

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID MANAGED CARE AND
HIV/AIDS**



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EXECUTIVE SUMMARY

PURPOSE

This inspection describes how some States address the treatment of persons with HIV/AIDS in Medicaid managed care.

BACKGROUND

Several factors currently affect both Medicaid financing and the treatment of Medicaid patients with HIV/AIDS. These factors include the devolution of Medicaid control from Federal to State authority, the continued expansion of managed care, the changing faces of HIV/AIDS, and new drugs to treat HIV/AIDS. We surveyed all States to examine the extent of managed care coverage of Medicaid beneficiaries with HIV/AIDS. We also visited six States operating various managed care models to observe how these States address concerns of persons with HIV/AIDS in Medicaid managed care.

FINDINGS

The Medicaid managed care organizations that are paid an AIDS-enhanced rate appear to provide all needed medical services and drugs to AIDS patients. Those not paid an enhanced rate report that they can not afford to continue providing these services and drugs without adequate financial compensation.

According to our survey of State Medicaid directors, 4 of the 37 States paying capitated managed care rates adjust the rates for providing care to persons with AIDS; none pay an HIV risk-adjusted rate. We visited Medicaid managed care organizations (MCOs) in these four States and in two other States and found that for the most part, they appear to provide comprehensive medical services and necessary drugs to enrollees with AIDS.

The MCOs we visited which are not paid an AIDS-adjusted rate are negotiating with their States to receive one so that they can continue to afford to provide these services and drugs. In the absence of an enhanced rate, MCOs risk a major financial loss if they attract an inordinate number of AIDS patients by advertising their inclusion of known HIV specialists.

In the States we visited, the Medicaid managed care and Ryan White programs do not coordinate the services they provide to persons with HIV/AIDS. The health of persons with HIV/AIDS is increasingly dependent upon the integration of these services.

In States we visited, Medicaid managed care respondents indicated that their States are not engaged in any efforts to involve Ryan White programs in the transition to managed care or to ensure coordination between the two programs. Medicaid beneficiaries with HIV/AIDS often depend on Ryan White providers for medical and ancillary services vital to their medical well-being. Respondents stressed the rising importance of these services in light of the changing demographics of the HIV/AIDS population. The HIV/AIDS population is increasingly comprised of low-income persons facing a host of social and environmental challenges which complicate their ability to access and comply with health maintenance routines.

RECOMMENDATIONS

The Health Care Financing Administration, in consultation with the Health Resources and Services Administration, should develop and disseminate technical assistance and guidance on strategies State Medicaid programs can use to establish appropriate managed care contracts for needed medical services and costs related to these services for beneficiaries with HIV and AIDS.

There is a lack of consensus among State Medicaid and plan administrators regarding what services Medicaid MCOs are responsible to provide to persons with HIV and AIDS, and how they are to be compensated for the costs of these services. Even in the four States which pay an AIDS-adjusted rate, State Medicaid and MCO administrators come to the negotiating table with widely divergent ideas about appropriate AIDS rates to cover the costs of the care they provide.

The Health Care Financing Administration (HCFA) in consultation with the Health Resources and Services Administration (HRSA) should develop a guidance document for the States regarding treatment of beneficiaries with HIV and AIDS in Medicaid managed care which includes the following information: the services to be potentially provided by Medicaid for persons with HIV and AIDS, based on the national guidelines on HIV care being developed by the Department; estimates of the costs of these services; and options on how to cover these costs in a Medicaid managed care program. Recognizing State variation, this information would provide States with a starting point to establish contracts with the MCOs requiring the provision of necessary medical care to HIV/AIDS beneficiaries in return for adequate compensation.

The Health Care Financing Administration should urge States to require Medicaid managed care plans to coordinate with Ryan White programs on the services they provide to Medicaid beneficiaries with HIV/AIDS. The Health Resources and Services Administration should continue to encourage Ryan White grantees to work with Medicaid managed care plans. Together, these agencies should work to develop strategies of coordination for Medicaid managed care and the Ryan White programs.

In the best interests of HIV/AIDS patients, MCOs and Ryan White agencies, it is essential that parties rendering services to HIV/AIDS patients coordinate these

services with comprehensive care for the patients in mind. Ryan White funds fill service gaps where no insurance or other funding streams exist to pay for care. Ryan White providers and MCOs serving the same patients must coordinate to prevent duplicating services and wasting scarce health care resources.

The State Medicaid agencies and Medicaid MCOs need to advise Ryan White grantees of the services they provide to HIV/AIDS patients. With this information, Ryan White eligible metropolitan areas and consortia will be able to assess the HIV/AIDS community's needs more accurately, and consequently be able to deliver services more rationally. Overlapping of services can be reduced and MCO capitation rates can more accurately represent the costs of services they provide.

Through coordination, MCOs and Ryan White providers can provide seamless care to patients with HIV and AIDS, addressing all their varied health needs. By coordinating with providers of services such as HIV counseling, HIV education and nutritional counseling, MCOs can better meet their prevention and health maintenance missions.

AGENCY COMMENTS

The Assistant Secretary for Planning and Evaluation (ASPE), HCFA and HRSA provided comments to the draft report. While all concurred with the report's findings and recommendations, they offered suggestions for clarifying the report and making other technical changes. Where appropriate, we changed the report to reflect their comments.

The HCFA felt that providing States with aggregate HIV/AIDS cost data would not be useful because of the wide variations in costs and felt it inappropriate that they develop model contract MCO language for State Medicaid agencies.

We feel that HCFA's current cost data complements other Departmental data on the costs of providing services to persons with HIV/AIDS. In terms of model Medicaid MCO contract language, this work is already underway and is funded by the Department. Presuming that States can use the model language that is suited to their distinctive Medicaid programs, we urge HCFA to work with HRSA to disseminate this information to States when completed.

The HRSA suggested that through HCFA, States be required to pay enhanced rates to Medicaid providers and MCOs with significant HIV/AIDS patients and States require Medicaid MCOs to contract with Ryan White agencies. With respect to financing additional costs, there are a variety of options to cover the cost of HIV/AIDS care. Paying an enhanced rate is one possible approach to ensure this.

We recommend that HCFA and HRSA jointly provide information States can use to make informed judgments on how best to reimburse MCOs equitably for services to HIV/AIDS patients. We do not agree that Medicaid MCOs be required to contract with Ryan White agencies. While in some locales, MCOs already contract with Ryan

White providers to furnish needed services to HIV/AIDS patients, Medicaid MCOs should not be required to duplicate services they can already provide. We recommend that Medicaid MCOs coordinate service delivery with Ryan White providers to avoid duplication and ensure comprehensive care.

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INTRODUCTION

PURPOSE

This inspection describes how some States address the treatment of persons with HIV/AIDS in Medicaid managed care.

BACKGROUND

Medicaid provides health and long term care services to low-income Americans. In 1995, Medicaid provided health care benefits to approximately 36 million Americans (more than 1 in 10), costing an estimated \$156.3 billion. The Federal Government provides matching funds to States to administer the program under Federal guidelines.

Nearly half of the persons living with AIDS rely on Medicaid for their health care. The Human Rights Campaign estimates that approximately 104,000 persons with HIV and AIDS receive Medicaid benefits. For children with HIV/AIDS, Medicaid provides 90 percent of their total health care costs. In fiscal year (FY) 1997, Medicaid spent an estimated \$3.3 billion for HIV/AIDS treatments.

Medicare expenditures on persons with AIDS increased from an estimated \$800 million for approximately 28,000 AIDS patients in 1994 to an estimated \$1.3 billion for FY 1997 for approximately 36,000 AIDS patients. The rise of Medicare expenditures for AIDS is a result of more people with AIDS becoming eligible for Medicare and the longer lifespans resulting from new therapies to treat AIDS.

Medicaid financing and treatment of Medicaid patients with HIV/AIDS has been profoundly affected by several factors, including: the devolution of Medicaid control, the continued expansion of managed care, the changing faces of HIV/AIDS, and new drugs to treat HIV/AIDS.

- The devolution of Medicaid control from Federal to State authority is marked by the proliferation of Medicaid waivers, allowing States to experiment with managed care service delivery. The Balanced Budget Act of 1997 eliminates the need for Federal waiver approval of managed care for States.¹ As a result, States may proceed more quickly with expanding Medicaid managed care.
- Increasingly, States are transforming their Medicaid programs from fee-for-service payment arrangements into capitated managed care programs. Currently, all States, with the exceptions of Alaska and Wyoming, have implemented managed care programs for all or segments of their Medicaid populations. For example, many States mandate managed care for beneficiaries who receive Medicaid because of their entitlement to Supplemental Security Income (SSI) benefits.² (People with AIDS on

Medicaid are typically eligible for Medicaid through the SSI program.) As of June 30, 1996, 13 million Medicaid beneficiaries (40 percent of all enrollees) were in managed care plans.

- As we documented in our earlier inspection, "The Ryan White Care Act: Local Implementation Issues" (OEI-05-93-00336), increasing numbers of women, children, heterosexuals and intravenous drug users are contracting HIV. These new groups present multiple service delivery problems for providers. In some locations, transmission of HIV now occurs more frequently from intravenous drug users sharing contaminated needles than from men having sex with men, as the disease was historically spread. This change complicates treatment, as this type of client may be less likely to comply with a treatment regimen.
- New drug treatments have been effective in treating HIV/AIDS. For most of those who stay on the drug regimen, powerful protease inhibitors have been shown to delay the onset of full-blown AIDS and mitigate other symptoms by increasing immune system resistance. These drugs can reduce the amount of virus in the blood to undetectable levels for some patients. Protease inhibitors are typically prescribed in combination with other drugs. However, these therapies are costly - up to \$12,000 a year for these drugs alone, not counting supplemental drugs and other tests and treatments. If viral load testing and other monitoring is included, costs can approach \$15,000 annually.

