybe comes up later on, or if something pops up later this week, you can always email us questions. Our email address is acetacenter@jsi.com.

So the easiest way to listen to this webinar is through your computer. So if you can't hear very well, be sure to check that your computer audio is turned on and the volume is turned up. If you're still having audio issues, you can mute your computer audio and call in using your phone. So you can use the number on the screen there and use the webinar ID listed there as well. We are also going to chat out this information in the chat box so you have that available for you as well.

All right, so here at the ACE TA Center, we help build the capacity of the Ryan White community to navigate the change in healthcare landscape and help people with HIV access and use their health coverage to improve health outcomes.

Specifically, we support Ryan White recipients and sub-recipients to engage, enroll and retain clients in Medicare, Medicaid, and individual health insurance options, build organizational health insurance literacy, thereby improving clients' capacity to use the healthcare system, and also communicate with clients about how to stay enrolled and how to use health coverage. We do this by developing and disseminating best practices and supporting resources and by providing technical assistance and training through national and localized activities.

This slide shows all of our key audiences. This includes program staff, clients, program managers and administrators, and also people who help enroll Ryan White clients such as navigators and certified application counselors and SHIP counselors.

Today's webinar will be archived on TargetHIV at targethiv.org/ace. That is our website. You can find links to all the tools that we're going to present today. And if you forget the direct link, you can also find us by going to the TargetHIV website homepage or searching the topic library.

So again, today's webinar is part three in the four part series. For those of you who may have participated in the previous webinars on Medicare enrollment and eligibility, welcome back. For anyone who might be new to this series or to the ACE TA Center, welcome. We are referring to these webinars as part of a series, but there's no requirement or expectation that you attend the previous sessions, so don't worry if you miss them. Again, if you want to view the recordings of the Medicare webinars, you can find those on our website. Again, targethiv.org/ace/webinars.

All right, so today I'm very excited to be joined by Amy Killelea and Mira Levinson for this presentation. Amy is an independent consultant providing public health policy and financing expertise to governmental public health agencies, nonprofits, payers and providers. Amy's focus areas include HIV and hepatitis programs, public and private insurance coverage, public health and healthcare financing strategies, and medication access and pricing.

And Mira is the ACE TA Center's principal investigator and has been part of the ACE TA Center leadership since 2013. We also have a few other teammates and experts joining us for the Q and A panel and I can introduce them later on. So again, please chat in questions at any point during this webinar and we will put them in the queue and address them later.

All right, so the roadmap, the plan for today's webinar, we are first going to go through the basics of the Medicaid program and how eligibility is determined. Then we'll cover the application and enrollment processes. And then finally, we will discuss what services Medicaid covers. Then we'll share with you how the Ryan White Program provides care completion for clients on Medicaid. And then again, we'll close it out with a Q and A session.

So with that, I'm going to hand it over to Amy, who's actually going to start us today with a quick update around the end of the Medicaid continuous coverage requirement.

Amy Killelea: Awesome. Thank you, Molly. And hi, everyone. It's great to be with you today. So yes, as Molly said, let's do a quick update. We have somewhat breaking news and the topic that will be covered in great detail, I think over the coming weeks, months, the next year, and that's the Medicaid continuous coverage requirement unwinding.

So as many of you are now aware, we've had continuous coverage in Medicaid since the spring of 2020. So as a response to the increased needs for Medicaid as a result of the COVID-19 pandemic, state Medicaid programs received extra funding from the federal government. In return for that bump in federal funding, Medicaid programs agreed not to kick anyone off of Medicaid.

So we've had people coming into Medicaid programs, but no one's been leaving the programs since 2020. So as you can imagine, that has caused the Medicaid program in every state to expand over the past several years. We have now a date certain for the end of this continuous coverage. In December, Congress announced an end date that the end date is March 31st with terminations happening again in April of this year.

So the ACE TA Center is on this topic. There'll be lots of resources in the coming weeks and months. I believe there's a blog post on the unwinding being chatted out now as well as an announcement about a webinar being held in March on this topic. So more to come, but a few things to flag right now because we are in a bit of a race to prepare for a lot happening starting April 1.

Number one, make sure that Ryan White clients update their contact information with their state Medicaid agency. This is really important. Any correspondence that someone is going to receive in terms of renewing their eligibility for Medicaid, they're going to need to be able to have updated contact information to receive that.

So that's an important one. Encourage clients that this is coming, check their mail, check any correspondence from the Medicaid agency to ensure that they are completing what's needed for a renewal. So if they are still eligible for Medicaid, they don't lose eligibility.

And then help clients complete and make sure that Medicaid renewal forms are returned. Not everyone will receive one, some people will be renewed based on data Medicaid already has, but if folks receive a renewal form, that means they have to submit data that Medicaid does not have on file.

