

## Medicaid Managed Care Reimbursement for HIV and Its Implications for Access to Care

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### Abstract

The rapid growth of managed care in state Medicaid programs has raised concerns about access to care for people living with HIV and AIDS (PLWH). Even the highest capitation rates that most programs pay to managed care organizations (MCOs) for disabled enrollees are substantially lower than the costs of care, especially when costly protease inhibitor therapy is taken into account. A national study has shown that Medicaid beneficiaries did not have the same level of access to protease inhibitors as did privately insured HIV patients in 1996 and 1997. Low capitation rates can limit access to care for PLWH by discouraging MCOs from having experienced HIV physicians on their provider panels and from enrolling PLWH. Since 1997, however, Medicaid programs in several states have adopted strategies to reduce the financial risks facing MCOs caring for PLWH and enrollees with other high-cost conditions. These strategies include global health-based (risk-adjusted) payment systems, AIDS-specific reimbursement rates, carve outs from capitation rates for medications and other services, risk pools for high-cost enrollees, risk corridors, and stop-loss insurance policies through which Medicaid programs share financial liability with MCOs for cat-

astrophic losses. In addition, several programs have developed HIV centers of excellence. Most state Medicaid programs have yet to adopt any of these strategies. However, the growing numbers and types of experimental approaches to capitating services for PLWH may provide models for other states whose low reimbursement rates currently limit access to care.

(*Am J Manag Care* 2000;6:990-999)

The rapid expansion of managed care in the United States has resulted in an increase in capitated arrangements to finance the payment of healthcare services. In 1991, just 9.5% of the Medicaid population participated in some type of managed care arrangement; by 1999, that percentage had risen to 55.6% (Figure).<sup>1</sup> Medicaid recipients, who number about 37 million people, comprise about 15% of the total population of the United States but include more than 50% of the country's adults living with AIDS and about 90% of the children.<sup>2</sup> A recent national probability sample of people under care for HIV (both AIDS and non-AIDS) found that 29.1% had Medicaid insurance, 32.3% had private insurance (HMO and other), 18.9% had Medicare, and 19.7% had no insurance.<sup>3</sup> Medicaid is thus the single largest payer of direct medical services for people living with HIV and AIDS (PLWH).<sup>2</sup>

A 1997 study found that in the first 9 statewide Medicaid managed care programs, capitation rates in every enrollment category were substantially below the cost of HIV and AIDS care.<sup>4</sup> Although that cost has changed since the introduction of protease inhibitor combination therapy,<sup>5,6</sup> it remains high relative to even the most generous of categorical capitation rates. However, since 1997, several state and

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No portion of the manuscript has been published previously. Some of the material in the manuscript was presented at a Twelve Steps to Managed Care meeting sponsored by the Infectious Diseases Society of America, June 2-3, 1999, Washington, DC.

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county-based Medicaid managed care programs have adopted special AIDS reimbursement strategies. These are meant to ensure that managed care organizations (MCOs) exposed to adverse risk as a result of attracting large numbers of enrollees with AIDS (and, in some cases, other high-cost conditions) receive higher capitation rates than do MCOs having lower-cost enrollees. The purpose of this paper is to describe the types of strategies that have been developed and to provide information about Medicaid programs that have adopted them.

... CAPITATION AND ACCESS  
TO CARE ...

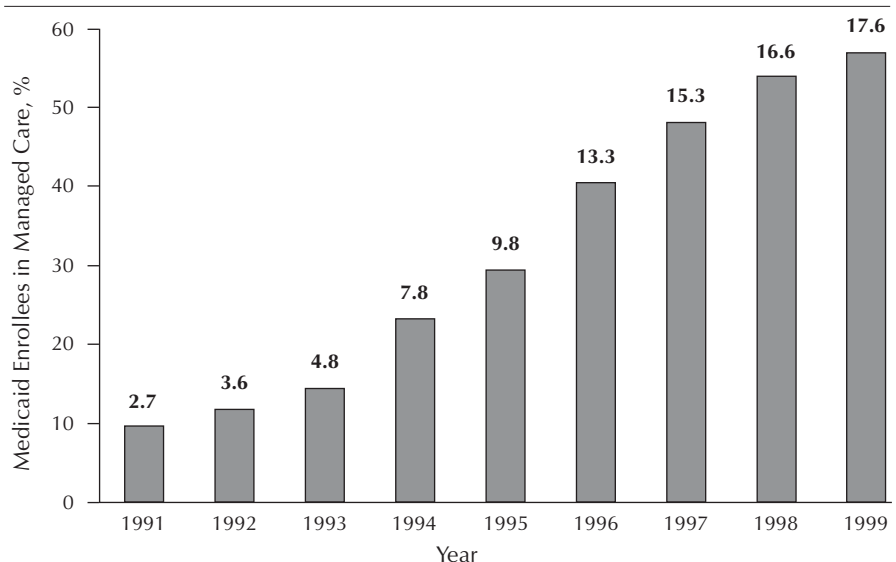
Obtaining adequate Medicaid reimbursement for AIDS (and HIV) care is a challenge that faces MCOs and experienced HIV providers alike. Capitation rates that states pay to MCOs are generally set on the basis of historical Medicaid fee-for-service (FFS) data. Such data have limitations: FFS rates are often low, reducing access to care by discouraging provider participation, and historical FFS data do not reflect the costs and effects of new treatment modalities. Nonetheless, Medicaid programs typically assume that managed care will achieve savings relative to FFS care and set managed care capitation rates so that they will total less—often 5% to 10% less—than total FFS reimbursement.