The intersection of these events presents a markedly different health care landscape for State Medicaid agencies, the Health Care Financing Administration (HCFA), the Health Resources Service Administration (HRSA) managed care plans, health care providers, Ryan White agencies and persons living with HIV/AIDS.

Types of Medicaid Managed Care

Managed care aims to reduce unnecessary services, lower health care costs and increase access to services. At one type of managed care plan - a health maintenance organization (HMO), "gatekeepers" direct patients only to needed care, usually within the managed care plan. Other types of managed care plans - Prepaid Health Plans and Health Insurance Organizations - are similar to HMOs. For the purpose of this evaluation, these types of managed care organizations will be treated like HMOs. The State pays HMOs a fixed capitated rate per member to provide health care to Medicaid members. The HMOs do not submit individual claims for payment for services rendered to the State. Roughly 75 percent of Medicaid recipients in managed care belong to HMO-type plans.

In a second type of managed care, called Primary Care Case Management (PCCM) an individual or group of providers act as a gatekeeper. The PCCMs serve as medical homes for their patients and refer patients to other providers when necessary. Medicaid reimburses them a fixed amount per patient for case management services

only. The physicians acting as PCCMs bill Medicaid on a fee-for-service basis for all medical care they provide.

Managed Care and HIV/AIDS

Currently, not all Medicaid patients with HIV/AIDS are enrolled in managed care plans. Some State Medicaid managed care contracts specifically exclude or "carve out" HIV/AIDS patients and others with chronic disabilities.

However, some Medicaid managed care plans include HIV/AIDS patients, and more States are looking to control medical costs for their most expensive Medicaid enrollees. Prior to the enactment of the Balanced Budget Act, HCFA approved 18 Statewide demonstration projects, 10 of which require enrolling all HIV/AIDS patients when fully implemented. Another 19 States received managed care waivers that include some or all HIV/AIDS patients.

In addition to specific State Medicaid waivers, the Ryan White program sponsors some demonstration programs, called Special Projects of National Significance (SPNS). Six SPNS projects test new methods to deliver HIV/AIDS care. Two SPNS managed care projects are in Los Angeles with one each in Boston, Baltimore, North Carolina and New York.

Ryan White Activities

In 1990, Congress passed the Ryan White Act as a comprehensive response to the HIV epidemic and its impact on individuals, families, communities, cities, and States. The Ryan White programs, which Congress has reauthorized through 2000, aim to provide health care and support services to persons with HIV/AIDS who would otherwise not have access to care. Unlike Medicare and Medicaid where individuals are specifically entitled to benefits, the Ryan White Act's four titles and Part F direct resources to various entities and allow grantees maximum flexibility in the use of funds, particularly at the local level.

- Title I provides emergency relief grants to eligible metropolitan areas (EMAs) disproportionately affected by the HIV epidemic. Grants are for HIV-related outpatient and ambulatory health and support services, including case management and comprehensive treatment services.
- Title II provides grants to States to improve the quality, availability and organization of health care and support services for individuals and families with HIV disease. Title II funds service delivery systems which provide essential services throughout the complex course of HIV disease including the AIDS Drug Assistance Program, which provides pharmaceutical treatments to persons living with HIV/AIDS.

States may establish HIV care consortia in areas most directly affected by the disease. Consortia are community-based, coordinated, continuums of care to which all persons with HIV/AIDS would have access. These continuums of care are intended to close existing gaps in services, coordinate health and support services, build community infrastructure and service networks with an emphasis on integration of expanded community resources, and provide continuity of care through case management.

- Title III supports early intervention services, including counseling, testing, referrals, clinical and diagnostic services, and therapeutic services. It provides grants to private non-profit organizations and public migrant, community, and homeless health centers, hemophilia centers, and federally-qualified health centers.
- Title IV aims to improve and expand comprehensive care services and increase access to research for children, youth, women and families who are infected with or affected by HIV/AIDS. Title IV grantees provide or coordinate a wide range of services, including prevention and education activities, primary medical care, psychosocial services, substance abuse treatment, housing, child welfare, and legal advocacy.
- Part F funds the SPNS programs, the HIV/AIDS Dental Reimbursement Program and AIDS Education and Training Centers.

Concerns About Medicaid Managed Care and HIV/AIDS

Including persons with HIV/AIDS in Medicaid managed care can be controversial. Many persons with HIV/AIDS are concerned that Medicaid managed care will disrupt the networks of medical care and social service providers established over recent years. Some of their specific concerns follow.

- Managed care plans may not include providers experienced in treating HIV/AIDS. These plans may also delay or deny the specialty care and medications that HIV/AIDS patients need.
- Managed care plans may exclude essential community providers and Ryan White agencies from their care networks.
- In capitated plans, capitation rates may be inadequate to provide all necessary HIV/AIDS services, drugs and testing.
- States and managed care plans might not include people with special health care needs in planning the move from fee-for-service Medicaid to managed care. The Balanced Budget Act does not require States to solicit or consider input from people with special health care needs as they make the transition to Medicaid managed care.

SCOPE AND METHODOLOGY

We surveyed all State Medicaid directors³ to examine the extent of managed care coverage of Medicaid beneficiaries with HIV/AIDS. To describe how some States address concerns of persons with HIV/AIDS in Medicaid managed care programs, we conducted site visits in six States operating various managed care models under HCFA-approved waivers - California, Georgia, Maryland, Massachusetts, Oregon and Utah. These States were selected to represent a mix of geographic locations, HIV/AIDS prevalence rates and approaches to serving persons with HIV/AIDS through managed care. We also purposely selected the four States which pay the Medicaid managed care organizations (MCOs)⁴ AIDS-adjusted capitation rates in order to examine delivery of care under an enhanced rate. Our State survey and site visits occurred in May, June and July 1997.⁵

In each of these six States we examined: the rates paid to contracted MCOs for serving persons with HIV/AIDS, access to care, quality of care and coordination between the Medicaid managed care and Ryan White programs. To examine these issues, we interviewed representatives of the State Medicaid managed care offices, representatives of the State Offices of AIDS, administrators of contracted MCOs serving beneficiaries with AIDS, representatives of the Ryan White EMAs and/or consortium, managed care physicians who treat beneficiaries with AIDS, local AIDS advocacy groups, and beneficiaries with AIDS enrolled in Medicaid managed care.

We questioned these individuals about State Medicaid payments to MCOs for beneficiaries with AIDS, delivery of certain AIDS services and drugs, the ability to access these services and drugs, oversight of the quality of care delivered by the MCOs to this population, and the existence of coordination activities between the MCOs and Ryan White agencies and providers. With an eye to content applicable to persons with HIV/AIDS, we also examined these States' waivers, their contracts with MCOs and informational materials MCOs provide to consumers.

We limited this inspection to a description of the delivery of care to persons with HIV/AIDS enrolled in Medicaid managed care. We did not compare the cost or quality of treatment of persons with HIV/AIDS in Medicaid managed care programs to that in fee-for-service Medicaid. We did not identify or establish a definitive standard of treatment of persons with HIV/AIDS in Medicaid managed care. We did not conduct any medical review of records of HIV/AIDS patients.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

The Medicaid managed care organizations that are paid an AIDS-enhanced rate appear to provide all needed medical services and drugs to AIDS patients. Those not paid an enhanced capitation rate report that they can not afford to continue providing these services and drugs without adequate financial compensation.

According to our survey of State Medicaid directors, 33 of the 37 States that pay capitated managed care rates do not adjust the rates for providing care to persons with AIDS. Only California (in certain counties), Maryland, Massachusetts and Utah pay contracted managed care organizations an adjusted capitation rate for providing care to enrollees with AIDS.⁶ No State adjusts the capitation rate they pay MCOs for serving persons who are HIV-positive but not AIDS-symptomatic.⁷

We visited the four States which pay an AIDS-adjusted rate to examine their delivery of AIDS care. We also examined the delivery of AIDS care in the absence of an AIDS-adjusted rate in one county in California and in Oregon and Georgia. However, Georgia is primarily a PCCM State and therefore uses fee-for-service reimbursement rather than capitation. (Appendices A and B provide more detail on the States and MCOs we visited.)

In every State we visited, physicians, MCO administrators and AIDS advocates emphasized the relationship between the rates received to care for persons with HIV⁸ and AIDS and the managed care organization's ability to provide comprehensive, quality care to these enrollees. According to these respondents, plans which are paid HIV and AIDS rates are more likely to ensure that HIV and AIDS patients have access to the services they need and HIV experienced doctors.

Plans not paid an adjusted rate for serving patients with AIDS risk financial loss by enrolling these patients. Hence, they have an incentive to avoid enrolling these patients. For example, MCOs can deter the enrollment of persons with AIDS by not including HIV specialists in their network or not advertising their inclusion of these providers. Managed care organizations likewise have a financial disincentive to determine which of their members have HIV and provide services and drugs to them.

Respondents representing the plans we visited in San Francisco and Oregon which were not paid an AIDS-adjusted capitation rate at the time of our study indicated that the capitation rates are a disincentive for them to enroll people with AIDS. These respondents said that while they provide all the necessary services and drugs for their HIV and AIDS enrollees, they would not be able to continue to provide these services and drugs and survive financially without an AIDS-adjusted rate. Both plans were aggressively seeking an AIDS-adjusted rate from their State Medicaid offices. (Subsequent to our study, the San Francisco MCO we visited began receiving an AIDS-enhanced capitation rate.)

