Challenges to Enhanced Reliance on Third Party Reimbursement for HIV Testing in the District of Columbia

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BACKGROUND

- Until recently, the costs of HIV testing have largely been covered by the CDC, departments of health, and local clinics and organizations.
- This resource climate however is changing due to Affordable Care Act (ACA) provisions through which health care coverage has been expanded and third party payers are now required or incentivized to cover many preventive services including HIV testing.
- In DC, the Department of Health (DOH) has provided strong categorical support for testing through grant funding and free rapid test kits. Through new funding opportunities, DOH is incentivizing sites to seek third party reimbursement (TPR).

OBJECTIVES

- To explore how primary care clinics in DC are making a transition from categorical support to TPR for HIV testing and associated barriers and facilitators.

METHODS

- Relied on an implementation science framework to guide this single case study's exploration of the funding transition.
- Used purposeful sampling to identify key informants and their organizational affiliations.
- Utilized an embedded case study design that incorporated 3 sub-units of analysis including:
  - DC government representatives n = 5
  - TPR stakeholders n = 5
  - DOH-supported primary care providers n =18
- Selected 4 clinics based on following criteria:
  - Number of clinic patients
  - Availability of dedicated resources for HIV testing
  - Testing models and their implications for billing and reimbursement.
- Used Atlas.ti 7.0 software for content analysis

RESULTS

Barriers Related to Receipt of Third Party Reimbursement	
Technology	Rapid testing results in more challenges to TPR than conventional testing incorporated into a clinical standard of care
Categorical Funding	Clinics indicated inability to bill for free rapid testing from DC DOH (double dipping)
Limited Reimbursement	Testing resulted in reimbursement between $0.00 – $16.80 and did not cover staffing and counseling
Staffing Model	TPR typically does not cover testing conducted by non-credentialed staff

Third Party Reimbursement Barriers by Payer Type	
Medicaid FQHC	o Flat encounter rate resulting in no additional revenue - disincentive for clinics to use preferred testing technology o No process in place through Dept. of Health Care Finance (DHCF) to request a Change in Scope to receive an enhanced rate
Medicaid Non-FQHC	o Bundled rates resulting in no additional revenue
DC Alliance	o Flat encounter rate o No coverage determination for routine testing
Medicare	o Flat encounter rate o No coverage determination for routine testing *(policy changed after interviews)*
Private	o Variance in what plans will cover, minimal ability to negotiate, limited transparency o Bundled rates

RESULTS

Resource Constraint Barriers	
Categorical Funding	Decline in categorical support resulting in decreased testing or increased reliance on general operating funds
Revenue Portfolio	Variation in the diversity of revenue streams; shift from strong reliance on grants and contracts to a growing reliance on TPR
TPR Infrastructure and Staffing	Short history of TPR, few insurance plans accepted, limited staff for billing

Organizational Support Barriers	
Leadership	Variation in degree of awareness of testing program and importance to organizational mission; reliance on staff champions at all clinics
Adaptability to Change	Variation in commitment for identification of alternative resources to support testing

Communication Barriers	
DOH and Clinics	o Clinics had desire for stronger support related to TPR implementation o DOH perception that clinics could do more to incorporate routine testing as part of standard of care
DHCF, DOH and Clinics	o Limited communication
Medicaid Managed Care Organizations (MCO) and Clinics	o Clinics indicated limited ability to negotiate contracts o Proprietary nature of contracts made it difficult for transparency

RECOMMENDATIONS

Policy Recommendations for DHCF	
Local review of DC FQHCs to assess current encounter rate	o Develop process for requesting a Change in Scope to increase encounter rate o Explore adoption of Alternative Payment Methodology that could incentivize and reward outcomes rather than reimbursement by encounter
Enhance requirements for DC Medicaid MCOs	o Increase underlying primary care visit rate for bundled plans o Improve transparency of TPR methodology
Adopt Centers for Medicare and Medicaid Services (CMS) policy allowing Medicaid fee for service coverage by non-credentialed providers	o Develop a State Plan Amendment (SPA) to allow coverage for non-credentialed providers o Require Medicaid MCOs to align their policies to updated SPA

Programmatic Recommendations	
Expand DOH's support to facilitate TPR of HIV testing	o Request more support from CDC and other technical providers o Partner with DHCF to adopt CMS policy
Strengthen communication between stakeholders	o Improve communication between DOH, DHCF, clinics, and MCOs
Clinic assessment of TPR and HIV testing strategies	o Implement a Revenue Cycle Group that conducts an ongoing assessment of current revenue streams, TPR infrastructure and capacity, and changes resulting from ACA o Assess best way to incorporate testing as a standard of care

CONCLUSIONS

- Clinics face numerous challenges as they transition from strong DC DOH support for HIV testing to a stronger reliance on TPR.
- The engagement of DHCF, DC DOH and clinics in the adoption of various policy and programmatic recommendations could mitigate current challenges and facilitate a stronger reliance on TPR moving forward.

LIMITATIONS

- Small sample size
- Limited ability to uncover contractual reasons for when payment for testing is separated out and when it is bundled with other services
- Limited generalizability

STRENGTHS

- Highlighted different perspectives and operational issues through the triangulation of data from different sources of evidence and across stakeholders
- Serves as an illustrative case study with implications for other jurisdictions, other preventive services, and reimbursement models and reform options

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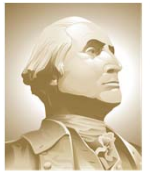

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