Generally, capitation rates for different Medicaid eligibility categories—such as Temporary Aid to Needy Families and Supplemental Security Income—are different, and these categorical rates are adjusted for enrollee age, sex, and geographic location. Most Medicaid programs operate under the assumption that the distribution of high- and low-cost enrollees within each eligibility category will be equal across MCOs. There are good reasons, however, for PLWH to enroll in MCOs that have HIV-experienced physi-

cians in their networks, given that patients of such physicians have better outcomes than do patients of less experienced physicians.<sup>7</sup> Should an MCO draw a disproportionate share of a Medicaid program's PLWH, the MCO is placed at financial risk. Such adverse risk has been documented as occurring in Oregon,<sup>8</sup> where one MCO has nearly four times the rate of enrollees with HIV as the state average, and in Maryland,<sup>9</sup> where one MCO has more than five times the overall rate and another has more than three times that rate.

Providing adequate reimbursement to MCOs caring for PLWH has implications for access to care. Medicaid programs typically require that enrollees receive approval from gatekeeper primary care physicians before seeing specialists, and some offer financial incentives for limiting specialist referrals. Some Medicaid managed care programs approved under section 1115 or section 1915(b) Social Security Act waivers allow HIV specialists to serve as gatekeeper physicians for PLWH. This is currently permitted in statewide programs in Maryland and New York and in several county-based California programs. Consumer materials, however, do not always identify experienced HIV providers in MCO networks. Thus, to locate experienced providers, PLWH may need to make specific inquiries when

**Figure.** The Growth of Managed Care Enrollment in Medicaid



Numbers at top of bar are the number of Medicaid enrollees in managed care (in millions) for that year.

they enroll in an MCO. Indeed, unless they receive adequate capitation, MCOs may have an interest in *not* publicizing experienced HIV providers in their networks so as not to attract enrollees whose cost of care exceeds the payment the MCOs receive from the Medicaid program. A national study of PLWH in healthcare has shown that Medicaid beneficiaries (including those in both FFS and managed care programs) had poorer access to HAART medications than did people with private health insurance during the first 2 years in which protease inhibitors were available.<sup>10</sup> It is not clear whether this finding is associated with drug costs, Medicaid physician experience with HIV, population characteristics (such as proportion of injection drug users) or other factors.

Medicaid programs have adopted a variety of strategies to ensure adequate capitation for MCOs caring for PLWH. A summary of the types of strategies, with examples, is given in Table 1. The most comprehensive strategies are *global health-based payment systems*, which assign enrollees to different capitation rate categories on the basis of their recent healthcare service utilization, and *AIDS-specific rates*. Some programs have *carveouts* from their capitation rates; through these, the state reimburses MCOs on an FFS basis for certain services, such as protease inhibitor therapy, on which there is little historical FFS data. States also redistribute withheld money to MCOs based on their risk exposure through *risk pools*. *Risk corridors* and *stop-loss insurance* are both mechanisms for limiting the risk exposure of MCOs that may draw high-cost enrollees.

The final mechanism shown in Table 1, *centers of excellence*, is qualitatively different from the others in that it is not necessarily linked with reimbursement. However, New York State's Special Needs Plans (SNPs), which will become operational at the end of 2000, will receive enhanced reimbursement for PLWH. Some Medicaid programs have adopted more than one of the strategies shown in Table 1.

#### ... GLOBAL HEALTH-BASED PAYMENT SYSTEMS ...

The first 2 states to provide health-based (also called risk-adjusted) payments to MCOs for all Medicaid enrollees were Maryland and Colorado. Maryland's mandatory managed care program began in July 1997, and Colorado's voluntary program, in October 1997. Although they have the same goal of sorting Medicaid enrollees into categories within which projected care costs are similar, the particular

mechanisms the 2 states use for computing capitation rates are different.

