

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Pre-Exposure Prophylaxis (PrEP), Session #4

11 October 2016

STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Pre-Exposure Prophylaxis, session number 4, Community of Practice webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, HIV TAC.

The Partnerships for Care project is a three-year, multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, to build sustainable partnerships between health centers and their state health department, and to improve health outcomes among people living with HIV, especially among racial and ethnic minorities.

The project is supported by the HIV Training, Technical Assistance, and Collaboration Center, HIV TAC.

Our speaker today is Amy Killelea. Amy is the director of health systems integration at the National Alliance of State and Territorial AIDS Directors, N-A-S-T-A-D, NASTAD. Amy joined NASTAD in June of 2012, and is leading NASTAD's health reform, public and private insurance, and health care financing efforts, including providing resources and technical assistance for state HIV/AIDS programs and developing recommendations to inform state and federal policy.

Prior to joining NASTAD, Amy worked as a Senior Fellow in Harvard Law School's Center for Health, Law, and Policy Innovation, conducting legal and regulatory analysis of federal health care reform, Medicaid, and private insurance.

Amy received her BA from Smith College and her JD from Georgetown University Law Center. Please join me in welcoming Amy Killelea.

AMY KILLELEA: Hi, everyone. This is Amy Killilea from NASTAD. And I want to thank the organizers for inviting me to participate in what I think is a really timely and important topic, HIV prevention and PrEP. And what I'm going to talk about are reimbursement and sustainable payer sources and strategies for PrEP.

So here's a little bit about me and here's a little bit about NASTAD. We are a national association and we represent the folks at the State Health Department level who oversee HIV, hepatitis, and drug user health programs.

So our game plan for today is to start out with a little bit of the why. And I think we're several years in now to Affordable Care Act, the ACA implementation and related health system transformations. So I want to set the stage on what are some of the key areas that are opening up opportunities for PrEP, in particular, but HIV prevention writ large, and then underscore some of the challenges to utilizing the broader health care system and payers for PrEP access.

I want to then go through a bit of an overview to NASTAD's fairly recently released billing guide that goes through some of the billing dos and don'ts and strategies for billing for and getting paid by third party payers for PrEP-related services and other HIV prevention services. Talk a little bit about the questions to ask as you assess your state's coverage landscape, because as you well know, every state is different in terms of the types of services particularly covered through a state Medicaid program. And then we'll leave plenty of time for questions and answers that we can take through that the chat function. So that is the game plan.

So setting the stage, the Affordable Care Act, and then really, how the Affordable Care Act has evolved into these broader health system transformation activities and opportunities.

So I want to talk about three, I think, fairly colliding issues and topics in the realm of the changing health care landscape. And it's how we as an HIV prevention paradigm and community are changing, and then how the world around us is changing.

So first, the prevention paradigm has and continues to change. And two of the, I think, major ways that that has happened is, number one, through the advent of PrEP, and number two, through the increasing recognition of the importance of treatment as prevention. And with both of those-- and we're going to focus today primarily on PrEP.

But with both of those interventions and changes of focus, it's really been a new opportunity for prevention in terms of a greater reliance and really a necessity for reliance on health care systems and a clinical system of care. Those both interventions really do rely on a biomedical intervention in terms of prescription drug coverage. So right off the bat, there's an increased reliance on health care payers. And they're both clinical interventions. So it's a different partnership between prevention programs and services with both clinical systems of care and third party payers in new ways.

So we, as a HIV prevention community, we are changing. And then just as we're changing, the world around us is changing. And I'm going to focus most of the health coverage and policy landscape shift on Medicaid a little later on in the presentation, and I think that that's what's driving a lot of the changes to how we think about insurance.

Medicaid, even five years ago, was not super concerned with social determinants of health. It was primarily a health and clinical-based model of care and services. And what we've really seen, particularly through the Obama administration and through many different moving parts and elements of the Affordable Care Act, is this new commitment in the form of demonstration projects, in the form of different models of funding, and different ways to pay for and deliver services, is a thumb on the scale from our federal partners that oversee the state Medicaid program-- or the Medicaid program and working in partnership with the states, a thumb on the scale for community-based services, services provided in community-based settings.

