

# South Carolina Ryan White All Parts Meeting

## “Health Care Reform and Its Impact on PLWHA: 2011 and Beyond”

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in HIV/AIDS



1

## Overview

- Context
  - Healthcare reform, state level system dynamics
  - National HIV/AIDS Strategy connections
  - Social determinants related to HIV & STIs
- Realities
  - Social determinants in South Carolina
  - Provider readiness
  - Case studies
- Actions
  - Establish state-level leadership
  - Distribute funding equitably
  - Specific recommendations

2

## Context – Health Care Reform

3

### Patient Protection and Affordable Care Act (PPACA) Public Law 111-148

- Medicaid Expansion
  - 23 million new Americans (more later)
  - State Options for Medical Homes
    - What qualifies for 'chronic condition'
    - Who ensures states will set up medical homes that are adequate for people living with HIV
    - State match is zero for 2014 & 2015, slow scale-up after that, how to launch a program with limited state funding?

4

## Patient Protection and Affordable Care Act (PPACA) Public Law 111-148

- Community Health Centers
  - HRSA to fund with increased dollars, how to convert some geographic areas with limited access?
  - Will CHCs want to expand to include persons living with HIV infection?
  - Work to help clinics become FQHCs.
- Preventive services in the private market
  - Routine HIV testing of adults and adolescents and expanded testing for those at increased HIV infection risk.

5

## Patient Protection and Affordable Care Act (PPACA) Public Law 111-148

- Establishes a new competitive private health insurance market.
- Holds insurance companies accountable by keeping premiums down and prevents abuses and denials, ends discrimination against Americans with pre-existing conditions.

6

## Patient Protection and Affordable Care Act (PPACA) Public Law 111-148

- September 23, 2010
- January 1, 2011
  - 85% of all premiums collected by insurance companies must go to healthcare.
- October 1, 2012
  - Value-based purchasing program pays incentives to hospitals that achieve improved health outcomes (Medicare).
- January 1, 2013
  - Preventive care options for state Medicaid programs to patients at little or no cost.
  - Medicaid primary care physicians reimbursements increased.
- October 1, 2013
  - Ryan White Care Act Sunsets...
- January 1, 2014
  - Establishes health insurance exchanges – if your employer doesn't offer insurance, individuals can purchase directly.
  - Medicaid Expansion to all who fall below 133% of the FPL (\$14,000 Individual / \$29,000 for a family of four).

7

## Context – National HIV/AIDS Strategy

8

## National HIV/AIDS Strategy

- National HIV/AIDS Strategy for the United States
- National HIV/AIDS Strategy: Federal Implementation Plan
- Vision: *“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstances, will have unfettered access to high quality, life extending care, free from stigma and discrimination.”*  
– President Barack Obama

9

## National HIV/AIDS Strategy

- Reduce new HIV infections
- Increase access to care and improve health outcomes for people living with HIV
- Reduce HIV-related health disparities
- Achieve a more coordinated national response.
  - Prevention
  - Care
  - Disparities
  - Coordination

10

## National HIV/AIDS Strategy

- Care
  - Increase the proportion of newly diagnosed linked to clinical care within 3 months of diagnosis from 65% to 85% (n=8,255)
  - Increase the proportion of Ryan White Program clients with at least 2 HIV medical visits in 12 months (at least 3 months apart) from 73% to 8% (n=23,795)
  - Increase the percentage of Ryan White Program clients with permanent housing from 82% to 86% (n=21,800).

11

## National HIV/AIDS Strategy

- Disparities
  - Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20%.
  - Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20%.
  - Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20%.

12

## National HIV/AIDS Strategy

- Prevention
  - Lower the annual number of new infections by 25% from 56,300 to 42,225 by:
    - Reducing the HIV transmission rate by 30% from 5 per 100 people to 3.5 per 100 people, and
    - Increasing from 79% to 90% percentage of people living with HIV who know their serostatus, from 948,000 to 1,080,000 people (n=132,000).

13

## National HIV/AIDS Strategy

- Coordination
  - Increase the coordination of programs across the federal government and between federal agencies and state, territorial, local, and tribal governments.
  - Develop improved mechanisms to monitor and report on progress toward achieving national goals.

14

## National HIV/AIDS Strategy

- Role for State and Local Governments
  - HHS will work with States to ‘encourage’ the development of statewide HIV/AIDS plans.
  - States will be ‘encouraged’ to establish a lead entity to coordinate the statewide plan and report on the progress.
  - Lead entity ‘could’ be made up of state and local HIV/AIDS agencies, health departments, private advocacy groups, community, Medicaid programs.

15

## National HIV/AIDS Strategy – Questions?

- What will state health care reform benefit packages include and exclude?
- What will the new provider networks look like?
- Who will make decisions?
- How will we protect those not covered by the Affordable Health Care Act? (Undocumented?)
- Who will provide (and pay) for HIV testing?
- How will people, once diagnosed, be assured they will be enrolled and enter care?
- What is the future of the Ryan White Program?
- What will bridge services from the expiration of Ryan White in 2013 to when coverage starts in 2014?

