

Community Health Centers and the President's HIV Initiative: Issues and Challenges Facing Health Centers in High-Burden States and Communities

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at <https://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy> or at www.rchnfoundation.org.

Executive Summary

Community health centers care for 16 percent of people living with an HIV diagnosis in the U.S., and 22 percent of all people with HIV who are receiving HIV-related care. The President's HIV initiative calls for a major expansion of health care: outreach to at-risk populations; services aimed at preventing new infections; and ongoing care and treatment for people living with an HIV diagnosis. All health centers will face challenges in expanding their services, but none more so than those located in the 10 states among those 26 identified as high-burden states or states containing high-burden regions that have not adopted the ACA Medicaid expansion. In these states, thousands of low-income, at-risk people remain exposed to a coverage gap. All health centers will need additional up-front resources to ramp up care capacity still further; those without the Medicaid expansion face the added hurdle of finding funds to sustain expanded services, once added. One key question facing policymakers is how to extend the Community Health Center Fund while adding additional resources for expanded care – and doing so for the 10-year life of the HIV initiative. Another is how to further incentivize adoption of the Medicaid expansion in remaining states. A further key question is whether CMS will modify its § 1115 Medicaid work and eligibility restriction experiments, which threaten to increase coverage interruptions for at-risk, non-exempt populations.

Background

In his 2019 State of the Union address,¹ President Trump called for ending the nation's HIV epidemic within 10 years. In a special communique published in JAMA² immediately following the President's speech, several senior administration health officials wrote that achieving this goal rests on "4 pillars":

1. Diagnosing people with HIV as early as possible after infection;
2. Treating HIV infection rapidly and effectively to achieve sustained viral suppression;
3. Preventing at-risk individuals from becoming infected, including use of pre-exposure prophylaxis (PrEP); and
4. Rapid detection and response to emergency HIV clusters to prevent new infection.

The President's initiative calls for targeting high-burden states, counties, rural areas and cities including 7 states with substantial rural HIV burden, 48 highly-burdened counties in 19 states, Washington, D. C. and San Juan, Puerto Rico.³

Notably the Centers for Medicare & Medicaid Services (CMS) administrator did not join the JAMA communique even though Medicaid represents the single largest insurer of people with HIV, accounting for 30 percent of all federal spending on HIV-related care.⁴ In the 14 states that to date have not expanded Medicaid,⁵ thousands of low-income people living with HIV/AIDS risk being uninsured; one estimate is that on average, a state's decision not to expand Medicaid affects over 2,200 uninsured, low-income people living with HIV who are left without a reliable

¹ Whitehouse.gov. (2019). President Donald J. Trump's State of the Union Address. Available at <https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-state-union-address-2/>

² A.S. Fauci, R. Redfield, G.Sigounas, M. Weahkee, and B. Giroir (2019). Ending the HIV Epidemic: A Plan for the United States JAMA (Feb. 7, 2019), available at <https://jamanetwork.com/journals/jama/fullarticle/2724455>

³ HIV.gov. (2019). Ending the HIV Epidemic: A Plan for America. Available at <https://files.hiv.gov/s3fs-public/ending-the-hiv-epidemic-flyer.pdf>

⁴ Kaiser Family Foundation. (2016). Medicaid and HIV. Available at <https://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>

⁵ Kaiser Family Foundation. (2019). Status of State Medicaid Expansion Decisions: Interactive Map. Available at <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

pathway to coverage.⁶ Based on CDC’s state-level estimates of the lifetime risk of HIV diagnosis,⁷ an estimated 3.3 million people⁸ are at risk of developing HIV during their lifetimes;⁹ 41 percent (over 1.3 million people) live in the 14 non-expansion states.

Community Health Centers and HIV

Reaching the President’s goal means significantly expanding outreach, clinical care, and patient support services to at-risk populations and communities. According to the administration, community health centers are expected to play a major role in this effort, given the scope of care they offer and their location in communities experiencing elevated poverty and health risks, and a shortage of affordable and accessible comprehensive primary health care.

In 2017, 1,373 federally funded health centers operating in over 11,000 urban and rural locations served more than 27 million patients. Health centers can be found in all the high-burden states, counties, and localities targeted by the initiative.

Federal data collected annually from health centers show steady growth in their role in fighting HIV/AIDS. In 2017, health centers served nearly 166,000 patients with an HIV diagnosis, a 44 percent increase over 2012 levels (Figure 1).

