Year 2 of the AIDS Drug Assistance Program transition to Affordable Care Act Qualified Health Plans in a Medicaid Nonexpansion State: ACA still showing positive effects on HIV viral suppression

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Background
With the Affordable Care Act, many state AIDS Drug Assistance Programs (ADAPs) are shifting their healthcare delivery model from direct medication provision (Direct ADAP) to purchasing Affordable Care Act (ACA) marketplace qualified health plans (QHPs). The Medicaid nonexpansion state of Virginia is the ideal state to study this shift in healthcare delivery because they have had a coordinated statewide plan since the first ACA enrollment in 2014. Moreover, during the 2014 ACA enrollment period, Virginia ADAP clients accounted for 2% of ADAP clients nationwide but they represented 17% of ADAP clients with QHP coverage nationwide and 56% of ADAP clients with QHP coverage in southern states.

Objectives
- To characterize the demographic and healthcare delivery factors associated with Virginia ADAP clients’ Year 2-QHP enrollment
- To assess the relationship between Virginia ADAP clients’ QHP coverage and HIV viral suppression.

Methods
The cohort included people living with HIV who were enrolled in Virginia ADAP. Data were collected from January 1, 2013 through December 31, 2014.

Four nested populations of interest were assessed in the study (see Figure 1):
- Cohort A: the largest group, all PLWH who were 18 to 64 years old on January 1, 2014, were ADAP clients by July 1, 2014, did not have Medicare, and had a Social Security Number
- Cohort B: members of Cohort A who demonstrated consistent engagement in care, as defined by at least one HIV VL recorded in 2014 and at least one between July 1, 2015 and December 31, 2015
- Cohort B2: members of Cohort B with 2015 QHP coverage
- Cohort C: members of Cohort B who had an initial detectable VL in 2013, indicating sub-optimally controlled HIV disease

Multivariable binary logistic regression was conducted to assess for associations with QHP enrollment and between QHP coverage and viral load suppression.

Results: QHP Enrollment
For year 2, 63% of Cohort A (n = 4,631) enrolled in QHPs compared with 47.1% of Year 1. Table 1 presents adjusted odds ratios for the association between QHP enrollment and patient and healthcare delivery characteristics.

Results: Achieving Good Virologic Outcomes
For Cohort B (n = 2,501), 66.8% were enrolled in QHPs and the remaining program-encouraged ART through Direct ADAP. In Cohort B, ADAP clients with QHP coverage had a higher rate of good virologic outcomes at 85.3% compared to 79.9% for those who remained on Direct ADAP.

Table 2 presents the percent of participants with viral suppression calculated for each demographic and healthcare delivery factor group. Table 3 also presents adjusted odds ratios for the associations with maintaining or achieving HIV viral suppression.

Results: Achieving New Viral Suppression
For Cohort C (n = 601), multivariate logistic regression was conducted to assess the associations with newly achieving HIV viral suppression, shown in Table 4. It also presents the percent of participants with viral suppression calculated for each demographic and healthcare delivery factor group.

Results: Poor Virologic Outcome Despite QHP Coverage
For Cohort B2 (n = 1,674), multivariate logistic regression was conducted to assess the associations, with poor virologic outcome, having viral detection, despite QHP coverage, shown in Table 5. It also presents the percent of participants with viral detection in each demographic and healthcare delivery factor group.

Conclusions
- QHP enrollment increased compared to year 1, but still varied significantly based on demographic and healthcare delivery factors, including a strong association with 2014 ADAP-funded QHP coverage.
- QHP coverage was associated with viral suppression, an essential outcome for individuals and for public health. However, the association between QHP coverage and good virologic outcomes did not persist for those who started with a detectable HIV VL in 2014.
- For Year 2, Region was newly associated with QHP enrollment, good virologic outcomes, and poor virologic outcomes despite QHP coverage. Future studies will need to assess the modifiable reasons why region affects QHP enrollment and achieving optimal HIV outcomes.
- Promoting QHP coverage in clinics that provide care to people living with HIV may offer an opportunity to increase rates of viral suppression. In addition, programs to promote engagement in care for those who fail to achieve viral suppression despite QHP coverage are essential.

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