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Affordable Care Act Priorities:

Opportunities for Addressing the

Critical Health Care Needs of Women

Living with or at Risk for HIV



A 30 for 30 Campaign white paper prepared in partnership with the Harvard Law School Center for Health Law and Policy Innovation and the Treatment Access Expansion Project.

Lead Authors: Amy Killelea, Malinda Ellwood, and Robert Greenwald of the Treatment Access Expansion Project and the Harvard Law School Center for Health Law and Policy Innovation

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INTRODUCTION: THE UNIQUE NEEDS OF WOMEN IN THE CURRENT ACCESS TO CARE AND PUBLIC HEALTH CRISIS

In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA), federal health care reform legislation that is already helping millions of Americans. On June 28, 2012, the U.S. Supreme Court issued its decision on the constitutional challenges to the ACA, and upheld most provisions of the law. The Court's decision paves the way for moving forward with health reform implementation. Provisions of the ACA – including major expansion of public and private insurance coverage and investments in prevention, wellness, health infrastructure, and coordinated models of care – have the potential to significantly increase access to comprehensive care for women living with or at risk for HIV.

Women comprise about a quarter of those living with HIV in the United States, and more than 30% in some states. The HIV epidemic has a disproportionate impact on women of color: for instance, in 2009, the rate of new HIV infections among black women was 15 times that of white women, and the rate of new infections among Latina women was over four times that of white women.¹ Preliminary data also suggest there are much higher HIV rates among transgender women (male to female), particularly among transgender women of color.² Though there has been much research and analysis on the opportunities within the ACA for HIV prevention, care, and treatment generally, there has been little analysis on the opportunities that will have the most relevance for women living with or at risk for HIV in particular. For instance, the discussion about comprehensive reproductive health services is often divorced from discussion about HIV care and services. The ACA provides a number of opportunities to better integrate those services in ways that take into account the unique health care and support services needs of women. Advocacy that focuses on the unique needs of women and that informs policies in ways that ensure they are responsive to these needs is critical.

For women, the HIV epidemic is compounded by the intersections of race, gender, gender identity, and poverty; these factors impact their health and social services needs. Often, women are the primary caretakers of children and other family members and are likely to put the needs of family members above their own health care needs. In addition, the majority of women living with HIV have incomes below the federal poverty level (FPL), meaning that added to their health care needs, these women are likely to have unmet housing, nutrition, and other social services needs.³ Low-income women, particularly women of color, also experience higher rates of domestic violence, which

can impact their ability to use contraception (or otherwise protect themselves from the sexual transmission of HIV and other sexually transmitted infections (STIs)) as well as to remain in care if they become HIV positive.⁴

The health care services needs of women living with HIV demand attention to the overlap between women's primary health care, HIV care, and reproductive health care needs. The multiple and overlapping needs of these women are often poorly addressed by fragmented systems of health care.⁵ These statistics point to the need for policies and programs that are tailored to the health care and social services needs of women living with or at risk for HIV and that incorporate their voices and experiences, particularly those of women of color and transgender women. Such an approach is needed now more than ever, as laws and policies aimed at restricting access to critical reproductive and women-focused health services are increasingly prevalent nationwide. This white paper provides an overview of the major opportunities for expanding access to care within the ACA as well as a road map for federal and state implementation priorities to ensure that the ACA is implemented in ways that work for women living with or at risk for HIV.

WOMEN AND HIV: THE FACTS

- The majority of women living with HIV have income below the federal poverty level.
- Women of color account for 80% of women living with HIV (64% and 17% of women living with HIV are Black and Latina, respectively).
- Women living with HIV who have private insurance are likely to face higher costs and more interruption in coverage due to gender discrimination (e.g., higher premiums).
- Women living with HIV are less likely than men to receive anti-retroviral therapy and thus have higher HIV/AIDS mortality rates.
- The South and Northeast have some of the highest rates of new HIV infections among women.

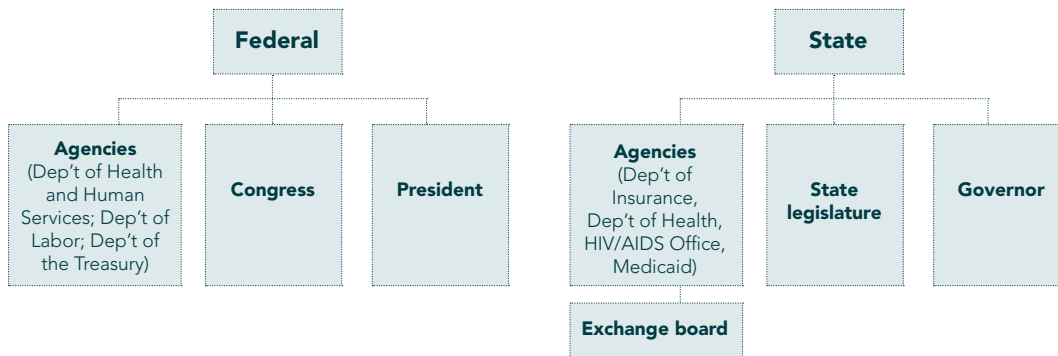
PRIORITIES FOR ACA IMPLEMENTATION

The ACA contains significant opportunities for expanding access to HIV prevention, care, and treatment for women living with or at risk for HIV, but only if advocates, policy makers, providers, and women living with and affected by HIV work to ensure that implementation decisions incorporate the needs of these women. Many decisions with regard to how the law is implemented will be made by the U.S. Department of Health and Human Services (HHS). HHS has already published a number of regulations and will continue to develop regulations, guidance, and other material that will ultimately shape how the law's hundreds of provisions will work.

In addition, HHS has increasingly indicated that many implementation decisions will not come from the federal government. Rather, states will be given flexibility to implement the law within broad standards and directives. While upholding the ACA's Medicaid expansion (providing for extending Medicaid coverage to most individuals

with income up to 133% of the federal poverty level) as constitutional, the Supreme Court's ruling held that the federal government cannot withhold *all* Medicaid funding—for both existing and expanded Medicaid—from states that do not implement the Medicaid expansion. By significantly reducing the federal authority to penalize states that do not expand Medicaid eligibility, the Court's decision effectively made Medicaid expansion under the ACA optional for states. Along with the flexibility extended to states from HHS, the Court's ruling makes it even more critical to focus education and advocacy efforts on state officials. While the ACA includes many provisions that will certainly benefit women living with or at risk for HIV, there are no earmarks specifically for this population. Unless state legislatures, state agencies, and other state policymakers are making decisions that take into account the needs of women living with HIV, barriers to lifesaving care, treatment and essential support services and geographic health disparities will continue.

ACA IMPLEMENTATION: GOVERNMENT DECISION POINTS



The most significant pieces of reform are discussed below, along with corresponding federal and state advocacy opportunities to ensure that the law is implemented in ways that work for these women.

MEDICAID

Medicaid provides coverage for about 91,000 women living with HIV nationally, or 31% of all women living with HIV.⁶ However, strict eligibility rules make the program unavailable to those who do not fall into a qualifying category of eligibility. For example, in most states, women living with HIV currently only qualify for Medicaid if they are low-income and are either: (1) parents or care-takers of young children; or (2)

so sick that they have become completely disabled.⁷ This leaves over 20% of women receiving care for HIV uninsured and unable to access consistent and comprehensive services.⁸ Given that the majority of women receiving treatment for HIV are responsible for minor children, this reduces the welfare not only of women living with HIV, but also of children.⁹

The ACA contains a provision requiring states to expand Medicaid eligibility, beginning January 1, 2014, to include most people with income up to 133% FPL (about \$14,800/year for an individual and \$30,000/year for a family of four). Essentially, the ACA creates a new "catch-all" category of mandatory eligibility – individuals under 65 years of age who meet the income threshold and who are not otherwise eligible for Medicaid.¹⁰ This means that women would no longer have to wait until they are disabled to be eligible for

Medicaid or risk losing coverage when their children age out of eligibility.

The ACA includes both “carrots” and “sticks” to encourage states to expand Medicaid eligibility. The “carrot” is the fact that the federal government will pay the overwhelming majority of the costs of the Medicaid expansion, covering 100% of the costs for the first three years, down to 90% in 2020.¹¹ The “stick” is the provision giving the federal government authority to withdraw *all* Medicaid funding from states that refuse to expand Medicaid eligibility. The Supreme Court found that the threat of withdrawing funding for states’ *existing* Medicaid programs was unconstitutionally coercive, and beyond Congress’ power. The Court held that states must have a “legitimate choice” of whether they will participate in a federal program such as Medicaid. In other words, Congress cannot put “a gun to the head” of states that do not wish to comply with its provisions.¹² The Court held that Congress **does** have the authority to condition *additional* funding on compliance with the Medicaid expansion requirement—thus the Medicaid expansion is constitutional so long as the federal government does not withdraw existing federal Medicaid funds from states that fail to participate in the expansion.

The practical effect of the Supreme Court’s decision is that states may opt to violate the ACA by not expanding Medicaid and then pay the penalty of losing additional federal funds. While some states have indicated that they will not expand their Medicaid programs, given the significant amount of federal funding on the table, it remains to be seen what states will do.¹³ Nonetheless, the Medicaid expansion remains the most significant opportunity to expand access to care to thousands of currently uninsured women living with HIV. Policy analysts predict that this change could result in coverage for up to 10 million women who are currently uninsured, including 34% of women living with HIV who are currently on Ryan White AIDS Drug Assistance Programs (ADAPs).¹⁴ Advocates must make state Medicaid expansion under the ACA a top priority, and policymakers at the federal and state levels must ensure that Medicaid benefits, outreach and enrollment programs, and models of care work for women living with or at risk for HIV. The following federal and state advocacy priorities will help to ensure that the Medicaid expansion and other Medicaid reforms are implemented in ways that expand access to care for this population.

1. ***Medicaid benefits for newly-eligible beneficiaries must be able to meet care and treatment needs of women living with or at risk for HIV***

The ACA requires the benefits for newly-eligible Medicaid beneficiaries (those currently ineligible) to consist of “benchmark” or “benchmark equivalent” coverage described in § 1937 of the Social Security Act.¹⁵ Under § 1937, a state has

the option of replacing its traditional Medicaid coverage with benchmark coverage that is based on private insurance plans.¹⁶ Those eligible for Medicaid under pre-reform law will receive the traditional state Medicaid benefits.

In addition to a number of mandated benefits already included in § 1937 (e.g., family planning and non-medical transportation), the ACA requires that benchmark coverage made available to newly-eligible beneficiaries include ten categories of “essential health benefits” (EHB). These are the same ten categories that private insurance plans sold through exchanges are required to provide. [See Appendix C]. Importantly, § 1937 already contains a number of protections for vulnerable populations, including the requirement that certain populations with chronic and complex medical conditions cannot be automatically placed into benchmark coverage. Recently, HHS published a bulletin outlining a similar benchmark framework to implement the essential health benefits requirements for private insurance plans sold through the state-based exchanges.¹⁷ Although the benefits requirements for plans sold through the exchanges are somewhat different than the § 1937 options described above, both private health plans sold on the exchange and Medicaid benchmark coverage (i.e., plans applying to newly eligible beneficiaries) must include a range of women’s preventive services without cost-sharing, including annual HIV and STI testing and screening for intimate partner violence.¹⁸ The inclusion of these benefits for newly eligible Medicaid beneficiaries is an important recognition of the intersection of gender, HIV, reproductive health, and intimate partner violence, and a critical first step towards reducing gender-related disparities in health care for low-income women.