Almost half of Oregon's Medicaid beneficiaries with AIDS are enrolled in CareOregon. CareOregon includes reputed HIV specialists in its provider network and publicizes this inclusion in its consumer materials. These efforts by the plan, despite the lack of any enhanced capitation, to meet the needs of the Medicaid AIDS population leave CareOregon at a financial disadvantage in comparison to its competitors. CareOregon estimates losing between \$750 and \$1,200 monthly for each of their AIDS patients.

Cost Estimates for AIDS and HIV Care

The absence of a consensus on the cost of AIDS treatment impedes the ability of States and MCOs to agree on an appropriate AIDS-adjusted capitation rate. Physicians and plan administrators we spoke with reported estimates between \$800 and \$3000 for the average monthly cost of providing all drugs and services to an AIDS patient.

States typically base capitation rates on fee-for-service expenditures for a given Medicaid population. However, using estimated fee-for-service expenditures to determine an appropriate capitation rate for treating persons with AIDS and HIV is problematic; there is a significant time lag between the collection and use of fee-for-service expenditure data. Much of the available data precedes the new and expensive therapies now being used. State Medicaid and managed care administrators reported a lack of current information on the potential costs of treating persons with HIV and AIDS through managed care programs.

The emergence of combination drug therapy in the past few years dramatically altered the costs of treating AIDS. The cost of the new drug therapy is estimated between \$10,000 and \$15,000 a year. In some cases, total treatment costs decline when an AIDS patient commences drug therapy because the need for more expensive treatment and inpatient care is reduced. In other cases, less effective drug therapy results in the need for more expensive care. Respondents repeatedly emphasized the unpredictability of current treatments and their effects on long-term costs.

While the impact of combination drug therapy on the costs of AIDS care is not clear, the use of this therapy by persons with HIV has led to a dramatic increase in the costs of caring for this population. According to a representative of the AIDS Health Care Foundation it now costs almost as much to care for a person with HIV as it does to care for a person with AIDS. As a result, normal Medicaid capitation rates may not cover the costs for persons with HIV who are asymptomatic.

Carving Protease Inhibitors and Viral Load Tests Out of the Capitation Rates

To contend with the unpredictable and high costs of protease inhibitors, 19 of the 37 States paying capitated rates do not require MCOs to pay for these drugs with their capitated payments. In States where protease inhibitors are not carved out of the

capitation rate, financial liability for the costs of drug therapy can result in substantial uncompensated costs to an MCO for treating persons with HIV and AIDS.

In June 1996, HCFA advised all State Medicaid directors to ensure that their Medicaid programs provide protease inhibitors to Medicaid beneficiaries with HIV/AIDS. They also instructed Medicaid directors to examine "whether capitation rates should be adjusted to account for the introduction of new drugs such as the protease inhibitors" if they are not excluded from the capitation rates.

Only Maryland and California (in some counties) specifically exclude Medicaid MCOs from financial responsibility for the viral load tests which measure the effectiveness of protease inhibitors. The tests cost between \$300 to \$800 annually per patient. Advocates in at least one State, Pennsylvania, are concerned that MCOs may restrict the frequency of viral load tests because they are not specifically compensated for providing them.

The following table shows the capitation range our sample States pay Medicaid MCOs to treat AIDS patients and whether protease inhibitors and viral load tests are carved out of the rates.

RATES TO MCOS FOR SERVING MEDICAID BENEFICIARIES WITH AIDS
(as of July 1997)

State Program: Managed Care Plans Visited	Monthly Rate Paid to MCOs for Medicaid Enrollees with AIDS	Estimated Enrollment of Beneficiaries with AIDS for whom these rates are paid and total plan enrollment as of July 1997	Is Payment for Protease Inhibitors Carved Out of the Capitation Rate?	Is Payment for Viral Load Tests Carved Out of the Capitation Rate?
MA: Community Medical Alliance (Rate is available to other non-targeted qualifying plans)	\$2,300 for active cases \$2,998 for advanced cases	115 active or advanced AIDS cases (45 others with HIV diagnosis) 450 total enrollees	YES	NO
MD: Chesapeake Health Plan	\$2,161 (\$1,812 for patients residing outside of Baltimore City)	Initial enrollment underway at time of study	YES	YES
CA: San Mateo County	\$1,300	73 out of 48,000	NO	NO
UT: United Health Plan	\$1,169	11 out of 16,131 (63 with HIV diagnosis)	YES	NO (chart continued next page)

State Program: Managed Care Plans Visited	Monthly Rate Paid to MCOs for Medicaid Enrollees with AIDS	Estimated Enrollment of Beneficiaries with AIDS for whom these rates are paid and total plan enrollment as of July 1997	Is Payment for Protease Inhibitors Carved Out of the Capitation Rate?	Is Payment for Viral Load Tests Carved Out of the Capitation Rate?
CA: Positive HealthCare, LA	\$1,139*	400 out of 400	YES	NO
CA: San Francisco Health Plan**	\$221	35 out of 24,000	YES	YES
OR: CareOregon**	\$104 - \$625	800 out of 26,000	NO	NO

**Note: Inpatient hospital costs are not included in this rate. California deposits the fee-for-service equivalent costs for inpatient care for Positive HealthCare patients into a risk pool for the plan to draw from. Any savings are shared equally at year's end.*

*** CareOregon currently is seeking an adjusted capitation rate for AIDS patients. Effective October 1997, the San Francisco Health Plan, after months of negotiations with the State, began receiving an enhanced capitation of \$1,130 monthly for each patient who meets the CDC definition of having AIDS.*

Access to Needed Services

For the most part, Medicaid MCOs we visited appear to provide enrollees with AIDS comprehensive medical services and necessary drugs. However, some State contracts with MCOs guarantee services for AIDS patients but do not mention persons with HIV. One respondent who has consulted with a variety of Medicaid MCOs on rate calculation issues indicated that States' failure to compensate MCOs for caring for persons with HIV may provide the MCOs with a disincentive to detect HIV disease in their enrollees and/or provide them with early treatment.

Although our sample MCOs appear to provide AIDS patients with access to needed services and drugs, some respondents indicated there are barriers to receiving the care due to MCO preauthorization requirements⁹ and limits on services. Respondents cited limited availability of nutritional counseling, nutritional supplements and home health services as particularly problematic. One sample MCO serving a rural area requires limited duration drug prescriptions. Some drugs are needed on an ongoing basis. When they are used up, it can take 10 days to 2 weeks to refill a prescription. Since it is so vital for HIV/AIDS patients to stay on their drug regimen, this presents a special problem for these patients.

Access to Providers and Specialists with HIV Experience

At the managed care organizations we visited, persons with AIDS have access to HIV-experienced physicians and can select a specialist as their primary care physician. Several MCOs we visited contract with university hospitals and "centers of excellence" that have histories of specialized HIV/AIDS care. They report that primary care physicians can refer patients for specialty care whenever necessary. Most plans say

that their members services staff can direct persons to HIV care or HIV-experienced providers if the patients ask specifically for this referral.

Despite this available expertise, unless they specifically ask, patients may not be aware which providers are HIV-experienced or which specialties treat HIV. Most MCO provider directories do not indicate which physicians or clinics specialize in treating HIV/AIDS patients or treat them currently. The MCOs may not advertise their inclusion of HIV-experienced physicians for fear of the financial consequences they may incur if they attract an inordinate number of HIV-positive patients for which they are not paid an enhanced capitation rate.

In the States we visited, the Medicaid managed care and Ryan White programs do not coordinate the services they provide to persons with HIV/AIDS. The health of persons with HIV/AIDS is increasingly dependent upon the integration of these services.

In the States we visited, Medicaid managed care and Ryan White programs serve many of the same clients, but seldom consider where their programs could work together to serve these clients. None of the six sample States require Medicaid MCOs to include Ryan White providers in their care networks. Nor do these States require managed care organizations to coordinate with Ryan White providers on the care provided to mutual Medicaid patients. Neither the State Medicaid offices nor the MCOs we visited coordinate with Ryan White grantee agencies on the care provided to the same population through these programs. The State Medicaid managed care representatives interviewed indicated that their offices are not engaged in any proactive efforts to involve Ryan White programs in the transition to managed care or to ensure coordination between the two programs. According to our survey of all States, none require Medicaid MCOs to share any HIV/AIDS data with Ryan White agencies.

State Medicaid programs are prohibited by law from disclosing the names of persons living with AIDS. The purpose of this prohibition is to protect patient confidentiality, not to prevent Medicaid programs from sharing other information or coordinating with Ryan White programs serving the same patients. However, this lack of communication and coordination is often attributed to the confidentiality requirements of the Medicaid law.

Beginning with the 1996 Ryan White authorization, Ryan White Title I planning councils must include a representative of the State Medicaid program. This representation of State Medicaid staff on the planning councils increases the knowledge Ryan White providers and State Medicaid staff have of each other's programs and enables a more informed allocation of Ryan White funds. However, in some States, Medicaid representation has been minimal, translating this requirement into a missed opportunity for increased coordination.

The Role of Ancillary Services in HIV/AIDS Care

Due to the lack of State Medicaid and Ryan White agency involvement in the integration of Ryan White and Medicaid managed care programs, many Ryan White providers who serve Medicaid beneficiaries are not included in MCO provider networks. Yet Ryan White providers are often the patients' source for ancillary services, such as nutrition counseling and supplements, psycho-social services, home attendant care and case management services.