Health center patients living with an HIV diagnosis represent about 16 percent of people in the U.S. with a known HIV diagnosis in 2015, and 22 percent of people who received some HIV medical care.¹⁰ In addition, health centers have significantly expanded HIV testing – from 231,000 tests in 2000 to over 1.8 million in 2017¹¹ – an increase of 682 percent in the number of patients being tested (Figure 2).

The quality of health center performance also has improved. In 2017, 85 percent of patients diagnosed with HIV by their health center had received follow-up care within 90 days; in 2014 (the first year this quality measure was reported), timely care performance stood at 77 percent.¹² A government comparison of data from the 2014 Health Center Patient Survey (HCPS) against data from the 2014 National Health Interview Survey (NHIS) found that health centers tested their non-elderly adult patients at a rate significantly higher than the testing rate among the general population (66 percent versus 53 percent),¹³ a level of performance consistent with the higher-risk nature of health center patients.

⁶ Snider, J.T., Juday, T., Romley, J.A., Seekins, D., Rosenblatt, L., Sanchez, Y., and Goldman, D.P. (2014). Nearly 60,000 Uninsured and Low-Income People with HIV/AIDS Live in States That Are Not Expanding Medicaid. *Health Affairs* 33(3): 386-392.

⁷ Centers for Disease Control and Prevention. (2016). Lifetime Risk of HIV Diagnosis by State. Available at <https://www.cdc.gov/nchhstp/newsroom/2016/croi-2016.html#Graphics2>

⁸ Although this is a rough estimate, the number of people at risk is 1% of the 2018 population, in line with the 0.95% lifetime risk reported by Hess, K. L., Hu, X., Lansky, A., Mermin, J., & Hall, H. I. (2017). Lifetime risk of a diagnosis of HIV infection in the United States. *Annals of Epidemiology*, 27(4), 238-243.

⁹ Based on applying the CDC’s lifetime risk to the 2018 state populations reported by the U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2018. Available at <https://www.census.gov/cps/data/cpstablecreator.html>

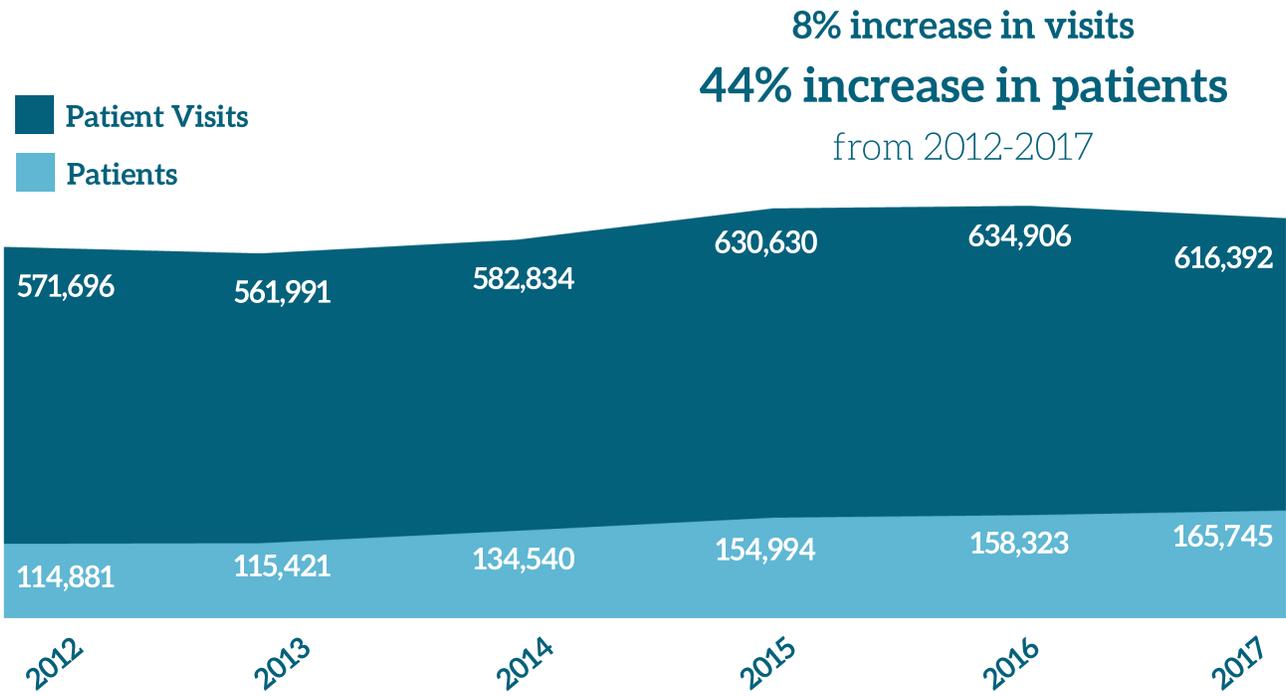
¹⁰ Based upon 1.1 million people with HIV in 2015 in the 50 states and DC, 965,694 of whom who had a diagnosis and 63% of whom received medical care, and roughly 153,000 health center patients in the 50 states and DC with a diagnosis of HIV in 2015. HIV.gov. (2018). U.S. Statistics. Available at <https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics>; GW analysis of 2015 UDS data.