ESSENTIAL HEALTH BENEFITS

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health/substance use services
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services
- Pediatric services

Future regulations and guidance on how states will be able to structure the benefits for newly-eligible beneficiaries are expected, but the federal government has indicated that states will have a great deal of flexibility in designing a benefits package.¹⁹ To the degree to which federal guidance on EHB falls short of mandating care and treatment that meets the needs of HIV-positive women, state definitions of these benefits will critically impact women’s access to HIV prevention and treatment services.

standards of HIV treatment, and includes, at a minimum, the services listed in the chart below.²⁰ A clear federal mandate for Medicaid EHB will help minimize ongoing barriers to care and reduce geographic disparities in health outcomes for low-income women. For example, currently women living in the southeastern United States experience disproportionately high rates of HIV infections and related morbidity, yet southeastern states also have particularly restrictive Medicaid programs.²¹

Advocacy Targets:

FEDERAL

- The Obama administration must work to educate both the public and state law and policymakers about the many pluses of expanding access to Medicaid as required under the ACA. The federal government will pay 100% of the costs of Medicaid expansion for all states for the first three years, with rates varying by state after that, but still decreasing only to 90% in 2019. There are also likely to be significant individual and public health benefits, as well as financial benefits, to having low-income people be able to access primary and preventive care, rather than seeking uncompensated care in emergency rooms.
- The Centers for Medicare and Medicaid Services (CMS) must issue regulations and guidance that set forth comprehensive benefits requirements for newly-eligible Medicaid beneficiaries. In order to meet the letter and spirit of the ACA – including its EHB and non-discrimination mandates – these requirements must mandate a Medicaid package that meets national

STATE

- First and foremost, states need to comply with the ACA requirement to expand Medicaid to individuals with income up to 133% of FPL. As noted above, the federal government will pay for the overwhelming majority of the costs of the expansion. Estimates are that the ACA Medicaid expansion would only increase state Medicaid costs 2.8% above what states would otherwise be spending in the absence of expanding eligibility.²² This also likely overstates the cost to states, as the estimates do not take into account state savings associated from lower uncompensated care costs, improved public health, and improved productivity. If states do not expand Medicaid, their poorest residents will be left without access to health insurance. Because the ACA anticipated that people with incomes up to 133% FPL would be covered under Medicaid, this population is not eligible for subsidized private coverage under the state health insurance exchanges.
- State Medicaid policymakers must incorporate the benefits and services that are essential to keeping women living with HIV healthy into their Medicaid programs. This approach is critical to reducing health

Women Living with HIV Are Entitled to a Benefits Package That Meets Their Care and Treatment Needs

Prescription drugs	Women living with HIV require unrestricted access to the range of antiretroviral medications available to effectively suppress the virus.
Ambulatory patient services & specialist care	Regular and unlimited access to experienced HIV medical providers is a key component of HIV care that supports engagement in and adherence to treatment, preventing disease progression.
Rehabilitative and habilitative services	Case management is important to support the comprehensive care and treatment required by many people living with HIV, particularly for women, and should be a required rehabilitative service for benchmark coverage. We recommend defining case management as including care coordination and navigation as well as treatment and care adherence and counseling.
Mental health and substance use treatment	Access to the range of services effective at treating mental illness and substance use disorders – including intensive case management, peer support services, day treatment, and alcohol and chemical dependence services – is critical to prevent inpatient hospitalizations and to support people living with HIV in maintaining the care and treatment that they need to stay healthy. Services and programs must be able to meet the needs of families, particularly women living with HIV and their children.
Preventive and wellness services	Routine HIV screening is critical to early diagnosis of HIV, and must be provided for all newly eligible beneficiaries. Annual HIV screening for women is already required, along with all other preventive services covered under § 2713 of the ACA and implementing regulations (including services with an A or B rating from the United States Preventive Services Task Force as well as women’s preventive services such as well-woman visits, domestic violence screening and counseling, and contraception). Viral hepatitis screening must also be included.

SPOTLIGHT ON EFFECTIVE MODEL OF PEER-BASED SUPPORT AND LINKAGE TO CARE: WOMEN ORGANIZED TO RESPOND TO LIFE-THREATENING DISEASES (WORLD)

WORLD's program in California utilizes Ryan White Program Part D grant money to fund a network of four peer advocates. Peer advocates are women living with HIV, tasked with providing:

- individual psychosocial, emotional and practical support for linkage to and retention in care
- assistance navigating the health care system
- education related to self-care and self-efficacy (including addressing intimate partner violence)
- referrals and linkages to other necessary services that support good health outcomes, including child care, job training, housing, nutrition services, and legal services

Peer advocates also facilitate weekly support groups where women living with HIV are provided with health education and have the opportunity to increase social support and reduce the impact of stigma. As part of the broader Family Care Network (FCN) of Alameda County, peer advocates also maintain direct relationships with health care providers and other social service agencies within the community to ensure that those entities are effectively meeting the needs of the women they serve.

disparities across states and improving the health outcomes of low-income women. Further, whereas the ACA defines the benefits that are required for newly eligible beneficiaries, it is also important to ensure that existing beneficiaries also have access to comprehensive care and treatment that meets their needs.

- One important component of HIV care and treatment for women is peer support. Peer support helps women living with or at risk for HIV to combat persistent barriers to prevention and treatment (e.g., by promoting self-empowerment, encouraging self-management, increasing adherence to treatment, and reducing the negative effects of stigma) and may be particularly important for women of color.²³ While states already have the option to cover peer support services under Medicaid, few have done so.²⁴ Peer support programs funded by Part D of the Ryan White Program, such as the program run by Women Organized to Respond to

Life Threatening Diseases (WORLD) in California, may provide good models for state Medicaid programs.²⁵ Similarly, domestic violence screening must be a standard part of HIV testing and counseling. Domestic violence screening without cost-sharing is a required benefit for newly eligible women on Medicaid, along with STI and HIV testing, but advocates must work to implement these benefits in ways that take into account the intersections between HIV, STIs, and intimate partner violence. New York, for instance, has made domestic violence risk assessment a standard part of the HIV testing protocol.²⁶

- State Medicaid offices and health departments should work with the HIV community to ensure that the providers currently serving women living with HIV are incorporated into Medicaid networks.²⁷ State Medicaid offices should also explore opportunities to expand telemedicine capacity. Such innovations are particularly important to women, where child-care responsibilities and lack of transportation can severely limit ability to access care.²⁸

2. Medicaid must provide unfettered access to a range of family planning services

Starting in 2010, the ACA created a new optional category of beneficiaries for family planning services.²⁹ This group consists of both men and women, and states have discretion to set an income cap for eligibility. While services available to this group are limited to family planning and related services,³⁰ the definition of family planning services is fairly broad, and the individual services covered vary by state. For instance, though a majority of states cover HIV testing in their Medicaid programs,³¹ few cover HIV testing as part of family planning services.³²

The new option under the ACA makes it easier for states to expand their Medicaid programs to cover family planning services for people who would not otherwise be eligible for

FAMILY PLANNING SERVICES

- Prescription contraception
- Over-the-counter contraceptives (including condoms and emergency contraception)
- Sterilization
- STI and HIV testing
- Cancer screening
- Human Papilloma Virus (HPV) vaccine
- Preconception care (including counseling and education)

Medicaid (e.g., because their incomes are too high) by allowing states to simply amend their Medicaid state plan. Prior to the ACA, states had to apply for a § 1115 Medicaid waiver to provide these services to this population. Notably, federal law requires that women who seek family planning services under Medicaid have the freedom to see the Medicaid-participating provider of their choice for these services, even if the provider is outside of a managed care network.³³ The family planning option – while an important opportunity to expand access to vital reproductive health care services – comes at a time when funding for family planning and reproductive health services are under increasing attack at both the federal and state levels, and few states have taken up this option.³⁴

Advocacy Targets:

FEDERAL

- CMS should provide guidance and support to states to expand their Medicaid programs to take up the family planning option, and this guidance should include information on how to structure the program to include integrated HIV and family planning services. CMS must also carefully monitor state attempts to roll back coverage of essential family planning services. Recent action in Texas – where the state attempted to cut Planned Parenthood clinics as eligible providers of family planning services – is an example of the type of state action that CMS should be monitoring to ensure compliance with federal law.³⁵

STATE

- State legislatures and state Medicaid offices should explore amending their Medicaid state plans to include the new family planning services eligibility category. Routine HIV testing should be included in the definition of eligible services to ensure that women can access HIV testing in reproductive health settings.

3. *Medicaid outreach, eligibility, and application processes should be simple and implemented in ways that reduce churning (i.e., gaps in coverage because of small fluctuations in income)*

The ACA includes a number of provisions aimed at ensuring that people are aware of insurance coverage options and are able to easily apply and enroll. Starting in 2014, applicants must be able to apply for Medicaid, the Children’s Health Insurance Program (CHIP), and other insurance affordability programs (e.g., premium subsidies) through one streamlined application.³⁶ Because women are often juggling the needs of family members and other caretaking responsibilities, and low-income women in particular may have needs addressed

by multiple social service agencies with different kinds of application requirements, the need for a simple and streamlined application process that allows applicants to sign up for insurance coverage for themselves and dependent children will increase access to care and ensure that women who are eligible for Medicaid coverage are able to enroll. Moreover, churning – a phenomenon where people experience gaps in coverage because of small fluctuations in income – has long been a problem for many Medicaid beneficiaries. Churning may be even more of an issue in 2014, particularly for people whose income hovers right around 133% FPL. This is a population who is already more likely to experience variations in income, and if income goes above or below the 133% FPL threshold, people may find themselves bouncing back and forth between exchange coverage and Medicaid coverage.³⁷ This problem is further compounded for women, who are even more likely to see fluctuations in their income or changes in life circumstances that cause them to experience disruptions in insurance coverage.³⁸ In general, long-term provider-patient relationships foster better care and minimize risk of missing a prescription or treatment.³⁹ For women living with HIV and other chronic conditions, disruptions in care can have serious medical consequences.⁴⁰

Advocacy Targets:

FEDERAL

- CMS must ensure that forthcoming regulations and guidance on accessibility standards (including language requirements) for availability of information to apply for Medicaid via website, telephone, or written application are robust and ensure that people with limited English proficiency have access to the information they need to apply for and enroll in coverage. This is particularly important given the large proportion of women living with HIV who are Latina.
- Though the final Medicaid eligibility rule contained a number of important safeguards to help minimize churning, there was little discussion of oversight mechanisms to ensure that these safeguards are followed. CMS should work with states to develop application and enrollment systems that address the needs of women living with HIV and should monitor whether their states are following the law’s requirements.

STATE

- States should explore the new option included in the ACA that allows states to cover people with income above 133% FPL as a new optional eligibility category. Creating this new category will expand access to care to low-income women and minimize churning as people switch between Medicaid and subsidized private insurance due to fluctuations in income. Alternatively, states should investigate other options for covering

people with income above 133% FPL, including implementing a “Basic Health Program,” which would allow the state to receive federal money to set up a public insurance option for people with income between 133 and 200% FPL.⁴¹

- The final rule on Medicaid eligibility processes offers some opportunities to mitigate churning; however much discretion is still left to the states to take advantage of these options: states have the option of calculating Medicaid income for enrolled beneficiaries based on either projected annual income or “point-in-time” income;⁴² states have the option to take into account reasonably predictable changes in income (e.g., seasonal work) in determining current monthly or projected annual income; and states may accept applicants’ attestations with regard to several application requirements (e.g., residency and household size) without requiring paper documentation.⁴³ States should adopt application procedures that are least burdensome to applicants to increase the likelihood that people successfully secure coverage.

