The Impact Of Medicaid Expansion On People Living With HIV And Seeking Behavioral Health Services

ABSTRACT

While Medicaid eligibility expansion created health care access for millions in California, its impact on people living with HIV has been more nuanced. Newly covered people living with HIV who have behavioral health care needs now must navigate separate mental health and substance use care systems, instead of receiving them in integrated care settings as they had under the Ryan White HIV/AIDS Program. We conducted forty-seven interviews in the period April 2015–June 2016 to examine the impact of Medicaid expansion on people living with HIV in California who had behavioral health care needs. California's historical division in its Medicaid funding streams created challenges in determining which payer should cover clients' behavioral health care. Compounding these challenges was a perceived lack of cultural competence for serving this population, insufficient infrastructure to facilitate continuity of care, and unmet need for nonmedical supportive services. The multipayer model under health reform has compromised the administrative simplicity and integrated delivery of HIV and behavioral health services previously available to uninsured patients through the Ryan White HIV/AIDS Program.

The Affordable Care Act (ACA) removed barriers to health coverage by eliminating preexisting condition restrictions in private insurance and enabling the expansion of Medicaid eligibility to legal residents with incomes below 138 percent of the federal poverty level.[1] The reforms were of importance to people living with HIV, many of whom had not previously qualified for Medicaid because they were not both low income and classified as disabled.[2] Even though expansion occurred in only a subset of states, Medicaid enrollment among people living with HIV increased by 6 percentage points nationally, to 42 percent.[2] Historically, the Ryan White HIV/AIDS Program has served as a "payer of last resort" for people living with HIV. Under the ACA, approximately 48 percent of people living with HIV (and 38 percent of such people on Medicaid) continue to rely on the Ryan White Program for HIV-related treatment and services.[2]

In California, the expansion of Medi-Cal (the state Medicaid program) resulted in eligible, low-income people living with HIV being transferred from integrated care through the Ryan White Program into Medi-Cal managed care plans. There were concerns that these coverage transitions would interrupt access to care and treatment,[3] particularly among people with psychiatric comorbidities, substance use disorders, or both. The prevalence of both of these conditions is high among people living with HIV, contributing to elevated rates of AIDS-related mortality.[4,5]

To comply with California's "benchmark" plan under the ACA's essential health benefits (section 1302 of the ACA), Medi-Cal is now required

to cover outpatient behavioral health (mental health and substance use disorder) diagnosis and treatment, as well as intensive inpatient and residential services.[6] Although this promotes access to some behavioral health services, the coverage is not as comprehensive as the support provided by the Ryan White Program, which includes ongoing mental health and substance use counseling delivered in culturally tailored, integrated care settings.[7] The program funds primary and selected specialty medical care for people living with HIV, as well as wraparound services that improve health outcomes along the HIV care continuum, increase patient engagement, and support care coordination.[7–9]

The transition from Ryan White to Medi-Cal-funded services was complicated further by California's decision to expand the use of managed care plans. Medi-Cal now pays plans a monthly per enrollee premium to cover most aspects of an enrollee's health care, including services for low-to-moderate mental health needs.[10] Two additional Medi-Cal funding streams are carved out or separately allocated to counties: one to address severe mental health needs, and another, known as Drug Medi-Cal, to address substance use. Counties also provide a range of behavioral health services funded from other sources, such as the Substance Abuse and Mental Health Services Administration and state behavioral health care funds. The Ryan White Program can pay only for services not covered by any other source.

Overall, the transition to Medi-Cal coverage means that newly eligible people living with HIV now need to navigate a complicated array of services

and payers. This transition to a system of multiple funding streams necessitates additional assessments not needed under a single-payer system: Before people can access behavioral health care, the severity and nature of their needs must be determined to ensure that they are referred to care under the appropriate funding source.[11] Previously, for people living with HIV who were covered only by the Ryan White Program, behavioral health care had been covered exclusively by one source and often provided in integrated care settings, in which the assessment of symptoms would be used simply to determine a care plan.[3]

We undertook this study to increase understanding of how people living with HIV in California navigated complex payer systems to access primary and behavioral health care after Medi-Cal was expanded. In this article we illustrate how HIV and behavioral health services are being used under current California law and provide recommendations for how best to support low-income people living with HIV within the health care system going forward.