In all six sample States, staff of State and local AIDS administration offices, Ryan White providers and managed care physicians emphasized the need to provide persons with HIV and AIDS access to ancillary and psycho-social services when addressing their medical needs. These respondents stressed the rising importance of these services in light of the changing demographics of the HIV/AIDS population.

The HIV/AIDS population is increasingly comprised of low-income persons faced with a host of social and environmental challenges which complicate their ability to access health care and comply with health maintenance routines. Persons challenged by income and physical constraints often depend on ancillary services such as transportation, day care and home attendant services to access needed medical care.

Respondents in several States noted that support services such as nutrition counseling, food bank assistance and health education are vital to helping HIV and AIDS patients comply with difficult drug regimens. Several respondents expressed concern that the case management services provided by Medicaid MCOs to patients with AIDS are focused on the utilization of plan services rather than focused on linking clients with needed services and resources in the community.

According to a Ryan White provider, MCOs need to work with community-based providers experienced in dealing with low-income persons with HIV and AIDS if they are to serve the health care needs of these enrollees.

They (the MCOs) start with the assumption that patients can follow a managed regimen.... We develop individualized methods to get folks to the point where they can take a drug regimen. For people living chaotic lives the role of the essential community provider is critical. It is something managed care organizations don't know how to do and don't want to do and are not really as set up to do it as are small, more flexible, community-based providers. It will be important for managed care organizations to look to Ryan White providers to do this kind of work.

Ryan White Providers serving MCO Clients

Where our sample managed care organizations include Ryan White providers in their networks, the plan administrators we interviewed are not aware of the non-medical services their enrollees receive through these providers which are not paid for by the plan. The absence of plan involvement in the coordination of managed care and Ryan

White services by plan providers has the potential to result in the use of Ryan White funds for services that the MCO is paid to provide.

For example, in one MCO we visited where the county AIDS clinic is a network provider, the clinic bills the MCO on a fee-for-service basis for the covered medical services they provide to plan enrollees. The clinic uses Ryan White funds to cover the cost of the non-medical services they provide to their patients, including health education, nutrition and mental health counseling. It appeared from our interviews that neither party is fully aware of all of the services for which the other is responsible. In this case, the MCO reports that they provide nutrition counseling and supplements to plan enrollees with a referral from the enrollee's primary care provider while clinic administrators say they use Ryan White funds to pay for nutritional counseling and supplements for all of their patients who need it.

Lack of Ryan White Experience with Managed Care and Lack of MCO Interest to Contract with Ryan White Providers

Respondents in every sample State cited Ryan White providers' inexperience in a managed care environment as a barrier to coordination between Ryan White providers and managed care organizations. Many Ryan White providers have no experience negotiating contracts with large commercial entities and do not share the MCOs' competitive cost-driven orientation.

Negotiating contracts and coordination agreements between Ryan White providers and managed care organizations also depends on the MCOs' commitment of resources. In large volume markets, managed care organizations may not view negotiating contracts and coordination agreements with small volume providers as a useful allocation of their resources. The co-chair of an EMA planning council said that "HIV is only a small portion of the managed care business. It is difficult for them to realize what is small potatoes for them is huge for us."

Another consideration impacting whether MCOs contract with Ryan White providers is MCOs' understanding of the Ryan White program. Managed care administrators unaccustomed to providing care to persons with HIV and AIDS may not be aware how important ancillary services are to the health of these people. Several managed care administrators indicated that they are not familiar with Ryan White programs in their local community. A respondent noted that "(Ryan White) providers may not be sophisticated enough to market and price their services. And the managed care organizations may not realize they need these services."

To facilitate the participation of Ryan White programs in managed care, HRSA has distributed a variety of informational and technical assistance materials to Ryan White programs, sponsored managed care training conferences, and implemented a training and technical assistance program in a number of States with plans for future expansion. State Medicaid and managed care plan administrators have been invited to participate in HRSA's training programs but their participation has been sporadic.

RECOMMENDATIONS

There is public concern about the spread of managed care. Some consumers fear that managed care organizations maximize profits by withholding medical services; others worry that MCOs are ill-equipped to provide specialty medical care to special populations. Our review of managed care in six States that cover persons with AIDS found that overall, the MCOs we visited appear to provide necessary medical services, access to specialty care, tests and medications. Some MCOs provide this care despite receiving capitation rates far below the actual cost of care. These managed care organizations argue that they will not be able to continue to provide necessary care unless they are paid AIDS-adjusted capitation rates.

In addition to concern over adequate payment rates, we are troubled by the absence of coordination by States and MCOs with the networks of comprehensive services constructed by Ryan White EMAs and consortia. These networks of providers often include a full range of social services available to all HIV positive individuals as well as those with AIDS. Persons with HIV/AIDS often rely on the Ryan White infrastructure for primary medical and ancillary services critical to their health and well-being.

The Health Care Financing Administration, in consultation with the Health Resources and Services Administration, should develop and disseminate technical assistance and guidance on strategies State Medicaid programs can use to establish appropriate managed care contracts for needed medical services and costs related to these services for beneficiaries with HIV and AIDS.

There is a lack of consensus among State Medicaid and plan administrators regarding what services Medicaid managed care organizations are responsible for providing to persons with HIV and AIDS and how they are to be compensated for the costs of these services. Current capitation rates in many cases do not consider changing HIV treatment strategies. Even in the four States which pay an AIDS-adjusted rate, State Medicaid and MCO administrators come to the negotiating table with widely divergent ideas about appropriate AIDS rates to cover the costs of the care they provide.

The HCFA, HRSA and others in the Department involved in HIV/AIDS treatment and research should develop a list of all of the services Medicaid potentially provides that beneficiaries with HIV and AIDS need, based on the national guidelines on HIV care being developed by the Department. The HCFA and HRSA should disseminate sample managed care contract language requiring provision of these services as well as HIV prevention services, perhaps using the model language currently being developed by HRSA and the George Washington University, Center for Health Policy Research.

The HCFA, which must provide information on actuarially sound capitation rates for specific Medicare populations, should calculate estimates of costs of providing services based on the developing guidelines to a patient with HIV and to one with AIDS.¹⁰

With the quantum growth of Medicare expenditures for persons with AIDS, HCFA will also need this data to project future Medicare costs for these beneficiaries under fee-for-service and managed care. Furthermore, HCFA should have available information on actuarially sound Medicaid capitation rates as the Department is required to provide this information at State request.

The rapidly changing nature of HIV/AIDS treatment requires the ability to react to dramatically increased or reduced costs or services. The HCFA's Medicare fee-for-service data provide information to project "real-time" capitation rates based on very current charge and payment information for covered medical services. At present, States often rely on data that is several years old and based on outmoded treatment practices to determine appropriate capitation rates. Although, Medicare fee-for-service data does not reflect the total costs of care provided to AIDS beneficiaries, this fee-for-service data provides a starting point for calculating the costs of AIDS care provided in accordance with the developing national guidelines.

The HCFA should utilize existing Departmental information to support this effort to collect and disseminate cost information. Besides the considerable Medicare fee-for-service data HCFA maintains, the Special Projects of National Significance funded by Ryan White can provide specific data on services and costs for treating persons with HIV/AIDS under a managed care model. The HRSA recently released a study of the adequacy of capitation rates to cover the costs of HIV care in nine states.¹¹ Information on the costs of HIV care under managed care and strategies to cover these costs was also presented at a May 1997 conference on HIV and risk adjustment sponsored by HRSA and HCFA and at the November 1997 Johns Hopkins AIDS Managed Care Conference. Other Departmental agencies may also contribute to this cost information based on research, service delivery or other policy considerations.

The HCFA should then present the variety of service options to States and provide a basis for States to estimate covering these costs in their Medicaid managed care programs. For example, based on these options and estimated costs, States could decide whether or not to carve out certain services or care provided by specialists from their MCO capitation rates, and/or carve out the protease inhibitors and viral load tests, or include all care in a fixed capitation rate adjusted to reflect the costs of this care. As a model means to disseminate this information to States, HCFA could use its' June 1996 letter to all States requiring Medicaid coverage of protease inhibitors and options to cover their costs.

The HCFA should disseminate this coverage and payment information to the States in the form of a guidance document to assist States in contracting with Medicaid managed care organizations, including information about how protease inhibitors and viral load tests are carved out of the capitation rates and how a beneficiary is able to get the items or services. This information would provide States with a starting point to establish contracts with MCOs for the provision of necessary care to beneficiaries with HIV and AIDS in return for adequate compensation.

State Medicaid agencies would benefit from this information because few have reliable data for HIV and AIDS care in part because of patient confidentiality. States will want to know if capitation rates should be reduced because of the decreased need for hospitalizations or home care, or should be increased because of changes in drug treatments. States also do not want HIV/AIDS centers of excellence threatened by inadequate funding. Furthermore, States will want to make informed decisions about future program expansions or carve outs.

The Health Care Financing Administration should urge States to require Medicaid managed care plans to coordinate with Ryan White programs on the services they provide to Medicaid beneficiaries with HIV/AIDS. The Health Resources and Services Administration should continue to encourage Ryan White grantees to work with Medicaid managed care plans. Together, these agencies should work to develop strategies of coordination for Medicaid managed care and the Ryan White programs.

In the best interests of HIV/AIDS patients, MCOs and Ryan White agencies, it is essential that parties rendering services to HIV/AIDS patients coordinate these services with comprehensive care for the patients in mind. The Congress believes that both programs are needed to provide the full range of medical and other services HIV/AIDS patients require.