4. Quality measures must evaluate how well Medicaid is working for women living with or at risk of HIV

Requiring collection of information on a set of quality measures is an important way to ensure that the Medicaid program is providing women with access to the care and treatment they need to stay healthy.⁴⁴ At the federal level, the ACA requires that HHS establish a federal “pre-rulemaking process” for the selection of quality and efficiency measures for government health programs (e.g., Medicaid and Medicare).⁴⁵ Earlier this year, CMS solicited public comment on quality measures for adult Medicaid beneficiaries – one quality measure requires states to monitor whether people living with HIV see their doctors every year.⁴⁶ CMS will continue to develop quality measures and reporting programs to better track the quality of care Medicaid beneficiaries are receiving.⁴⁷

Advocacy Targets:

FEDERAL

- Proposed quality measures developed by CMS must include measures that reflect the health care needs and experiences of women living with or at risk for HIV. A starting place for the development of such quality measures could be, for instance, the seventeen HIV quality measures published by the American Medical Association, National Center for Quality Assurance, the Health Resources and Services Administration (HRSA), and others which assess a wide range of HIV care measures (including patient retention, screening and prophylaxis for opportunistic infections,

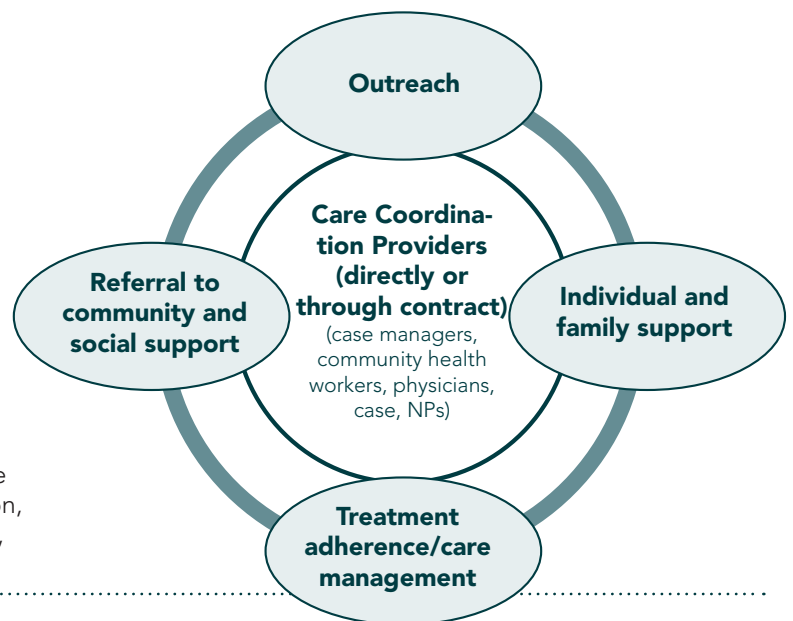
immunizations, and initiation and monitoring of antiretroviral therapy). In addition, the National Quality Measures Clearinghouse provides a range of quality measures, including measures that assess screenings for intimate partner violence.⁴⁸

5. Coordinated care models within Medicaid must address the needs of women living with or at risk for HIV and include family-centered care models

Coordinated, “whole person” care that addresses a range of medical and social services needs is vital not only to connecting women living with HIV to care and enabling them to stay in care. For instance, caretaking, household, and employment-related responsibilities can create barriers to women seeking medical care.⁴⁹ Family-centered models that are able to facilitate access to primary medical care, specialty care, and support services (e.g., childcare and transportation assistance) will therefore greatly benefit women.

To encourage and support new, innovative models of coordinated care, the ACA established a Center for Medicare and Medicaid Innovation (CMMI), which is tasked with evaluating payment and service delivery models for Medicare and Medicaid. In approving pilot and demonstration projects, CMMI considers factors such as: how well services are integrated, how health information technology is used to coordinate care, how medical homes are used, and how the project proposes to manage or reduce overall costs of care. Currently, CMMI is supporting pilot projects ranging from Accountable Care Organization (ACO) models to patient-centered medical homes in Federally Qualified Health Centers (FQHCs).

In addition, the ACA includes a Medicaid health home program, which allows states to amend their Medicaid state plans to provide coordinated care to individuals with chronic conditions.⁵⁰ In response to successful advocacy efforts, CMS specified that HIV is an eligible chronic condition, and sever-



al states are moving forward with proposals that will provide care coordination services to people living with HIV.⁵¹

Advocacy Targets:

FEDERAL

- CMMI should fund a collaborative project between HRSA (which oversees the Ryan White Program) and CMS to evaluate key program components of the comprehensive and coordinated care, treatment, and services model that is the hallmark of the Ryan White Program. This project would benefit from the oversight and input of the federal inter-agency Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-related Health Disparities, which is tasked with improving data collection, research, intervention strategies, and training, to improve women's health.⁵² This project should include quality metrics that specifically measure how well the Ryan White Program model of care works for women and should aim to catalogue the Ryan White Program services that are particularly important to support women's ability to access and remain in effective care and treatment.

SPOTLIGHT ON NEW YORK MEDICAID HEALTH HOME PROGRAM

New York is currently implementing a Medicaid Health Home Program to help serve people living with chronic conditions, including HIV. Eligible "health home providers" are charged with coordinating patient care, including primary medical, specialist, and behavioral health care, within a model that is culturally appropriate and patient and family-centered. Health home services include peer supports, support groups, and self-care programs to help patients understand and address their own health care needs, including adherence. Individual patient plans must also include appropriate linkages to community-based resources and other support services and provide 24-hour access to a case manager.

Health home providers must be enrolled in the Medicaid program, but can subcontract with community-based organizations (e.g., Ryan White Program funded community-based organizations providing non-medical support services) for provision of health home services. Health homes can provide medical and support services directly or through these subcontracts.

STATE

- State Medicaid departments should amend their Medicaid plans to take advantage of the Medicaid health home program and should specify HIV as a qualifying condition. The Medicaid health home program is an opportunity both for Ryan White Program primary care providers to become eligible health homes, as well as for Ryan White Part D and other community-based support programs to contract with Medicaid health homes to provide family-centered services (including peer support) for women living with HIV. State Medicaid directors should promulgate certification standards for the health home program that require cultural competence training for all providers and include quality measures that assess delivery and integration of STI and intimate partner violence screening, as well as family planning services. Certification standards should also require Medicaid health homes to contract with existing local community providers and ensure they have access to technical assistance to meet health information technology requirements. New York, for example, is moving forward with a Medicaid health home program that will provide care coordination services, including patient and family-centered care and peer support services, to people living with HIV.⁵³

PRIVATE INSURANCE

Starting in 2014, states will be required to have "exchanges" - regulated marketplaces that will allow people to compare and purchase health insurance. Insurance exchange markets have the potential to provide greater health security for women by allowing them to maintain coverage in the absence of employer-sponsored options or long term job security. Approximately two-thirds of women have employer-sponsored health insurance, but suffer from disruption in coverage or provider networks when transitioning between jobs.⁵⁴ Only 7% of women are able to purchase individual coverage, leaving 18% uninsured.⁵⁵ HHS published a final regulation detailing key requirements for exchange design and implementation, but leaving many implementation decisions to states. The following federal and state advocacy priorities will help to ensure that exchanges are designed and implemented in ways that expand access to care for women living with or at risk for HIV.

If a state fails to establish its own exchange, HHS will operate the state's exchange. The ACA provides federal assistance in the form of premium tax credits and cost-sharing subsidies to help people with income between 100 and 400% FPL (as well as legal immigrants ineligible for Medicaid because of residency requirements) purchase insurance through the exchanges. In addition to making insurance more affordable, the ACA makes it easier for people living with HIV (and other

chronic conditions) to purchase private insurance by prohibiting many discriminatory insurance practices (for instance charging higher premiums because of gender or health status, or imposing lifetime or annual limits on coverage).⁵⁶ Private insurance plans are also required to cover certain preventive services for women without cost-sharing, including screenings for HIV, STIs, and intimate partner violence, as well as all FDA-approved contraception. The availability of contraception without cost-sharing may be particularly beneficial for women of color, who experience higher rates of unintended pregnancies and are less likely to be able to afford cost-sharing.⁵⁷ Plans must also allow women to access OB-GYN providers without requiring prior-authorization or a referral.⁵⁸ These private insurance reforms will mean that thousands of women living with or at risk for HIV who have never had access to private insurance will be able to purchase private insurance starting in 2014. Policy analysts estimate that approximately 21.2% of women living with HIV who are currently receiving services through ADAPs will be eligible for insurance subsidies in 2014.⁵⁹

1. Exchanges must incorporate the voices and experiences of women living with HIV and must be designed in ways that take into account the needs of women living with or at risk for HIV

In March 2012, HHS published an extensive final rule for establishment and operation of state-based exchanges. The rule includes standards and requirements for: stakeholder involvement; consumer outreach; Qualified Health Plan (QHP) certification; provider network adequacy; and application and enrollment processes.⁶⁰ It is clear that states will have a great deal of discretion in designing and operating their exchanges.⁶¹

Advocacy Targets:

FEDERAL

- As of May 2012, only thirteen states and the District of Columbia had passed legislation or issued executive orders to establish a state-run exchange.⁶² This means that the federal government will likely be running a significant number of exchanges, making it even more important for the rules and regulations governing federally facilitated exchanges to contain robust consumer protections and requirements. Many of the state advocacy targets listed below may also be relevant to shape implementation of these federally facilitated exchanges.

STATE

- In establishing and operating their exchanges, states

must consult with a range of stakeholders, including consumers, advocates for hard-to-reach populations, and public health experts.⁶³ HIV and reproductive health advocates – and women living with or affected by HIV in particular – must be at the table as important state decisions about exchange design and operations are made. Opportunities for stakeholder involvement include public hearings, task forces, and consumer consultations.

- States must ensure that people who enroll in coverage through exchanges have access to providers they know and trust and who are able to meet their care and treatment needs. Federal regulations require any plan operating within the exchange to have an adequate provider network and to contract with “essential community providers” (which include Ryan White Program providers and FQHCs). However, the federal standards are broad, giving states discretion to select which essential community providers will be included in QHPs. State plan certification requirements for these plans must include: mandatory inclusion of Ryan White Program providers in plan networks and robust accessibility standards that ensure access to a range of providers that are able to meet the care and treatment needs of women living with HIV, including prohibiting increased costs for access to specialists.
- QHP certification requirements must address the needs of women, including: requiring providers to undergo cultural competence training; requiring that plans adhere to nationally recognized standards of care for HIV and women’s care in particular; and requiring plans to collect data on health care utilization for women living with HIV.

2. Essential Health Benefits must be defined and implemented in ways that ensure access to comprehensive care and treatment

The same set of ten categories of essential health benefits (EHB) that are required to be provided to newly eligible Medicaid beneficiaries are also required to be part of any private insurance plan sold through the exchanges.⁶⁴ In December 2011, HHS published guidance (in the form of a bulletin) laying out its implementation plan for the EHB.⁶⁵ Instead of creating a robust national standard (which HIV advocates had urged HHS to do), the bulletin allows each state to adopt its own definition of the EHB. This state “flexibility” means that health disparities that currently exist are likely to persist. Women living in states that historically have not invested in health, such as those in the South, will almost certainly end up with an EHB package less robust than those in states that have prioritized health spending. A state can choose an insurance plan (among ten options) to serve as the state’s EHB “benchmark.” This means that all private insurance plans sold on the exchange must provide the scope of services and plan design features of the chosen

benchmark plan in that state. If the chosen benchmark does not include a specific EHB category, the state must supplement the plan to provide that benefit. The benchmark must include the ten EHB categories; however, there will still be incredible variation among plans with regard to things like service limits and cost sharing.

Advocacy Targets:

FEDERAL

- HHS will be issuing more detailed regulations on the EHB requirements, and it is imperative that there are strong federal standards with regard to what private insurance plans sold through exchanges must cover. HHS regulations and guidance must incorporate the vital services that are essential to keeping women living with HIV healthy (see above discussion of EHB for Medicaid benchmark plans for key benefits that must be included).
- There have been attempts in Congress to allow providers and employers to opt out of providing access to certain services (e.g., contraception) because of religious or moral objections. Members of Congress must oppose these measures and ensure that women have access to mandated services.⁶⁶

STATE

- State departments of insurance should make detailed information on the options for benchmark plans publicly available so that the HIV community can determine which plans will be best for women living with or at risk for HIV. The actual benefits covered will likely not vary much by plan, but there could be significant variation in terms of service limits, prescription drug formularies, and other plan design features.

3. *The patient navigator program must be designed in ways that utilize the expertise of women living with and affected by HIV and enable the program to effectively reach this population*

The ACA requires exchanges to have outreach processes in place to provide applicants with the information they need to apply for and enroll in health insurance coverage. For instance, every exchange is required to have a patient navigator program that will provide applicants with information about their public and private coverage options and that will be able to ferry applicants through the application and enrollment processes. Federal regulations have provided broad standards for this program, including the requirement that the program include at least one community-based non-profit, but much discretion is left to states to design their own navigator programs. For women living with HIV, having

a patient navigator who is also a peer – a woman living with HIV – is critical and has been shown to be effective in getting women into and retaining them in care.

Advocacy Targets:

FEDERAL

- The final rule published by HHS on the establishment of exchanges includes broad standards and protections, but very few oversight and enforcement mechanisms. HHS must provide a process for how patient navigator programs will be evaluated to ensure they are complying with the letter and the spirit of the ACA, particularly around protections that address use of agents and brokers as navigators (who may have conflicting financial interests to push people into certain plans) as well as an enforcement mechanism if programs are not in compliance.