Maryland's Ambulatory Care Group (ACG) mechanism<sup>11</sup> sorts Medicaid enrollees into 1 of 9 "families with children" rate cells or 1 of 8 "people with disabilities" rate cells. These rate cells apply to PLWH whose disease has not progressed to AIDS; which cell they are assigned to depends (as it does for other Medicaid enrollees) upon the presenting diagnoses they had in the index year on which rate cell determinations are based. The monthly capitation rates for the rate cells currently range from \$47 to \$1462 (the latter being for disabled enrollees less than 1 year of age); these rates took effect in July 2000. For comparison purposes, a study of HIV patients with Medicaid coverage at the Johns Hopkins HIV Service in Baltimore during calendar year 1997 found that the cost of care including antiretrovirals for PLWH with CD4<sup>+</sup> counts between 201 and 500 averaged \$1305; without antiretrovirals, the average was \$949.<sup>6</sup> Maryland does not use the ACG mechanism for children with HIV, whose care is paid for on an FFS basis, or for people with AIDS, for whom there are special capitation rates (discussed below in the "Special AIDS Rates" section). Protease inhibitors, nonnucleoside reverse transcriptase inhibitors (NNRTI), viral load tests, and mental (behavioral) healthcare are all carved out of Maryland's capitation rates.

Colorado's Disability Payment System (DPS) mechanism has base rates that depend on an enrollee's eligibility category and region (inside or outside the Denver metropolitan area), with adjustments for age and gender. Incremental amounts are added to these adjusted base rates for each of 18 major categories of diagnoses for which enrollees may have been treated during the index year. In 10 of the categories (including the one for AIDS), only the most severe diagnosis in the index year is taken into account in computing capitation rates; in the other 8 categories (including the one for neoplasms), all diagnoses add to the capitation rates. Thus, diagnoses for both HIV-related opportunistic conditions and other illnesses will increase the capitation rates paid to MCOs for PLWH. As an example, the monthly capitation rate in 1998 for a 45-year-old man in Denver with no diagnoses other than AIDS was \$704. Colorado carves out protease inhibitors from the rates, paying for these medications on an FFS basis.

Several other states have adopted the DPS or are planning to do so. Oregon began using it in June

1998 for 3 of 6 Medicaid eligibility categories, including people with disabilities but excluding those eligible for both Medicaid and Medicare (a category that includes people who have had AIDS for several years). As an example of the reimbursement that Oregon was making under the DPS in late 1998, for a 25- to 44-year-old man in Portland with AIDS and no additional diagnoses, the capitation rate was \$938; protease inhibitors were included in the rate. Because the quality and completeness of encounter data available from MCOs vary widely, Oregon decided not to use the DPS fully in setting its initial risk-adjusted capitation rates. Instead, within each eligibility category, the state's program is limiting variations in capitation rates to 10% on either side of the overall average, although the DPS scores of MCOs actually vary from 22% below the average to 13% above it. This mechanism, which is similar to risk corridors but increases the risk of MCOs that have costs outside the corridor rather than reducing it, is to be reevaluated annually. Oregon's limits on risk adjustment, its inclusion of protease inhibitors in the capitation rate, and its exclusion of dual eligibles from risk-adjusted rates all increase the risk exposure of MCOs that draw disproportionate shares of PLWH.

Each state using the DPS computes capitation rates based upon its own Medicaid experience. New Jersey will begin using the DPS to make health-based payments for Supplemental Security Income enrollees in October 2000, and