The State Medicaid agencies and the Medicaid MCOs need to advise Ryan White grantees of the services they provide to HIV/AIDS patients. With this information, Ryan White eligible metropolitan areas and consortia will be able to assess the HIV/AIDS community's needs more accurately, and consequently be able to deliver services more rationally. Overlapping of services can be reduced and MCO capitation rates can more accurately represent the costs of services they provide. Ryan White funds fill service gaps where no insurance or other funding streams exist to pay for care. Ryan White providers and MCOs serving the same patients must coordinate to prevent duplicating services and wasting scarce health care resources.

Persons with HIV and AIDS may transition on and off Medicaid, and rely on Ryan White providers for their total care in the interim. Coordination is vital to ensure the continuity of care for these patients. Coordination of services also reduces the potential for MCO enrollees with HIV/AIDS to seek medical care elsewhere (which occurs even though the MCOs are paid a capitated rate to serve these patients.) All the individuals we interviewed who treat persons with HIV and AIDS also emphasized the need to integrate ancillary and medical services in order to effectively deliver health care to persons with HIV and AIDS.

Non-medical services are often critical to improving the health status of a person with HIV or AIDS. While many of the ancillary services provided by the Ryan White program may fall outside of the defined set of services MCOs provide, they do not fall outside of the set of services needed to improve the health of a person with HIV/AIDS.

Coordinating the services available through Ryan White and Medicaid managed care clearly benefits the patients and ultimately benefits the MCO. In the long run, healthier patients means a reduced need for services, including costly hospitalizations. Indeed, this holistic approach to patient care is consistent with the managed care philosophy.

Through coordination, MCOs and Ryan White providers can provide seamless care to patients with HIV and AIDS, addressing all their varied health needs. By coordinating with providers of services such as HIV counseling, HIV education and nutritional counseling, MCOs can better meet their prevention and health maintenance missions.

The HCFA should encourage Medicaid agencies to include the Ryan White infrastructure in the shift to Medicaid managed care. Without their inclusion, the emergence of MCOs may result in restricting patients' access to these needed services.

The HRSA has begun efforts to educate Ryan White grantees about Medicaid managed care. These efforts need to emphasize that Ryan White grantees be aware of services Medicaid capitation pays MCOs to provide and also be alert to changes in Medicaid coverage or contracts with MCOs that may affect their clients. Through their existing HIV/AIDS work group, HCFA and HRSA should develop a coordinated strategy to educate both State Medicaid administrators and Ryan White grantees about each others' programs and the need for coordination among their contracted providers.

AGENCY COMMENTS

The Assistant Secretary for Planning and Evaluation (ASPE), HCFA and HRSA provided comments to the draft report. While all concurred with the report's findings and recommendations, they offered suggestions for clarifying the report and making other technical changes. Where appropriate, we changed the report to reflect their comments. The complete text of ASPE's, HCFA's AND HRSA's comments can be found in Appendix C.

The ASPE questioned whether there were any differences in service delivery and access for HIV/AIDS patients between those Medicaid MCOs receiving an enhanced rate and those who were not. We found there is no difference at present, but are concerned that Medicaid MCOs who do not receive enhanced capitation to deal with the HIV/AIDS population will not be able to continue to do so.

The HCFA felt it inappropriate for HCFA to develop model contracts for Medicaid MCOs to use in treating persons with HIV/AIDS. Instead HCFA suggests they develop a document outlining the specialized needs of these patients as well as likely gaps or problem areas in service delivery.

We support this approach in conjunction with our recommendation that HCFA and HRSA jointly develop technical guidance in these areas. Our discussion of model

contract language did not suggest that HCFA dictate contract language to States. Rather, it called for HCFA and HRSA to disseminate model contract information to States that the Department is already funding.

The HCFA also argues against providing State Medicaid agencies with aggregated cost information that HCFA collects from fee-for-service data. They suggest the wide variations in costs makes the data suspect.

We believe that HCFA should provide States with HCFA's current fee-for-service information, despite the lack of State-by-State specificity, in addition to all of the other Departmental data cited in the report. These collective data will provide States with a more complete picture of services and payments for HIV/AIDS patients and this knowledge will benefit them in arriving at equitable MCO capitation rates for these patients.

The HCFA also felt State Medicaid agencies should be active participants in coordinating service delivery, along with Ryan White agencies and MCOs. We agree that Medicaid agencies have a role in this coordination and can use their contracting authority to encourage MCOs to do so.

The HRSA raised a question about whether the way Medicaid MCOs reimburse providers influences service delivery. We cannot comment since all the MCOs we visited paid providers on a fee-for-service basis.

The HRSA asked about the impact of enhanced rates on providing non-medical services. All MCOs we visited provided services like transportation and translation services, whether or not they were receiving enhanced capitation. We did not gather any cost or reimbursement data for these services.

The HRSA also pointed out that in addition to ancillary services, Ryan White pays for considerable primary health care. Approximately half of all Ryan White funds is spent on primary care. In some cases, Medicaid MCOs include Ryan White providers to provide primary medical care and/or ancillary services.

Our report emphasizes Ryan White ancillary services since respondents expressed concern about the lack of coordination between Medicaid MCOs and ancillary service providers rather than concern about primary medical care.

APPENDIX A

Descriptions of Sampled States' Inclusion of HIV/AIDS Patients in Medicaid Managed Care Plans

Descriptions of Sampled States' Inclusion of HIV/AIDS Patients in Medicaid Managed Care Plans

- California - California's Medicaid program (Medi-Cal) operates several managed care models on a county basis. We examined the "County Organized Health System" model in San Mateo county, the "2-Plan" model in San Francisco, and "Positive HealthCare," a limited AIDS-specific capitated managed care project in Los Angeles which receives Ryan White Special Project of National Significance funding.

In San Mateo county, Medi-Cal beneficiaries are mandated to enroll in the Health Plan of San Mateo (HPSM). The HPSM receives an enhanced capitation rate for serving persons with AIDS. The plan has an average of 70 members a month who have AIDS.

Under the 2-Plan model, there is a commercial Medicaid managed care plan and a "Local Initiative" plan in San Francisco. We limited our inspection to the Local Initiative plan. The San Francisco Health Authority operates the Local Initiative plan through contracts with six medical groups. Although there is some voluntary SSI enrollment, only persons on Medi-Cal through eligibility criteria related to Aid to Families With Dependent Children must enroll in managed care in San Francisco. Until October 1997, the San Francisco Health Authority did not receive an enhanced rate for persons with AIDS. As of June 1997, the plan had 35 enrollees using AIDS drugs, 28 of whom were voluntary SSI enrollees.

Positive HealthCare is a managed care project for Medi-Cal beneficiaries with AIDS operated by the AIDS Health Care Foundation (AHF) of Los Angeles. All enrollment is voluntary and limited to beneficiaries who receive Medi-Cal through SSI eligibility criteria and meet the CDC definition of having AIDS. The AHF receives an enhanced capitation rate for serving these enrollees. There are 400 Medi-Cal enrollees with AIDS in the Positive HealthCare program.

- Georgia - Georgia operates a PCCM managed care program called Georgia Better Health Care (GBHC), which covers over 500,000 members. Persons with HIV/AIDS are included in this Statewide program but GBHC has no estimate of the number of those members. Providers are paid for services on a fee-for-service basis.
- Maryland - Maryland began its Statewide capitated managed care program in July 1997. As yet, Maryland has no estimate of the number of persons with HIV/AIDS enrolled. The HIV/AIDS patients are included in MCOs which are paid an enhanced rate for AIDS patients. All Medicaid beneficiaries are required to enroll in managed care except those who are dually eligible for Medicare and Medicaid.

- Massachusetts - Massachusetts mandates Medicaid beneficiaries to enroll in the State's Medicaid managed care program. However, beneficiaries who are dually enrolled in Medicare and Medicaid and others with third party liability are not required to enroll in managed care, but have the option to do so. All other beneficiaries choose either the Primary Care Clinician (PCC) program or a contracted MCO. The PCC program is similar to a PCCM program except that the PCCs receive an enhanced rate for all primary care visits rather than a gatekeeper fee for serving as a referral point for their patients. The MCOs are paid an enhanced rate for serving persons who meet a definition of having active or advanced AIDS if they demonstrate that they have the required capacity to treat these enrollees. More than 5,000 persons with AIDS enrolled in Medicaid managed care in Massachusetts in 1995-1996, however the majority of these enrollees were in the PCC program. The State does not have an estimate of the number of HIV-positive enrollees without AIDS.
- Oregon - The Oregon Health Plan is a Statewide managed care initiative covering Oregonians not covered in private health plans. Oregon has 1700 HIV/AIDS patients enrolled in its Statewide Medicaid managed care plan. Oregon does not pay an enhanced rate for HIV/AIDS patients.
- Utah - Utah operates a capitated mandatory managed care program for all Medicaid beneficiaries in the four-county Salt Lake area. Outside of this area, beneficiaries can enroll in MCOs or in Utah's PCCM program. The MCOs receive an enhanced rate for serving persons with AIDS. Utah pays an enhanced capitated rate for approximately 60 Medicaid beneficiaries who meet the State's criteria for the AIDS-adjusted rate which is more restrictive than the Center for Disease Control and Prevention (CDC) definition of having AIDS. Additionally, the University of Utah Infectious Disease clinic reports serving slightly over 200 HIV-positive Medicaid recipients. Utah does not pay an enhanced rate for these patients.