And then finally, there are going to be people who are no longer eligible for Medicaid, that over the years their income may have changed and their eligibility for Medicaid may in fact be found to no longer exist. So there's going to be a need to help folks enroll in other forms of health coverage, Medicare, Marketplace. And there is a need right now to start thinking about what those types of transition assistance activities will look like. So again, more to come. This is just but a preview of some of the topics that will be covered in that March webinar.

All right, next slide.

So with that, and again, we will cover this in detail, so don't worry, but we're going to dive into the regularly scheduled programming and go through the foundations of Medicaid. So we're going to start at the beginning and talk through the basics of how eligibility is determined in Medicaid.

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So first, let's start at the very beginning with the purpose and the structure of the program. Medicaid's a public insurance program and the purpose of the program is to provide coverage to low income people. So it's a state and a federal partnership. And what that means is that Medicaid is funded with both state and federal dollars.

In return for federal funding, state Medicaid programs have to follow federal Medicaid rules. That's the hook, states get Medicaid funding from the federal government, and in turn they have to abide by a floor of Medicaid requirements.

However, states are also kicking in money and states have a good deal of flexibility to structure their Medicaid programs in different ways, which means that one state's Medicaid program might look very different from another. And we'll talk throughout about how some of the ways state Medicaid programs differ from one another.

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So when we look at the role of the Medicaid program specifically for Ryan White clients, we see that the program is just very, very important for the folks that the Ryan White Program is serving. It's the single largest source of coverage for Ryan White clients with 31% of all Ryan White clients having Medicaid coverage in 2020, and then an additional 8% of clients on both Medicare and Medicaid. So they're dual eligible for those two programs. So this is just a context check of understanding how Medicaid works is not extra, it's really essential to ensure access to care and treatment for the clients that the Ryan White Program serves.

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So let's move to the Medicaid eligibility categories. And I'm going to start with the five categories on the left, so the five bars to the left. And these are often referred to as traditional Medicaid eligibility categories. And what that means, why they're referred to as traditional categories is they existed before the Affordable Care Act. We'll talk about what the Affordable Care Act and that did for Medicaid and that expansion group eligibility category on the far right.

But before the ACA, you had these five categories. You had eligibility for children, pregnant women, parents, individuals with disability and elderly individuals. And these five eligibility categories required folks to both meet the category of eligibility, so for example, in the kids' bucket, you had to be a kid, and an income threshold. So it was not enough to be only low income, you had to be low income and meet another categorical requirement to be eligible for the program.

So then you see the ACA comes along and really shakes up this whole dynamic. So the ACA expansion category allows states to expand Medicaid eligibility to folks with income up to 138% of the federal poverty level. And that really transforms the Medicaid program in those states.

Unlike in the traditional eligibility categories, so the five to the left, unlike those categories, the Medicaid expansion category is based on income. And so for the first time you saw the doors of the Medicaid program open to single childless adults to finally have access to a program. And that began in January 2014.

So I believe we're going to pause right now for a poll. So you see the poll in front of you asking which of the following Medicaid eligibility categories are most common for your clients. So you've got all of the ones we just talked about, children, pregnant women, adults and families with dependent children, individuals with disabilities, folks 65 and older, and then the ACA Medicaid expansion group. So folks up to 138% of the FPL.

All right, we've got pretty good participation. Great. So you see the results here. Really, it's a mixed bag. You've got a lot in the expansion group and a whole bunch in the individuals with disabilities and then the 65 and older. So those three are really the big three of eligibility and that makes sense, that matches national data. And so we'll talk through those eligibility categories in more detail.

Okay, so in addition to those full categories of coverage that we just went through, states may also offer what are called limited benefit Medicaid options. So these options, and again, they are state options, so they're not available in every state, but they provide some services for folks who qualify, but they don't provide full coverage and they don't count as minimum essential coverage.

So as a quick reminder, minimum essential coverage, it's important because individuals are only eligible for premium tax credits on cost-sharing reductions on the Marketplace if they don't have access to minimum essential coverage. Well, the takeaway here is that most folks who have limited benefit Medicaid can choose to purchase subsidized Marketplace coverage instead of enrolling in Medicaid, if they meet the other eligibility criteria for those subsidies.

And that's important because limited benefit means just what it means, you're not getting the full Medicaid benefit. You're getting a subset of services that don't count as full coverage. So you don't have to be limited to that. You can go into the Marketplace and get subsidized coverage.

But these benefits options, they vary by state. They include some of the things you see in front of you, like family planning services, emergency services only, limited pregnancy benefits. So again, it's a constellation of services that are usually very specific to one need and don't cover the full gamut of certainly what people living with HIV would need.

All right, so now let's really dive down into the two eligibility categories and we're really going to focus on the disability and the ACA group and just know

we'll talk some about the over 65 group and flagged some resources for that group as well because loud and clear, that's a group that a lot of people are serving, too.

