WORKING TOGETHER TO MEET THE NEEDS OF HIV-INFECTED POPULATIONS: *CHALLENGES PRESENTED BY MANAGED CARE SYSTEMS*

JULIA HIDALGO

CENTER FOR HEALTH SERVICES RESEARCH & POLICY

GEORGE WASHINGTON UNIVERSITY &

POSITIVE OUTCOMES, INC.

Today we will discuss…

- ✓ Environmental changes confronting HIV providers
- ✓ Approaches to managing HIV-infected members used by Medicaid managed care plans
- ✓ Basic tenets of managed care and their application to HIV members
- ✓ Managed care model used by Michigan Medicaid program
- ✓ Rationale for participation in managed care by HIV providers
- ✓ Integrated HIV care networks as a strategy to effectively negotiate participation in managed care plan networks, improve care coordination, and optimize resources

ENVIRONMENTAL CHANGES

New Opportunities and Challenges Presented by HAART

- **HIV services have shifted from a death and dying model to a chronic disease medical model**
- **Primary care, medications, and virologic testing have become the locus of the HIV care continuum**
- **Services like case management, substance abuse and mental health treatment, transportation, and housing have moved from primary to adjunctive services**
- **Service demand by new and ongoing patients is increasing sharply**

New Financial Challenges Resulting From HAART

- **Local HIV care systems struggle to meet the growing cost of care, drugs, and virologic testing**
- **Complexity of HAART has resulted in the need for new services (e.g., adherence education) to support patients' clinical care**
- **Policy makers experience pressure to sustain outmoded services despite declining demand (e.g., LTC)**
- **Some communities have insufficient funds to support HIV care and some providers report inadequate funding**

New Insurance Challenges Resulting From HAART

- **HAART has delayed disability previously experienced by HIV-infected individuals**
- **While able to continue employment, individuals on HAART are often under-insured (e.g., no prescription or dental coverage) or have caps on the number of annual or "life-time" services**
- **Employers are increasingly selecting managed care plans to reduce health insurance costs**
  - **Inadequate coverage, HIV inexperienced clinicians, prior authorizations, caps on service use, limited or no mental health or chemical dependency services, inadequate reimbursement for HIV providers**

Other Challenges

HIV-infected individuals are eligible for multiple discretionary and entitlement programs

- **These programs are often poorly coordinated, inaccessible, result in gaps in insurance coverage, and lead to duplication and gaps in benefits**
- **A complex set of bureaucracies and eligibility criteria must be navigated during the course of HIV infection**
- **As a result, many HIV-infected individuals experience periods in which they are inadequately insured for HIV treatment, drugs, virologic testing, and ancillary services**

Other Challenges

- Medicaid enrollment has grown rapidly during the HIV epidemic- it is the single largest payer of HIV care, far exceeding the CARE Act
- Welfare and Medicaid reform, welfare diversion initiatives, and an improved economy have resulted in declines in Medicaid enrollment
- Despite declines in enrollment, two-thirds of Medicaid program report that expenditures exceed their budgets
- Medicaid enrollment among HIV-infected individuals that are not disabled is likely to increase as States expand eligibility
- Large numbers of Medicaid enrollees must enroll in capitated managed care systems; disenrollment is not an options in many States

Other Challenges

- **Some HIV providers experience decreasing reimbursement for their patients enrolled in Medicaid and/or erosion of their patient base because they do not participate in networks**
- **Mainstream managed care plans are poorly prepared to provide a minimal standard of HIV care; access to experienced HIV care providers is limited; care is often significantly constrained**
- **States are making significant and varied changes in Medicaid eligibility and coverage, leading to geographic inequities**

APPROACHES TAKEN BY STATE MEDICAID PROGRAMS TO FINANCE & DELIVER CARE TO PERSONS WITH HIV

APPROACHES TO ENROLLING HIV POSITIVE INDIVIDUALS IN MEDICAID

- **Facilitate rapid enrollment through:**
  - **Presumptive eligibility**
  - **Fast-tracking SSI applications**
  - **Training disability determination staff regarding HIV**
  - **Training HIV clinical and case management staff to prepare SSA applications**
- **Expanding Medicaid eligibility to include individuals that are HIV-infected but that do not meet the SSA disability criteria**
  - **DC, MA, ME, GA, FL, CA, WI**