STATE

- State exchanges must develop patient navigator requirements and certification standards that work for women living with or at risk for HIV. State exchanges should go above the federal floor of having at least one community-based entity serving as a navigator and should urge exchanges to contract with Ryan White Program grantees, particularly those with experience reaching out to and enrolling women in public programs to carry out navigator functions. Exchanges should also adopt certification and training standards that ensure that navigators are able to effectively reach women living with or at risk for HIV. For instance, navigators should be available to assist people outside of normal business hours. Navigators should also undergo cultural competence and language training as well as training on a range of public programs available for women living with HIV (including non-health social services like the Women Infants and Children (WIC) program, Supplemental Nutrition Assistance Program (SNAP), and resources for women experiencing intimate partner violence).⁶⁷ Successful peer support programs funded by Ryan White Part D provide good models for care coordination and should be incorporated into navigator programs.⁶⁸ Exchanges may also look to Ryan White case management certification and training guidelines for their navigator standards.⁶⁹

4. *Monitoring and oversight mechanisms must ensure strong enforcement of non-discrimination and inclusion mandates that will bar discrimination against women living with HIV and expand access to quality care*

The ACA and implementing regulations contain strong non-

discrimination language that will benefit women who are disproportionately affected by harmful insurance underwriting practices. For instance, the ACA prohibits insurance plans sold through an exchange from charging higher premiums based on gender and health status and prohibits all plans from denying or dropping someone from coverage based on a pre-existing condition, or imposing lifetime or annual limits on services. In addition, the final exchange regulation prohibits exchanges and QHPs from discriminating on the basis of “race, color, national origin, disability, age, sex, gender identity, or sexual orientation.”⁷⁰ However, without adequate oversight and enforcement mechanisms, this language will do little to end harmful insurance practices that disproportionately affect women.

Advocacy Targets:

FEDERAL

- HHS must develop strong oversight and monitoring processes and ensure that implementation of the non-discrimination mandates means that women living with or at risk for HIV, including transgender women, will not be discriminated against in terms of access to vital health care services and the ability to see a qualified provider.

STATE

- State exchanges must ensure that state non-discrimination laws, particularly around prohibitions on discrimination based on sex, sexual orientation, gender identity, and health status or disability, are followed as states design their exchanges and QHP certification standards. Health care consumers should also have access to adequate information on the appeals processes for denial of coverage.

INVESTMENTS IN HEALTH INFRASTRUCTURE, PREVENTION, WELLNESS, AND WORKFORCE

In addition to the insurance expansion provisions discussed above, the ACA includes a number of investments and initiatives aimed at increasing prevention and wellness and shoring up the nation’s health workforce and infrastructure. These investments are essential to ensuring that health care providers are able to meet the care and treatment needs of the millions of people who will be moving into the health care system in 2014 and to ensure that access to insurance translates to access to comprehensive care. The following

federal and state advocacy priorities will help to ensure that these investments benefit women living with or at risk for HIV.

1. **ACA investments in health infrastructure, including significant investments in community health centers, must ensure that clinics and programs are designed to meet the needs of women living with or at risk for HIV**

The ACA includes billions of dollars in funding and grants for community health centers. For instance, in August 2011 the federal government awarded \$28.8 million to community health centers to expand care to an additional 286,000 patients. Over the past decade, health centers have experienced a 94% increase in the number of low-income women of childbearing age that they serve; nationally, health centers provide a health home for 1 in 5 women in that demographic.⁷¹ Community health centers (and any safety net provider that receives state or federal money) must be held accountable for providing comprehensive, culturally sensitive care to diverse populations, including women living with HIV. There are many opportunities through these new investments to increase collaboration among community health centers, Ryan White Program and reproductive health providers, and other safety net clinics to integrate reproductive, primary, and HIV care and ensure that women have access to the range of services they need to stay healthy.

Advocacy Targets:

FEDERAL

- The newly formed federal Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-related Health Disparities should investigate successful models of integrated reproductive health and HIV care (including services for intimate partner violence) and help develop best practices to encourage use of these models.

STATE

- The HIV community, state primary care associations, community health centers, and safety net providers should work together to encourage collaboration between HIV providers and other health care clinics that serve women, including those who assist women experiencing intimate partner violence.⁷² Collaboration could include affiliation agreements between HIV providers, community health centers, and/or other safety net providers that encourage referrals or training designed to give HIV and community health center providers the information they need to identify and effectively treat overlapping reproductive and HIV health

INTEGRATING HIV AND REPRODUCTIVE HEALTH SERVICES: CHOICES

Choices in Memphis, Tennessee began as an organization exclusively focused on women's reproductive health, including services and counseling for women experiencing or at risk for intimate partner violence. Over time, Choices has expanded its services to create a more comprehensive model of care, and has helped educate HIV providers within the community around women's health issues. HIV providers are now able to refer their patients to Choices for integrated reproductive health services, including intimate partner violence counseling and prevention, and fertility services. In turn, Choices provides HIV testing and referrals to HIV specialists. By reaching out and building relationships with the HIV community, Choices has been able to create a supportive system of care and referral that promotes a "no-wrong door" model for entry into care for women, and ensures access to experienced, culturally competent providers who understand the unique reproductive health needs of women living with HIV.

care needs. An effective model for this collaboration is *Choices*, a Tennessee-based program where training and increased dialogue between reproductive health and HIV providers has promoted integrated care that meets the care and treatment needs of women living with HIV.⁷³

- Initiatives aimed at expanding HIV care in community health centers must include training that is specific to the needs of women living with or at risk for HIV. The AIDS Education and Training Centers' (AETC) National Center for HIV Care in Minority Communities, for instance, is an initiative funded by HRSA's HIV/AIDS Bureau and being implemented by HealthHIV in collaboration with the National Association of Community Health Centers. The program provides funding and intensive technical assistance and training to community health centers around the country to expand HIV care and treatment capacity. This initiative could be strengthened by focusing some of its technical assistance and training to enable community health

centers to meet the care and treatment needs of women living with or at risk for HIV.⁷⁴

2. *Investments in the Prevention and Public Health Fund must be allocated to prevention initiatives geared toward women*

The Prevention and Public Health Fund allocates billions of dollars to prevention initiatives and programs throughout the country. For example, grants funding HIV testing, linkage to care, and data collection for high-risk populations have been awarded to Alabama and Iowa, among other states.⁷⁵ Despite the potential for this initiative to improve HIV prevention, there have been numerous efforts in Congress to defund the Prevention and Public Health Fund. Most recently, the House of Representatives proposed to use the Fund as an offset for student loan interest rates.

Advocacy Targets:

FEDERAL

- Congress must protect the Prevention and Public Health Fund as a vital source of funding for a range of cost-effective initiatives that will greatly benefit women at risk for HIV and help to meet the prevention goals of the National HIV/AIDS Strategy.
- HHS should target funds to support HIV prevention and public health services aimed at women, including grants for community-based organizations and funding for studies and initiatives addressing stigma.

STATE

- Community-based organizations, health centers, and state health officials must be aware of federal funding opportunities under the Prevention and Public Health Fund and submit proposals that include women-specific initiatives.

3. *Health care professionals must be equipped to meet the care and treatment needs of women living with or at risk for HIV*

Thousands of women living with HIV will be entering public and private insurance systems in 2014, many for the first time. Health care providers must have the expertise to not only treat the medical needs of women living with HIV, but to also provide care in a culturally competent way that promotes trust. This expertise is particularly important given the

fact that women living with HIV, and transgender women in particular, often face stigma from health care professionals.⁷⁶ The ACA includes several initiatives that could provide this type of targeted training to providers that serve women living with HIV:

- Expansion of the National Health Service Corps, providing incentives to place health professionals in health professional shortage areas and to provide health care services in underserved areas in exchange for loan repayment and scholarships;⁷⁷
- Health Professional Opportunity Grants (HPOG), which provide funding for states to offer skilled health professional training programs to TANF recipients and other low-income individuals, and to work with community partners to provide support services such as transportation, dependent care, and temporary housing for participants;⁷⁸ and
- Capacity-building grants for primary care to strengthen the primary care workforce, with preference given to programs that provide training in the care of vulnerable populations, including people living with HIV.⁷⁹

Advocacy Targets:

FEDERAL

- Congress must preserve federal funding for important health workforce investments, particularly as proposals that will roll back ACA funding continue to be introduced.

STATE

- States, hospitals, and community-based organizations applying for health workforce grants must include training for providing integrated HIV and reproductive health care and treatment to women living with or at risk for HIV.
- Medical schools should work with the HIV community to ensure that medical school curricula includes cultural competence training as well as training on the new benefits mandates of the ACA.

FILLING THE GAPS: ENSURING THAT CARE, TREATMENT, AND SUPPORT SERVICES NEEDS ARE MET

Though the ACA offers unprecedented opportunities to expand access to care for millions of Americans, there will be gaps in covered services and affordability. Because of the federal government's move toward state flexibility, many of the geographic disparities with regard to benefits mandates and affordability will likely continue. For example, while research has demonstrated that women who receive Medicaid generally face fewer barriers to care than women who are uninsured, even for women who receive Medicaid, cost remains a barrier.⁸⁰ There will also be individuals who cannot access public or private insurance; one of the chief limitations in the Medicaid expansion provided through the ACA is that undocumented immigrants and legal immigrants within the five year ban will not be eligible for Medicaid coverage. Undocumented immigrants will also be barred from seeking coverage through exchanges. These gaps and limitations in the ACA mean that safety net programs – including the Ryan White Program – will need to be able to fill in these gaps and provide the vital services that will connect women to health care services and keep them in care. It is too early to consider any major changes to the Ryan White Program because many key implementation decisions that will determine the services that will be available under ACA-

related insurance expansion have not yet been made.

1. *The Ryan White Program must be able to exist effectively in a post health care reform world to ensure continued access to vital services, including those services needed to connect women to care and keep them healthy.*

The Ryan White Program is changing – and must change – as the health care system as a whole undergoes a major transformation over the next several years. Though it is too early to know the exact impact that many of the ACA provisions will have on access to HIV care (and thus too early to discuss any major transformations of the Ryan White Program), the HIV community has already started to think about how to ensure that the health care needs of women living with or at risk for HIV will be integrated into health care reform as well as the future role of the Ryan White Program.⁸¹ For example, advocates are working to ensure that the comprehensive support and linkage to care services that are the hallmark of Part D of the Ryan White Program (which provides family-

VITAL SERVICES FOR WOMEN THAT WILL LIKELY NOT BE FULLY COVERED THROUGH INSURANCE:

- Dental services
- Transportation
- Housing
- Nutrition services
- Legal services
- Peer support services
- Case management
- Child care services
- Domestic violence services
- Insurance assistance

centered services to 90,000 women and children living with and affected by HIV each year) are integrated into reforms. This is particularly important as Part D of the Ryan White Program is already facing significant changes on top of cuts in federal funding in recent years.⁸² Part D program grantees must “re-compete” for funding under different criteria that emphasize primary and clinical care in targeted areas of need.⁸³ While it is too early to evaluate the impact of the re-compete, coupled with a funding cut in the FY 2012 budget, it may result in an increased number of clinics that receive less funding than in previous years.⁸⁴

Advocacy Targets

FEDERAL

- HRSA and the HIV/AIDS Bureau in particular must ensure that the Ryan White Program continues to serve the needs of women living with or at risk for HIV, including the Ryan White funded services that are essential for women to access care and stay healthy, particularly those services that will likely not be fully covered by public and private insurance. HRSA recently solicited public comment on the 2013 reauthorization of the Ryan White Program,⁸⁵ and advocates are preparing written comments on the importance of these services in a post health care reform world. Massachusetts offers a successful model of the continued and vital role for the Ryan White Program in a reformed health care system where the vast majority of people living with HIV have public and private insurance.⁸⁶

MASSACHUSETTS: A POST HEALTH CARE REFORM STATE IN A PRE HEALTH CARE REFORM COUNTRY

- Majority of ADAP funds now go to insurance assistance (as opposed to full pay for medications)
- More Ryan White Program dollars are focused on early intervention and support services, enabling more people to access care and stay in care
- Between 2006 and 2009, HIV diagnoses in Massachusetts fell by 25% compared to a 2% national increase
- Cost per HIV-positive Medicaid beneficiary has gone down, particularly the amount spent on inpatient hospital care

- Congress and HRSA must ensure that the vital programs funded through Ryan White Part D continue to serve women and families living with and affected by HIV. Part D funded programs are essential to connecting women living with HIV to health care and social services and keeping them in care. Congress and the Administration must commit to preserving these successful models.