So figuring out how to provide holistic care to individuals that braid and weave together prevention and care, and linkage to other social and health care services that are needed really to address the entire person's needs. And I think that we've seen through that new focus, and new attention, and new funding opportunities, space has opened up for, not only HIV prevention, but prevention writ large.

And we'll talk about some specific examples of where HIV programs and providers have really been able to leverage some of those new funding streams and new commerce opportunities through Medicaid because of this different focus in the Medicaid program, and to a certain extent and a smaller extent, commercial insurance as well.

And then finally, this could come as no surprise to folks on the call, but the primary way that the coverage landscape has changed in the past four years with the Affordable Care Act is a huge and unprecedented drop in the percentage of uninsured in the United States.

And so this just shows the precipitous drop as of the first quarter of 2016. Throughout 2016, that's continued to drop. And I think it goes without saying, but I'll say it anyway, that the fact that so many more people have access to both Medicaid and insurance through qualified health plans really has changed the landscape in terms of what prevention programs we're able to leverage in terms of third party payer sources.

NASTAD periodically surveys our Health Department numbers on barriers and challenges to billing and reimbursement. And prior to 2014 when the Affordable Care Act's insurance expansions went into effect, across the board, the number one challenge to billing for HIV prevention services was that there simply was no billing source. There was no insurance source attached to folks who were coming in for HIV prevention services. So that's changed.

That's changed, not only in the Medicaid expansion states, where it's changed more, but it's also changed in the states that have not yet expanded Medicaid, where you're seeing a bump up in folks who are insured through commercial insurance through qualified health plans. So this landscape has changed in every single state.

So with that as background in context, I want to talk about where PrEP fits into this changing landscape, in particular, and really give some context as to NASTAD's focus on PrEP.

So NASTAD has focused on the barriers, and opportunities, and strategies related to PrEP financing in particular. And so when we think about some of the challenges to PrEP uptake that undergird that very, very low PrEP uptake number-- and that number is derived from Gilead data. Gilead is the maker of the only drug approved for PrEP at this moment, Truvada. Less than 4% of folks eligible for PrEP actually have taken up PrEP. And that, actually-- that number is a little bit outdated. It's crept up to about between 6% and 7% now, but still very, very low.

And I think that there are many, many reasons for that, and reasons beyond the financing reasons that I'm going to focus on. But some of the financing reasons that I think are in part driving that low uptake number are funding gaps. We do not have a safety net for folks who don't have access to either comprehensive insurance or insurance at all. So they are either uninsured or underinsured.

And that reason, I think, is driven by a couple of factors. Number one, unlike the HIV care system, where we've had a safety net in place for many, many years now through the AIDS Drug Assistance Programs and the Ryan White Program, we're in a funding no man's land when it comes to PrEP.

We've got a statutory bar on using Ryan White Program funds to cover medications for people who are not living with HIV. So that's a statutory bar that really limits the use of Ryan White Program and ADAP funding. And then we've got a CDC policy decision that prohibits CDC grantees from using their funds to purchase PrEP medication.

So that means that there's space for coverage of some of the ancillary services, and I don't want to overlook look that, but when it comes to funding the medication for PrEP, we've really had to be creative and look elsewhere. There's a big gap there.

And I think when it comes to Medicaid, that you've got the Medicaid Expansion map in front of you. The states that are dark in that map are the states that have not yet expanded Medicaid, which means that the lowest income folks in those states do not have access to Medicaid, do not have access to subsidies to purchase commercial insurance on the exchanges.

So that's a big gap right there in a world where we have to rely on other payers, because we can't rely on CDC and HRSA for the medication. And relying on other payers, and particularly, commercial insurance has come with a high cost, and we'll talk about what that has looked like too.

So there are a lot of barriers up there, and I think that that's what's driven NASTAD's focus on really looking at the barriers-- the financing barriers and some of the strategies when it comes to PrEP.

So in order to give some context for some of the challenges and, I think, opportunities to navigate the very complex waters of insurance coverage, I wanted to bring your attention to a recently released formulary analysis that NASTAD put out. We analyzed the Public Use Files. So

every plan that sells in a federally facilitated marketplace states, which is the majority of states, they have to submit all of their formulary and other plan information to the federal government. So all told, we had access to 91,000 plans, the formulary data for 91,000 plans. So a big chunk of the market. And the link is available right there.