¹¹ Bureau of Primary Health Care. (2018). 2017 Health Center Data: National Data. Health Resources and Services Administration. <https://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2017&state=>

¹² Bureau of Primary Health Care. (2015). 2014 Health Center Data: National Data. Health Resources and Services Administration. The 2014 percentage is also reported online under the “Clinical Data” tab at this link: <https://bphc.hrsa.gov/uds2015/datacenter.aspx?year=2015>

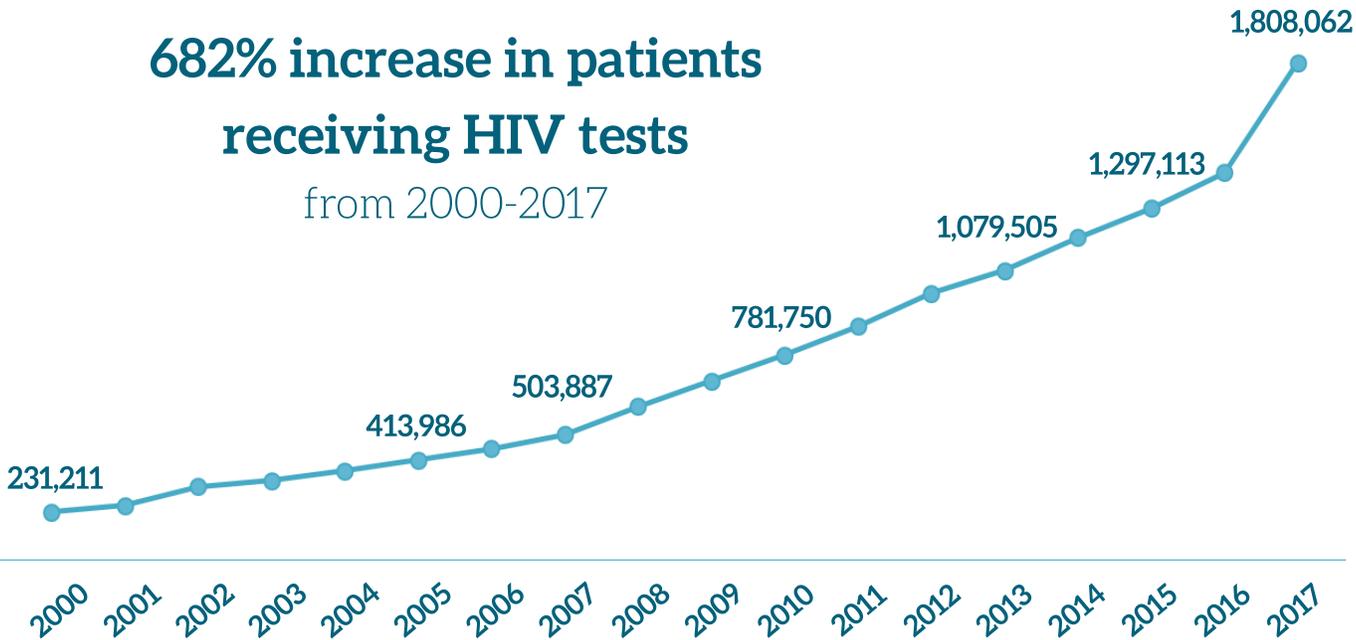
¹³ Health Resources and Services Administration. (2018). HRSA-Funded Health Center Patients are More Likely to Receive HIV Testing than the General Population. Available at https://bphc.hrsa.gov/datareporting/research/hrsafundedhealthcenter_.html

Figure 1. Total Patients and Visits for Health Center Patients with a Diagnosis of Symptomatic/Asymptomatic HIV, 2012-2017



Note: Comparisons to earlier years are not possible because previous years reported only patients and visits with a primary diagnosis of HIV.
Source: 2012-2017 Uniform Data System (UDS) National Reports, Health Resources and Services Administration, HHS.