2. *The National HIV/AIDS Strategy must be updated and implemented in ways that address the care and treatment needs of women living with HIV.*

The National HIV/AIDS Strategy (NHAS) represents a milestone in HIV policy, setting specific goals for inter-agency collaboration, connecting people to care, addressing health disparities and reducing the number of new HIV infections.⁸⁷ However, the NHAS lacked specific goals and metrics that adequately incorporated the unique needs of women. Recently, the Presidential Advisory Council on HIV/AIDS (PACHA) passed a resolution recommending that the NHAS be updated to reflect more specific metrics and goals for women living with or at risk for HIV. These goals include important areas of overlap with the implementation of the ACA, including “mak[ing] quality and effective gender-sensitive care for women living with HIV more widely and readily available through the integration of HIV care and prevention services with sexual and reproductive health care and intimate partner violence prevention and counseling.”⁸⁸

Fulfilling NHAS goals for women can be accomplished only if the ACA is implemented in ways that meet the care and treatment needs of women living with or at risk for HIV, in conjunction with the Ryan White Program (as described above).

FEDERAL

- Realizing NHAS access to care, prevention, and health disparity goals will require that public, private, and civil society partners work together to fully meet three distinct, but inter-related, objectives: (1) fully implementing ACA reforms in ways that meet the care and treatment needs of women living with or at risk for HIV; (2) adequately supporting the ongoing Ryan White Program's ability to address gaps in core health and social services until successful integration of HIV care, treatment and service models into health reforms is demonstrated; and, (3) re-tooling the Ryan White Program to address outstanding gaps in coverage (e.g., vision and dental care, and transportation, child care, and case management services) and gaps in affordability

(associated with insurance premium and co-payment obligations), that will likely remain even after full implementation of the ACA.

STATE

- States also have a vital role to play in ensuring that the NHAS access to care, prevention and health disparity goals are met through full and effective implementation of the ACA as well as the Ryan White Program. Because of the degree to which implementation decisions are left to states, it is essential that state governments work closely with a diverse group of women (including advocates and providers working in HIV, health, public health, sexual and reproductive health, and domestic violence) to maximize the potential that the ACA and Ryan White Program are implemented in ways that meet the care, treatment, and prevention needs of women living with or at risk for HIV and address their health disparities.

CONCLUSION AND ONGOING CHALLENGES

The ACA offers unprecedented opportunities to expand access to care to thousands of uninsured and underinsured women living with or at risk for HIV, but ensuring that the ACA works for this population will take leadership and commitment from state and federal policymakers, HIV providers, and women living with HIV. As access to insurance is expanded, there are opportunities to shape what this coverage looks like by developing and expanding models of care that integrate reproductive health care and HIV services and that

incorporate support and care coordination services. Finally, ACA implementation is occurring against a backdrop of economic recession, a polarized political system, and increasing attacks on women's reproductive health care rights. This challenging environment makes it more important than ever that the statutory and regulatory provisions of the ACA are used to advocate for women's rights to health care coverage and systems that work for them.

APPENDIX A: MAJOR HEALTH CARE REFORM PROVISIONS AFFECTING WOMEN LIVING WITH HIV

2010

- States may amend their Medicaid state plans to provide family planning services to women who are not otherwise eligible for Medicaid
 - Pre-existing Condition Insurance Plans (PCIPs) for people with pre-existing conditions
 - Prohibition against rescissions in all private health insurance plans
 - Prohibition against lifetime benefit limits for all private health insurance plans
 - Prohibition and/or restrictions on annual benefit limits in all private health insurance plans[~]
 - \$250 Rebates for beneficiaries in the Medicare Part D coverage gap
 - Required coverage of preventive care and immunizations without cost sharing for all private health insurance plans*
 - Increased funding for community health centers by \$11 billion over the next 5 years
 - Creation of Prevention and Public Fund, which allocates \$750 million in FY 2011, increasing annually up to \$2 billion in FY 2015 and later
-

2011

- Medicaid Health Home program allows states to provide coordinated care through a health home for individuals with chronic conditions
 - Center for Medicare and Medicaid Innovation (CMMI) established to evaluate payment and service delivery models
 - All health insurance plans must cover preventive services without cost-sharing, including USPSTF A and B recommended services, as well as women's recommended preventive services (well-woman visits, STI counseling and screening, cancer screening, domestic violence screening, and contraception)
 - ADAP contributions can be used to assist Part D beneficiaries in meeting cost-sharing obligations and will count toward the beneficiary's true out-of-pocket deductible or copayment obligations (TrOOP)
 - 50% discount on brand-name drugs for Medicare beneficiaries who enter the Medicare Part D coverage gap
-

2012

- States must choose essential health benefits benchmark plan for private insurance plans sold through exchanges
-

2013

- Exchange blueprints must be certified by HHS
 - Open enrollment for exchanges begins
-

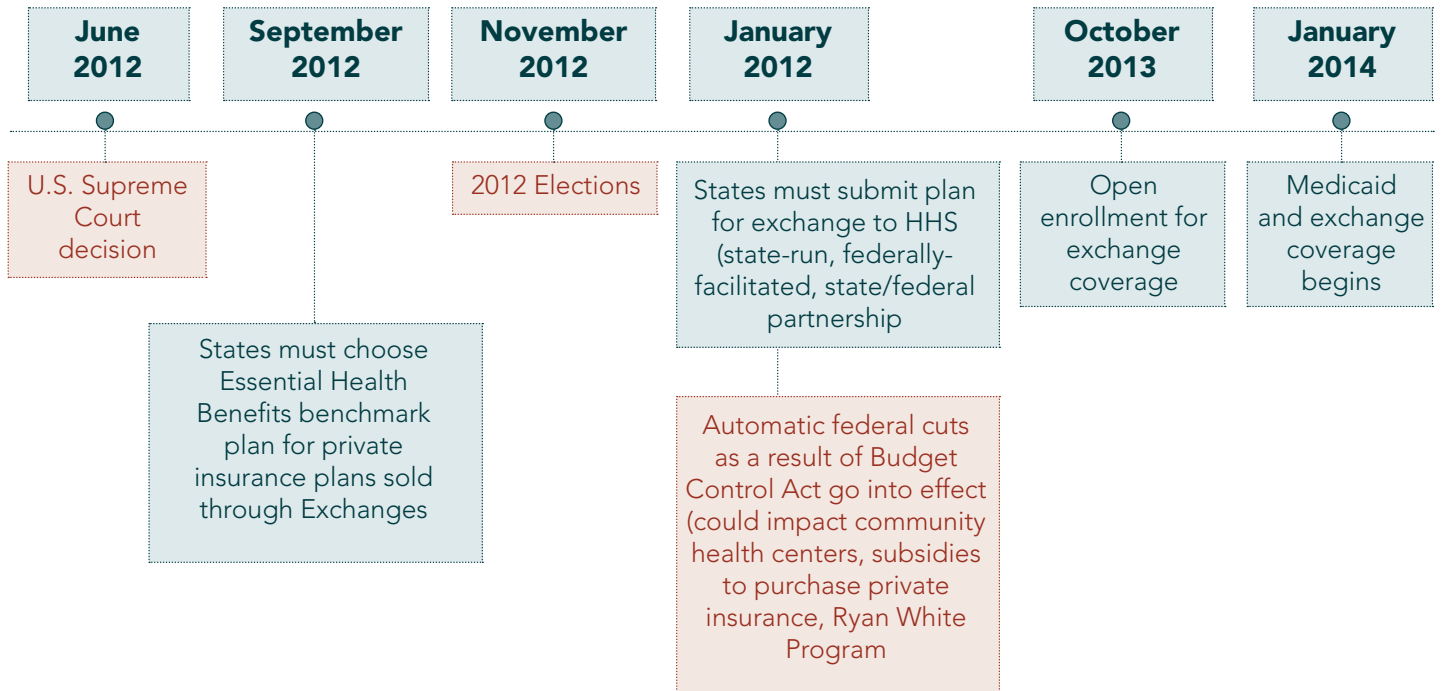
2014

- Medicaid eliminates categorical eligibility and expands coverage to all those with income up to 133% of the federal poverty level (FPL) (about \$14,800/year for an individual and \$30,000/year for a family of four) with increased federal funding to pay for newly-eligible beneficiaries
- Qualified health plans offered through state exchanges as well as Medicaid benefits packages for newly-eligible beneficiaries must include "essential health benefits," to be defined by the Secretary of Health and Human Services*
- Prohibition on pre-existing condition exclusions for all private health insurance plans (starts in 2010 for children)[~]
- Prohibition on discrimination based on health status for all private health insurance plans[~]
- Premiums charged by health insurance issuer for new coverage offered in individual or small-group markets and exchanges may only vary by whether an individual or family is covered; the geographic rating area; age; and tobacco use*
- Guaranteed availability of coverage from insurance carriers selling health plans in individual and group markets and exchanges*
- Premium tax credits and cost sharing subsidies for people with income up to 400% FPL to purchase insurance through exchanges
- Eventual elimination of Medicare Part D coverage gap by 2020

* Does not apply to grandfathered plans (defined broadly as a group health plan or group or individual health insurance coverage in which individuals were enrolled on March 23, 2010).⁸⁹

[~] Applicable to grandfathered group health plans, but does not apply to grandfathered individual health insurance coverage.

APPENDIX B: ACA IMPLEMENTATION TIMELINE



Federal regulations still to come:
 Medicaid reimbursement
 Essential Health Benefits (exchanges AND Medicaid)
 PCIP transition
 Basic Health Program

APPENDIX C: MEDICAID BENEFITS AND ACA MANDATES

Traditional Medicaid programs include a set of mandatory services, which every state must provide, and a set of optional services, which states have the choice to provide. Section 1937 of the Social Security Act allows states to offer Medicaid beneficiaries a benefits package based on the private insurance market, however there are a number of mandated benefits that must be included if a state chooses to offer a benchmark Medicaid package. The ACA includes additional benefits mandates, requiring that benchmark plans include the ten categories of “Essential Health Benefits” described in §1302 of the ACA (the same set of ten categories required for private plans sold through exchanges).⁹⁰

TRADITIONAL MEDICAID SERVICES		ACA MANDATED CATEGORIES
Mandatory Services⁹¹	Optional Services	Essential Health Benefits⁹²
Inpatient hospital services	Prescription drugs	Ambulatory patient services
Outpatient hospital services	Clinic services	Emergency services
EPSDT	Physical therapy & rehab.	Hospitalization
Nursing facility services	Dental services	Maternity and newborn care
Home health services (if elig. for nursing home care)	Podiatry services	Mental health and substance use disorder services (including behavioral health treatment)
Physician services	Optometry services, glasses	Prescription drugs
RHCs and FQHCs	Primary care case mngmt.	Rehabilitative and habilitative services and devices
Lab and x-ray services	ICF/MR services	Laboratory services
Family planning	Home health care services	Preventive and wellness services & chronic disease management
Nurse midwife services	Personal care services	Pediatric services, including oral and vision care
Transportation	Hospice services	
	Chiropractic services	
	Other diagnostic, screening, preventive & rehab. services	

Comparison of Section 1937 Benchmark Mandates with the ACA Non-Discrimination Mandates	
§1937 Benchmark Mandated Benefits	The ACA Non-Discrimination Mandates
Prescription drugs	In defining the EHB, the Secretary is directed to “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”
Mental health services	
Family planning services	
Non-emergency transportation	
EPSDT	The Secretary is also directed to “take into account the health care needs of diverse segments of the population, including women, children, [and] persons with disabilities.”
Inpatient and outpatient hospital services	
Physicians’ surgical and medical services	
Laboratory and x-ray services	Finally, the Secretary is directed to “ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted-disability.”
Well-baby and well-child care	
Emergency services	
Benchmark and benchmark equivalent benefits packages must ensure access to rural and federally qualified health centers and maintain same prospective payment system rate	



(ENDNOTES)