So as a reminder, people with HIV are in all eligibility categories, and it's important to ensure that folks are screened for the right eligibility categories because sometimes some people could be eligible for more than one category, and it's important to know what category somebody's eligible for because the benefits could be slightly different. So for people with HIV, the two most common pathways are disability and then the ACA expansion category. So let's start with each one and we'll start with the disability category on the next slide.

So most states actually provide automatic Medicaid eligibility based on anyone receiving Social Security disability. And SSI is the disability program for folks with low income and without a work history. SSDI is the program for folks who have a work history.

But SSI is a federal disability benefits program and it has its own extensive application and eligibility screening process. So HIV by itself does not automatically qualify someone for SSI, but HIV may be one of the many factors that contribute to someone's disability.

Individuals who qualify for Social Security Disability Insurance, so the SSDI, which I just mentioned automatically qualify for Medicare. However, there's that 24 month waiting period before Medicare coverage is effective. So individuals in that waiting period may qualify for Medicaid, and that's really important to make sure that people have access to coverage in that 24 month period before their Medicare coverage begins.

The other thing I want to mention here is that states must also offer Medicare savings programs to assist Medicare and Medicaid dually eligible beneficiaries, many of whom are disabled with low incomes. And that's also going to be the category that folks noted in the poll of individuals who are over 65 who are duly eligible for Medicare and Medicaid. Medicaid is often coming in to help with the cost sharing for Medicare for low income beneficiaries who are over the age of 65.

So I just want to note we are not going to get into the world of dual eligible folks today, but there are resources and webinars on this very topic, and so there are

places to look there. But that's an important group, an important intersection between Medicaid and Medicare.

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So the ACA expansion group is the other very, very important eligibility category for people with HIV and it's important context to think about prior to the ACA, you had people with HIV, and even in non-Medicaid expansion states today we still have this situation where you've got people with HIV who are subject to this catch-22. So they have to become, in most cases, completely disabled to be eligible for the disability category and eligible for care and treatment that could have prevented the disability in the first place.

So it is this conundrum in traditional Medicaid categories and the ACA really gets rid of that and it says you don't have to both be disabled and low income where again, we're going to open the doors to folks based on income alone and it really allowed states to just eliminate that catch-22, make Medicaid available based on income. And so you see access to early care and treatment that can prevent some of the disability determinations that come with not having access to appropriate care and treatment for HIV.

So as I said, people can be eligible for more than one category. So even in states that have expanded Medicaid, it's really important for people with HIV to be screened for all eligibility categories and make sure if they are disabled to be applying for the appropriate Social Security disability benefits.

Different eligibility categories sometimes have different benefits available, and in some states the disability-based category may actually have additional supports because the assumption there is that Medicaid beneficiaries who qualify based on disability may have higher needs. So that's important to just make sure that folks are being screened for the appropriate eligibility category and basically the appropriate benefits that they may be eligible for.

So as I've mentioned, the Medicaid expansion category is an option for states. As of today, 11 states, so the ones in lighter blue on your lovely map there, 11 states have not yet expanded Medicaid under the ACA. And I will say this map changes. So South Dakota is a really good example that went from dark blue to light blue based on a ballot initiative this past November and South Dakota will start its Medicaid expansion this summer.

So these change, these are not static, but as of right now we have 11 states who have not yet expanded under the ACA. So in those states, in those dark blue colored states, you only have access to the traditional categorical eligibility buckets that we talked about. Those are the options that are available for people with HIV. So it's a limited way and pathway into Medicaid for folks with HIV in those states.

So I believe we're going to do another poll. This one's a quick one. Has your state expanded Medicaid? Yes, no, or I am not sure. Okay, so reflective of the map, we've got 61%, so a good number of you in a Medicaid expansion state and then about a quarter in a non-Medicaid expansion state. And your not sures out there, I will refer you to that color coded map. You do not have to be not sure for long. So that's a good mix.

And as you all know, the conversation about Medicaid just looks very, very different in a non-Medicaid expansion state. So we'll try to pull that out and those differences out as we go. All right, so with that, let's move on to the actual Medicaid application and enrollment processes.

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So income is a critical eligibility criteria. It's critical across all of the different disability categories. So I'm going to spend a few minutes talking about how Medicaid programs assess income. And so first, some groups are automatically eligible for Medicaid and don't need to submit an additional Medicaid application, so for instance, we just talked about the disability category.

In the vast majority of states, folks receiving SSI are automatically eligible for Medicaid and that makes it a lot easier. It's basically a twofer, right? You get SSI eligibility and that serves as your Medicaid eligibility application. And so you are automatically eligible for Medicaid. It makes it a lot easier for that group to access Medicaid.