Figure 2. Number of Health Center Patients Who Received an HIV Test, 2000-2017



Note: Data points above are indicated for 2000, 2005, 2007, 2010, 2013, 2015, and 2017
Source: 2000-2017 Uniform Data System (UDS) National Reports, Health Resources and Services Administration, HHS

Strengthening HIV-Related Care: the Challenges Facing Health Centers

Because health centers are now a significant source of care for people at risk for or living with HIV, the President’s initiative intends to rely on their services in both preventing and treating HIV infection. To meet this challenge – as is true in all efforts to expand medically necessary care in underserved communities – health centers will need to both ramp up service capacity and devise a sustainable means of covering the cost of accessible, affordable care going forward. Ramping up requires expanding outreach, prevention, treatment and management, and patient support activities. Sustaining capacity over time requires reliable funding sources for ongoing activities.

In ACA Medicaid expansion states, Medicaid will cover a large portion of these ongoing costs for low-income adults. Sixteen of the states designated as high-burden, either broadly or as a result of the presence of high-burden counties, as well as the District of Columbia, have

implemented Medicaid expansion (**Table 1**). However, there is no Medicaid expansion in another 10 states considered high-burden or in which are located one or more high-burden counties (**Table 1**). The sustainability challenge will be far greater for health centers in these states. Many members of the low-income high-risk population in these states lack any reliable pathway to affordable coverage unless they fall into a traditional eligibility category (parents of minor children, pregnant women, or people who qualify for Medicaid on the basis of disability). Furthermore, as shown in **Table 2**, financial eligibility rules for non-disabled adults are highly restrictive, as illustrated by the financial rules for parents. For the estimated 2.07 million people in these states who fall into a coverage gap – ineligible for Medicaid, but too poor to qualify for subsidized Marketplace plans¹⁴ – the Medicaid financial eligibility limits are daunting; nearly all states exclude even those working full time at minimum wage jobs. Yet among adults with diagnosed HIV who were in care in 2016, 42 percent had incomes at or below the federal poverty level.¹⁵

¹⁴ Garfield, R., Damico, A., & Orgera, K. (2018). The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Kaiser Family Foundation. Available at <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-Medicaid>

¹⁵ Centers for Disease Control and Prevention. (2019). Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Available at <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf>

Table 1. Locations Targeted for Funding Under the Presidential Initiative

Targeted Location Type	Locations
7 States	<p>Medicaid Expansion States (2 States): AR and KY</p> <p>Non-Expansion States (5 States): AL, MS, MO, OK, and SC</p>
48 Counties in 19 States	<p>Medicaid Expansion States (14 States): 30 Counties in AZ, CA, IL, IN, LA, MD, MA, MI, NV, NJ, NY, OH, PA, and WA</p> <p>Non-Expansion States (5 States): 18 Counties in FL, GA, NC, TN, and TX</p>
Other Locations	<p>Washington, DC</p> <p>San Juan Municipio, Puerto Rico</p>

Note: Medicaid expansion status based on states’ decisions to expand as of February 26, 2019.

Sources: Kaiser Family Foundation. (2019). Status of State Medicaid Expansion Decisions: Interactive Map. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>; HIV.gov. (February 7, 2019). Ending the HIV Epidemic: A Plan for America. Available at <https://files.hiv.gov/s3fs-public/Ending-the-HIV-Epidemic-Counties-and-Territories.pdf>

Sustained grant funding will be essential in all states. Health centers treat significant numbers of uninsured patients (6.2 million, or 23 percent of all patients served in 2017). Added grant funding under the health centers program, as well as grants under the Ryan White Care Act, will be essential, as will access to a ready supply of necessary prescription drugs through the Care Act’s AIDS Drug Assistance Program (ADAP). In 2017, only 13 percent of all health centers (175 grantees) received Care Act grants totaling \$77 million, underscoring a need for additional funding through the health center grant program itself.¹⁶ Most of these funds (86 percent) went to health centers in the 26 high-burden states, the District of Columbia, and Puerto Rico.