APPENDIX B

Descriptions of Sampled Managed Care Plans

Descriptions of Sampled Managed Care Plans

Community Medical Alliance (CMA), Boston, MA:

Payment: The Community Medical Alliance is paid a per member per month (PMPM) capitation rate of \$2300 or \$2998 for individuals with "active" or "advanced" AIDS. The Community Medical Alliance receives one of these two AIDS adjusted rates for any plan enrollee who has tested positive for HIV, or has a CD4 count of less than 200 or CD4 percentage less than 14; and who has received treatment for one of several listed diagnosis associated with advanced or active AIDS within the past year.

Delivery Approach: Each CMA patient is assigned a nurse practitioner and a physician who use a team approach to care for the patient. The nurse practitioners act as the front-line care coordinators for the patients, working primarily with the patients in their homes. They link the patients to the other services they may need, such as infusion therapy or support services. The nurse practitioners together with the team physicians, are given a great deal of latitude to make medical decisions regarding the patients' care.

The Health Plan of San Mateo, San Mateo County, CA:

Payment: The Health Plan of San Mateo receives a PMPM capitation rate of \$1300 for individuals who meet the 1993 AIDS surveillance case definition of AIDS. The 1993 CDC definition includes all HIV-infected persons who have <200 CD4+ T-lymphocytes, or a CD4+ T-lymphocyte percentage of total lymphocytes of <14 and pulmonary tuberculosis, recurrent pneumonia, or invasive cervical cancer, in addition to the clinical conditions included in the AIDS surveillance case definition published in 1987.

Delivery Approach: All AIDS enrollees who meet the 1993 CDC definition of having AIDS are referred to as "special members" in the health plan. The special members do not have to select and/or use a primary care provider to receive care under the plan. Special members can seek care from HIV specialists within the provider network of the plan without having a referral from another provider. Most of the AIDS enrollees in the plan receive their care from the Edison Clinic of the San Mateo County General Hospital. The Edison Clinic provides a full range of HIV medical and ancillary care to their patients using a combination of Medicaid and Ryan White funding.

United HealthCare of Utah, Utah:

Payment: United HealthCare of Utah receives a PMPM capitation rate of \$1169 for all individuals who have = or <200 CD4+ T-lymphocytes. This definition of qualifying for the enhanced rate is more restrictive than the 1993 CDC definition.

Delivery Approach: Medicaid beneficiaries enrolled in the United HealthCare plan do not have to choose a primary care provider. Plan members can seek care from any primary care provider in the plan's network, including specialists if the specialist has agreed to serve as a primary care provider and is listed in the primary care provider directory. HIV specialists are not identified as such in the provider directory but the member services staff of the plan can direct interested patients to these providers. The plan has several HIV specialists within its network who serve as primary care providers to individuals with HIV or AIDS. Most of the plan enrollees with HIV and AIDS seek their care from the University of Utah's Infectious Diseases Clinic which is staffed by experienced HIV specialists.

Positive HealthCare, AIDS Health Care Foundation (AHF), Los Angeles, CA:

Payment: The AIDS HealthCare Foundation receives a PMPM capitation rate of \$1139 for all individuals who meet the 1993 CDC definition and who are receiving MediCal through the SSI program.

Delivery Approach: Individuals must select a primary care provider on staff with AHF within 90 days of enrolling in the Positive HealthCare program. The primary care providers are located in four AHF outpatient clinics. Registered nurse case managers provide case management services to the patients in an interdisciplinary team approach with the primary care physicians and other health care professionals employed by AHF in the clinics. Through case management, patients have access to a wide spectrum of medical and ancillary services, including mental health benefits, nutrition services, advocacy, HIV education and referrals to community resources. This program is one of five Special Projects of National Significance, funded by HRSA to test an innovative model for delivering HIV/AIDS care in a managed care setting.

San Francisco Health Plan, San Francisco, CA:

Payment: At the time of our study, the San Francisco Health Plan received \$221.89 PMPM for individuals enrolled in its plan who are eligible for MediCal through the SSI program and \$88 PMPM for individuals eligible for MediCal through criteria related to the former Aid to Families with Dependent Children program. The plan receives the \$88 PMPM capitation rate for 7 of the 35 plan enrollees requiring AIDS drug therapy. Effective October 1997, the San Francisco Health Plan, after months of negotiations with the State, began receiving an enhanced capitation of \$1,130.64 monthly for each patient who meets the CDC definition of having AIDS.

Delivery Approach: Plan members are required to select a primary care provider from the primary care provider directory. Individuals may select a specialist to serve as their primary care provider if the specialist has elected to be listed as a primary care provider in the directory. The HIV specialists are not identified as such in the directories. Every provider in the San Francisco Health Plan network is part of a medical group. The Plan contracts with six medical groups, each of which is affiliated with a hospital. Individuals are required to seek their care from the specialists and hospital within the medical group of their primary care provider. The University of California at San Francisco and San Francisco General Hospital are both part of medical groups under contract with the San Francisco Health Plan. These two institutions are considered centers of excellence in HIV care.

CareOregon, Portland OR

Payment: CareOregon does not receive an enhanced rate for treating HIV or AIDS patients. Oregon Medicaid pays CareOregon between \$104.40 and \$625.59 PMPM based on the recipient's eligibility to Medicaid. CareOregon receives the lowest rate for the majority of its' AIDS patients. The capitation rate includes all medical services (except dental and mental health) and drugs, including protease inhibitors. CareOregon has 800 AIDS patients, approximately half the State's AIDS population, among its' 26,000 Medicaid clients.

Delivery Approach: This MCO includes Oregon Health Sciences University (OHSU,) an HIV center of excellence, and the Multnomah County Health Department Clinics, a large provider of HIV and AIDS services in its' network. Patients choose their primary care provider. The CareOregon AIDS patients have chosen either OHSU, the Multnomah County Health Department or other physicians for primary care in approximately equal numbers.

Chesapeake Health Plan, Baltimore MD

Payment: Maryland Medicaid pays MCOs an enhanced rate to treat patients with AIDS. The MCOs receive \$2161 PMPM for patients residing in Baltimore and \$1812 for those outside Baltimore. Medicaid carves out protease inhibitors and viral load testing from the capitation and pays these on a fee-for-service basis. Chesapeake estimates 90 AIDS patients in their 17,000 Medicaid enrollees. Chesapeake pays 98 per cent of the capitation to Johns Hopkins' Moore Clinic to treat members with AIDS.

Delivery Approach: Chesapeake contracts with the Moore Clinic and the University of Maryland and a few other HIV specialists throughout the State. The bulk of the AIDS patients are treated at the Moore Clinic which is devoted exclusively to HIV and AIDS care. The Chesapeake AIDS patients can select a specialist as their primary care provider, but those with HIV cannot.

APPENDIX C

Agency Comments



FEB 24 1998

To: Juns Gibbs Brown
Inspector General

From: Margaret A. Hamburg, M.D. *M.A.H.*
Assistant Secretary for Planning and Evaluation

SUBJECT: *OIG Draft Report, Medicaid Managed Care and HIV/AIDS--COMMENTS*

Thank you for the opportunity to review the above captioned inspection report. We found this draft to be an improvement from the earlier iteration we informally reviewed last November. The significant issues that ASPE raised with your staff at that time have, for the most part, been satisfactorily addressed.

We still have lingering concerns, however, about the study finding that pertains to "enhanced capitation rates." Because of the expensive nature of HIV-related care, one might conclude that health plans receiving an AIDS-adjusted capitation rate would be more likely to ensure access to appropriate services and quality care for people with HIV/AIDS--indeed, the survey respondents indicated just that. But the plans that did not receive an enhanced capitation rate expressed concern about their ability to continue to provide the necessary services and therapies for people with HIV/AIDS in the absence of such a rate. Neither of these findings are surprising. Yet the reader is left to wonder about the types of services and drugs the AIDS-adjusted rate "buys" and whether there is any difference in service delivery and access between those plans that receive an enhanced rate and those that do not. This type of comparative analysis would be instructive to decision makers wrestling with the issue of risk-adjustment in setting capitation rates, particularly for people with HIV/AIDS. Additionally, although the information about the specific plans contained in Appendix B (which should be referenced on page 6 of the report) is helpful, it does not tell the whole story and mostly describes the type of "gatekeeper" or primary care provider arrangements that the plan uses.

Finally, we have a few specific comments that are noted below by page number.

- Page 1: The third paragraph states that "approximately 104,000 persons with HIV and AIDS receive Medicaid." We question the accuracy of this figure. Previously, HCFA actuaries have estimated that 160,000 people with HIV and AIDS are served by Medicaid. The 104,000 figure likely refers to people with AIDS only. We suggest double-checking with HCFA to be certain.

- **Page 1:** The fourth paragraph presents the number of people with AIDS and related expenditures covered by Medicare. This paragraph should make it clear that in both cases the figures are estimates.
- **Page 2, second paragraph:** The second sentence of this paragraph describes the impact of combination antiretroviral therapy, but fails to mention the profound effect this regimen has on a patient's viral load, often substantially lowering the amount of virus in the blood to undetectable levels. Also, the last sentence of the paragraph is misleading. The estimated annual cost of combination therapy (including protease inhibitors) usually ranges from \$10,000-\$12,000. If viral load testing and other monitoring is included, costs can approach \$15,000-\$16,000.