**Table 1.** Strategies for Equitable AIDS Reimbursement and Quality HIV Care in Medicaid Programs

Strategy	Description	Examples
Health-based payment system (global risk adjustment)	Bases capitation for all Medicaid enrollees on the average health status of each MCO's enrollees in a past year	<ul style="list-style-type: none"> <li>• Ambulatory Care Group method adopted in Maryland, July 1997</li> <li>• Disability Payment System adopted in Colorado, October 1997, and in Oregon, June 1998; New Jersey adoption planned for October 2000</li> <li>• Major diagnostic class system in a voluntary Indiana program</li> </ul>
AIDS-specific reimbursement rate	Pays a special AIDS rate for each enrollee documented AIDS (generally by the 1993 CDC definition, which includes people with CD4+ counts <200)	<ul style="list-style-type: none"> <li>• Two AIDS rates in Maryland (Baltimore/elsewhere) and in one Massachusetts MCO (active/advanced AIDS)</li> <li>• AIDS add-on to categorical eligibility rates in Salt Lake County</li> <li>• Enhanced reimbursement in New York mainstream plans through 1999 and some California county plans</li> </ul>
Carveout	Pays for medications, viral load tests, and/or other services on an FFS basis above and beyond the capitation rate	<ul style="list-style-type: none"> <li>• Protease inhibitors in Colorado, Maryland, a Massachusetts specialty plan, Utah, and several California county programs</li> <li>• Arizona makes a retrospective monthly payment for enrollees documented to be using protease inhibitors</li> </ul>
Risk pool	Sets aside funds to be reallocated to MCOs with disproportionate shares of high-cost enrollees	<ul style="list-style-type: none"> <li>• Southeastern Pennsylvania</li> <li>• Tennessee has 2 pools, one for high-cost enrollees and one for new technologies</li> </ul>
Risk corridor	Each MCO shares profits and losses outside a specified band (eg, ±5%) with the state	<ul style="list-style-type: none"> <li>• SNPs in New York State</li> <li>• Oregon is using a risk corridor-like mechanism to limit adjustments paid to MCOs</li> </ul>
Stop-loss insurance	Limits MCOs' exposure from high-cost patients by covering amounts above a threshold	<ul style="list-style-type: none"> <li>• Available to California counties</li> <li>• Adopted in New York</li> <li>• Available 1997-1999 in Maryland but since discontinued</li> </ul>
Centers of excellence	Develop special programs to ensure enrollee access to specialists, supportive services	<ul style="list-style-type: none"> <li>• Tennessee network</li> <li>• SNPs in New York</li> </ul>

MCO = managed care organization; CDC = Centers for Disease Control and Prevention; FFS = fee for service; SNP = Special Needs Plan.

Minnesota is also considering implementing the DPS for Medicaid enrollees with disabilities. (For other Medicaid enrollees, Minnesota may use the ACG mechanism.) Two other midwestern states, Ohio and Indiana, have experimented with different health-based payment systems. A small and now discontinued pilot program in Ohio, Accessing Better Care, based payments upon enrollees' cost of care rather than on their diagnoses during an index year. A study of the program found that overall, cost was a better predictor of future service expenditures than was diagnostic information. For certain conditions, however—including HIV—diagnostic-based predictions were superior.<sup>12</sup> Indiana has a voluntary managed care program with 150 enrollees that uses a major diagnostic class system for health-based payments. There are 15 such classes, and HIV/AIDS seems to fit into the one for high-cost/high-risk conditions.

... SPECIAL AIDS RATES ...

Medicaid programs in Maryland, Massachusetts, Utah, several California counties, and New York have all adopted special capitation rates for people living with AIDS. Each of the state programs that have adopted an AIDS capitation rate has done so in a different way. Currently, only New York's Special Needs Plans (SNPs) are to pay special rates for enrollees with HIV that has not progressed to AIDS. However, a study commissioned by the Maryland State Legislature has examined the feasibility of developing both HIV- and AIDS-specific rates that would also include retrospective payments to MCOs for treating comorbid conditions.

In Maryland, the AIDS rate differs depending on where the enrollee lives; it is \$2111 per month in the Baltimore area and \$1770 elsewhere in the state. The study of Maryland Medicaid enrollees cited above<sup>6</sup> found monthly care costs averaging \$2585 with antiretrovirals (\$2105 without) for people with CD4<sup>+</sup> counts below 50, and \$1615 with antiretrovirals (\$1184 without) for those with counts between 51 and 200. As noted in the "Global Health-based Payment Systems" section, these rates do not cover protease inhibitors, NNRTI, viral load testing, or mental healthcare, all of which the state pays for separately. Maryland is unique in having both a global health-based payment system for all Medicaid enrollees and a special AIDS rate.

In Massachusetts, mainstream MCOs generally receive a Medicaid capitation rate for disabled popu-

lations but no special rate for AIDS and no protease inhibitor carveouts. However, one small MCO in Massachusetts, the Community Medical Alliance (CMA), does receive special AIDS rates as a result of having developed a managed care program specifically for people with disabilities. (CMA has since been absorbed by the Harvard Pilgrim Health Plan.) CMA is the only Massachusetts health plan that specifically cares for enrollees with disabilities and other high-risk conditions such as AIDS. But all MCOs may receive enhanced capitation rates for AIDS if they satisfy several conditions, most notably having (1) a sufficient number of experienced and geographically accessible primary care providers who specialize in the treatment of HIV; (2) a well-developed case management program for PLWH, and (3) relationships with researchers engaged in clinical trials open to PLWH. Massachusetts' enhanced capitation rates are based on severity of illness; criteria include CD4 count, AIDS-related diagnoses, mental health and/or substance abuse diagnoses, and receipt of highly active antiretroviral therapy (HAART). In 1997, there were two AIDS rates: for enrollees with "active" AIDS, the rate was \$2300; for those with "advanced" AIDS, it was \$2998.\* Protease inhibitors were excluded from these rates, but viral load testing was included. The Massachusetts Division of Medical Assistance has not publicly disseminated current rates.