- 1 Centers for Disease Control and Prevention (CDC), "HIV among Women," August 2011, at <http://www.cdc.gov/hiv/topics/women/pdf/women.pdf>.
- 2 For example, in New York City from 2005 to 2009, 95% of the new HIV diagnoses among transgender persons were transgender women, (with 90% of transgendered persons newly infected with HIV being people of color (black or Hispanic)). CDC, "HIV among Transgendered People," August 2011, at <http://www.cdc.gov/HIV/transgender/pdf/transgender.pdf>; See also Jeffrey H. Herbst, et al., "Estimating HIV Prevalence and Risk Behaviors Among Transgendered Persons in the United States: A Systematic Review," *AIDS Behav.*; 2008; 12(1):1-17 (finding higher rates of HIV infection among African American transgendered women).
- 3 Samuel A. Bozzette, et al., "The Care of HIV-Infected Adults in the United States," *New England J. of Medicine*, 1998; 339(26), 1897-1904 at: <http://www.nejm.org/doi/full/10.1056/NEJM199812243392606> (finding that 64% of women in medical care had incomes below \$10,000, compared to 41% of men); Lucy Bradley-Springer, "Women and HIV Infection," *J. of the Association of Nurses in AIDS Care*, 2007; 19(1): 1-2 (finding that women with HIV were more likely to be living in poverty than men living with HIV); Mark A. Schuster, et al., "HIV-Infected Parents and their Children in the United States," *American J. of Public Health*, 2000; 90(7): 1074-1081, at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446301/pdf/10897185.pdf> (finding that 60% of women (in care) had children under 18 years of age, while 76% of those women had their children living with them); National Women's Law Center (NWLC), "Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act," March 2012, at http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf (finding for example, that in states that still allow gender-rating, 92% of the best-selling plans charge 40-year old women higher premiums than men; and that the practice of gender-rating costs women approximately \$1 billion per year); Martin F. Shapiro et al., "Variations in the Care of HIV-Infected Adults in the United States," *J. of the American Medical Association*, 1999; 281 (24): 2805-2815 (finding that women were less likely than men to have accessed combination therapy and had more hospitalizations and emergency room visits); L.R. Hirschhorn et al., "Gender Differences in Quality of HIV Care in Ryan White CARE Act-Funded Clinics," *Women's Health Issues*, 2006; 16(3):104-112 (finding that women are less likely than men to receive HAART, PCP prophylaxis, or know their Hepatitis C status despite being seen more regularly); see also John A. Fleishman, et al., "Hospital and Outpatient Health Services Utilization Among HIV-Infected Adults in Care 2000-2002," *Medical Care*, 2005; 43(9)(Supp.)(finding that women had higher rates of hospitalization and outpatient visits than men); Susan Reif, Kathryn Whetten, and Elena Wilson, Duke Center for Health Policy and Inequalities Research, Southern HIV/AIDS Strategy Initiative, "HIV/AIDS Epidemic in the South Reaches Crisis Proportions in Last Decade," December 2011, at <http://globalhealth.duke.edu/news/2011/ResearchReportFinal3-12.pdf> (finding that the South and the Northeast had the highest proportion of HIV infections and the highest rates of new HIV infections among women; and noting that in general the South has the highest HIV-related death rates and the highest level of HIV morbidity among people living with HIV/AIDS); See generally, Kaiser Family Foundation, "Women and HIV in the United States," March 2012, at <http://www.kff.org/hiv/aids/upload/6092-10.pdf>.
- 4 National Organization for Women, "Violence Against Women in the United States: Statistics," at <http://www.now.org/issues/violence/stats.html>; Seth C. Kalichman, et al., "Sexual Coercion, Domestic Violence, and Negotiating Condom Use Among Low-Income African American Women," *J. of Women's Health*, 1998; 7(3): 371-378 at <http://online.liebertpub.com/doi/pdf/10.1089/jwh.1998.7.371>; Black AIDS Institute, "Getting Real: Black Women Taking Charge in the Fight Against AIDS," December 2005, at http://www.blackaids.org/docs/12_05_women.pdf. Domestic violence rates among HIV-positive women may also be even greater: for example, Medical AIDS Outreach of Alabama in Montgomery initiated a study that included focus groups to examine the impact of intimate partner violence on women living with HIV. However, when they attempted to put together a control group of HIV-positive women who had not been impacted by intimate partner violence, they were unable to find a single client. Phone interview with Dr. Laurie Dill, Medical Director, Medical AIDS Outreach of Alabama, May 8, 2012.
- 5 For instance, studies have shown that women infected with HIV are at increased risk for a range of gynecological problems, including vaginitis, genital herpes, genital condylomata, pelvic inflammatory disease (PID), and lower genital tract dysplasia and neoplasia. Monique A. Tello, et al., "HIV Women's Health: A Study of Gynecological Healthcare Service Utilization in a U.S. Urban Clinic Population," *J. of Women's Health*, 2008; 17: 1609-2614 (citing multiple studies).
- 6 Jen Kates, Kaiser Family Foundation, "Medicaid and HIV: A National Analysis," October 2011, at <http://www.kff.org/hiv/aids/upload/8218.pdf> (Medicaid data as of FY 2007); Kaiser Family Foundation, "Women and HIV/AIDS in the United States," July 2007, at <http://www.kff.org/hiv/aids/upload/6092-04.pdf>.
- 7 The most common Medicaid eligibility pathway for people living with HIV is disability (approximately 74% of enrollees with HIV). Because women with HIV are more likely to be caretakers of young children (and therefore may qualify under the parent category), women living with HIV are more likely to be covered by Medicaid than men, and make up 43% of persons on HIV with Medicaid, despite making up just 25% of the epidemic overall. Jen Kates, Kaiser Family Foundation, "Medicaid and HIV: A National Analysis," October 2011, at <http://www.kff.org/hiv/aids/upload/8218.pdf> (Medicaid data as of FY 2007).
- 8 Kaiser Family Foundation. *Fact Sheet: Women and HIV/AIDS in the United States*, at 2. March 2012
- 9 *Id.*
- 10 The Patient Protection and Affordable Care Act (PPACA), § 2001(a)(1); In March 2012, the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) also issued implementation regulations, 42 CFR Parts 431, 435, and 457. Most provisions of the March 2012 Medicaid rule are final with several provisions released as interim final and out for further comment. The text of the final and interim final provisions can be found at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/html/2012-6560.htm>.
- 11 The federal government will cover 100% of the costs for those people who are newly eligible for Medicaid in the years 2014 to 2016. Starting in 2017, federal funding for newly eligible beneficiaries will vary by state until 2019, after which the matching rate will be 90% for this population. PPACA, §2001(a)(3). Overall, the government will cover nearly 93% of the costs of the expansion over the next nine years, with state costs expected to increase only by about 2.8% from what they would have otherwise spent on Medicaid. The 2.8% increase may also be an over-estimate, since this number does not reflect any of the savings states will experience from the decrease in money spent on uninsured individuals. January Angeles and Matthew Broaddus, Center on Budget and Policy Priorities, "Federal Government Will Pick Up Nearly All Costs of Health Reform's Medicaid Expansion," revised March 28, 2012, at <http://www.cbpp.org/files/4-20-10health2.pdf>.
- 12 National Federation of Independent Business v. Sebelius, 567 U.S. ____ (2012), Case No: 11-393 at 51.
- 13 Scott Hensley, "Medicaid Expansion: Who's In? Who's Out?," National Public Radio courtesy of Center for American Progress, July 5, 2012 at <http://www.npr.org/blogs/health/2012/07/05/156312388/medicaid-expansion-whos-in-whos-out>.
- 14 This percentage represents the mean national average of clients moving from Ryan White Program AIDS Drug Assistance Programs (ADAP) onto Medicaid, as estimated by the "State Health Reform Impact Modeling Project: Estimating the Transition of People Living with HIV to Medicaid and Subsidized Private Health Insurance through Affordable Care Act Reforms," a paper being developed by the Center for Health Law and Policy Innovation at Harvard Law School and the Treatment Access Expansion Project. The individual percentages in each state vary greatly, ranging from 1.2% to 80.1%. These estimates also require a number of assumptions and caveats as described more fully in the Estimates. In addition, applying this percentage to women further assumes that the percentages of women and men currently in

- ADAP who will be newly Medicaid eligible are equal, which may not be the case given that the ADAP program currently serves more men than women, and that women may be more likely than men to be already eligible for Medicaid. As with the mean national average, there are also varying numbers of women on ADAP programs in each state. Overall, this estimate includes only those people living with HIV/AIDS who are being served by ADAP, and is not an estimate of the total number of people moving from the Ryan White Program as a whole. Harvard Law School Center for Health Law and Policy Innovation, State Health Reform Impact Modeling Project: Estimating the Transition of People Living with HIV to Medicaid and Subsidized Private Health Insurance through Affordable Care Act Reforms (2012) (publication forthcoming). 42 U.S.C. § 1396u-7.
- 15
16 Benchmark options under §1937 are: Federal Employee Health Benefits Program (FEHB)-equivalent health insurance coverage (the standard Blue Cross/Blue Shield preferred provider option service benefit plan); state employee coverage; coverage offered through the HMO with the largest commercial, non-Medicaid enrollment; or secretary-approved coverage (any other health benefits coverage that the Secretary determines, upon application by a state, provides appropriate coverage for the population proposed to be provided such coverage). A state may also provide benchmark-equivalent coverage that is actuarially equivalent to one of the three specified benchmark plans.
- 17 Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011, http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. (One difference between the benchmark options for Medicaid described in § 1937 of the Social Security Act and the benchmark options described in the HHS bulletin is that in the latter, states have the option of choosing one of the three largest small group plans as the benchmark).
- 18 All non-grandfathered, private health plans and Medicaid benchmark plans for newly eligible beneficiaries will be required to cover preventive services given an A or B rating by the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Provisions (ACIP), and additional preventive services for women as recommended by the Health Resources and Service Administration (HRSA) without any cost-sharing (including well-woman visits, contraception, and domestic violence screening). PPACA, §2713; 45 CFR §147.130; CMS, "Frequently Asked Questions on Essential Health Benefits," February 2012, at <http://ccio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>. While states are incentivized to cover the recommended services from USPSTF and ACIP without cost-sharing in their Medicaid plans for existing beneficiaries (through a 1% increase in federal matching rates,) it is not a requirement. PPACA, § 4106.
- 19 CMS, "Frequently Asked Questions on Essential Health Benefits," February 2012, at <http://ccio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.
- 20 There are no specific provisions in federal Medicaid law that address coverage of gender-confirming care for transgender persons (such as hormone therapy or sexual reassignment surgery). However, some state laws explicitly prohibit these services for transgendered individuals, while other states make case by case determinations based on medical necessity. Some advocates argue that denial of services such as hormones or breast augmentation for transgendered people when Medicaid otherwise provides these services for non-transgendered persons (for example, post-cancer treatment) is a violation of federal law. See Dean Spade, "Medicaid Policy & Gender-Confirming Healthcare for Trans People: An Interview with Advocate," *Transgender Issues and the Law*, 2010. These arguments can be strengthened by the additional non-discrimination language included in the ACA, particularly in regards to health exchange entities and Qualified Health Plans (QHPs), which are explicitly forbidden from discrimination on the basis of gender or gender identity.
- 21 Susan Reif, Kathryn Whetten, and Elena Wilson, Duke Center for Health Policy and Inequalities Research, Southern HIV/AIDS Strategy Initiative, "HIV/AIDS Epidemic in the South Reaches Crisis Proportions in Last Decade," December 2011, at <http://globalhealth.duke.edu/news/2011/ResearchReportFinal3-12.pdf>.
- 22 See note 11.
- 23 Kathleen E. Squires, et al., "Health Needs of HIV-Infected Women in the United States: Insights from the Women Living Positive Survey," *AIDS Patient Care and STDs*, 2011; 25(5):279-285, at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3085953/> (finding that of HIV-positive women in the survey who wanted additional support beyond their health care providers, African-American women and Hispanic women relied more on support groups, while Caucasian women primarily identified therapists).
- 24 CMS, State Medicaid Director Letter, August 15, 2007, at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>.
- 25 More information on the WORLD peer support program can be found at WORLD, Peer Advocacy, <http://www.womenhiv.org/peer-advocacy/>.
- 26 In New York, domestic violence risk assessment is a standard of practice within counseling, testing, referral and partner notification services. New York State Department of Health, "Protocol - Domestic Violence Screening in Relation to HIV Counseling, Testing, Referral & Partner Notification," at <http://www.health.ny.gov/nysdoh/rfa/hiv/protocol.htm>; see also New York State Department of Health, "Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral & Partner Notification" at <http://www.health.ny.gov/nysdoh/rfa/hiv/guide.htm>.
- 27 Medicaid reimbursement rates have historically been much lower than Medicare and private insurance rates, acting as a barrier to provider participation and ultimately to access to care and treatment. See e.g. Peter J. Cunningham & Jessica H. May, Center for Studying Health System Change, "Medicaid Patients Increasingly Concentrated among Physicians," *Tracking Report No. 16, August 2006*, at <http://hschange.org/CONTENT/866/?topic=topic09#note7>. As a temporary solution, from 2013 through 2014 the Affordable Care Act (ACA) increases rates paid to primary care physicians in Medicaid up to the same levels as Medicare, with the federal government paying the cost of this increase. See PPACA, §1202(a)-(b); CMS has also recently issued proposed implementation regulations, 42 CFR Parts 438, 441, and 447, "Medicaid Program; Payments for Services Furnished by Certain Primary Care Physicians and Charges for Vaccine Administration Under the Vaccines for Children Program," May 9, 2012, at http://www.ofr.gov/OFRUpload/OFRData/2012-11421_PI.pdf. In the long-term however, it will be essential to advocate for higher reimbursement rates to ensure access to an adequate number of providers for all people on Medicaid.
- 28 For example, through a grant from the Access to Care initiative from AIDS United, Medical AIDS Outreach of Alabama has recently initiated a telemedicine project that has helped bring access to HIV specialty care to people with HIV living in some of the most rural parts of Alabama. In this model, persons in rural areas can go to their local hospital or health provider and then connect over electronic video to a specialist. Being able to connect to an HIV specialist in a local community clinic that is not otherwise known as an "HIV" clinic is also important, as stigma is still pervasive in many rural areas. For more information, see AIDS United Access to Care Grants, at http://www.aidsunited.org/uploads/SIF_grantee_descriptions.pdf?phpMyAdmin=dOP3-9mnuBqPcdmFxbidE2aA-wb.
- 29 PPACA, § 2303. This provision also allows states to provide the new family planning eligibility group a period of presumptive eligibility based on preliminary information that an individual meets the eligibility criteria.
- 30 CMS, State Medicaid Director Letter, "Family Planning Services Option and New Benefit Rules for Benchmark Plans," July 2, 2010, at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf>.
- 31 While all states cover HIV screening when medically necessary, only about half of state Medicaid programs cover routine HIV screenings. See Kaiser Family Foundation, "State Medicaid Coverage of Routine HIV Screening," March 2012, at <http://www.kff.org/hiv/aids/upload/8286.pdf>.
- 32 Kaiser Family Foundation, "State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings," November 2009, at http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf.
- 33 42 U.S.C. 1396n, 42 U.S.C. 1396a (§§1902(a)(23) and 1915(b) of the Social Security Act).
- 34 Guttmacher Institute, "State Policies in Brief: Medicaid Family Planning Eligibility Expansions," May 2012, at <http://www.guttmacher.org/>

