HIV Medical Services and the Affordable Care Act

June 28, 2011 By Paul Kawata

2014 is the year for full implementation of the Affordable Care Act (ACA). What does this mean to HIV services? **Are you ready?**

As we continue to examine the transformation of our movement, what could your agency do to get ready for the ACA? How will it impact your clients? ...budget? ...future?

I don't know the answers; however, I do know its time to start planning. It can get overwhelming. In my 22 years at the National Minority AIDS Council (NMAC), I've never seen so many critical issues coalesce at the same time.

Health Resources and Services Administration (HRSA) recently noted "the transition of HIV to a treatable chronic disease calls for increased provision of HIV/AIDS services by health centers (HC)..." They made recommendations to increase integration of HIV/AIDS services across HC programs by:

1. Adopting electronic health records (EHR),
2. Collecting and meaningfully using HIV/AIDS related data, and
3. Becoming patient-centered medical homes for patients living with HIV or at increased risk for HIV infection.

For many, HIV/AIDS has become a manageable, chronic condition, but it is also an infectious disease. Unlike heart disease, cancer and other chronic diseases, HIV can be transmitted to otherwise healthy individuals. HIV is an infectious disease that is also a chronic disease. The ACA seems to promote transitioning HIV care into medical centers like **Community Health Centers** (CHC). What does this mean for your agency?

Are CHCs good for the AIDS movement?
Why does HIV get is own separate funding? Why are we funding this single disease when there are other diseases that kill more Americans? Why does HIV have separate systems of care?

HIV is funded separately because when AIDS was first discovered nobody would take care of us. We were turned away from hospitals. We were turned away from CHCs. In fact, we were turned away from most of the institutions that were established to take care of sick people.

We aren't separate by choice, we're separate because nobody else would take care of us. So we had to take care of our own. We had to set up our own systems.

The Ryan White Care Act (RWCA) may not have been necessary if the existing medical infrastructure was willing to care for **People with AIDS** (PWA). Unfortunately, this did not happen. As a result, our new systems of care required new financing, this led to the establishment of the RWCA.

Don't get me wrong, not everyone turned their backs on us. Thanks to many heroic friends, particularly gay and lesbian doctors, nurses, and healthcare providers, we were able to cobble together systems of care.

Unfortunately, those heroes were few and far between. It wasn't surprising to have food trays left in hallways, bed pans not picked up, calls for assistance ignored, and medical practitioners refusing to provide care.

We've spent the last 28 years building a new and better infrastructure to take care of PWAs. It was never our intention to be better. This is just a fortunate by-product of our work.

I have to wonder "Are CHCs good for the AIDS movement?"

They are asking us to go back to the same institutions that would not serve our community. They are asking us to go to institutions, many of whom still do not take care of People with AIDS.

Certainly there are many great CHCs, but for the majority of them, HIV services will be brand new.

Why are we moving HIV medical services to CHCs when we already have established systems? Are CHCs ready?

- Is the stigma and discrimination that initially closed CHCs to our community gone?
- Are CHC doctors ready to take on HIV medicine? Currently most HIV cases at CHCs are referred to doctors outside of the clinic.
- Are CHC pharmacies willing to stock HIV medicines, especially the expensive pills?
- Do we have enough CHCs to take care of the 1,178,350 Americans living with HIV (minus those that have private insurance)?
- Are CHCs located in the zip codes where HIV is most prevalent?
- Can CHCs handle all the new clients from the ACA and start new HIV services?

What Does The ACA Mean To Your Agency?

As I've been saying, those CBOs that are also CHCs and/or Federally Qualified Health Centers (FQHC) are in the best position to bridge this gap. However, CBOs who are also FQHCs need to provide more then HIV services. Is your agency ready to provide services for people who don't have HIV? Are you ready to

change services specifically developed to support PWAs into services that are fundable under the ACA?

Becoming a CHC and/or an FQHC is a very difficult process and will take years to accomplish. For most CBOs, this will never happen.

For your consideration, given our limited knowledge and no insider information, NMAC suggests an alternative solution where CBOs develop key partnerships with CHCs and/or FQHCs. These partnerships could be a **hybrid solution** to provide HIV care.

In this scenario, PWAs will get healthcare via a CHC and their non-medical HIV care via their CBO. Non-medical HIV care includes: housing, transportation, translation, food banks, treatment education/adherence, support groups, mental health services, case management, substance abuse programs, employment referrals and other services. Until 'non-medical HIV' services are reimbursable within the ACA, we will need continued funding of the RWCA.

These difficult discussions need to start now. 2014 is sooner than you think. If you wait too long you may miss critical opportunities. There are many more CBOs than CHCs. **Are you ready?**

Your leadership is essential. Successful ASOs will be flexible, open to change, and have the infrastructure to manage and maintain government funding.

NMAC will monitor and discuss possible changes/solutions as they arise. Let's meet at the United States Conference on AIDS (USCA) to begin our strategy! **Dr. Mary Wakefield**, the Administrator of HRSA will give a keynote address at this year's meeting. I am very excited to hear what she will say about the RWCA and the ACA.

Yours in the struggle,

Paul Kawata

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