But then you've got other groups, so for instance, the ACA expansion group. Those folks have to demonstrate that they meet an income threshold based on what's called modified adjusted gross income or MAGI. And I'm going to talk about what that looks like in a minute. But those are our two pathways. We talk about the most common eligibility pathways for people with HIV. You've got one that's fairly straightforward and then you've got another that's going to be an assessment of income.

So let's do one more poll. All right, knowledge check, true or false, individuals with incomes at or below 150% FPL automatically qualify for Medicaid coverage? Okay, all right. The poll is in. So the majority of you got this answer right. That is false, being under 150% FPL is not an automatic qualification for Medicaid. The low income ACA group is 138% of the federal poverty level. So that, the 138 is the number to remember for that ACA expansion category.

All right, let's move on then to MAGI and how you calculate it. So as I said, I mean, MAGI, and anyone who's familiar with the tax system or even looking at Marketplace eligibility income criteria, MAGI, it's a shorthand of assessing income and it's based on a person's household taxable income. So it's very much aligned with how the IRS looks at income.

And there's familiarity with the concept because this is how Marketplaces assess eligibility for the subsidies to purchase Marketplace coverage. A lot of ADAPs have also either tweaked or moved their income eligibility determinations to be based on MAGI just in order to align how programs are assessing income.

And you can see why you'd want to do that, right? You really wouldn't want wildly different calculations of income by program because that's going to be confusing for all concerned. So there has been movement to align the income criteria across Medicaid, Marketplace and now even ADAPs and other public programs.

One important difference though about how Medicaid looks at income that is a little bit different than how Marketplace subsidies work is that Medicaid eligibility is usually based on current monthly and not annual income. So the Marketplace goes the opposite way.

Really it asks folks to predict out, make assumptions about their annual income and usually looks at the most recent tax year to give a projection into the tax year ahead of you. Medicaid assumes a different baseline and they're just looking at current monthly, not annual income. And that's important, and particularly for lower income folks whose income may fluctuate over the year.

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Another big difference between the Marketplace application process and the Medicaid application process is that unlike Marketplace coverage, which

requires folks to enroll during an open enrollment period, or if you're outside of the open enrollment period to be eligible for a special enrollment period, people can apply for Medicaid at any time during the year and they should.

The exact application process varies a bit by state, but it usually includes a multiple pathway to apply. You can apply online in most states now, via phone through a state's call center, or buy a paper application. The ACA also emphasizes a no wrong door approach to applications and actually allows Marketplaces to screen individuals for Medicaid coverage when they're being screened for subsidy eligibility. So there's really multiple ways to apply for Medicaid and to get screened for eligibility to Medicaid.

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So once someone is determined eligible for Medicaid, coverage is effective either on the date of the application or the first day of the month of application.

Medicaid is also a fairly, I think, generous program in some ways in that it allows retroactive coverage. So this is something that you don't typically see in the private insurance space. Medicaid allows retroactive, so it backdates essentially coverage to start up to three months before your application went in as long as you would've been eligible for Medicaid during that period.

So this means that Medicaid coverage could actually begin three months before the date of your application. And when this happens, Medicaid will actually reimburse providers for care provided during the retroactive eligibility period. And some states will also reimburse beneficiaries who paid for care out of pocket.

Now, if you're a Ryan White provider, this might be important to you. You could get reimbursement from the Medicaid program for services you provide to someone who actually was Medicaid eligible, for an ADAP, ADAPs often are back-billing Medicaid if Medicaid should have been primary payer for drugs, and yet ADAP was paying for drugs during that eligibility period. So that's an important facet both for beneficiaries and for providers.

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And then the last of this trifecta before we move on to the Ryan White Medicaid intersection, but let's dive deep here. We're gone through the enrollment and eligibility period criteria. What do you get once you're on Medicaid?

So it's important to really highlight that Medicaid's a full insurance coverage program with the exception of the limited benefits Medicaid that we talked about. So asterisk on that. Medicaid coverage is full insurance coverage, and this makes it very different from the Ryan White Program, which provides essential services, but it's a program that's limited to HIV related care and treatment.

So Medicaid really opens the door to certainly HIV care and treatment, that's part of what Medicaid covers, but also all of these other services that are going to cover different needs outside of what the Ryan White Program can cover.

So Medicaid has a series of what are called mandatory benefits, which every state has to cover. So those are non-negotiable. That's the hook that the federal government says, you get federal money, these are the things you have to cover, they're mandatory. And you see all of the mandatory benefits on the left side of the chart. And they're pretty standard and they're pretty important, inpatient hospital care, diagnostic and treatment services, lab and x-ray.

So those are the mandatory ones. And then you have optional services, and those are the ones on the right side of the chart. And so those are the ones that not every state covers, states cover them at varying degrees. You see a lot of variability in them.