- statecenter/spibs/spib_SMFPE.pdf.
- 35 CMS quickly responded that the Texas plan violated the freedom of choice requirement in Medicaid and that if the state wanted to pursue this course of action, it would have to forgo federal funding; Texas decided to forgo federal funding and the family planning Medicaid waiver is expected to end within the next several months. Emily Ramshaw and Thanh Tan, "Feds to Halt Funding for Women's Health Program," *The Texas Tribune*, March 15, 2012, at <http://www.texastribune.org/texas-health-resources/abortion-texas/feds-halt-funding-womens-health-program/>.
- 36 PPACA, §2201, 45 CFR §435.907.
- 37 The way that income is calculated to determine if a person is eligible for Medicaid will change for most people in 2014 when income eligibility will be based on "Modified Adjusted Gross Income" (MAGI). The biggest change from the way that income eligibility is currently determined is that the new formula will no longer require an asset test. Receipt of child support will not be considered as income under MAGI, a change from current Medicaid standards. In addition, states will no longer be allowed to use "income disregards" to discount certain income. This was a strategy many states employed to make it easier for people to meet the income eligibility requirements for the program. There is also 5% across-the-board disregard of income, making the effective eligibility threshold for newly eligible beneficiaries 138% FPL. As a result of the new MAGI rules, some people may lose eligibility, although certain groups will be exempt from MAGI. Additional guidance is expected on how states should convert some of their existing populations to MAGI equivalent standards. PPACA, § 2002, 45 CFR §435.603. See also, Kaiser Family Foundation, "Explaining Health Care Reform: The New Rules for Determining Income Under Medicaid in 2014," June 2011, <http://www.kff.org/healthreform/upload/8194.pdf>.
- 38 Pamela Farley Short, et al., "The Commonwealth Fund, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," November 2003, at http://www.commonwealthfund.org/usr_doc/Short_churn_688.pdf.
- 39 M. Preau et al., "Health-Related Quality of Life and Patient-Provider Relationships in HIV-infected Patients During the First Three Years After Starting PI-Containing Antiretroviral Treatment," *16 AIDS Care* 649, 653 (2004).
- 40 Elena Losina, et al., "Racial and Gender Disparities in Life Expectancy Losses Among HIV-infected Persons in the United States: Impact of Risk Behavior, Late Initiation and Early Discontinuation of Antiretroviral Therapy," *Clinical Infectious Disease*, 2009; 49(10):1570-78, at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2783631/?tool=pubmed>.
- 41 PPACA, § 1331. Massachusetts recently completed a cost-benefit analysis of implementing the Basic Health Plan and appears to be ready to move forward with implementing legislation. For example, the state found that creating a Basic Health plan run by the state Medicaid office will help ensure continuity of care for individuals between 133 and 200% FPL, the population that often experiences the most churning, and will be more cost-effective for the state. The state Medicaid office is expected to seek approval from the state legislature to exercise this option later this summer. Massachusetts Executive Office of Health and Human Services, Briefing on Basic Health Plan Option, May 3, 2012, at <http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/stakeholder-meetings/previous-quarterly-stakeholder-meetings.html>.
- 42 45 CFR § 435.603(h).
- 43 45 CFR § 435.956.
- 44 42 U.S.C. § 1396u-2(c).
- 45 PPACA, § 3014.
- 46 HHS, "Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults," 77 Fed. Reg. No. 2, January, 4, 2012, at <http://www.gpo.gov/fdsys/pkg/FR-2012-01-04/pdf/2011-33756.pdf>. At the state level, Medicaid managed care plans are required to monitor quality measures and there is some variation as to the types of measures states have required plans to use (many use national performance measures like HEDIS and the Consumer Assessment of Health Care Providers and Systems and others develop state-specific quality measures). Contracts that states require Medicaid managed care plans to abide by must include requirements around plan monitoring of quality measures. 42 U.S.C. § 1396u-2(c). Advocates should ensure that these contracts include measures on proposed quality measures, asking that CMS include measures that reflect the women's health care experience (e.g., reproductive health measures).
- 47 CMS, "Proposed Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals," at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/Eligible-Providers-2014-Proposed-EHR-Incentive-Program-CQM.pdf>. See also, Health Resources and Services Administration (HRSA), National Quality Measures Clearinghouse, at <http://www.qualitymeasures.ahrq.gov/search/search.aspx?term=intimate+partner+violence>, for some examples of quality measures that look at screenings and follow up for intimate partner violence.
- 48 Michael Horberg, et al., "Development of National and Multiagency HIV Care Quality Measures," *Clinical Infectious Diseases*, 2010; 51(6): 732-38.
- 49 Kathleen E. Squires, et al., "Health Needs of HIV-Infected Women in the United States: Insights from the Women Living Positive Survey," *AIDS Patient Care and STDs*, 2011; 25(5):279-285, at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3085953/>; Elise D. Riley, et al., "Poverty, Unstable Housing, and HIV Infection Among Women Living in the United States," *Current HIV/AIDS Reports*, 2007; 4(4):181-186; W.E. Cunningham, et al., "The Impact of Competing Subsistence Needs and Barriers on Access to Medical Care for Persons with Human Immunodeficiency Virus Receiving Care in the United States," *Medical Care*, 1999; 37(12): 1270-1281.
- 50 PPACA, § 2703; CMS, State Medicaid Director Letter, "Health Homes for Enrollees With Chronic Conditions," November 16, 2011, at <https://www.cms.gov/smdl/downloads/SMD10024.pdf>.
- 51 Center for Health Care Strategies, "State-by-State Health Home State Plan Amendment Matrix: Summary Overview as of December 1, 2011, at http://www.chcs.org/usr_doc/State_by_State_HH_SPA_matrix_120511.pdf.
- 52 The White House, "Presidential Memorandum-Establishing a Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-related Health Disparities," March 30, 2012, at <http://www.whitehouse.gov/the-press-office/2012/03/30/presidential-memorandum-establishing-working-group-intersection-hivaids->.
- 53 New York State Department of Health, "Provider Qualification Standards for Chronic Medical and Behavioral Health Patient Populations," at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm
- 54 Lisa Codispoti, Brigitte Courtot, & Jen Swedish, "Nowhere to Turn: How the Individual Health Insurance Market Fails Women," *National Women's Law Center*, at 3 (2008).
- 55 Id.
- 56 The ACA also requires insurance plans to spend the majority of consumer premium dollars (80% for small group plans and 85% for large group plans) on direct medical services and quality improvement, and to refund the difference back to consumers if these standards are not met. See <http://www.healthcare.gov/news/factsheets/2010/06/aca-new-patients-bill-of-rights.html>. Some policy analysts estimate that because of these requirements, called medical loss ratios, insurance plans will have to refund over \$1.3 billion to business and consumers by August 2012. Kaiser Family Foundation, "Insurer Rebates Under the Medical Loss Ratio," April 2012, at <http://www.kff.org/healthreform/upload/8305.pdf>.
- 57 Susan A. Cohen, "Abortion and Women of Color: The Bigger Picture," *Guttmacher Policy Review*, 2009; 11:3 at <http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html>; Jessica Arons and Lucy Panza, "Women of Color Benefit from Contraceptive Coverage in Employer Plans," *Huffington Post*, February 29, 2012, available at http://www.huffingtonpost.com/jessica-aron/women-of-color-benefit-from-contraceptive-coverage_b_1307549.html; Vanessa Cullins, "Why Birth Control With No Co-Pay Will Help African American Women," *Huffington Post*, August 4, 2011, available at: http://www.huffingtonpost.com/vanessa-cullins/why-free-birth-control-wi_1_b_916702.html.
- 58 PPACA, §§ 2713, 2719(A)(d); 45 CFR §147.130; The specific guidelines adopted by the Health Resources and Services Administration (HRSA) can be found at: <http://www.hrsa.gov/womensguidelines/>; See also NWLC, "Access to Preventive Health Care for Women Under the New Health Care Law, Frequently Asked Questions," March 2012, at <http://www.nwlc.org/resource/access-preventive-health-care-women-new-health-care-law-frequently-asked-questions>. The guidelines do not

apply to grandfathered plans (defined broadly as a group health plan or group or individual health insurance coverage in which individuals were enrolled on March 23, 2010), however, most health plans will likely lose this status by 2014. Id.

59 This percentage represents the mean national average of clients currently on ADAPs who will be eligible for insurance subsidies in 2014, as estimated by the "State Health Reform Impact Modeling Project: Estimating the Transition of People Living with HIV to Medicaid and Subsidized Private Health Insurance through Affordable Care Act Reforms," a paper being developed by the Center for Health Law and Policy Innovation at Harvard Law School and the Treatment Access Expansion Project. The individual percentages in each state vary greatly, ranging from .5% to 47%. These estimates also require a number of assumptions and caveats as described more fully in the paper. In addition, applying this percentage to women further assumes that the percentages of women and men currently in ADAP who will be eligible for insurance subsidies are equal, which may not be the case given that the ADAP program currently serves more men than women, and that women may be more likely than men to be already eligible for Medicaid. As with the mean national average, there are also varying numbers of women on ADAP programs in each state. Overall, this estimate includes only those people living with HIV/AIDS who are being served by ADAP, and is not an estimate of the total number of people moving from the Ryan White Program as a whole. Harvard Law School Center for Health Law and Policy Innovation, State Health Reform Impact Modeling Project: Estimating the Transition of People Living with HIV to Medicaid and Subsidized Private Health Insurance through Affordable Care Act Reforms (2012) (publication forthcoming).

60 45 CFR Parts 155, 156, and 157. Most provisions of the March 2012 exchange rule are final with several provisions released as interim final and out for further comment. The text of the final and interim final provisions can be found at, <http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf>.