And so I want to go over some of our findings, and particularly, the findings that I think are relevant for PrEP. So this paper-- and as you'll see if you go through it-- and I urge you just to take a look at it if you haven't already. The paper really evaluated ARV access sort of writ large, with a focus on single-tablet regimens.

So I'm not going to go through all of the rich findings having to do with the coverage and affordability gaps in coverage for a single-table regimen, but I do want to focus on the analysis that we did of Truvada. And so what we found is that, yes, Truvada was included on the vast majority of plans, but it was super expensive.

So 34% of plans place Truvada on the specialty tier. And so for those of you new to the insurance plan design world, the specialty tier-- every formulary organizes itself by different tiers, and the specialty tier is the highest tier. So that's where you would find your most expensive medications, and that's where you would find your highest consumer cost sharing.

So the fact that so many plans are placing PrEP on the specialty tier means that there's a really high out-of-pocket cost when it comes to PrEP. And just for background, without insurance, PrEP would cost a consumer a little over \$1,400 a month. So we need access to insurance to ensure affordable access to PrEP. And yet even when it's on insurance, it's often placed on this specialty tier.

And so what does that mean exactly? So the specialty tier-- so as we said, that's the highest tier that a plan can place a drug on, and that comes with higher cost sharing. And so what that has meant is that plans, instead of using your flat out copay for prescription drug coverage. So it's OK. It's probably what folks are most familiar with. When you go to your pharmacy, and you pick up your prescription drug, and you're charged maybe \$10, \$15, \$20 in a copay. It's an amount that you know ahead of time, and you pay it, and that's the copay.

What plans are doing, and even more so with the specialty tiers, is instead of doing that copay amount, they're placing a co-insurance amount on the medication. And so that means, instead of paying a fixed dollar amount for your cost sharing for your prescription drug, you are paying a percentage of the cost of the prescription drug. And so depending on how expensive the drug that you're trying to access is, that can be very expensive. That's often 25% up to 50% co-insurance. So 50% of the cost of the drug.

And so what that means is that if you're enrolling in a bronze plan, so those are the plans with the lowest premiums but the highest cost sharing, you could be paying over \$500 per fill to access Truvada.

And that bottom chart really spells out the percentage by which the different plan levels are using co-insurance. So if you're really attracted by low premiums, which if you are a young person who doesn't have any other health conditions, so maybe someone who is particularly-- would be eligible for PrEP, you might be really attracted to that bronze level plan, because it's a really low premium. But as soon as you try to pick up your medications, you're going to find that you're hit with a very, very high co-insurance or copay.

So that as context has really proven to be a barrier to adequately and effectively leveraging insurance coverage to help increase access to PrEP.

And so compounding that-- and I wanted to show this, because we are very, very close to the fourth open enrollment period, which starts on November 1. So compounding the issues that we've seen arise in terms of the affordability of insurance and this rise in specialty tiers for Truvada and other HIV medications, this rise in co-insurance instead of copays, you've also got a shrinking amount of plans who are actually being offered in marketplaces.

So this is from the Kaiser Family Foundation. And this is an estimate for the number of insurers who are planning to sell products for the 2017 plan year. So that would start January 1, 2017. And open enrollment for that plan year starts November 1, 2016.

So this just shows that there are many, many areas of the country where there are only one or two insurers who are selling plans in a given area. And so that combined with the affordability issues we're seeing just creates access issues. And it makes it that much more important for HIV prevention programs to familiarize themselves with the plan assessment landscape and challenges to make sure that folks are enrolling in the plans that are actually going to allow them affordable access to PrEP and other services.

So I hope that has given you some context for the slice of the overall PrEP access landscape that NASTAD has decided to focus on. Because of all of the challenges of the changing landscape that I just went over, we have chosen to focus on the financing elements for PrEP. So really focusing on private and public insurance enrollment.

If the landscape for plan coverage is shrinking, and it matters what plans folks enroll in to make sure they can actually access PrEP, we really want to figure out how to support really strategic and intentional insurance enrollment and education activities on the part of HIV prevention programs.

Better coordination between HIV prevention and care programs, and we'll talk about what that looks like and some of the collaborative opportunities between Ryan White CARE and ADAP programs, in particular, and PrEP access programs.

Engagement with health care systems and payers.