And I just want to hover, and hopefully this is jumping out to everybody because I think it's an oddity that prescription drugs are technically an optional benefit. It's odd that they are. They are an incredibly important part of somebody's medical needs, and though they are technically an optional benefit, every single state includes this benefit. So for all intents and purposes, it doesn't vary, every state covers prescription drugs.

The Medicaid statute actually requires states to cover every single Food and Drug Administration approved drug that is part of the Medicaid drug rebate program. So in other words, manufacturers agree to give Medicaid programs a pretty big discount on their drugs. And what the manufacturers get in return is that those programs have to cover their drugs. So it's a symbiotic relationship. Manufacturers say, here's a discount, and Medicaid say, cool, we will definitely cover your drugs so that people have access to them.

Particularly for people with HIV and for antiretroviral drugs, it doesn't necessarily translate into open access to all drugs people need. Even if a drug is covered, we all know that there are other ways to create barriers to access to that drug. So states can and do use things like prior authorization, step therapy to preference certain HIV drugs over others.

So I don't want to leave anyone with the impression that there's no issue ARV drugs are covered and they're always accessible. They're not. There are ways that states can limit access and prefer certain drugs over others, and we certainly do see that come up, but there is a baseline requirement that the drugs be accessible even with utilization management and some process to get access to it.

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So we've covered, and we're going through this rapidly, but hopefully you're getting a sense of how the program works. The last part that I want to talk about is both the delivery and then cost of Medicaid. And by delivery I mean the way that people actually access services and the way that the Medicaid program is paid for. And those two things actually are related to one another.

So there are basically two main ways that Medicaid services are delivered. The first is through fee for service. And that happens when a state Medicaid program pays providers in the state, so any provider who is participating in Medicaid, based on a fee schedule. So the state will have, it's usually publicly available, a fee schedule that is attached to a whole bunch of codes. And every service code has an amount that the state Medicaid program will reimburse the provider for providing to the beneficiary. So it's very straightforward.

A lot of states have moved away from that. You could see some problems with that, right? I mean, first of all, it's a little bit wonky. State Medicaid agencies don't move so nimbly. And so many, many states for a variety of reasons, including as ways to provide more efficient care and to provide more cost-effective care, states have used what's called Medicaid managed care.

And so that's when the state Medicaid program, instead of paying providers directly based on a fee schedule, we insert a middle person. State Medicaid programs pay health plans to deliver Medicaid service. So Medicaid managed care is really where the majority of Medicaid beneficiaries, including people with HIV and Ryan White clients get their care in this country. And it looks a lot

like private insurance and sometimes the same issuers are providing both Medicaid plans and Marketplace plans.

So you see there's a lot of consistency across the types of plans that people who are in Medicaid get. And then if they transition to Marketplace, that transition is often somewhat smoother if you're in a state that that has the same issuer selling in both markets. And I would say, people will disagree about this, but I don't know that one delivery mechanism is better than another. I think it's just a different set of considerations.

So for Medicaid managed care plans, it's really important for Ryan White recipients to understand any differences across Medicaid managed care plans. It adds another layer of assessment. Often, if you're enrolling in Medicaid, you get a choice of, okay, there are five Medicaid managed care plans operating in the state, which one do you want to enroll in?

And then you have to do a similar inquiry as you would do for a Marketplace plan. You're looking at provider network, you're looking at drug formulary and you're looking at does one plan have prior authorization or step therapy on a treatment regimen that my client's on, and is that not going to work for him or her? Should we look at a different plan whose formulary is a little bit different?

So it adds a bit of a layer of complexity. And I would also say Medicaid managed care plans on the flip side of that, often add different services that may not be available through the state Medicaid agency. So Medicaid managed care plans can add services like linkage services that try to link people with other social services. Some Medicaid managed care care plans are trying to do more on social determinants of health who have added far more substantive housing access services.

So you see some innovation there and it all depends, one is not necessarily better than the other. But Medicaid managed care does require a little bit more of an assessment across plans to make sure that clients are picking the plan that's going to work best for them.

And next slide.

So I want to end with just a super quick review on the premiums and cost sharing that clients may see in Medicaid. So first and foremost, federal law

limits the ability of states to charge premiums and cost sharing in Medicaid, particularly for folks under the federal poverty level.

However, you could have folks see nominal cost sharing, particularly for prescription drugs and outpatient services, which you see there, so between $4 and $8. The over 150% crowd is going to potentially be subject to more cost sharing, but anyone 150 and below, it's fairly nominal cost sharing.

And I will note also that there's a limit of 5% of household income. That's a cap of how much anyone can pay in premiums and cost sharing who's in Medicaid. And we will hear a bit about how the Ryan White Program can assist with clients with these costs in the next section. So I'm going to end there and turn it back over to our next speaker.