61 In addition, the ACA allows states to cover abortion through QHPs sold through exchanges, however (as is the case under current law) no federal funds may be used to subsidize abortion coverage. PPACA, § 1303. States will also still have the option of covering abortions through their Medicaid programs, as long as this coverage is funded with only state money.

62 Center on Budget and Policy Priorities, "Status of State Health Insurance Exchange Implementation," May 1, 2012, at <http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf>. To help with the costs of creating an exchange, millions of federal dollars in planning grants have been made available to states, and additional money has been made available through early innovator grants (to develop IT infrastructure to support the new exchanges) and establishment grants. All states except Alaska received these grants, although six states have announced that they will return all or some of this money (Louisiana, Wisconsin, Kansas, Florida, Oklahoma and New Hampshire). Id.

63 45 CFR §155.130.

64 PPACA, § 1302.

65 Center for Consumer Information and Insurance Oversight, "Essential Health Benefits Bulletin," December 16, 2011, at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. (One difference between the Medicaid benchmark options described in § 1937 of the Social Security Act and the benchmark options described in the HHS bulletin is that in the latter, states have the option of choosing one of the three largest small groups plans as the benchmark).

66 Following a highly politicized public debate about the ACA's requirement that health plans provide insurance coverage for women's contraceptives without cost sharing, HHS published a rule proposing keeping in place the requirement that women have access to contraceptives without cost sharing, but provided an exemption for certain religious institutions. However, interim regulations also allow additional non-exempt religious organizations who object to the requirement on moral grounds to opt out of actually paying or directly providing these services. In the latter case, insurance companies would have to cover the cost of contraceptives. "Certain Preventive Services Under the Affordable Care Act," Federal Register Vol. 77, No. 55 (March 21, 2012), at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-21/pdf/2012-6689.pdf>. The controversy over this particular ACA provision highlights

a larger debate over the scope of religious and moral objections to provision of a range of vital health services. For instance, although ultimately defeated in the U.S. Senate, "the Blunt amendment" introduced by Senator Roy Blunt (R-MO) would have greatly expanded the ability of insurance plans and providers to avoid compliance with benefits and coverage requirements under the ACA based on a religious or moral objection. Respect for Rights of Conscience Act of 2011, HR1179/ S1813 (112th Congress) (amending the ACA to prevent the imposition of benefit/coverage mandates that violate the religious or moral convictions of health insurance plans and providers).

67 Fatima Morales, et al., Community Health Councils, Inc., "Designing the Navigator System for California's Health Benefits Exchange (Draft)," January 2012, at <http://www.healthexchange.ca.gov/BoardMeetings/Documents/2.%20CHC%20-%20Designing%20the%20Navigator%20System%20for%20CA's%20Exchange%20Jan%202012.pdf>. In addition to trainings for navigators, advocates should also urge states to require that information on these resources be readily available for women to access on their own. For example, states could require that community resource packets and/or brochures be available at all navigation sites, and that internet links to these resources be made visible during the web-based application process.

68 For example, existing peer supports with experience reaching women with HIV, such as those established by Women Organized to Respond to Life-Threatening Disease (WORLD), could be certified as navigators. "Peer Advocacy," at <http://www.womenhiv.org/programs/peer-advocacy>.

69 For advocacy resources on how to ensure that consumer assistance programs are able to serve low-income and vulnerable populations see Families USA, Consumer Assistance Programs Resource Center, at <http://www.familiesusa.org/resources/resources-for-consumers/consumer-assistance-programs-resource-center/>.

70 45 CFR § 155.120(c).

71 In addition, over 90% of community health centers provide multiple primary and preventive care services on site, including health education, pap tests, family planning, HIV testing and counseling, mental health and substance abuse care, and gynecologic care.

Peter Shin, et al., Geiger/Gibson RCHN Community Health Foundation Research Collaborative, "Role of Community Health Centers in Providing Services to Low-income Women," March 14, 2012, at http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_09822648-5056-9D20-3DF35D4E2F822F28.pdf.

72 For example, there are many overlapping goals and requirements between FQHCs and Title X family planning clinics that offer additional opportunities for integration of sexual and reproductive health care into primary care systems. See, e.g., Rachel Benson Gold, et al., Geiger/Gibson RCHN Community Health Foundation Research Collaborative, "A Natural Fit: Collaborations Between Community Health Centers and Family Planning Clinics," October 2011, at: http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_13AFEE26-5056-9D20-3D3479861216C7E4.pdf.

73 Choices, at <http://memphischoices.org/about.asp#History>; Phone interview with Jennifer Marshall, Assistant Director, Choices, May 9, 2012.

74 HealthHIV, National Center for HIV Care in Minority Communities, at <http://www.aidsetc.org/aidsetc?page=ab-01-07>; See also, "HIV Screening and Women's Health," December 2007, at <http://www.aidsetc.org/aidsetc?page=etres-display&resource=etres-350> (a model curriculum for providing HIV education and screening of women in family planning clinics).

75 For information on the Prevention and Public Health Fund in individual states, see "The Affordable Care Act's Prevention and Public Health Fund in Your State," February, 2012, at <http://www.healthcare.gov/news/factsheets/2011/02/prevention/ia.html>.

76 For example, one study found that 19% of transgendered persons reported being refused medical care due to their transgender or gender non-conforming status; 28% postponed care when they were sick or injured because of discrimination, and 50% reported having to educate their medical providers about transgender care. Such discrimination can be the result of multiple, inter-connected factors such as HIV status, race, culture, poverty, sex, sexual orientation, and gender identity. Jaime M. Grant, et al., "Injustice at Every Turn, A Report of the Transgender Discrimination Survey," February 3,

- 2011 at http://www.thetaskforce.org/reports_and_research/ntds. See also Lambda Legal, "When HealthCare Isn't Caring: Low-Income or Uninsured LGBT People and People Living with HIV, Results From Lambda Legal's Healthcare Fairness Survey," 2009, at http://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-insert_low-income-or-uninsured.pdf.
- 77 PPACA, § 5207.
- 78 The Department of Health and Human Services, Health Profession Opportunity Grants, at http://www.hhs.gov/news/press/2010pres/09d/state_charts.html.
- 79 PPACA, § 5301.
- 80 States can impose cost-sharing requirements and other service utilization limitations on Medicaid services such as emergency room visits and prescription drugs. Kaiser Family Foundation, "Medicaid's Role for Women Across the Lifespan: Current Issues and the Impact of the Affordable Care Act," January 2012, at <http://www.kff.org/womenshealth/upload/7213-03.pdf>.
- 81 For example, over the past year, Christie's Place in California (a service provider for HIV positive women partially funded through Ryan White Part A) reached out to educate community health centers and other local providers about the overlap between many of the standards used to certify Patient Centered Medical Homes (PCMHs) by the National Committee on Quality Assurance (NCQA) and the family-centered, peer-oriented services Christie's Place had developed through its CHANGE (Coordinated HIV Assistance and Navigation for Growth and Empowerment) for Women program. Through CHANGE for Women, Christie's Place worked to develop collaborative agreements with local community health centers and other HIV and women's health providers throughout San Diego County. While health centers and other medical providers offer clinical care, in turn Christie's Place and CHANGE for Women provide integral services such as behavioral health, patient navigation, peer case work, and family-centered care to ensure that access to clinical treatment translates to better health outcomes for HIV-positive women. While it took time and effort to develop these trusting relationships, the San Diego County HIV community's resulting network of coordinated, holistic care for women living with HIV now mirrors the requirements that have been adopted as the gold standard of the PCMH movement. Through these evolving, collaborative relationships, the community is now prepared to meet the challenges and opportunities offered by the ACA's emphasis on PCMHs and investments in FQHCs, while still retaining the model of whole-person care that is the hallmark of the Ryan White Program. Phone interview with Elizabeth Brosnan, Executive Director, Christie's Place, May 10, 2012, Christie's Place, at <http://www.christiesplace.org/index.html>.
- 82 AIDS Alliance for Children Youth and Families, "Ryan White Program Part D," March 2012, at <http://www.aids-alliance.org/policy/aids-alliance-ryan-white-part-d-2012-advocacy-fact-sheet.pdf>.
- 83 To read the new grant application, see Health Resources and Services Administration (HRSA), at <https://grants.hrsa.gov/webExternal/FundingOppDetails.asp?FundingCycleId=6348BECF-77C6-4632-871F-587F62F174B6&ViewMode=EU&GoBack=&PrintMode=&OnlineAvailabilityFlag=&pageNumber=&version=&NC=&Popup>.
- 84 The President's Budget reflected a \$7 million decrease from FY11 levels, a decrease that correlates with the amount of funding previously set aside for prevention programs that exclusively target adolescents. While in some ways the re-compete encourages Part D programs to serve the broader population of women, infants, children and youth through more integrated clinical care, as health care reform implementation moves forward, advocates will need to educate Congress and federal agencies about the importance of both integrated clinical care and maintaining the vital family-centered services provided by the Part D program in order to ensure that increased access to coverage actually results in positive health outcomes for women. For example, despite the high rates of poverty among HIV-positive women and the resulting cost-sharing difficulties they may experience post-health care reform, the Part D Program is the only Ryan White part that is not permitted to utilize funds for cost-sharing in insurance coverage. Conversation with Carole Treston, Executive Director, AIDS Alliance for Children Youth and Families, May 8, 2012.
- 85 Health Resources and Services Administration, "Ryan White HIV/AIDS Program Reauthorization," <http://hab.hrsa.gov/reauthorization/>.
- 86 Center for Health Law and Policy Innovation of Harvard Law School, "Massachusetts HIV/AIDS Resource Allocation Project (Working Paper)," December 2011, at <http://www.taepusa.org/Portals/0/Documents/Massachusetts%20HIV%20AIDS%20Resource%20Allocation%20Project%20Dec.%202011.pdf>.
- 87 National HIV/AIDS Strategy, available at: <http://www.aids.gov/federal-resources/policies/national-hiv-aids-strategy/>.
- 88 The Presidential Advisory Council on HIV/AIDS, "Resolution on the Needs of Women At Risk for and Living with HIV," May 17, 2012.
- 89 PPACA, § 1251(b). HHS issued a regulation on June 28, 2010 clarifying the PPACA's application to grandfathered plans. For example, actions that will cause a plan to lose grandfathered status include: significantly reducing benefits; significantly raising co-insurance charges, co-payment charges, or deductibles; and significantly lowering employer contributions. 45 CFR §147.140; 29 CFR § 2590.715-1251; 26 CFR § 54.9815-1251T.
- 90 PPACA, § 2001(a)(2).
- 91 42 CFR § 440.1, et seq.
- 92 PPACA, § 1302(b).

30 FOR 30 MEMBER ORGANIZATIONS

The Afiya Center HIV Prevention & Sexual Reproductive Justice, African Services Committee, AIDS Alabama, AIDS Alliance for Children Youth & Families, AIDS Foundation of Chicago, AIDS United, Bailey House, Campaign to End AIDS (C2EA), Center for Health and Gender Equity (CHANGE), Center for HIV Law and Policy (CHLP), Community Healthcare Network, HIV Law Project, HIV Prevention Justice Alliance, Housing Works, International Community of Women Living with HIV/AIDS (ICW), IRIS Center, Memphis Center for Reproductive Health, National AIDS Housing Coalition (NAHC), National Alliance of State and Territorial AIDS Directors (NASTAD); National Black Leadership Commission on AIDS, Inc. (NBLCA), National Black Women's HIV/AIDS Network (NBWHAN), National Health Law Program (NHeLP), National Network to End Domestic Violence (NNEDV), National Women and AIDS Collective (NWAC), Sisterlove Inc., SMART University, South Carolina HIV/AIDS Council, Southern HIV/AIDS Strategy Initiative (SASI), U.S. Positive Women's Network (PWN), The Well Project, The Women's Collective, Women Organized to Respond to Life-threatening Diseases (WORLD), Women with a Vision

WHO WE ARE:

The 30 for 30 Campaign is dedicated to ensuring that the unique needs of women living with and affected by HIV, including transgender women, are addressed in the national HIV response. We are especially committed to illuminating and eliminating the gaps in prevention and care services for Black and Latina women who currently make up over 80% of the epidemic among women.

CAMPAIGN CONTACT INFO:

For more information please visit our Facebook page at www.facebook.com/30for30, or email us at 30for30Campaign@gmail.com