And then I'm not going to talk so much about this last piece. But through a different scope of work, NASTAD has focused on provider education as well. And so His Health is the name of the website that that other endeavor has come up with. And I'm happy to answer more questions offline about that, but I want to focus on our financing realm through our health systems integration work.

One way that we have started to think about PrEP financing and which models to support PrEP financing is really the trifecta of models that you have in front of you here. And why we have framed the PrEP financing models in terms of these three paths is because no one path is going to work in every single jurisdiction. And I know even on this call, there is a mix of Medicaid Expansion and non-Medicaid Expansion states on the line. There is a variability in terms of resources in a particular jurisdiction.

So there really isn't a one size fits all model for PrEP financing and access. And so we've really tried to focus on different ways that states, and programs, and provider programs have really been able to set up and stand up different types of PrEP programs.

One is through community health centers. The second is using the ADAP assistance program, Ryan White's insurance purchase infrastructure. So building off the back of what have been really high functioning programs that have provided both medications to uninsured folks and insurance assistance help to insured folks in every state.

And then STD clinics, which is a similar model to community health centers, but a little bit of a different focus. So those are just like our trifecta, our pillars of what some of these models can and do look like in different jurisdictions.

And so here, I know that there's a lot going on in this slide, and I'm not going to go over every single element. But In thinking about a PrEP financing program and thinking about how to compare our three pillars of different models, we wanted to look at what are the elements of different programs? What needs to be covered? And how are different programs covering things differently?

And I think the first takeaway is that I think these are the big pieces in terms of the elements of these different programs. You've got, first and foremost, what is your drug financing mechanism? If these programs are purchasing drugs, particularly for uninsured folks, how are they doing that? Are they able to leverage 340B pricing? What's your drug delivery mechanism? Are you leveraging ADAP's infrastructure or other in-house or contract pharmacy infrastructure?

Lab financing. And we'll talk about that when we talk about individual billing, including challenges. So that's been a real challenge that we've heard, and there's no one or best way to really cover that, particularly for uninsured folks.

Enrollment. And we just talked about the importance of enrollment assistance for folks to make sure that you're enrolling in a plan that's actually going to be affordable and cover what you need it to cover.

Provider network, which we know that there are not enough providers who are willing and able to prescribe PrEP. So that is an issue right out of the gate.

And then so how are these programs either using provider detailing or expanding existing networks to increase the provider network for PrEP prescriptions?

And then out of pocket costs. And we talked about the challenges that NASTAD has identified through some of its assessment work. And these are some of the ways that programs are trying to address those out of pocket insurance costs, either through building that into a program to help folks who are needing PrEP with their out of pocket insurance costs or, for the most part, referring to industry copay programs. That's been a primary model of addressing the prescription copays associated with PrEP coverage.

So that's a big landscape on that. Happy to talk more in detail about any one of those models, and where we're seeing each of these models pop up depending on jurisdiction.

So that is our overview of the health care landscape, and PrEP financing challenges, and then at least NASTAD's focus areas when it comes to PrEP financing models.

I want to shift gears a little bit, get into the weeds a little bit more, and really talk about the billing and coding challenges, and some of the strategies. And what I'm going to do here-- and I want to be clear about what I'm going to do and what I'm not going to do. I'm going to give a bit of an overview as to NASTAD's billing and coding guide, and that there's a link included at the end of my slide. So if you haven't done so already, I urge you to take a look at that.

I'm going to talk through the key areas identified in that coding guide and give you the broad brushstroke of some of those areas, as opposed to really going-- and I am not a certified coder so I will not be going in-depth on individual coding scenarios, but walk you through how you use the coding guide.

So as background-- and this was the coding guide that was supported through a cooperative agreement that NASTAD has with the Centers for Disease Control and Prevention. So to put together this coding guide, we convened an advisory group. So we did include a coding expert, the HIV Medicine Association, and then we included health department staff as well as clinical providers, who are particularly PrEP providers to inform creation of this billing and coding guide. And I'm sure many people on this call are familiar with some of the many coding guides that have come out of HIV prevention Capacity Building Assistance providers, in particular, but it really focused on HIV testing and some of the dos and don'ts of coding and billing for HIV testing.