16

## National HIV/AIDS Strategy – Questions?

- Will Ryan White need to focus on what and who won't be covered such as wrap-around/support services, undocumented persons, accessing the new system, and quality?

17

## Context – Social Determinants of Health

18

## Global view of SDH

- There is a range in life expectancy of 48 years among countries globally and 20 years or more within the same country; this does not have to be inevitable.
- World Health Organization's European Office published *The Solid Facts* in 2003.
  - It identified ten messages on SDH – the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, transport.
  - It was downloaded over 218,000 in the 12 months following publication.
- The Ministerial Alliance of Canada released the *HIV/AIDS and Health Determinants: Lessons for Coordinating Policy and Action* document in 2002.
  - It identified the need to broaden their range of collaboration
- Public Health Reports published the Social Determinants of Health in July, 2010. [Related to the next two slides].

Marmot, M, Social determinants of health inequalities, Lancet 2005: 365:1099-104  
 Wilkinson, R, Marmot, M, The Solid Facts. Copenhagen: World Health Organization, 2003.

19

## NCHHSTP\* Priority

\*CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

- **Promote health equity & reduce health disparities**
  - Through adopting a social determinants approach to prevention activities

Dean, HD, Fenton, KA, Addressing social determinants of health in the prevention and control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections, and Tuberculosis, Public Health Reports, 2010 Supplement 4: Volume 125.

20

## What are Social Determinants of Health (SDH)?

### National HIV/AIDS Strategy

Further, in some heavily affected communities, HIV may not be viewed as a primary concern, such as in communities experiencing problems with crime, unemployment, lack of housing, and other pressing issues. Therefore, to successfully address HIV, we need more and better community-level approaches that integrate HIV prevention and care with more comprehensive responses to social service needs.

- The ecology of population health outcomes are complex, and integrated and have overlapping social, and economic structures collectively referred to as social determinants of health (SDH).
- SDH include, but are not limited to, childhood development, education, employment, food security, health services, housing, income, social exclusion, social safety net, job security.

Sharpe, TT, Harrison, KM, Dean, Hazel D, Summary of CDC Consultation to Address Social Determinants of Health for Prevention of Disparities in HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis, *Public Health Reports*, 2010 Supplement 4, Volume 125.

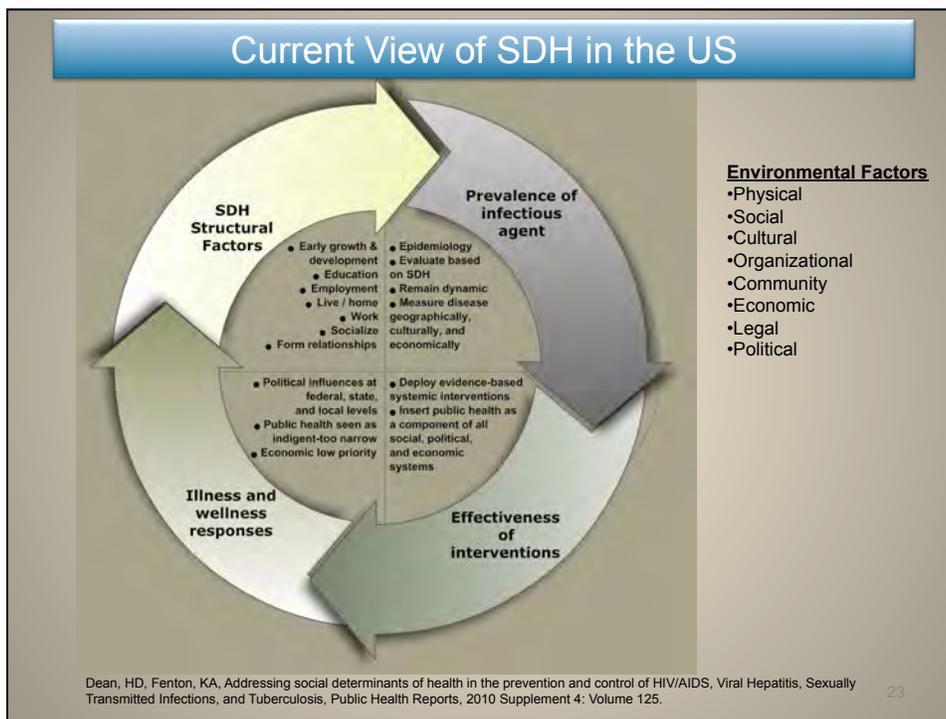
21

## How do SDH impact disease?

- For HIV, other races as compared to whites:
  - Blacks are affected at 6-18 times higher rates
  - Hispanics are affected at 2-4 times higher rates
- 2007, 66% of all new HIV/AIDS diagnoses were among men, half of all new diagnoses were among those who reported male-to-male sexual contact.
- Black MSMs at lower income levels are more likely to engage in high-risk sexual behaviors that put them at greater risk for acquiring STIs when compared with black MSMs with higher income levels.