Study Data And Methods

Study Sample

Our research was based on interviews with public health officials, state and local policy makers; and clinical or service providers involved in HIV and behavioral health care. Two of the authors (EA, VK) conducted forty-seven semistructured interviews during the period April 2015–June 2016. Most were conducted individually, but a few were conducted with two or three

participants because they preferred being interviewed as a group with other clinic or agency staff. In total, our sample included fifty-three participants: seventeen key informants, including public health officials and state and local policy makers; and thirty-six clinical or service providers. Sixteen people declined to participate because of limited time or referred us to a more knowledgeable person in their organization.

Interview subjects came from one of five California counties (Alameda, Fresno, Los Angeles, San Diego, and San Francisco). Counties were sampled based on their HIV prevalence and sprawl index scores.[12] Scores higher than 150 indicated more compact and connected areas, which we termed "urban." Decreasing scores indicated progressively less compact and connected areas, which we categorized as "suburban" (scores of 110–49) or "rural" (scores below 110).[12] Our sample included two urban counties with high sprawl index scores and higher HIV prevalence (San Francisco and Los Angeles), two suburban counties with medium scores and moderate HIV prevalence (Alameda and San Diego), and one rural county with a low score and lower HIV prevalence (Fresno).[13] We relied on community collaborators familiar with HIV and behavioral health care systems to identify potential interview subjects, who were invited via email or telephone to join the study. Participants also referred the authors to additional informants. Sampling continued until no new findings emerged—a process known as data saturation.[14] Interview topics included funding streams supporting behavioral health care services for people living with HIV, descriptions of these services,

and integration of these services into other health care. (The interview guides for key informants and providers are in online appendix A1.)[15] In-person or phone-based interviews lasted sixty to ninety minutes and were recorded and later transcribed. Interviewers wrote summaries immediately following each interview.

The Institutional Review Board at the University of California San Francisco reviewed and approved the study protocol. All participants provided oral consent.

Analysis

To analyze the contents of the interviews, we followed procedures from thematic analysis, developing and defining thematic codes to capture transcript segments related to access to behavioral health care for people living with HIV.[14] We used both deductive and inductive approaches to characterize the data, relying on interview topics and emerging findings to develop thematic codes. Meeting regularly, three of the authors acted as analysts (EA, SF, VK) and organized the thematic areas into a defined set of codes. We then applied the codes to a subset of transcripts until code application was consistent across coders. We subsequently coded all transcripts and conducted cross-case comparisons to ensure the consistency of the coding structure. Analytic memos summarized discussions and coding decisions.

Limitations

There were a few limitations to this study. First, we collected information based on qualitative interviews with key informants in five diverse counties in California, covering urban, suburban, and rural settings as well as settings with high and low HIV prevalence, but we did not collect data from all California counties. Second, we did not collect data from Ryan White Program patients or people living with HIV who transitioned to Medi-Cal. Third, some of our findings are unique to people living with HIV and might not be generalizable to other populations. Fourth, because California expanded Medi-Cal, our findings may not be generalizable to states that did not expand their Medicaid programs.

Study Results

We interviewed fifty-three participants in five counties, with the most in Alameda County (fourteen) and the fewest in Fresno County (eight) (exhibit 1). Several themes emerged from these interviews. First, the participants affirmed that Medicaid expansion improved access to behavioral health services, but the Ryan White HIV/AIDS Program remained necessary for more comprehensive coverage. Second, informants believed that cultural competence to serve people living with HIV was inadequate within Medi-Cal and county-run behavioral health care systems. Third, as a result of the fragmentation of care across multiple payers and providers, informants noted that there was a need for greater care coordination and integration. Lastly, participants believed that people living with HIV need comprehensive wraparound support services. Each of these themes is described below.

Supporting quotes appear in appendixes A2–A5;[15] in the text, we refer to applicable quotes using brackets (for example, "[Q1]") without specifically citing the appendix at each mention.