\*Criteria (and their *International Classification of Diseases*, Ninth Edition, codes) for active AIDS in the Massachusetts program include candidal pneumonia (112.4); *Pneumocystis carinii* pneumonia (136.3); cutaneous Kaposi's sarcoma (KS) (176.0); recurrent mucosal candida (112.0 and 112.1); herpes simplex, including disseminated, with ophthalmic complications (054, 054.X, and 054.XX); peripheral sensory neuropathy (357.8 and 357.9); salmonella septicemia (003.1); tuberculosis (010-018, 010.X-018.X, and 010.XX-018.XX); or 2 episodes of bacterial pneumonia (481, 482, 482.X, 482.XX, 485, and 486). Criteria for advanced AIDS include coccidiosis, isosporiasis, and cryptosporidiosis (007.2); *Mycobacterium avium* intercellulare or complex (031.8 and 031.9); progressive multifocal leukoencephalopathy (046.3); cytomegalovirus (078.5 and 484.1); toxoplasmosis (130 and 130.X); KS, organ involvement (176.1-176.9); lymphoma (non-Hodgkins) (200, 200.0, 200.2, and 200.8); coccidiomycosis (114 and 114.X); histoplasmosis (115, 115.X, and 115.XX); cryptococcosis, cryptococcal meningitis (117.5 and 321.0); chronic renal failure (585 and 586); myelopathy (336.9); cardiomyopathy (425.9); disseminated candida (112.5); invasive cervical cancer (180 and 180.X); AIDS dementia complex with moderate or severe functional limitations not attributable to alcohol, substance abuse, substance abuse withdrawal, or psychiatric disorders (290.1, 294.1, 294.9, and 348.3); and abnormal weight loss or wasting (involuntary weight loss  $\geq 10\%$  in addition to daily loose stools for >1 month or weakness and fever in the absence of an explanatory concurrent illness) (783.2 and 799.4).

Utah has a voluntary Medicaid managed care program in an 8-county area around Salt Lake City. Instead of paying separate AIDS rates like the programs in Maryland and Massachusetts, Utah's program adds an increment for AIDS on top of the usual capitation rates paid for people in the various eligibility categories. As of July 1998, those categorical rates ranged from \$54 to \$381; for disabled adults, the range was from \$203 to \$381. The AIDS increment is \$1256 per enrollee, making the maximum capitation rate including the increment \$1637. Utah's capitation rates do not cover mental health services or outpatient pharmacy drugs (such as protease inhibitors), which the state pays for on an FFS basis, but they do cover viral load testing.

In California, there are 6 basic models for Medicaid managed care; the state's 58 counties may opt for any of the model types, some of which require mandatory enrollment in managed care and some of which are voluntary. For only 3 of the models are Medi-Cal's AIDS capitation rates publicly available:

- In the 12 counties with 2-plan models, enrollment is mandatory, but enrollees have a choice between a public and a locally-based private (commercial) MCO. In these counties, AIDS capitation rates—which exclude newer antiretroviral drugs, such as protease inhibitors, and mental health services—range from \$962 to \$1123.
- Five counties have prepaid health plan models with voluntary enrollment. One such county (whose highest capitation rate is \$692) has no AIDS-specific rate, 2 have AIDS capitation rates of \$1252, and 2 have AIDS rates of \$1925. There are no carveouts from these rates, leaving the MCOs at risk for the costs of antiretroviral drugs.
- Finally, among the 5 California counties with voluntary primary care case management models, just 1 has a program with a special AIDS rate.<sup>13</sup> The rate in that program, operated by the AIDS Healthcare Foundation, is \$1139, excluding inpatient hospitalization and antiretroviral drugs. Antiretrovirals are paid for by the state, but the

AIDS Healthcare Foundation receives a separate capitation rate for inpatient hospitalization of \$657 per enrollee per month. That amount is placed in a risk pool, with any savings being shared equally between the program and the state. The outpatient and inpatient capitation rates for the AIDS Healthcare Foundation total \$1796.

New York State is instituting mandatory managed care with 2 tracks—both a mainstream program and SNPs.<sup>13,14</sup> SNPs have been developed for both PLWH (including their family members to age 19 years) and people with serious mental illness; only the SNPs for PLWH are discussed here. Both tracks offer enhanced AIDS capitation rates. In the mainstream program, capitation rates paid to MCOs for *all* enrollees (not just those with HIV/AIDS) were enhanced incrementally through the end of 1999 to a maximum of 4.64% above standard rates whenever PLWH exceed certain percentages of either the number of reported AIDS cases in their regions or their total Medicaid enrollment. The details are shown in Table 2.