Sharpe, TT, Harrison, KM, Dean, Hazel D, Summary of CDC Consultation to Address Social Determinants of Health for Prevention of Disparities in HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis, *Public Health Reports*, 2010 Supplement 4, Volume 125.

22



### Housing as an SDH

- Homeless people with HIV/AIDS:
  - have poorer health
  - are less adherent to medication regimens
  - are more likely to be uninsured
  - are more likely to be hospitalized

**National HIV/AIDS Strategy**

Key steps for the public and private sector to take to reduce HIV-related health disparities are:

- Reduce HIV-related mortality in communities at high risk for HIV infection.
- Adopt community-level approaches to reduce HIV infection in high-risk communities.
- Reduce stigma and discrimination against people living with HIV.

Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.

Kidder, DP, Wlitski, RJ, Campsmith, ML, Nakamura, GV. Health status, health care use, medication use, and medication adherence among homeless and housed people living with HIV/AIDS. Am J Public Health 2007; 97-2238-45. 24

## National Governor's Association – SDH Political

### National HIV/AIDS Strategy

The Nation can succeed at meeting the President's goals. It will require the Federal Government and State, tribal and local governments, however, to do some things differently. Foremost is the need for an unprecedented commitment to collaboration, efficiency, and innovation.

- Insurance Regulation
  - "...should not diminish or impede the long standing establishment of state regulation of health insurance."
- Medicaid
  - "Governors oppose changes to the Medicaid program that will result in an unfunded mandate imposed on the states."
  - "There simply are not enough providers willing to treat additional Medicaid enrollees with complex conditions and situations at current reimbursement rates (including at parity with Medicare reimbursement rates)."
  - "...Medicaid's continued coverage of long-term care (dual eligibles) may be fiscally incompatible with an increased role in coverage of all low-income Americans."

Testimony by National Governor's Association Executive Director Ray Sheppach before the Subcommittee on Health, House Committee on Energy and Commerce on comprehensive health reform, June 24, 2009.

25

## National Governor's Association – SDH Political, continued

- Exchange Mechanisms
  - "Should be maintained and operated at the state level."
  - "State flexibility is needed to design the structure, specify the functions, and determine how insurance products operate within a marketplace that has an exchange."
- Long-Term care and the Dual Eligibles
  - "The demographic changes and escalating costs for services and new technologies make it critical for states to begin to transition to the federal government much of their current financial responsibility in Medicaid for financing of long-term care."
- Transition Timelines
  - "Federal policymakers should work with states and the territories to determine an appropriate transition and implementation timeline for all health care reform changes."
  - "Significant health care reforms will require a lengthy process of state-federal, and market changes. This includes sufficient transition time for any coverage expansions, the proposed removal of income disregards, changes to benefit package requirements and services, new requirements which may involve a health insurance exchange entity, and other changes being considered."

Testimony by National Governor's Association Executive Director Ray Sheppach before the Subcommittee on Health, House Committee on Energy and Commerce on comprehensive health reform, June 24, 2009.

26

## SDH-Political Environment

### SDH - Healthcare Reform Political Environment

**Legend:**  
■ Involved in Healthcare Reform Lawsuit Republican Governor as of 2011  
■ Democratic Governor as of 2011  
■ Some form of Healthcare Reform Workgroup Underway

Nelson, Melissa, States' lawsuit against health care reform likely to see trial, federal judge says, Huffington Post National Governor's Association, www.nga.org/files/pdf/2010\_elections.pdf, site accessed 12/1/2010.  
 State structures for implementing health reform, August 5, 2010, National Governor's Association, www.nga.org/files/pdf/2010healthreformstructures.pdf, site accessed September 26, 2010.

**Take Home Points**

- 20-state lawsuit over required health insurance and whether states should pay additional Medicaid costs, judge to determine mid-October
- Of the 18 states with some form of healthcare reform workgroup, none have reported to the NGA focus on chronic, communicable diseases other than discussions about caps and the fu