Medicaid Expansion Improved Access

According to our informants, the ACA made mental health services more accessible to people with low-to-moderate needs (appendix A2).[15] Previously, low-income people could generally access services through the county only for severe mental health needs. With ACA implementation, services to meet low-to-moderate mental health needs became accessible through the Medi-Cal managed care plans [Q1]. However, under the new system, a complex assessment of acuity determined the treatment plan and payer source. Informants noted that the multipayer divisions based on acuity and insurance status, and the assessments needed to assign responsibility for care, did not align with the nature of mental health issues—which, providers explained, can naturally increase and decrease in severity over time [Q2]. Although this multipayer system required acuity-based determinations to assign payer responsibility, it often proved difficult for clinics and counties to gauge and agree upon the severity of a person's changing symptoms, particularly among those deemed to be in moderate need or those in need of treatment for both substance use disorders and mental health issues. Several participants noted, for example, that service claims were denied because a Medi-Cal managed care plan determined that

the patient should have been placed in the county-level system for severe needs.

The Ryan White Program continued to cover people who were deemed ineligible for Medi-Cal or who experienced a coverage gap and to cover additional counseling sessions for patients who required more care [Q3]. Additionally, the program was used to address limitations—therapy licensure restrictions and same-day billing restrictions—that two Medi-Cal managed care regulations imposed on access to behavioral health services—limitations that people living with HIV had not encountered when using only the integrated services through the program. Under managed care plan rules in effect during our data collection period, billed therapy sessions had to be conducted by someone with licensed clinical social worker or greater licensure. Although the rule is in the process of being changed,[16,17] marriage and family therapists—historically the most common providers under the Ryan White Program—could not be reimbursed through Medi-Cal in certain practice settings. Informants reported that licensed clinical social workers had higher caseloads than marriage and family therapists did, and few were bilingual. Additionally, medical and mental health visits cannot be reimbursed through managed care plans if they are scheduled for the same day, a rule that remains unchanged. According to informants, this posed a challenge when a medical provider discovered a mental health need that would benefit from same-day services [Q4]. They explained that asking patients to return on a different date often yielded high no-show rates. This

was especially problematic in rural settings, where there were few mental health care providers and wait times for an initial counseling appointment could be as long as a month. To address both limitations, providers used Ryan White Program funds to cover services otherwise precluded from payment by Medi-Cal regulations.

Perceptions Of Lack Of Cultural Competence

Cultural competence, or the "ability to interact effectively with people of different cultures," includes sensitivity to differences based on race and ethnicity as well as other characteristics such as gender, sexual orientation, income level, and education.[18] When people transitioned from Ryan White Program care settings, with their culturally tailored systems of care, to Medi-Cal or county-run behavioral health services, they often struggled to find providers who were well versed in issues and experiences relevant to people living with HIV (appendix A3).[15] Informants across all counties described a perceived lack of cultural competence within the county-run behavioral health services and the Medi-Cal managed care plans [Q5 and Q6]. Lack of availability compounded the issue: Because so few behavioral health care providers had openings, providers were forced to refer patients to behavioral health services they knew were not culturally appropriate [Q7 and Q8].

Particularly for gay, lesbian, bisexual, or transgender-identified patients, the perceived lack of cultural competence in the Medi-Cal managed care plans and county-run behavioral health clinics led to people dropping out of care [Q9]. One rural county recognized that cultural competence was

key to accessing care and implemented programs to assist diverse patients in navigating their HIV and behavioral health services, yet our informants noted that these programs were not billable to Medi-Cal [Q10].

Fragmentation Of Care

The funding and administrative divisions between HIV care and behavioral health care meant divisions and differences among the data systems and data-sharing regulations used by each payer (appendix A4).[15] With different payer sources covering various services, Medi-Cal patients often accessed separate providers and clinics to treat substance use, mental health, and primary care needs, and their providers lacked a standardized way to share information, such as through a common electronic health record (EHR) system. Many informants recommended implementing a more integrated information system, with regular communication across systems of care and among providers to improve care coordination [Q11].

In all counties, HIV care providers also recommended establishing robust, patient-centered referral networks for people needing behavioral health care [Q12]. Examples of such networks existed within the integrated service system of the Ryan White Program. In one suburban county, these funds supported a consortium in which providers could share information and resources, engage in cross-training, and develop referral networks—all to support retention in care among patients with complex needs [Q13].