The Administrator
Washington, D.C. 20201

DATE: MAR 11 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle *NMD*
Administrator

SUBJECT: Office of Inspector General Draft Report: "Medicaid Managed Care and HIV/AIDS," (OEI-05-97-00210)

We reviewed the above-referenced report that describes how some states address the treatment of persons with HIV/AIDS in Medicaid managed care. The report found that Medicaid managed care organizations (MCOs) that are paid an AIDS-enhanced rate appear to provide all needed medical services and drugs to AIDS patients. MCOs not paid an enhanced rate report that they cannot afford to continue providing these services and drugs without adequate financial compensation. The report also found in the states visited, the Medicaid managed care and Ryan White programs do not coordinate the services they provide to persons with HIV/AIDS.

The Health Care Financing Administration (HCFA) concurs with both of the OIG report recommendations. Our detailed comments are as follows:

OIG Recommendation

The Health Care Financing Administration, in consultation with the Health Resources and Services Administration, should develop and disseminate technical assistance and guidance on strategies state Medicaid programs can use to establish appropriate managed care contracts for needed medical services and costs related to these services for beneficiaries with HIV/AIDS.

HCFA Response

We concur. HCFA could develop a document providing information about the specialized needs of persons with HIV/AIDS, and likely gaps or problem areas in services provided under managed care. However, it is inappropriate for HCFA to develop model contracts since the factors which influence contract provisions (e.g., existing provider networks, existing access measures, state funding, political pressures, etc.) vary greatly from state to state.

The Medicaid program in each state must cover certain mandatory services and may cover other optional services. The services may be covered through managed care or fee-for-service. It is important to look at both managed care contracts and fee-for-service contracts to determine where coordination should occur. States could use the information developed by HCFA, modified by state-specific coverage policies to develop contract language.

The recommendation states that the estimates of the costs of services for persons with HIV/AIDS be provided. These costs are not available to HCFA on a state-by-state basis. The state-by-state analysis would be useful in developing managed care contracts. The wide variation in costs among states could be misleading. In addition, it is not clear what is meant by providing "options" on how to cover these costs in a Medicaid managed care program.

OIG Recommendation

The Health Care Financing Administration should urge states to require Medicaid managed care plans to coordinate with Ryan White programs on the services they provide to Medicaid beneficiaries with HIV/AIDS. The Health Resources and Services Administration should continue to encourage Ryan White grantees to work with Medicaid MCOs. Together, these agencies should work to develop strategies of coordination for Medicaid managed care and the Ryan White programs.

HCFA Response

We concur. Although coordination with managed care plans is useful, it is critical that state Medicaid agencies, which manage and monitor the implementation of Medicaid managed care programs, be active participants in any coordination activities with Ryan White agencies. HCFA has been working to encourage these relationships. It is the state, not managed care plans, that could offer Ryan White grantees the most objective description of the services MCOs should provide and it is critical that the Medicaid agencies get feedback if services are not being provided. Although coordination about the availability of related services or coordination on a case-by-case basis is important, the more critical discussions exist between Ryan White agencies and the state Medicaid agencies in describing which services should be provided by Medicaid, either through MCOs or fee-for-service.

Technical Comments

Page 14 suggests that HCFA distribute coverage and payment guidance. The guidance should also include information about how protease inhibitors and viral load tests are carved out of the capitation rate and how a beneficiary is able to get the item or services.



Health Resources and
Services Administration
Rockville MD 20857

FEB 25 1998

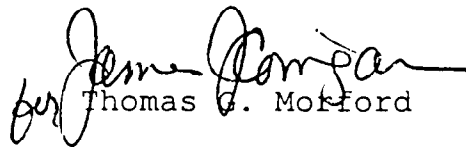
TO: Inspector General, DHHS

FROM: Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report,
"Medicaid Managed Care and HIV/AIDS."
(Code OEI-05-97-00210)

Attached is HRSA's response to your memorandum dated December 17, 1997, requesting comments on the subject draft report.

Questions may be referred to Michael Herbst on 443-5256.


Thomas G. Morford

Attachments

HEALTH RESOURCES AND SERVICES ADMINISTRATION COMMENTS ON
THE OIG DRAFT REPORT, "MEDICAID MANAGED CARE AND HIV/AIDS."
(CIN: OEI-05-97-00210)

GENERAL COMMENTS:

The report makes some extremely important points about the delivery of care to people with HIV/AIDS in Medicaid managed care.

HRSA agrees to consult with HCFA regarding the OIG recommendation that HCFA develop and disseminate technical assistance and guidance on strategies State Medicaid programs can use to establish appropriate managed care contracts for needed medical services and costs related to these services for beneficiaries with HIV and AIDS. HRSA agrees that an AIDS enhanced rate can provide incentives for managed care organizations (MCO) to provide all needed medical services and drugs to AIDS patients. As highlighted in the report, people living with HIV/AIDS require a full continuum of medical and enabling/ancillary services. HRSA has already initiated several projects including one with George Washington University Medical Center for Health Policy Studies to develop model contract language for State Medicaid agencies. In addition, HRSA recently published a report, "HIV Capitation Risk Adjustment," which documents the findings of a two-day conference on risk adjustment. The report has been distributed widely and has been frequently cited as a reference guide on the issues of risk adjustment for HIV and AIDS. The OIG should also discuss the impact of the enhanced rate on the provision of non-medical services. In addition, the report is silent on the reimbursement paid to AIDS providers by the MCOs, who also face major financial losses if they are not adequately reimbursed.

HRSA agrees that Medicaid managed care plans and Ryan White agencies must be integrated in order to provide seamless, coordinated care to people living with HIV/AIDS. However, HCFA should urge States to require Medicaid managed care plans to contract with Ryan White agencies to avoid duplication of effort. Several times in the report, the OIG states that Ryan White providers are the patient's source of ancillary care, which could give the impression that these are the only services they provide. In fact, more than 50% of Ryan White CARE Act funds are expended on primary care and other medical services. People living with HIV/AIDS depend on Ryan White providers for the full continuum of primary care and ancillary services.

The report documents the need and benefit for rate adjustments or enhancement, but fails to recommend that HCFA work with the State Medicaid agencies to assure that there is an appropriate rate adjustment to managed care companies and providers who serve a significant HIV/AIDS population.

OIG RECOMMENDATION:

The Health Resources and Services Administration should continue to encourage Ryan White grantees to work with Medicaid managed care plans.

HRSA RESPONSE:

HRSA concurs. HRSA has initiated a technical assistance and training program to assist Ryan White agencies to participate in managed care.

OIG RECOMMENDATION:

Together these agencies (HCFA and HRSA) should work to develop strategies of coordination for Medicaid managed care and the Ryan White programs.

HRSA RESPONSE:

HRSA concurs. The technical assistance and training program HRSA has initiated also seeks to develop collaborative relationships between key stakeholders including State Medicaid agencies, Medicaid managed care plans and Ryan White agencies. HRSA is planning to expand this program to ten additional states in the next six months.

TECHNICAL COMMENTS:

Clarification is needed under the section summarizing the Ryan White CARE Act. The section describing Title II should be expanded to include the AIDS Drug Assistance Program (ADAP) which provides pharmaceutical treatments to people living with HIV/AIDS. Further detail is also needed on the programs funded under Part F, as most readers will probably not be familiar with these programs. It is the Title III program, not Title III(b). Attached is a fact sheet on the HIV/AIDS Bureau which describes the programs funded by the CARE Act.

The description of the Special Projects of National Significance (SPNS) managed care projects gives the reader the impression that

they are managed care plans. The Ryan White CARE Act supports demonstration and evaluation projects through the SPNS. Six of the SPNS projects are funded to test new methods of delivering HIV/AIDS care in managed care settings. These projects are located in Los Angeles, Boston, Baltimore, North Carolina, and New York.



F A C T S H E E T

HIV/AIDS BUREAU

NOVEMBER 1997

HIV/AIDS Bureau

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA), administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act was signed into law On August 18, 1990 to improve the quality and availability of care for people with HIV/AIDS and their families. Amended and reauthorized in May 1996, the Act is named after the Indiana teenager, Ryan White, who became an active public educator on HIV/AIDS after he contracted the disease. He died the same year the legislation was passed.

Within the HIV/AIDS Bureau, the Division of Service Systems administers Titles I, II and the AIDS Drug Assistance Program (ADAP); the Division of Community Based Programs administers Titles III, IV and the HIV/AIDS Dental Reimbursement Program; and the Division of Training and Technical Assistance administers the AIDS Education and Training Center (AETC) Program. The Bureau's Office of Science & Epidemiology administers the Special Projects of National Significance (SPNS) Program.

HRSA's HIV/AIDS Bureau conducts programs to benefit low-income, uninsured and underinsured individuals and families affected by HIV/AIDS. Total appropriations for HRSA-funded CARE Act programs from FY 1991 through FY 1997 was \$3.8 billion.

HRSA's HIV/AIDS Bureau administers HIV/AIDS programs under four titles and Part F of the CARE Act:

- Title I HIV emergency relief grant program for eligible metropolitan areas (EMAs)
- Title II HIV care grants to States
- Title III HIV early intervention services
- Title IV Coordinated HIV services and access to research for children, youth, women, and families
- Part F Special Projects of National Significance (SPNS) Program; HIV/AIDS Dental Reimbursement Program; AIDS Education and Training Centers (AETCs)

Title I

Title I funding provides formula and supplemental grants to EMAs that are disproportionately

affected by the HIV epidemic. These areas are eligible for Title I formula grants if they have reported more than 2,000 AIDS cases in the preceding 5 years, and if they have a population of at least 500,000 (this provision does not apply to EMAs funded prior to FY 1997).