By April 2000, New York had selected 8 HIV; SNPs through a competitive procurement process; these SNPs are to begin operation at the end of 2000.<sup>15</sup> These specialized MCOs will receive enhanced capitation rates for enrollees with HIV and for those with AIDS; the rates are shown in Table 3. Note that the highest capitation rate available for HIV is \$737, and for AIDS it is \$2867; both rates are for adults in New York City. All pharmaceuticals are carved out from the SNP rates and are paid for by the state on an FFS basis.

**Table 2.** Rate Adjustments for Mainstream New York MCOs Enrolling AIDS Patients

Region's Symptomatic AIDS Population Enrolled, %	Symptomatic AIDS Enrollees as a % of the Health Plan's Total Medicaid Membership	Total Capitation Adjustment, %
0-20	0.0-0.1	Included in base rate
>20-40	>0.1-0.2	1.16
>40-60	>0.2-0.3	2.32
>60-80	>0.3-0.4	3.48
>80-100	>0.4-0.5	4.64

MCO = managed care organization.

... CARVEOUTS ...

As the examples already discussed suggest, it is typical for Medicaid programs with special AIDS capitation rates to carve out the cost of protease inhibitor therapy from the rates. The programs that do so include those located in some California counties, Colorado, Maryland, Massachusetts, and Utah. In Arizona, the state makes a monthly payment of \$634.50 to MCOs for each enrollee with HIV who is documented as receiving protease inhibitors. Maryland also carves out viral load testing and mental health services, and it pays for all the care of children with HIV on an FFS basis. It is expected that as states gain more experience with HAART—its cost and its impact on the need for other services—the states will come to incorporate the costs of these therapies into capitation rates.

... RISK POOLS ...

Yet another mechanism for states to protect MCOs against risk is to withhold a proportion of

Medicaid revenues and place them into a risk pool. The contents of the pool are then redistributed among participating MCOs on the basis of the number of high-cost enrollees (such as PLWH) they serve. The HealthChoices program in southeastern Pennsylvania has such a risk pool, but the state does not disclose the total or per-capita amounts of revenue that are transferred through it. Prior to 2000, Tennessee had 2 risk pools, but these did little to ensure an adequate flow of revenue for HIV care to the MCOs participating in the state's mandatory Medicaid managed care program, TennCare.

TennCare's high-risk pool had an annual budget of \$15 million, while a new technology pool (to cover such modalities of care as protease inhibitor therapy) had a budget of \$5 million. These pools were meant to cover all TennCare enrollees, and not just the 4500 living with HIV/AIDS.<sup>16</sup> Nonetheless, calculating the contribution the pools would make to the capitation rate if they went for the care of PLWH alone gives an upper limit for HIV reimbursement. Dividing the total of \$20 million in the 2 pools by the 4500 TennCare enrollees with HIV/AIDS results in an annual per capita reimbursement of \$4444. This translates to a monthly amount of about \$370; adding this to the base capitation rate of \$145 per month yields \$515 per month. Such a rate, which substantially overestimates the actual capitation that would have been paid for PLWH, still fell far short of the cost of HIV/AIDS care. Tennessee's current reimbursement arrangements are discussed below.

Tennessee's current reimbursement arrangements are discussed below.

**Table 3.** Capitation Rates for New York's HIV SNPs\*<sup>14</sup>

Region	Category			
	ADC/Home Relief Adult	ADC/Home Relief Child	SSI Adult	SSI Child
	<u>HIV/Non-AIDS</u>			
New York City	\$459	—	\$737	—
Downstate Metro	\$610	—	\$625	—
Rest of state	\$413	—	\$534	—
Statewide	—	\$246	—	\$609
	<u>AIDS</u>			
New York City	\$2187	—	\$2867	—
Downstate Metro	\$1613	—	\$2356	—
Rest of state	\$1016	—	\$1191	—
Statewide	—	\$1302	—	\$1779

\*Numbers are rounded to the nearest dollar.

SNP = Special Needs Plan; ADC = Aid to Dependent Children; SSI = Supplemental Security Income.

... RISK CORRIDORS AND STOP-LOSS INSURANCE ...

Risk corridors and stop-loss insurance are mechanisms for protecting MCOs against catastrophic losses that may be incurred in paying for the care of any enrollee.