Mira Levinson: Thank you, Amy. And hi, everyone. So now that we've covered eligibility and enrollment and coverage, I'm going to talk a little bit about how the Ryan White Program can support clients on Medicaid. And then after that we'll continue on to the question and answer period. So definitely keep those questions coming. You can chat them in at any time.

So the Ryan White Program supports Medicaid clients by providing enrollment support and also care completion services and helping clients with Medicaid cost sharing. And of course it also serves as a safety net for people with HIV when they churn off of Medicaid.

Medicaid application and enrollment processes are generally separate from Ryan White application and enrollment processes, but Ryan White recipients and sub-recipients still play an important role here by screening clients for Medicaid eligibility and also helping people navigate that Medicaid application system.

So similar to Marketplace enrollment, enrollment support for Medicaid often includes helping clients provide required documentation to complete or renew their applications at least every 12 months. And also, Medicaid applications can take up to 45 days to process.

So during that time, the Ryan White Program can provide services that will eventually be covered by Medicaid, and that includes ADAP drug coverage. So Ryan White can actually back bill Medicaid to recoup what the program paid

during that time. And back-billing is an administrative process. It's conducted by the Ryan White recipient and usually doesn't affect the consumer directly at all.

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The Ryan White Program also provides care completion services for both insured and uninsured clients and serves as a safety net when clients churn off of Medicaid. And that's when a person transitions between coverage types due to changes in eligibility. So I'm going to talk a little bit about care completion and churn in more detail in a few minutes.

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So one resource that can help you prepare to talk with clients about enrollment is our discussion guide. And this ACE TA Center resource is designed for case managers and other frontline staff who work closely with consumers. And the formal title for this resource is Common Questions and Suggested Responses for Engaging Clients in Health Coverage.

The discussion guide is designed to help you talk with consumers about five common concerns that might impact your client's decision making process about getting covered. So things like changes in healthcare providers and medication coverage, communication challenges, mistrust of health systems, paying for insurance and health services, and immigration status.

And programs have used this tool in a number of ways, including using it to role play enrollment conversations with other staff members. It's definitely not a script, but just hearing yourself use some of the sample responses or playing around with how you might respond to a certain question or concern can be a really nice way to get comfortable with some of the more challenging conversations that might come up. So I think we're chatting out a link to this discussion guide now.

The discussion guide can also help navigate discussions about how the Ryan White Program complements Medicaid coverage. And the Ryan White Program provides access both to services that are not covered and also those that are only partially covered by Medicaid. So this is sometimes referred to as care completion.

Clients with Medicaid coverage may rely on the Ryan White Program to provide complementary services that support retention in care and viral suppression. These services might include case management, housing, mental health, behavioral health, or access to medications, for example.

And on the next few slides, I'm going to walk through some examples of how Ryan White service categories might intersect with Medicaid coverage. And again, I just want to be clear that these are all just examples. The specific availability and scope of services provided both through the Medicaid program and through the Ryan White Program are going to vary by state. But regardless, as the payer of last Resort, the Ryan White Program pays for HIV related services that Medicaid, Medicare and private insurance do not cover or only partial cover. So let's start with the example of case management.

Next slide, please.

Case management through Medicaid includes assessment and care management services to help individuals access needed medical, educational, social, and other services. And this can include tailored case management services focused on specific populations or conditions, but it may be limited to particular provider types.

So overall, case management coverage in Medicaid varies by state. The Ryan White Program often offers more comprehensive services beyond what Medicaid covers. So this is where the Ryan White Program provides care completion. And Ryan White provides both medical and non-medical case management, which might include assessment, care management services, as well as benefits counseling. And many Ryan White Programs use a range of non-clinician providers to provide that case management, including peers and community health workers.

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Let's now look at direct housing services as another example. Medicaid is not allowed to cover direct housing services. Ryan White recipients and sub-recipients on the other hand, may be able to fill this gap by providing direct housing services in some cases, including transitional, short-term or emergency housing assistance to clients.

Next slide. Thank you.

So mental and behavioral health services are another example we can look at here. These are both often covered by Medicaid, but many programs limit the number of visits allowed per year, and states may also have limited provider networks or lengthy waiting periods for services.

And Ryan White recipients and sub-recipients can fill these gaps in care by providing outpatient psychological and psychiatric screening, assessment, diagnosis, treatment and counseling services, as well as outpatient services for the treatment of drug and alcohol use disorders.

Now, in terms of access to medications, Amy's already talked about this a bit on the earlier section in terms of Medicaid. For example, even though Medicaid programs must cover antiretroviral treatment, some states do significantly limit access such as through monthly limits on coverage of brand name drugs. So here's where ADAPs or Ryan White AIDS drug assistance programs can provide medication access when there are gaps in access through Medicaid.