27

## SDH – Poverty / Economics

### Two statistics related to SDH: Poverty and current Federal Funding flow --what do they mean?

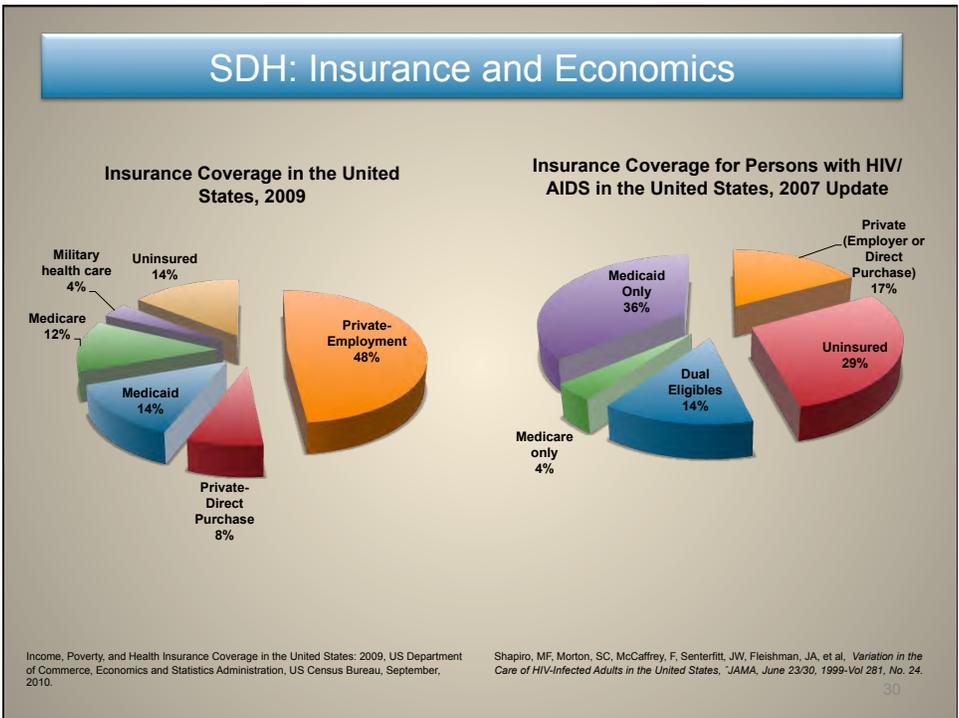
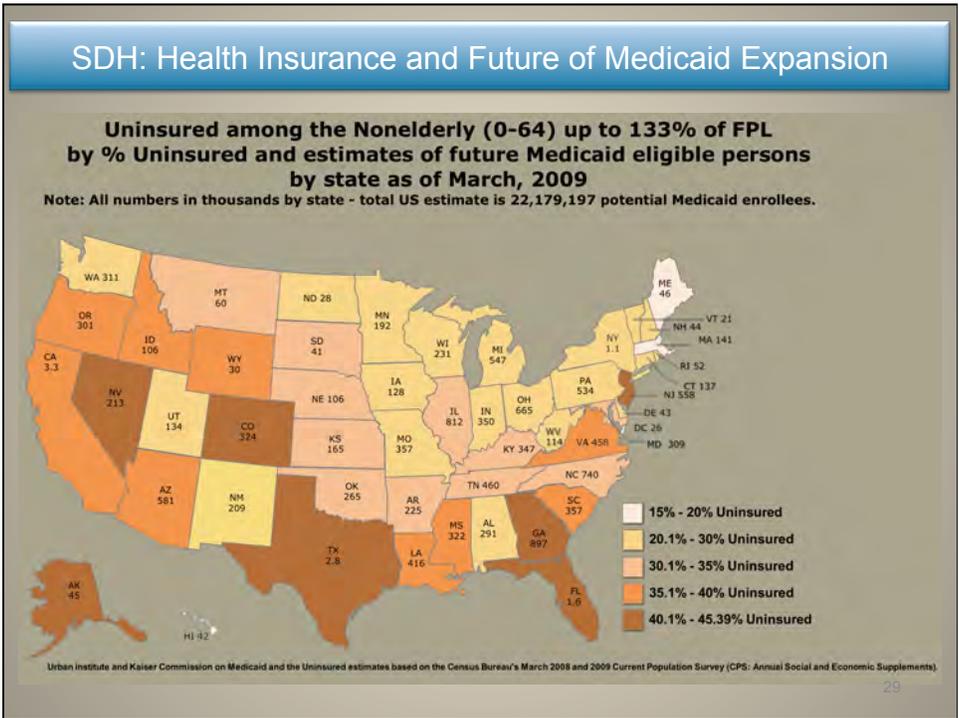
Note: No conclusion is intended from this presentation of two pieces of objective data; it is intended only as context.