As noted in the discussion of "Global Health-Based Payment Systems," Oregon's capping of the risk adjustment paid to MCOs reverses the usual purpose of risk corridors. New York is adopting a more typical risk corridor strategy for its SNPs. These MCOs will be at risk for medical profits and losses (excluding administrative costs) within 2% of their aggregate capitation rates, and profits or losses outside of this corridor will be shared equally with the state.<sup>14</sup>

In Tennessee, TennCare has faced serious problems since its institution in 1994. Partly in response to the threat of a pull-out by its largest participating MCO in mid-2000, the state legislature approved a 19% increase in state spending for the program, most of which went to increasing capitation payments to TennCare MCOs from \$145 to \$173 per member per month. Pharmacy benefits are included in the rate but are carved out for enrollees also eligible for Medicare. Participating managed care plans must agree to pass 85% of fees to providers and limit administrative costs to 15%. (The Health Care Financing Administration [HCFA] has not yet ruled on other components of the state's plan that include some premium increases for enrollees as well as some benefit reductions.) In May 2000, HCFA approved risk-sharing arrangements between TennCare and participating MCOs. MCOs can choose 1 of 3 options: (1) not participating in the program and assuming 100% of profits and/or losses; (2) assuming 2% of the risk and dividing additional profits or losses with the state; or (3) sharing all of the risk equally with the state. Tennessee is also instituting stop loss insurance, for which participating MCOs will contribute premiums amounting to an as yet undetermined percentage of their capitation rates.

Stop-loss insurance also limits the risk exposure of MCOs by capping the per-enrollee amounts they are required to cover. The insurance may call for a sharing of risk with the insurer (which is sometimes the state; California offers such coverage) for expenditures within a certain range, with the insurer taking on all the risk above a particular threshold. Maryland initially offered stop-loss insurance with a \$61,000 threshold but discontinued this program in 1999.

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... CENTERS OF EXCELLENCE ...

Two states have developed programs to ensure that PLWH have access to comprehensive systems of care through MCOs. Tennessee, a largely rural

state, has only about a dozen physicians caring for a majority of the 4500 PLWH enrolled in TennCare, who represent about 80% of the state's PLWH. (This percentage is so high because when Tennessee switched to managed care, it made Medicaid coverage available to all uninsured residents with low incomes and to all uninsurable residents; the latter class includes PLWH.) A coalition of consumers, providers, and MCOs came together with support from the Robert Wood Johnson Foundation to design Tennessee's AIDS Centers for Excellence program. Planning began in 1997 for the program, which took effect in 1999, with 9 such centers located throughout the state. These centers offer coordinated services, use experienced HIV gatekeeper physicians, and provide consulting services for one another. There are still some rural areas of the state, however, in which it may be difficult for TennCare enrollees to gain access to experienced HIV providers.

New York's SNPs constitute a centers of excellence program.<sup>14</sup> For the enhanced HIV and AIDS reimbursement rates they receive, SNPs must offer an enhanced benefit package. Among its elements are clinical coordination and medical case management in consultation with the enrollee's primary care physician. The SNPs must also provide utilization management, quality assurance and continuous quality improvement, and nonintensive psychosocial case management. Treatment adherence services and HIV prevention and risk-reduction education are also a part of the benefit package. These features of the SNPs build on practices that have been in place for several years in the state's FFS Medicaid program. HIV providers participating in that program have received enhanced reimbursement rates, eligibility for which has been tied to their ability to demonstrate linkages with enabling services that include case management. The number of HIV SNPs in New York State will be limited to 12, and enrollment in them will be voluntary until every county offers Medicaid beneficiaries a choice of at least 2 SNPs. Initial voluntary enrollment is expected to be approximately 25,000, expanding to about 75,000 when enrollment becomes mandatory.

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... EXPANDING ACCESS TO HEALTHCARE FOR PLWH THROUGH MEDICAID ...

One of the challenges of getting access to care for many uninsured PLWH is that in most states, their



illness has to advance to AIDS before they can become eligible for Medicaid through disability. Several states, most notably Oregon and Tennessee, have used Section 1115 waivers to expand eligibility for Medicaid for indigent populations. Maine is the first state to receive a waiver specifically to enroll people with HIV (non-AIDS) into Medicaid. While there has been growing support for such Medicaid HIV expansion, the most formidable challenge has been satisfying the budget neutrality requirement—that the cost of the expanded program over a 5 year period not exceed the cost that the Federal government would otherwise incur. Maine used a number of mechanisms to limit the cost of its program, including defining a limited benefit package, capping the number of potential enrollees at 300 individuals, and securing special drug rebates. More recently, Massachusetts and Wisconsin have announced plans to request similar waivers. The Massachusetts State Legislature has already passed legislation guaranteeing state funding for the expansion (through tobacco settlement money) and has submitted to HCFA an amendment to its current section 1115 waiver.<sup>17</sup> Wisconsin's legislature has passed authorizing legislation but is still struggling with the budget neutrality requirement.

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... IMPLICATIONS OF MCO REIMBURSEMENT  
FOR PHYSICIAN REIMBURSEMENT  
AND PATIENT ACCESS ...