As important as grants are, unlike Medicaid they are subject to annual aggregate limits. The lack of Medicaid boosts the uninsured numbers in non-expansion states. In Medicaid expansion states, the proportion of uninsured patients (18 percent in 2017) is far lower than in the non-expansion states (36 percent in 2017).¹⁷ The President’s initiative further intensifies the focus on expansion in these states.

Even in Medicaid expansion states, however, health centers may face challenges. Currently, of the 37 expansion states, nine either are formally seeking approval to implement Section 1115 Medicaid work demonstrations or have received an approval to move forward.¹⁸ Although the CMS conditions approval on exemptions for people receiving active treatment for opioid addiction,¹⁹ the agency has established no similar policy for people with or at risk for HIV. Based on the experience of beneficiaries in Arkansas – the only state that to date has implemented an approved work experiment – mandatory work and reporting requirements, combined with other eligibility restrictions such as premiums and lock-out periods, are likely to cause additional coverage disruptions as a result of people’s inability to consistently pay premiums, fulfill weekly work hour rules, or navigate reporting requirements.

Table 2. Medicaid Income Eligibility Standards as a Percentage of the Federal Poverty Level for Parents and Other Adults in Non-Expansion States Identified as High-Burden in Whole or in Part Under the President’s HIV Initiative (January 2018)

State	Parents (in a family of three)	Other Adults (for an individual)
Alabama	18%	0%
Florida	33%	0%
Georgia	36%	0%
Mississippi	27%	0%
Missouri	22%	0%
North Carolina	43%	0%
Oklahoma	43%	0%
South Carolina	67%	0%
Tennessee	98%	0%
Texas	18%	0%

Source: Kaiser Family Foundation. (2019). Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, as of January 1, 2018. Available at <https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/>

¹⁶ GW analysis of 2017 UDS data

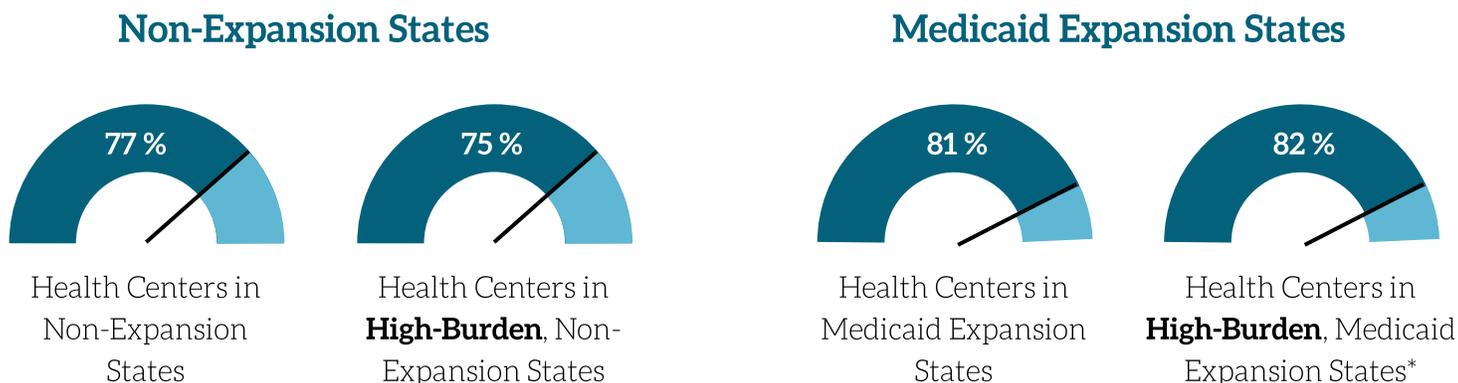
¹⁷ Sharac, J., Shin, P., Gunsalus, R., & Rosenbaum, S. (2018). Community Health Centers Continued to Expand Patient and Service Capacity in 2017. Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University. Policy Research Brief No. 54. Available at <https://www.rchnfoundation.org/?p=7172>

¹⁸ Kaiser Family Foundation. (2019). Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. Available at <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>