Grants are awarded to the chief elected official (CEO) of the city or county that administers the health agency providing services to the greatest number of people living with HIV in the EMA. The CEO must establish an HIV Health Services Planning Council that is representative of the local epidemic and includes representatives from specific groups such as health care agencies and community-based providers. At least 25 percent of voting members must be people living with HIV disease. The planning council sets priorities for the allocation of funds within the EMA, develops a comprehensive plan, and assesses the grantee's administrative mechanism in allocating funds.



Community-based services funded under Title I may include:

- Outpatient health care, including medical and dental care and developmental and rehabilitative services;
- Support services such as case management, home health and hospice care, housing and transportation assistance, nutrition services, and day or respite care; and
- Inpatient case management services that expedite discharge and prevent unnecessary hospitalization.

Providers may include public or nonprofit entities; private for-profit entities are eligible only if they are the only available provider of quality HIV care in the area.

When the first Title I grants were awarded in FY 1991, 16 EMAs were identified; in FY 1997, there were 49 EMAs in 19 States, Puerto Rico, and the District of Columbia. EMAs received \$429.3 million in Title I formula and supplemental funds in FY 1997. Since FY 1991, more than \$1.8 billion in Title I grants has been awarded.

Title II

Title II provides formula grants to States, the District of Columbia, Puerto Rico and eligible U.S. territories to provide health care and support services for people living with HIV disease. Grants are awarded to the State agency designated by the governor to administer Title II, usually the health department.

Grants are awarded based on: (a) the estimated number of living AIDS cases in the State or territory; and (b) the estimated number of living AIDS cases within the State or territory but outside of Title I EMAs. States with more than 1 percent of the total AIDS cases reported nationally during the previous 2 years must contribute their own resources to match the Federal grant, based on a yearly formula.

Title II funds may be used to support a wide range of services, including:

- Home and community-based health care and support services;
- Continuation of health insurance coverage

through a Health Insurance Continuation Program (HICP);

- Pharmaceutical treatments through an AIDS Drug Assistance Program (ADAP);
- Local consortia that assess needs, organize and deliver HIV services in consultation with service providers, and contract for services; and
- Direct health and support services.

Since FY 1991, HRSA has awarded more than \$1.26 billion in Title II grants. In FY 1997, \$397.9 million was awarded, which includes \$167 million in ADAP funding.

Title III

Title III of the CARE Act supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. Medical, educational, and psychosocial services are designed to prevent the further spread of HIV/AIDS, delay the onset of illness, facilitate access to services, and provide psychosocial support to people with HIV/AIDS.

Since FY 1991, \$369.4 million has been awarded under Title III; in FY 1997, \$69.5 million was awarded to 166 facilities in 37 States, Puerto Rico, and the District of Columbia. Nearly one-half was awarded to community and migrant health centers; the other half funded homeless programs, local health departments, family planning programs, comprehensive hemophilia diagnostic and treatment centers, Federally-qualified health centers, and private nonprofits.

Title IV

Title IV programs focus on the development and operation of systems of primary health care and social services that benefit children, youth, and women living with HIV and their families. These systems aim at building comprehensive, community-based, coordinated programs that include both health and social outreach elements, as well as prevention. Title IV also works to develop new ways to effectively link these care systems with HIV research supported by the National Institutes of Health (NIH) and other organizations.



Title IV, in collaboration with the Special Projects of National Significance (SPNS) Program, funds The Women's Initiative for HIV Care and Reduction of Perinatal HIV Transmission (WIN). This initiative supports 3-year cooperative agreements to develop models of care that enhance outreach, HIV counseling and testing services for women of childbearing age, especially during pregnancy, and offers perinatal ZDV prophylaxis and maintenance of ongoing care for mothers with HIV and their children. Title IV also collaborates with the National Institute of Child Health and Human Development, NIH, to support models of care and research investigating HIV disease and utilization of care among adolescents with or at risk for HIV.

In FY 1997, \$36 million was awarded to projects in 23 States, the District of Columbia, and Puerto Rico. More than eighty percent of the clients are from poor, minority families with limited access to transportation and housing. Beginning in 1988, the Pediatric AIDS Demonstration Program and, since 1994, the CARE Act Title IV program, have provided more than \$200 million to States and communities.

Part F

Special Projects of National Significance (SPNS) Program

The Special Projects of National Significance (SPNS) Program supports the development of innovative models of HIV/AIDS care, designed to address special care needs of individuals with HIV/AIDS in minority and hard-to-reach populations. These projects are designed to be replicable in other parts of the country, and have a strong evaluation component.

SPNS Program models focus on managed care; infrastructure development; training; access to care through reduction of sociocultural, financial, and transportation barriers for rural residents, women, adolescents, and children; legal advocacy; comprehensive primary care (including managed care); integration of mental health and primary care services; and services for correctional populations. In FY

1996, Integrated Service Delivery Models were funded to create formal linkages to integrate health and support services.

The SPNS Program has collaborated with the Substance Abuse and Mental Health Services Administration and the National Institute of Mental Health, NIH, to co-fund 11 mental health services demonstration projects for people living with HIV/AIDS. Projects are funded for 4 years and received approximately \$4.5 million in FY 1996.

Since FY 1991, \$60.6 million has been awarded in SPNS Program funding. In FY 1996, 62 grantees received more than \$25 million.

AIDS Education and Training Centers

The AIDS Education and Training Center (AETC) Program is a national network of 15 centers that conduct targeted, multi-disciplinary education and training programs for health care providers in designated geographic areas. The AETCs increase the number of health care providers who are educated and motivated to counsel, diagnose, treat, and manage care for individuals with HIV/AIDS and to help prevent high risk behaviors that may lead to infection.

AETCs collaborate with CARE Act-funded organizations, Area Health Education Centers (AHECs), community-based HIV/AIDS organizations, medical and health professional schools, local hospitals, health departments, community and migrant health centers, medical societies, and other professional organizations.

From FY 1987 to 1996, HRSA received \$153.7 million to fund the AETCs. In FY 1997, the AETCs received \$16.3 million in funding.

HIV/AIDS Dental Reimbursement Program

HRSA's HIV/AIDS Dental Reimbursement Program assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV-positive patients. Eligible applicants must have documented uncompensated costs of oral health care for HIV-positive persons, and must be accredited by the Commission on Dental Accreditation. Funding takes into account the



number of patients served by each individual applicant and unreimbursed oral health costs, as compared to the total number of patients served and total costs incurred by all eligible applicants.

Since FY 1994, \$28.4 million has been awarded to the HIV/AIDS Dental Reimbursement Program; in FY 1997, \$7.5 million was allocated to support dental care at 103 eligible institutions.

Other HRSA HIV/AIDS Programs

National HIV Telephone Consulting Service

Through the Western AIDS Education and Training Center funded by HRSA, an on-line

telephone consulting service is available exclusively to primary care providers. Operating out of San Francisco General Hospital, the service offers a toll-free number (800-933-3413) from 10:30 AM-8:00 PM EST Monday through Friday.

A multidisciplinary consulting team of physicians, nurse practitioners, and clinical pharmacists is available to answer HIV-related clinical management questions. After hours, primary care providers may leave a recorded question that is later answered by a consultant. Approximately 1,200 calls are received per quarter. Through Oct. 1, 1997, more than 18,000 calls covering every aspect of HIV disease and treatment were received.

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APPENDIX D

Endnotes

1. States must exempt recipients who are also eligible under Medicare and children with special needs from mandatory enrollment. These recipients may enroll in Medicaid managed care plans on a voluntary basis.
2. The Supplemental Security Income program provides financial assistance to needy aged, blind, and disabled persons. In many States, once individuals are eligible for both Medicare and Medicaid, they are disenrolled from managed care.
3. Medicaid directors from Washington D.C. and Puerto Rico also were included in our survey for a total of 52 respondents.
4. For this report, we use the term "managed care organization" to include the primary care case management plan operated by Georgia Medicaid and known as Georgia Better Health Care.
5. All of the information in this report is as of July 1997.
6. Arizona pays managed care plans a supplemental \$634 PMPM for Medicaid enrollees who are using protease inhibitor drugs.
7. Beginning in July 1997, Massachusetts began paying the Community Medical Alliance, an MCO specializing in AIDS care, an AIDS-adjusted capitation rate for individuals with "active" or "advanced" AIDS. The Community Medical Alliance receives an AIDS adjusted rate for any plan enrollee who has tested positive for HIV, or has a CD4 count of less than 200 or CD4 percentage less than 14; and who has received treatment for one of several listed diagnosis associated with advanced or active AIDS within the past year. This criteria is less restrictive than the Centers for Disease Control and Prevention's (CDC) definition of having AIDS. Other States paying an AIDS-adjusted rate use CDC's definition of AIDS.
8. Persons with HIV refers to persons who are HIV positive but are not symptomatic with AIDS. Persons with AIDS refers to persons who are symptomatic with the AIDS virus.
9. Some MCOs require preauthorization of certain services and drugs, including protease inhibitors. Recently, physicians at the University of New Mexico (not one of the States in this evaluation) reported difficulties in getting MCO approval for drugs to treat HIV.
10. The HCFA currently is gathering similar information for patients with End-Stage Renal Disease.

11. "The Adequacy of Reimbursement for HIV under Section 1115 Medicaid Waivers", Richard Conviser, Ph.D., Deanna Kerrigan, M.P.H., and Stephen Thompson, M.A., Office of Science and Epidemiology, HIV/AIDS Bureau, HRSA, US DHHS, July 1997.