And so what we wanted to do with this guide is identify, like, where are the gaps? What types of services are not well incorporated into existing testing guides? And frankly, what are some of the services that are just not well translated into the language of payers?

And so what we identified as key areas were, number one, PrEP services were difficult to bill for. It's fairly new. There's inconsistent use of diagnosis codes attached to the PrEP services that providers were trying to bill for. So it was hit or miss. That's what we found particularly from the PrEP clinical providers that were on our advisory group.

We also heard, and continue to hear, that HIV linkage and these amorphous care coordination services are difficult to translate into billable services in units. So HIV linkage is just not something you'd ever find in a CPT code book, and it was hard to parse out what are the specific codes that make up HIV linkage that we could actually translate into a billable code. So that was the second area.

And then we also find, and again, continue to find, payer restrictions on different provider types and place of service requirements. Those are a real barrier to reimbursement. And I'll walk through what this looked like in practice, but this was especially true for community-based providers and settings. So if you've got a mobile testing van, for instance, or if you've got a community-based organization that's providing a whole lot of ancillary services associated with PrEP, we heard and continue to hear that that has been a real tough nut to crack in terms of figuring out what, if any, of those services and provider types are actually billable.

So that was the PrEP work and the advisory work. And so after taking the different issues and challenges into account, we worked with a certified coder consultant and we came up with this Billing Coding Guide for HIV Prevention.

And so the areas of focus that we chose to emphasize in this coding guide were, number one, PrEP initiation and follow-up. Adherence, linkage, and counseling services. So trying to widen the universe of HIV linkage services, some of those supportive and care coordination services. And then lab tests for HIV and other STIs, with a particular emphasis on the new ACA requirements and then the lab tests associated with PrEP as well.

And so for each area of focus, the guide goes through the appropriate CPT code or codes, so recommendations on the types of codes, requirements for provider licensure and credentialing requirements. And then finally, the allowable ICD-10 diagnosis code.

So I want to go through the three areas and just call out some examples. But I will say, these are just mere snippets of what ended up being a comprehensive coding guide. So this is just to give you a taste of the types of detail and examples that we included in there, and there are more.

So for PrEP services, again, the acknowledged challenge at the outset that using the right diagnosis code was difficult, we really tried to break out what diagnosis codes, based on the provider interviewing that we did, are working. There is no diagnosis code for PrEP, in

particular, and that's not going to change for a while, likely. So given that, what types of diagnosis codes are actually working as well as the codes that providers are using and that are working to document the services that they provide for initiating PrEP, counseling patients, and then the testing for regular SCI testing associated with PrEP.

So in addition, and closely linked-- and I feel like we chose these buckets of categories because they all are very closely linked to each other. And so in addition to the PrEP initiation specific services, we also looked at adherence, linkage, and counseling services.

And so as I said at the outset, the primary challenge with this kind of bucket or suite of services is that we did not have-- our public health nomenclature was not readily translatable into a third party payer nomenclature. So what we tried to do at the outset was take that bucket of rather amorphous services that we called adherence, linkage, and counseling, and divide them up into what are CBT-defined services. And so there, you had some of the ones that we were able to identify, of chronic care management, target case management, behavioral risk counseling, mental health assessment.

So some of these are directed at people who have an HIV diagnosis. Some of them are more preventative in nature. And then as you can see on the right, and this is where there's just variation depending on jurisdiction, and particularly within state Medicaid rules. But credentialing requirements and the types of providers who are able to actually bill for these services really did vary in some states.

And we'll talk about some of the movement we've seen in jurisdictions that widen the reimbursement opportunities for community-based and peer workers and providers. In some states, community health workers may be reimbursed, and other peer providers, but that very much varies by jurisdiction, and it is not in any way the norm across states.

And then finally, lab services. And again, I emphasize the US Preventative Services Task Force Grade A and B services. Those are the services that private insurance and Medicaid Expansion services have to cover. And so this is not an inclusive list of all of the preventive services that now have to be covered, but some of the most important ones for HIV prevention and related public health screening, routine HIV screening, HCV, STD screening and counseling. So spelling out what are those services that are included in those USPSTF A and B rated recommendations.

And then what we found, and some of the questions that we attempted to answer, number one, it requires a particular way to build to make sure that if you are providing one of those USPSTF A or B recommended service, that you are actually billing for it as a preventive service, and that means that there's no copay associated for that service. So that was a question that we tried to answer that we had heard providers raise.