¹⁹ State Medicaid Directors Letter. (January 11, 2018). Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>

Figure 3. Health Center HIV Linkage-to-Care Quality Measure by Medicaid Expansion, 2017

Average Performance on the HIV Linkage-to-Care Measure



*Significantly different from high-burden, non-expansion state health centers ($p < 0.05$)

Note: This analysis does not include health centers in U.S. territories but does include health centers in Washington, DC. Medicaid expansion status based on states' decisions to expand as of 2017. Source: GW analysis of 2017 UDS data

Health Center HIV Performance in Expansion Versus Non-Expansion States

Access to Medicaid among health center patients living with an HIV diagnosis appears to be significantly associated with the quality of performance in high-burden states. As **Figure 3** shows, performance on the key HIV linkage-to-care measure used by the federal government to assess the quality of care furnished by health centers was significantly greater among health centers in the group of states and Washington, DC that have been designated as high-burden and that were also Medicaid expansion states in 2017, than for health centers located in high-burden states that had not adopted the expansion. This finding is consistent with previous research showing better performance and stronger health center capacity in states that have more generous Medicaid coverage policies.²⁰ Although health insurance alone does not in and of itself ensure better quality care, more generous coverage enables providers including health centers to

secure the follow-up care their patients may need, while also providing the operating revenue necessary to strengthen the availability and quality of care. For this reason, both Medicaid expansion and federal grant funding increases have been shown to be associated with increases in patient capacity and the number of patient visits.²¹

Looking to the Future

The feasibility of the administration's HIV initiative ultimately turns on the availability, accessibility, and quality of health care. More at-risk people must be identified and moved into preventive care. More people will need to be reached with diagnostic and continuing treatment and care management services. In the highest-burden states and communities, the need to ramp up existing efforts can be expected to be substantial, especially given what is already known about the considerable number of people with HIV diagnoses who are not in regular care arrangements.

²⁰ Markus, A., Sharac, J., Tolbert, J., Rosenbaum, S., & Zur, J. (2018). Community Health Centers' Experiences in a More Mature ACA Market. Kaiser Family Foundation. Available at <https://www.kff.org/medicaid/issue-brief/community-health-centers-experiences-in-a-more-mature-aca-market/>; Shin, P., Rosenbaum, S. J., Bruen, B. K., Lu, A., Arguello, R., & Tolbert, J. (2012). Medicaid and Community Health Centers: the Relationship between Coverage for Adults and Primary Care Capacity in Medically Underserved Communities. Kaiser Family Foundation. Available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8293.pdf>

²¹ Han, X., Luo, Q., & Ku, L. (2017). Medicaid expansion and grant funding increases helped improve community health center capacity. *Health Affairs*, 36(1), 49-56. Available at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0929>

For this reason, key questions must be answered:

- Will Congress reauthorize the Health Center Fund, which is set to expire at the end of FY2019, and if so, will lawmakers extend the period of authorization beyond the two-year funding cycles previously used? The President's 10-year initiative rightly assumes that reaching the goal will require 10 years of active efforts to expand access to prevention and treatment services. The same time period could be used for the Health Center Fund, given health centers' role in HIV treatment and the need for additional resources that will enable expanded HIV care without detracting from other vital services such as treatment of opioid addiction, high-quality maternity and pediatric care, and expanded efforts to reach and treat persons with serious and chronic physical and mental health conditions.
- What steps can Congress take to further incentivize adoption of the Medicaid expansion in remaining states? One option is to restore the highly-enhanced funding levels for newly adopting states that expired at the end of 2016. An additional option would be to provide expansion adoption states with additional and complementary grant resources targeted to health improvement activities for Medicaid beneficiaries facing heightened health and social risks.
- Will CMS, using both its ongoing administrative and innovation authority through the Center for Medicare and Medicaid Innovation (CMMI), promote delivery models and demonstrations aimed at improving the accessibility and quality of HIV preventive and treatment services in the highest-risk communities, and for both Medicaid and Medicare beneficiaries, as well as for people who rely on subsidized Marketplace coverage and live in medically underserved communities?
- How will CMS address the issue of HIV risk and diagnosis in the policies it pursues related to § 1115 demonstrations whose purpose is to restrict eligibility? Will HIV risk or an HIV-positive status be the basis for an exemption from the risk of coverage termination or denial?