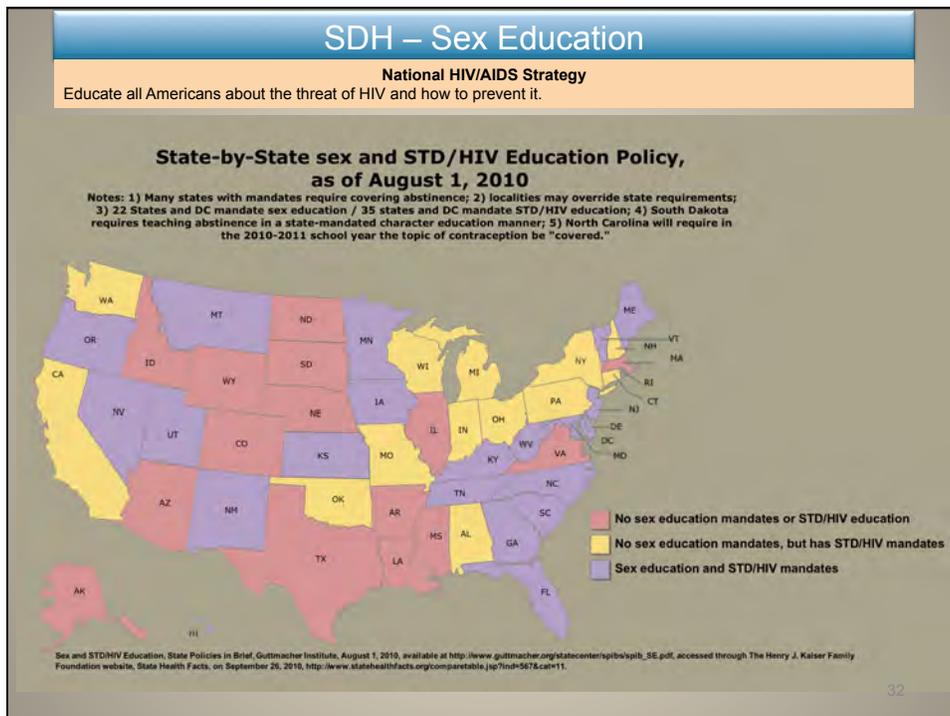
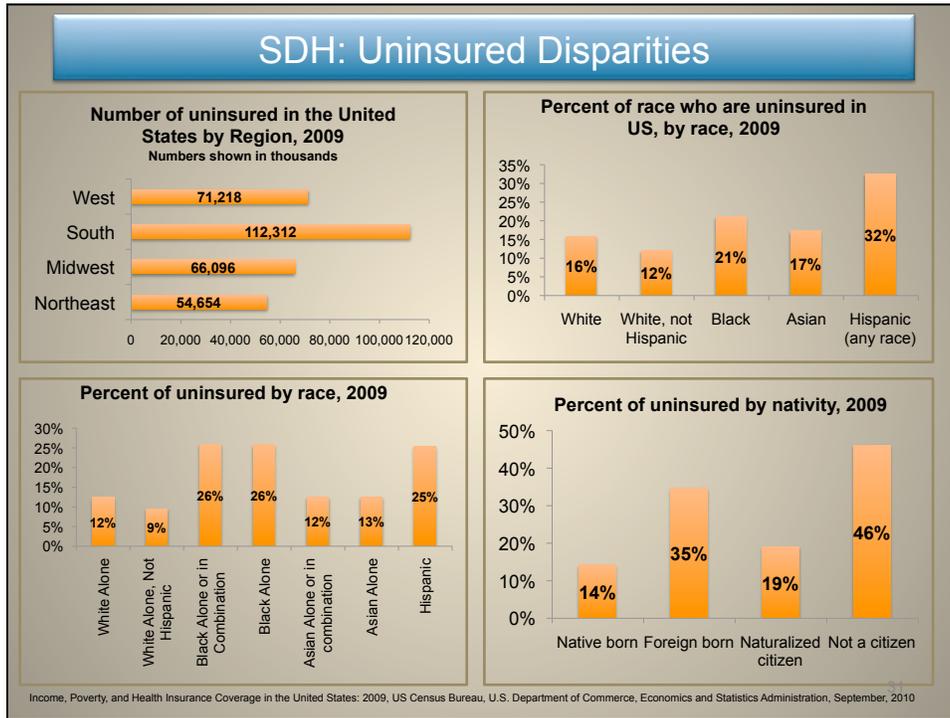
**Legend:**  
■ Red numbers are the state's % of persons at or below 133% of the FPL.  
■ Green numbers are the state's % of all HIV/AIDS-related federal dollars.  
■ Varies -9.6% (higher % funding than poverty)  
■ Varies 0% to -3.8% (higher % funding than poverty)  
■ Varies 0% to .5% (lower % funding than poverty)  
■ Varies .51% to 1.0% (lower % funding than poverty)  
■ Varies 1.1% to 2.0% (lower % funding than poverty)

Note: Each 1/10% is equal to \$2,993,030.

\*Federal Poverty Rate numbers and percentages represent 133% of the Federal Poverty Level and below for each state, found on The Henry J. Kaiser Family Foundation website for year 2008. http://www.statehealthfacts.org/comparable.jsp?map=1&mid=5&cat=1&skin=2, site accessed September 26, 2010.  
 \*\*Federal funding for HIV/AIDS Programs includes CDC, HOPWA, SAMHSA, OMI, Ryan White funding with varying distribution formulas and histories. The total funds are \$2,993,029,621. These amounts are found on The Henry J. Kaiser Family Foundation website for year 2008. http://www.statehealthfacts.org/comparable.jsp?mid=528&cat=11, site accessed September 26, 2010.

28





## SDH: Stigma and HIV disease

### National HIV/AIDS Strategy

Reduce stigma and discrimination against people living with HIV.  
 Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.  
 Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.  
 Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.

### Four Manifestations of Stigma:

- 1) Public stigma – people's social and psychological reactions to someone with a perceived stigma.
- 2) Self stigma – how one reacts to the possession of a stigma
- 3) Stigma-by-association – social and psychological reactions to people who are somehow associated with a stigmatized person or how people react to being associated with a stigmatized person
- 4) Institutional stigma – the legitimization and perpetuation of a stigmatized status by society's institutions and ideological systems.