And then are there frequency or facility restrictions for the number of screening tests done in a benefit year? And this is probably the single most question associated with lab services when it comes to PrEP. And it's been a challenge that has been noted across the board in terms of the

ability to bill, as part of the ACA service, multiple HIV tests, for instance, associated with someone who's on PrEP. So it's going to be more than just annual.

So what we found there is that providers were able to bill under the ACA Preventive Services modifier for an annual HIV test. But subsequent tests, they're able to bill for, but they have to bill it as a diagnostic test. So that's getting into the weeds a little bit, but I wanted to bring that out, as that's been a challenge, and that's been something that has been difficult for providers to navigate their way through and make sure that they're doing it in a way that is going to benefit the patient by limiting his or her cost sharing, and then in a way that's not going to get denied by an insurer.

The topic that I want to end with is to go back to some of the linkage and adherence and counseling services. One of the key themes that we found in structuring that part of the billing and coding guide or really just a key theme in terms of a coverage and reimbursement challenge was that there are just variable and, frankly, very little, at least right now, coverage and reimbursement opportunities for community-based providers in community-based settings. And we know that for HIV prevention, that's been an important part of the HIV prevention is through a system of services.

And so what I wanted to sort of note and flag some specific examples what's going on in some of the P4C states, but then also writ large, nationwide, is that there really has been a trend, and I'm going to focus on Medicaid coverage, because I think, as I said at the outset, that's really where a lot of the focus has been, but a trend toward increased opportunities for community-based services and coverage. Even though they're slow to emerge, and many are in a demonstration project phase right now, the fact that there are so many demonstration projects, and the fact that more states are moving in this direction, I think it's indicative of where Medicaid is going.

And so I think it's something to keep monitoring, and keep an eye on, and look at what your state is doing. And so what I put on this side are just links to the federal Centers for Medicare and Medicaid Services, CMS, so the federal agency that oversees Medicaid. They actually have a very, I think, user-friendly website where you can search, what's my state up to when it comes to state plan amendments? So that's just a way for a state Medicaid program to amend the types of services that it provides.

Or did my state apply for a Medicaid 1115 waiver or demonstration project? If so, what does that actually look like? You can actually-- you can look to see what your state is doing and see if there are any prevention elements to some of those coverage amendments or demonstration projects or waivers.

And so I want to talk about three different examples. And I hate to just leave it as, oh, there's a lot of innovative things going on in Medicaid, you should check out the CMS website, because I want to be specific, that there are a lot of things going on in Medicaid.

But I want to talk about some of the specific Medicaid innovations via three avenues, via Medicaid 1115 waivers, state plan amendments, and then Medicaid managed care through flexibility and innovation, and we'll call it. And talk about some of the prevention-specific ways that these are playing out to give you a little bit of an example as a concrete way that some of these different payment and delivery reforms can benefit HIV prevention systems of care providers.

So this first set of three examples are Medicaid waivers. So these are 1115 waivers. If you're not familiar with the term, a longstanding Medicaid practice. And it is a way for state Medicaid programs to get flexibility from the federal government on some of the federal restrictions that undergird the entire Medicaid program. So they get federal flexibility to be innovative, to put together these demonstration projects where they can play around with benefits packages in new ways, where they can play around with payment models in different ways, and delivery systems.

And so one of the ways that the benefits structure has been changing is just the way that community-based services and providers are being incorporated into Medicaid. And that's the one that I really want to draw your attention to. So these are just three examples of where states are going with this.

Massachusetts, that's one to watch. They have a fairly expansive waiver proposal that's being reviewed by the federal government right now. And if that gets approved, I would say, everybody watch how Massachusetts actually implements it, because there's a huge community-based organization and community-based service component to that waiver. And I think we could see some different ways that Medicaid can actually fund prevention services provided in community-based settings in different ways, and how they can support better relationships and partnerships between community-based organizations and large clinical providers. So that one is not yet implemented, not yet approved, but something to watch.

Texas is another one. They've used a waiver to implement expansive-- thousands of different projects across the state. And so I won't get into the specifics, but I will say, one of the ways that they've used their waiver is to develop projects that are HIV-specific. So they've been able to incorporate HIV linkage projects and services into this waiver that uses Medicaid program funding for these services.