All of the reimbursement mechanisms described herein increase the flow of resources to MCOs and/or limit the risk of MCOs that have disproportionate shares of high-cost enrollees such as PLWH. They thus remove some of the financial disincentives facing MCOs that enroll large numbers of PLWH, and they also make more resources available for the reimbursement of providers in MCO networks. In states with global health-based payment systems and special AIDS rates, capitation amounts approximate the cost of AIDS care. Still, a greater flow of resources from the state to adversely selected MCOs does not guarantee that those resources will be shared with physicians, especially if the MCOs rely on historical data to decide upon physician reimbursement. Physician payments in many FFS Medicaid programs have been notoriously low, discouraging provider participation in Medicaid, and these payments do not reflect the increased level of responsibility that managed care

networks require of primary care physicians. Also, the availability of HAART has, at least in the short run, shifted resource consumption away from inpatient settings and onto pharmaceuticals and outpatient settings. To ensure equitable distribution of capitation rates among types of providers, it will be necessary to continue conducting studies that examine HIV-related resource consumption. Existing studies with this goal include the HIV Cost and Services Utilization Study<sup>18</sup> and a federally supported multicenter HIV resource utilization study recently undertaken by the HIV Quality Care Network, a section of the Infectious Diseases Society of America.

As several of the examples discussed in this article suggest, the existence of enhanced AIDS capitation rates is neither necessary nor sufficient to guarantee that providers will receive adequate reimbursement for their services.

- In Tennessee, despite the development of AIDS Centers of Excellence, MCOs for several years received capitation rates for HIV care that were substantially below the cost of that care. The first of the Centers to begin operation has negotiated with the 6 MCOs in which it participates to pay physicians for HIV care on an FFS basis. But the fee schedule under which they are paid averages only about 40% of Medicare costs.
- Similarly, the MCO in Oregon that has the highest proportion of enrollees with HIV initially reimbursed all of its physicians on a capitated basis, thus sharing the risk of high-cost patients with the physicians. It quickly became evident, however, that this reimbursement arrangement did not come close to meeting HIV physicians' cost of care, and the MCO switched its HIV physicians to FFS reimbursement. The advent of health-based payments to Oregon MCOs has not changed this arrangement.
- A comparable situation exists in one California program, CalOPTIMA (California Orange Prevention and Treatment Integrated Medical Assistance), which operates on a county-organized health system model. CalOPTIMA does not receive any health-based payment or AIDS rate from the state, but it has arranged to pay an AIDS-specific rate of \$1722 to its 17 participating MCOs and 12 physician-hospital consortia.

In all 3 of these examples, the MCOs have chosen to protect HIV physicians from risk by absorbing some of the differential between state reimbursement and the cost of care. It is fortunate for these physicians that their MCOs have made this choice. But in the longer term, it may be necessary for

physicians who are armed with information about the cost of HIV care to take their case to state Medicaid programs to enlist their support in negotiating appropriate reimbursement rates with MCOs.

Without adequate capitation, access to quality care is likely to continue to be a problem for PLWH enrolled in Medicaid programs. Michigan provides a case in point. The state enacted a section 1915(b) Medicaid waiver in 1998 that includes people living with HIV and AIDS. (Those with dual eligibility for Medicaid and Medicare may, however, opt out of managed care.) One Detroit institution, the Henry Ford Hospital, cares for about 1800 HIV/AIDS patients, 1100 of whom are enrolled in Medicaid. Medicaid's capitation rate for these enrollees averages \$350 per month, including HAART and viral load testing. The Infectious Disease Clinic at Henry Ford Hospital estimates, however, that its per-enrollee care cost is approximately \$1667 per month. Thus, the hospital is losing more than \$17 million annually on its Medicaid enrollees with HIV/AIDS.

There is considerable diversity in the way in which Medicaid managed care programs around the country have addressed capitation for AIDS care. The examples discussed herein suggest that enhanced reimbursement for AIDS care may increase the number of experienced HIV providers to whom enrollees have access. There are likely already some innovative attempts to finance care for people in earlier stages of HIV disease. All of this is taking place against a backdrop of rapidly changing care standards, necessitating ongoing research to establish appropriate reimbursement rates for HIV care. While assuring that adequate reimbursement rates are paid to MCOs is an important step to providing quality care for PLWH, there is no guarantee that the financial incentives will translate into appropriate quality of care. Studies currently underway in New Mexico and Maryland (funded by the federal government and the Henry J. Kaiser Family Foundation, respectively) are examining issues relating to quality of care for PLWH in capitated environments. Another study undertaken by the Center for HIV Quality Care (through the Infectious Diseases Society of America) funded by the Health Resources and Services Administration is examining the financing, delivery, and organization of care for PLWH in all 50 states. Information on this project can be accessed via the internet at [www.idsociety.org](http://www.idsociety.org).

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