Pryor, JB, Illinois State University, Presentation at the 17<sup>th</sup> Texas HIV/STD Conference, May 25, 2010

### Presenter's comments

There is a dearth of research and commitment to understanding homophobia and HIV in these contexts. It is hard to measure what is unspoken, there is no prevalence measure possible. Elected officials, school board superintendents, Mayors, corporate executives, government officials, faith leaders, criminal justice system leadership, and countless other systems will not "rock the boat" for fear they will be stigmatized by association, even if they are personally empathetic to the need to stop it. "Don't ask don't tell" comes to mind.

33

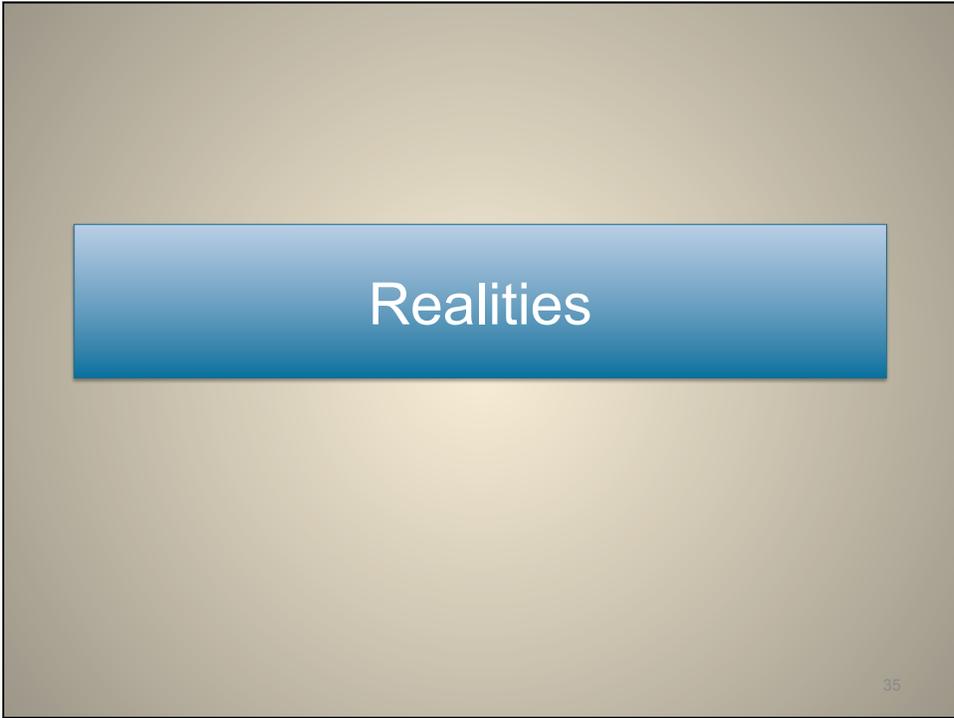
## SDH: Context Summary

### National HIV/AIDS Strategy

- Increase the proportion of HIV diagnosed gay and bisexual men with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Blacks with undetectable viral load by 20 percent.
- Increase the proportion of HIV diagnosed Latinos with undetectable viral load by 20 percent.

- Social determinants of health will drive the success of the National HIV/AIDS Strategy.
- There are leadership gaps at the state levels to ensure the collaborations and connections necessary to prepare providers, consumers, and community partners are ready 3 years from now.
- Race, Poverty, Housing, Economics, Politics, Funding Formulas, Stigma, and shifts in provider coverage (insurance) are a few SDH related to STIs.

34



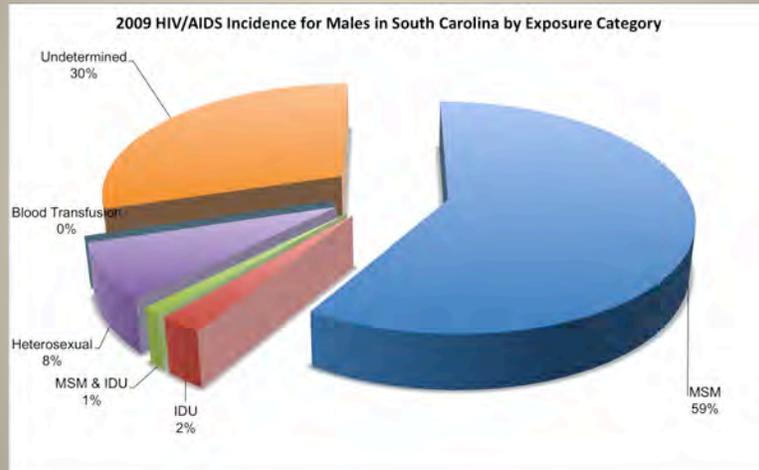
35

**SDH, ACA, NHAS functions are predominately influenced and managed at the state and municipal levels: many leaders**

- Who is in charge of reform readiness and overall National HIV/AIDS Strategy at the state level?
- State-level connections required for Medicaid, public health, corrections, education, housing, etc. – State AIDS Director's do not have authority over Medicaid or other critical areas – how are partnerships going to be formed?
- A new way of doing business – those states already underway with reform have not yet prioritized chronic, communicable disease.