And that's in a state that has not yet expanded Medicaid. So I wanted to include that to let you know that this is the sort of innovation in these different payment and delivery reform opportunities are really happening everywhere. This is not limited to the states that have chosen to expand their Medicaid programs.

And the same's true for Mississippi, a state that has not expanded its Medicaid program, but chose to implement an 1115 waiver, which would allow flexibility under the Affordable Care Act to provide family planning services to both women and men to generally high income. I mean, if you think of the regular Medicaid Expansion income is only 138%, this is all the way up to 194%

over the federal poverty level. And that's allowed Mississippi to incorporate PrEP into their Medicaid family planning services and coverage.

So that's just another example of a non-Medicaid Expansion state taking advantage of some new opportunities through Medicaid payment and delivery reform to expand access to HIV prevention.

So if you think about the 1115 waiver, that's your big ticket item. Your state has to formally apply to CMS. It's got to get approval. It's often a year or two-year-long process to apply. So that's labor intensive, and it's a hard and heavy lift for states.

The next one down would be a state plan amendment. That's a fairly regular, and less threshold, and less expansive way for states to amend some of their coverage or other requirements in the Medicaid program.

And so these are just some examples of how states have used both the state plan amendment and then some of the related and other demonstration project opportunities specifically for prevention. So you've got New York, which has a state plan amendment proposal to incorporate harm reduction counseling services in some Medicaid programs. So a set of services that is very related to HIV prevention that does utilize a peer and community workforce. And so that's under consideration in the state of New York.

A similar advocacy in Washington, DC, around a state plan amendment that would implement preventative services that could be provided by community health workers and other non-licensed prevention providers. In Washington, DC, you get reimbursement for those services through Medicaid. So they're figuring out how to structure that in Washington, DC.

And then in terms of the demonstration project avenue, Maryland. Maryland is one of the many states that's gotten a State Innovation Model funding, which is just the name of this demonstration project model that's out of federal CMS. And that project incorporates community health workers. It incorporates HIV population health outcome goals into some of its projects.

And so I think we're going to continue to see both prevention avenues writ large, but then HIV prevention-specific opportunities in many of these different Medicaid payment and delivery reform models that are cropping up in many, many, many states.

And then the example that I wanted to end with are Medicaid managed care plans. So if you think of the levels of intensity, I suppose, for utilizing flexibility or different payment delivery reform models in Medicaid, the 1115 waiver is the highest intensity, then you've got your state plan amendments and/or your demonstration projects, and then you've got Medicaid managed care plans, which just by virtue of being Medicaid managed care plans have flexibility to cover nontraditional services, and are doing so.

And I think that inherent flexibility within Medicaid managed care plans, combined with the fact-- and I'm sure folks out there on the call can speak to this in your own jurisdictions-- combined with the fact that for many, many states, the vast majority of Medicaid beneficiaries are getting their care through Medicaid managed care plans now, not through Medicaid fee for service. That really does open up the importance of Medicaid managed care plans for HIV prevention. And so we've seen some really interesting models come out of various states.

And I've got some resources that I've included that highlight some of the best practices in case studies that NASTAD has highlighted in various white papers, highlighting both examples of HIV prevention and linkage services, then also drug user health and harm reduction services.

So this example in one of the white papers that we've cited, and that the link is in the resources section, highlighted Louisiana, where they were able to work with the Louisiana Medicaid managed care plans-- the HIV program and the health departments work with the Medicaid managed care plans to incorporate a Medicaid quality incentive payments through improved services for Medicaid beneficiaries living with HIV.

So that's not PrEP-specific, but I wanted to include that as an example of emerging and new partnerships between HIV prevention programs and, in this case, Medicaid managed care plans to forward public health objectives. So there it was around viral suppression, but I think we can and will see different types of projects and initiatives aimed at HIV HIV prevention, and hopefully, PrEP uptake as well. I think we've got some really good models that I think we are able to build off of in the future. So this is something to definitely stay tuned on, as some of these models grow and are replicated.