And this is important care completion for some people to ensure that clients do have continuous access to their antiretroviral therapy to maintain viral suppression, which of course helps people with HIV stay healthy and prevents new infections. So again, with all of these care completion services, please do check with your state's Ryan White and ADAP programs to see exactly what they offer.

Now, Ryan White funds may be used to cover Medicaid premiums and cost sharing, though again, this does vary by jurisdiction and recipient. Ryan White recipients may be able to provide co-payment assistance, which can help people with HIV avoid missed appoints. This means helping people avoid gaps in care and maintain consistent access to essential HIV medications. In general though, as Amy explained, Medicaid cost sharing is limited and nominal.

Next slide please.

So some states may have a medically needy or spend down option for certain Medicaid groups such as individuals that qualify based on age and disability, children and pregnant women. Medically needy programs allow people to deduct certain qualified medical expenses from their income while they're uninsured. This allows people to reduce or spend down their income to qualify for Medicaid.

Medically needy programs vary by state, but essentially these programs allow individuals whose income would otherwise be too high to qualify for their state Medicaid program to spend down to the Medicaid income thresholds.

It is important to note that federal funds, including the Ryan White Program, cannot be used to meet an individual's spend down. In other words, any federal Ryan White funds used to pay for a client's medical services while that person is spending down income to meet Medicaid income eligibility will not be counted as qualified expenses.

That said, some states are able to allocate state or local funds to assist clients to meet spend down requirements, but that definitely varies by state as well. So again, Ryan White recipients are strongly urged to assess state policies when it comes to assisting folks with their spend down.

And now let's talk a little bit about what happens when people lose Medicaid coverage. So many Ryan White clients may turn on and off of Medicaid in other programs, and we call this churn. It happens when clients lose eligibility for a program such as when their income rises above the threshold or if they fail to renew their eligibility.

So as a safety net program, the Ryan White Program does provide access to HIV care and treatment for individuals who may be in between other coverage. But remember, this is just HIV care and the Ryan White Program is not health insurance. So it's really important to work with clients to figure out if they may be eligible for full coverage whenever that may become available.

One example that we've already heard about from Amy is that clients may churn off of Medicaid through the Medicaid unwinding process that's just getting started. As you know, states have been required to keep all of their Medicaid beneficiaries continually enrolled since 2020 in order to qualify for additional federal Medicaid matching funds.

But now as the states begin the process of unwinding, which might look different in any number of states, the different states are reviewing all of their enrollees' eligibility and we do know that many people may lose Medicaid coverage if they're deemed ineligible or if they don't respond to requests for information.

So I do want to just quickly remind everyone that it's crucial to help folks avoid gaps in coverage related to Medicaid unwinding by making sure everyone is updating their contact information with the state Medicaid agency, including mailing address, phone number, and email address because they may be contacted in any number of ways.

Also, encourage your clients to check their mail frequently for letters from their state Medicaid agency, which might include notices of eligibility or renewal forms, help clients complete their Medicaid renewal form quickly if they receive one to avoid gaps in coverage, and finally, identify clients that may not be eligible anymore and help them look for alternative coverage options.

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So before we get to the question and answer period, let's do a quick knowledge check. So just take a look at your screen at this poll and answer the question, how does the Ryan White HIV/AIDS Program complement Medicaid coverage? And you can check all that apply here.

So option one, and again, you can check all that apply, the Ryan White Program provides both medical and non-medical case management. The second option is the Ryan White Program may provide direct housing services including transitional, short-term or emergency housing. The third option is ADAPs provide medication access when there are gaps in access through Medicaid. And then the fourth is that Ryan White recipients may help clients on Medicaid with their cost sharing.

So the poll, it's closed, and it looks like folks have responded in pretty high numbers across the board, especially on the ADAPs providing medication access. But that's great because it's actually true that all of these are possible. So I'm glad it sounds like all of you have been listening and that the Ryan White Program does provide a vast array of care completion services, including all of the ones that are listed here. So great job, everyone.

So now I want to let you all know about an important ACE TA Center resource that captures a lot of what we talked about today. And this is called Medicaid 101 for Ryan White HIV/AIDS Program Recipients and Providers. And it's designed for case managers and other program staff to help you and your colleagues understand the eligibility and enrollment rules for Medicaid, what the program covers, and how to ensure your clients can access the services they

need. So we've just chatted that out and I hope you all will take a look at that and share it with your colleagues as well.

So now we're going to turn to your questions, and for this I will hand it right back to Molly Tasso.

Molly Tasso: Awesome, thank you so much Mira and Amy. All right, we've received a number of wonderful questions and I do recognize we've got about seven minutes left in our time together today. So we're going to jump right in.