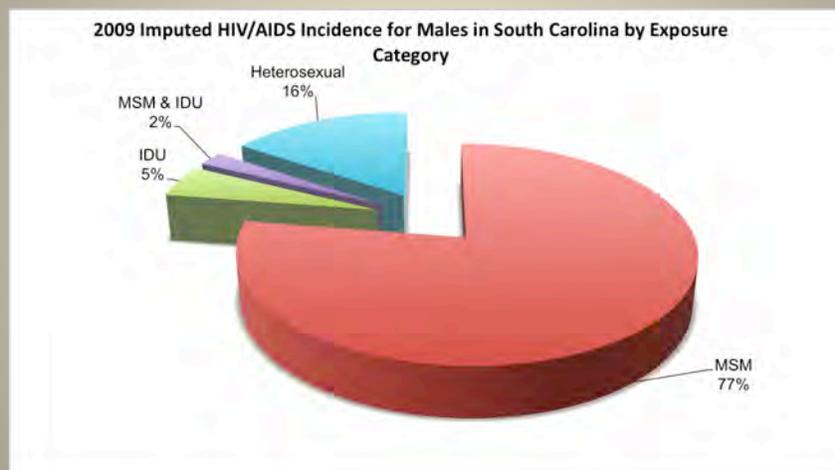
36

## South Carolina Incidence 2009, Males by Exposure Category



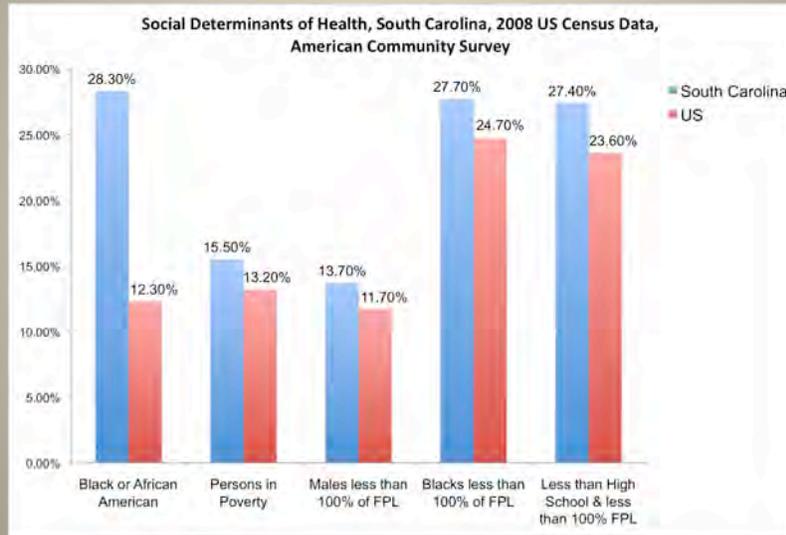
37

## South Carolina Imputed Incidence 2009, Males by Exposure Category



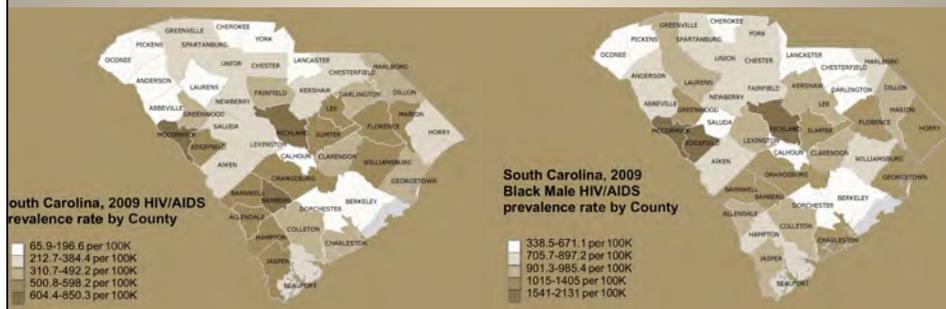
38

### Social Determinants of Health, South Carolina, 2008 US Census Data, American Community Survey

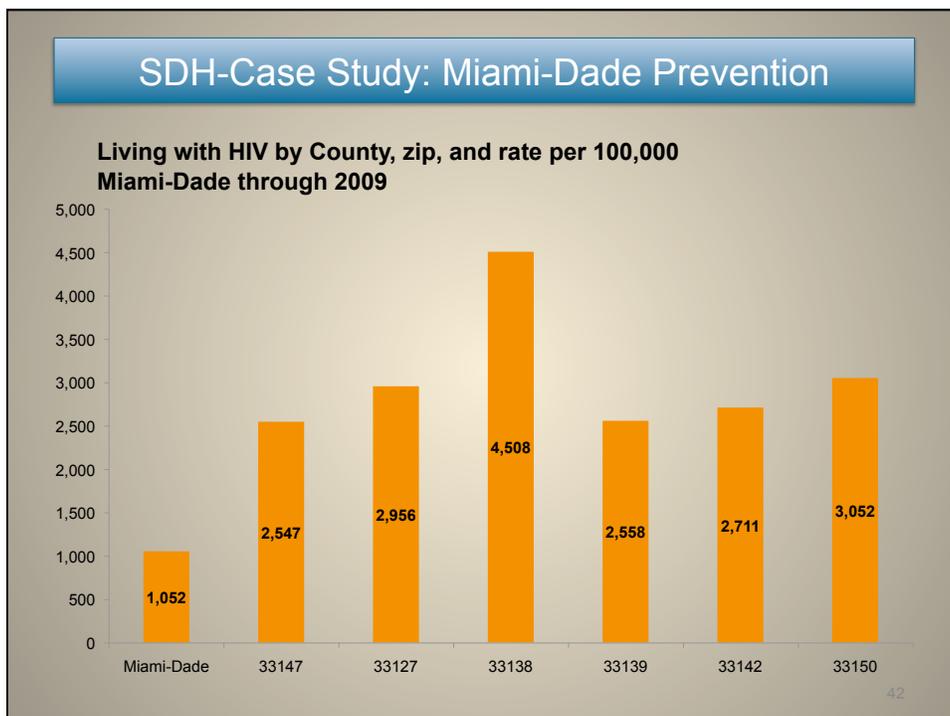
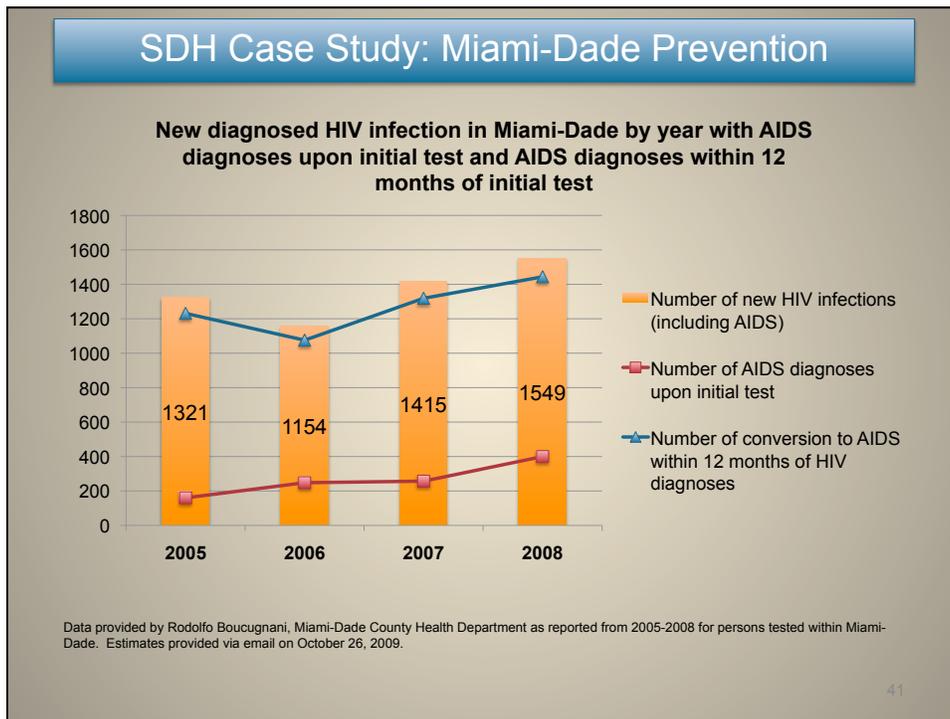


39

### South Carolina HIV/AIDS Prevalence Rates through 2009, Total HIV/AIDS compared to Black Males



40



## SDH Case Study: Miami-Dade Prevention

**National HIV/AIDS Strategy**  
Intensify HIV prevention efforts in the communities where HIV is most heavily concentrated.  
Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.

Highest new HIV Infections, AIDS cases, and persons living with HIV in these six zip codes.

6 zip codes surrounding 33147 center of epidemic.

Center of Miami-Dade High incidence with 93% late testing.

Access to health care settings within geography include Jackson Hospital, University of Miami, County STD Clinic, and private physicians.



6 zip codes with highest numbers of persons living with HIV

- 33127 – Center Miami
- 33138 – Center Miami
- 33139 – Miami Beach
- 33142 – Center Miami
- 33147 – Center Miami
- 33150 – Center Miami

Map from the U.S. Census Metropolitan/Micropolitan Maps  
[http://www.census.gov/geo/www/maps/msa\\_maps2008/us\\_wal\\_1108.html](http://www.census.gov/geo/www/maps/msa_maps2008/us_wal_1108.html),  
site accessed October 31, 2009  
HIV/AIDS data from the Miami-Dade Department of Health, Ryan White Part A report for 2007, report is presently being updated.

43

# Actions

44

## What Can We Do?

1. Be a part of a statewide planning effort to coordinate Health Care Reform, the National HIV/AIDS Strategy, and the move to Social Determinants of Health to prepare for change.
2. Prevention, Testing, Care, Access – all about to change – do we have an assessment saying we're ready for the change?
3. Who do we work with at the state for Medicaid, State Insurance Commissioner, Mental Health, Housing, to organize the currently disconnected systems?
4. Prepare are own organizations for the environmental shifts.
5. Think future from now on.

45

## Thank you

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46