Informants also felt that the care coordination and case management models used by the Ryan White Program worked best to promote adherence

to care and treatment among people living with HIV with behavioral health care needs. Integrated, coordinated care could be found in some settings. For example, Ryan White Program funds were sometimes combined with Medi-Cal to support clinical “homes” that provided good continuity of care for people living with HIV. In many cases, people preferred to access behavioral health care through the Ryan White Program’s HIV care center [Q14] because of its specialized, culturally competent care.

Need For Supported Essential Wraparound Services

In addition to filling gaps in core behavioral health services that existed under Medi-Cal managed care, the Ryan White Program provided wraparound services that Medi-Cal did not (appendix A5).[15] Informants described these services as crucial to supporting engagement in medical and behavioral health care among people living with HIV. The services included support for transportation, housing, child care, and case management [Q15 and Q16].

The Ryan White Program also enabled people living with HIV to receive services beyond those authorized under Medi-Cal by enabling clinics to provide counseling and early intervention services for those newly diagnosed with HIV. Combined with patient navigation and case management, these services allowed clinics to address behavioral health issues proactively [Q17]. In this way, the Ryan White Program supported comprehensive care, allowing patients to address needs that might have gone unmet if they had to rely solely on Medi-Cal.

Discussion

Through interviews with informants knowledgable about services for people living with HIV, we found that California's Medi-Cal expansion and essential health benefits mandates improved these patients' overall access to behavioral health care but that they encountered new challenges and barriers to care following the movement from the single-payer integrated care system of the Ryan White HIV/AIDS Program to the multipayer fragmented system under Medi-Cal. Patients experienced coverage gaps, payment disputes, and coordination challenges that they did not encounter when accessing behavioral health services provided solely by the Ryan White Program. Clinics continued to use Ryan White funds to augment behavioral health services where Medi-Cal coverage gaps existed or when patients encountered challenges navigating separate programs and payers within the Medi-Cal managed care and county systems. The continued availability of the Ryan White Program may have enabled people living with HIV who had behavioral health care needs to remain in care and on treatment during and after Medi-Cal expansion. Although Ryan White Program providers in California transitioned 53 percent of their clients to Medi-Cal, caseloads have remained high because many clients still seek specific services not available in Medi-Cal.[19]

Our data indicate that the Medi-Cal behavioral health care benefits mandated by California's essential health benefits are necessary. In fact, our informants suggested that the Medi-Cal benefits should expand to cover

same-day billing, more counseling sessions, and a broader range of licensed professionals serving patients with low-to-moderate mental health needs. Workforce shortages that could be alleviated through changing the licensing laws were particularly acute in rural settings where there were fewer behavioral health care providers and HIV-related care was more centralized —requiring most patients to travel to obtain needed services. While new state legislation (AB-1863) will allow federally qualified health centers in California to bill for the services of marriage and family therapists, implementation has been delayed.[17] That delay could particularly affect people living with HIV, for whom comprehensive and durable access to behavioral health services has been found to reduce mortality and morbidity over time.[20]

Our findings across counties support expanding integration and collaboration among providers across the Medi-Cal managed care plan and county and Ryan White Program care systems to share culturally competent practices for serving people living with HIV, as well as increasing the use of care settings equipped to address a range of needs. Our participants described greater continuity of care for people living with HIV who received behavioral health treatment from clinics that had Ryan White Program funds to provide wraparound services not otherwise covered by Medi-Cal (for example, transportation and child care). Many of the qualities informants cited as reducing barriers to behavioral health care are standard features of integrated Ryan White Program clinics, including the use of integrated EHRs

to foster better communication among providers and with patients and the creation of “one-stop shops” that offer comprehensive medical, behavioral health, and psychosocial services.[21] Research has shown that people living with HIV who seek services in integrated care settings are three times more likely to achieve viral suppression than those in HIV care alone.[22] A growing body of literature has documented that integrated care settings can also be successful at treating low-income patients with behavioral health issues and other forms of chronic disease.[23]