So I'm going to have Amy tackle the first couple questions. We've got two questions around the fee for service or Medicaid managed care approaches. So Amy, can you talk to us about how Medicaid managed care programs work? Do they act as intermediaries or the middle person? How are those structured?

Amy Killelea: So it's a good question. They do act as intermediaries, but it's important to note who they're the intermediary between, it's really the state Medicaid agency. So think of the state Medicaid agency as the payer. At the end of the day, they're held with the bill. And the plan sits in between the state Medicaid agency, the payer, and providers out there providing Medicaid services to folks.

So instead of the state agency paying providers directly using a fee schedule, so that's fee for service, state Medicaid agencies are paying the managed care plan and they'll say, okay, managed care plan, you get this set amount of money per year or per month, per member, per month.

There are different ways to do it, but you get a set amount of money and then the plan sets up contracts with providers. The plan structures its benefits. And the plan is really in charge of procuring services and getting services delivered. And the idea there is that the plan is better situated than the state agency to be cost-effective and to find efficiencies in the system, so to be able to negotiate with providers, negotiate for drugs. So that's where the plan is acting as an intermediary.

Molly Tasso: Thanks, Amy. And then somewhat related, someone asked if a state has to choose between fee for service or managed care?

Amy Killelea: That's a really good question, and the short answer is no. And some states go wholesale either way, but more and more, states, it's generally a transition to Medicaid managed care where you start with a smaller slice of your Medicaid

beneficiaries and then you grow it. But the short answer is that no, it's not a pick or choose thing.

Some states for instance, they decide that prescription drugs are not going to be in managed care and prescription drugs are carved out of managed care and put on the shoulders of the state. So the state takes charge of that. They don't say, managed care, here's a set amount of money, now go negotiate and figure out the drug thing and then get drugs out to people because drugs are expensive. And so states take on that burden themselves.

So it really does vary by different eligibility categories and even in services themselves, like prescription drugs. That's a good question. It does definitely vary even within a state.

Molly Tasso: Great. Thanks, Amy. All right, so we've got a question here related to the Medicaid unwinding process. So this person noted that they talked to someone and informed by the statewide customer service center that any Medicaid renewals that were due last year will be due this year in the same month. So for example, someone's eligibility that was up for a renewal of April of 2022 will be renewed or reviewed in April 2023, et cetera. Is that the case, or how are states managing this process of figuring out how to unwind?

Amy Killelea: I mean, so for this person, this will not be a reassuring answer because I'm not going to answer a state-specific question. I think you're right to raise it. I do want to direct people though, because you are not the only one who's asking the question of how are these renewals going to roll out and when should clients be expecting renewals?

And so I want to just flag, states get to decide. Medicaid as it does, the federal Medicaid program, the Centers for Medicare and Medicaid Services, they put out a lot of guidance that is steering states to do this unwinding in a way that is efficient, in a way that protects people. And then states get to decide ultimately what their plan is going to be.

So every state has to stagger the renewals. A state for instance, can't say, you know what? I'm going to renew everybody on April 1 and we're going to just get her done in one month. States have to stagger it over the course of the 12 months. But how it staggers the renewals is basically up to the state.

So what I would recommend everybody do is to check your state Medicaid agency, the public resources available on the Medicaid agency website. And then some state Medicaid agency websites are not the best, so our friends at Georgetown have actually published a great unwinding tracker where they do the work for you. They track down the different state documents and plans for renewals, for instance, and they plug it into their own tracker.

So we've got the link going out to you for that, and it's a great resource to look at as well. So I know that's not a satisfying answer to that specific question, but hopefully it helps others to look at it and just know it's not going to be the same across the board. It's not going to be the same for every state.

Molly Tasso: Yeah, great. Thanks, Amy. So I think that that is all the time that we have for questions today, but I think Amy, that last question and answer was a good segue into a reminder about both the Medicaid, Medicare dual eligibility webinar that we have coming up in two weeks from today.

And then it's not on this slide, but again, we are hosting a Medicaid unwinding webinar two weeks after the dual eligibility one, which will be March 14th. And so we strongly encourage everyone to join that webinar and to learn some more about this process of unwinding. And thank you, Trisha just chatted out a link to register for that webinar as well.

Okay. So I think that ... Okay, great. Thank you. So again, thank you everyone for joining us today. Please keep your webinar window open to complete the evaluation when it pops up when we end the webinar. It's very, very helpful for us to hear your thoughts and feedback on these webinars so that we can continue to improve our TA offerings and provide everyone with more opportunities to engage with us and build your capacity on these important topics.

You can sign up for our mailing list, download our tools and more by visiting our website, again, targethiv.org/ace. And again, if you think of any further questions after today's session ends, please don't hesitate to send us an email, again, acetacenter@jsi.com. All right, thanks everyone. Have a great afternoon and we hope to see you in a couple weeks. Take care.