So I wanted to end with some of the limitations and challenges. And these are limitations and challenges that we identified for this part of the billing and coding guide process, but I think our part of this entire endeavor to really focus on the role of health care payers in HIV prevention coverage. And I wanted to temper my exuberance and excitement about some of the emerging opportunities, particularly in Medicaid, with just the realistic piece that some of the actualizing Medicaid's ability and willingness to really cover the full scope of the HIV prevention services we need them to, that's a far way off. We're not quite there yet. We've got some really good steps in the right direction, but we also have a lot of gaps at the moment.

So many HIV prevention services simply don't translate well into the language of payers. I gave you some examples in the coding guide, where we were able to find CPT codes by rethinking or reimagining the different component parts that make up HIV preventive services, but some of them are not going to be in the language of payers. Partner services, at least right now, might be one of those examples, and I think we could probably think of others. And I think that's important, because that means being very strategic with the grant funding and public health funding that we have.

And then I want to underscore, while there are some emerging opportunities for reimbursing community health workers and other peer providers in community-based organizations, and I

highlighted some of those emerging opportunities a moment ago, this is far from universal, and I wouldn't want folks to leave this thinking that, oh, well, if I've got a CPT code and I've got a community health worker employed on my staff, we can go ahead and bill for this service, because that's just not the case in many, many states.

So I think it's something to watch, because community health worker associations are mobilizing in many, many states. And I think that there's a lot of momentum behind increasing the ability of Medicaid to reimburse for those types of providers, but it's not universal just yet.

And then finally, we haven't really talked about this, but I think it's important just to note. So even if we clear the hurdle of finding a CPT code for our HIV prevention-related services, and even if we clear the hurdle of ensuring that the provider on staff is credentialed and has the licensure requirements that are up to par with the payer for reimbursement. So we clear those two.

And then even if we bill to the hilt, we've got our coding and reimbursement strategy and protocol down, and we bill for that, the reimbursement rates are often lower than both grant funding and even, in some cases, the cost of actually providing those services. And I think that's also sort of an important point. And this is particularly true for smaller organizations, but I think it's true across the board, of really doing that math, and making sure that we're being specific in sort of knowing the limits of leveraging third party payers for HIV prevention services, and knowing what we'll still need in terms of provision of a safety net for the costs that are not provided and then for those services and populations that are not going to be covered or insured.

So with those three limitations and challenges, I think that's important to keep in mind and keep us realistic about the opportunities available through public and private insurance.

So I want to open it up for questions from folks, but I did want to just ensure that you all had the resources that I mentioned. You've got my contact information, but then you've got the link to the Billing Coding Guide right there, the white paper that I talked about, highlighting some of the examples of drug user health coverage mostly through Medicaid, but some other unique financing arrangements for drug user health services, and then our white paper on financing HIV prevention services, which highlights, in depth, four case studies highlighting partnerships between the HIV program for prevention services and Medicaid.

So I will leave that, and I will open it up for questions.

STEVE LUCKABAUGH: OK. We have some time here to take few questions. So if you have a question. Give folks a minute.

OK. We have a question. Is there any thought given to making the coding consistent for billing?

AMY KILLELEA: The coding consistent for billing. So I'm not quite sure I follow the question. The coding is based on a universal CPT code. So those are consistent.

What isn't consistent-- and so I'm going to try to answer this, but if it's not the correct answer, let me know, and we can go in a different direction. What inconsistent is the actual covered services. So you might be able to code for and bill for a subset of services in your Michigan Medicaid program that's not covered in your Florida Medicaid program. So that part is not consistent.

I would say, I don't think that there's efforts for consistency, although I think across the board, at least from the HIV program and provider subset, there's a real push to push the envelope in terms of coverage for HIV prevention services-- comprehensive HIV prevention services and state Medicaid programs.

STEVE LUCKABAUGH: OK. And the follow-up was, yes, the covered services codes. If you have any other questions, please enter them now. OK, I'm not seeing any more questions. Did you have any closing thoughts or anything?

AMY KILLELEA: I would urge you that, take a look at the resources. And if you've got additional either questions or just thoughts on what are the challenges that you're seeing, what would be helpful in terms of additional resources and attention on the financing side, please feel free to shoot me an email. I always like to hear what the experience on the ground is, and what we as NASTAD can do to make sure we're staying on top of some of the emerging issues and challenges.

STEVE LUCKABAUGH: OK. Thank you for participating in today's webinar. Take care, everybody, and we'll see you next time.