Our informants widely reported challenges in maintaining continuity of care for patients in the fragmented Medi-Cal managed care and county-run systems, an issue that also affects patients who do not have HIV[24] and thus do not have the Ryan White Program to fill in coverage gaps. Informants representing providers reported that they lacked support and resources for assessing patients’ behavioral health care needs, echoing a recent Substance Abuse and Mental Health Services Administration report that found behavioral health screening to be underused and inconsistently applied across care sites.[25] Also, when patients were referred to behavioral health services, providers noted that there was a marked need for data sharing, preferably through common EHRs, to ensure coordination and retention in care as the patients moved between the different care settings.[26] When Ryan White Program funds were used to support a consortium of HIV, mental health, and substance use providers in one of the counties we studied, HIV care providers were able to make more-informed referrals,

cross-train, and build capacity. Implementation of collaboration and data-sharing agreements may thus improve access to high-quality HIV care.

Finally, informants reported that access to comprehensive wraparound services encouraged people living with HIV to remain in care and on treatment. These services, such as those offered in many Ryan White Program–funded clinical settings, have previously been found to be effective in promoting connections to care, supporting viral suppression, and reducing costs.[27] Should Medicaid expansion be reversed or curtailed, it is possible that people living with HIV who now receive access to care and treatment under Medi-Cal expansion would lose coverage. For those who would not be able to access replacement coverage, the Ryan White Program would once again need to provide medical care—which would in turn reduce the funds available for wraparound services that promote engagement in care.[1]

Collectively, our results highlight both the public health benefits that have accrued under the ACA and the complications that have arisen from reliance on multiple payer sources to support health care. The expansion of coverage under the ACA has unequivocally improved access to health services for people living with HIV in California. Expanded eligibility for Medi-Cal and private insurance have given people comprehensive coverage intended to treat all diseases, as opposed to relying only on the Ryan White HIV/AIDS Program, which limits its coverage to HIV and a select set of associated conditions.[1] But for people who previously had HIV and behavioral health services covered exclusively by the Ryan White Program, expanded

eligibility has perversely fragmented their care. They are now shuffled among different payer sources—and potentially different care facilities—to receive the full complement of needed services. California could reduce some of these problems through Medi-Cal policy changes—for example, by discontinuing the carve-outs that separate funding for severe behavioral health and substance use disorder services from funding for other health care services and incentivizing use of integrated care delivery systems for people with behavioral health care needs and chronic illness. However, to fully reap the benefits brought about by the ACA and regain the simplicity that existed for people living with HIV who received Ryan White Program services before the ACA, a single-payer health care system would be needed, as others have suggested.[28] Such a system could ensure comprehensive coverage while eliminating the gaps between services that are inevitably created in systems with multiple payers.

Conclusion

In California, overall access to behavioral health care increased for people living with HIV when Medi-Cal expanded, yet care also became more fragmented when provided under multiple payers. We found that patients continued to rely on the Ryan White Program for services that Medi-Cal did not provide.[8] If federal efforts to limit Medicaid are successful, some states may be forced to reduce benefits, such as behavioral health care, to maintain base Medicaid coverage for more people. Or states may choose to reduce Medicaid enrollment, forcing many low-income people living with HIV

to lose coverage that they would have difficulty replacing in the private insurance market.[2] These Medicaid reductions would place greater demand for care on the Ryan White HIV/AIDS Program, curtailing its capacity to address behavioral health care needs among people living with HIV. Access to behavioral health care—a critical component of high-quality HIV care—is essential to achieving positive health outcomes. The significant gains that have been made in controlling the HIV epidemic can be maintained and optimized only with a strong commitment to funding comprehensive medical and behavioral health services for people living with HIV.

Notes

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EXHIBIT LIST

Exhibit 1 (table)

EXHIBIT

Exhibit 1: Interview participants in five California counties, by type and location

Location	All	Key informants[a]	Providers[b]
All study counties	53	17	36
Alameda	14	6	8
Fresno	8	2	6
Los Angeles	10	1	9
San Diego	10	3	7
San Francisco	11	5	6

SOURCE Authors' analysis. [a]Includes public health officials and state and local policy makers. [b]Clinical or service providers involved in HIV and behavioral health care.

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