APPROACHES TO MANAGING HIV-INFECTED RECIPIENTS IN MEDICAID FEE FOR SERVICE (FFS) SYSTEMS

- "Mainstream" Medicaid recipients in FFS, whether the State has an expansive or narrow covered benefits package
- Enhanced covered benefits package (e.g., HIV targeted case management)
- Enhanced payments
- Coordination with State and local HIV planning efforts
- Collaboration with State HIV/AIDS surveillance efforts

APPROACHES TO MANAGING HIV-INFECTED RECIPIENTS IN MEDICAID MANAGED CARE SYSTEMS

- "Mainstream" recipients
- Carve-out HIV positive recipients into fee-for-service, if a mandatory enrollment system
- Carve-out HIV-related services
- Carve-in HIV services by broadening covered services
- Require HIV-specific product features (e.g., experienced HIV providers, network standards, HIV QA measures, HIV-specific access standards, plan staff training)

APPROACHES TO MANAGING HIV-INFECTED RECIPIENTS IN MEDICAID MANAGED CARE SYSTEMS

- Enhance capitation rates (for chronic disease populations or HIV/AIDS), special risk pools, and other special financing arrangements
- HIV/AIDS disease management
- HIV/AIDS managed care “special needs” plans
- “Mixed” approach based on assistance category

Overview of the Michigan Medicaid Program

Michigan Medicaid

- 1.4 million enrolled, down 1.5% between 1995-1998
- In 1998, 51% of enrollees were children, 21% adults, 7% elderly, 20% blind/disabled
- 44% of Medicaid beneficiaries receive cash assistance
- $5.6 billion in expenditures, 3.5% increase
- Medicaid finances 38% of MI births
- Mandatory managed care enrollment

MICHIGAN MEDICAID

MANAGED CARE PLAN ENROLLMENT

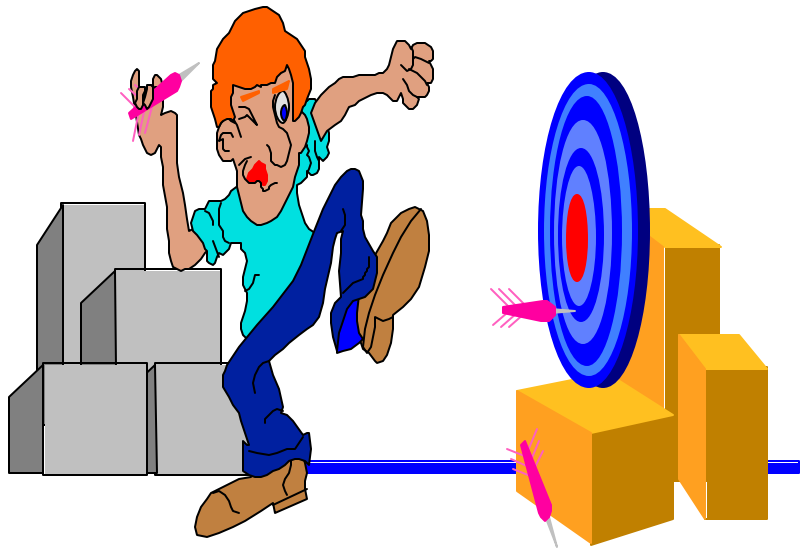
The Wellness Plan	113,407
Great Lakes Health Plan	76,291
Community Choice MI	68,428
OmniCare Health Plan	66,044
HealthPlus of MI	55,174
Total Health Care	44,661
Cape Health Plan	40,140
Midwest Health Plan	32,873
Health Plan of MI	29,578
Community Care Plan	28,067

Priority Health	25,256
Molina Healthcare of MI	24,380
Physicians Health Plan of Mid-MI	22,689
Physicians Health Plan of SW MI	22,459
Upper Pen. Health Plan	17,303
McLaren Health Plan	14,505
M-Care HMO	11,950
Care Choices HMO	7,454
Botsford Health Plan	6,684

Review of
Basic Managed Care Concepts
And Their Application to
Financing And Delivering
HIV Care

Some MCO goals...

- Clearly define patient populations, modify their care seeking behavior, & predict their care use & costs
- Identify high risk & high cost patients
- Identify & minimize financial risk
- Maximize profitability
- Organize systems of care that achieve these goals



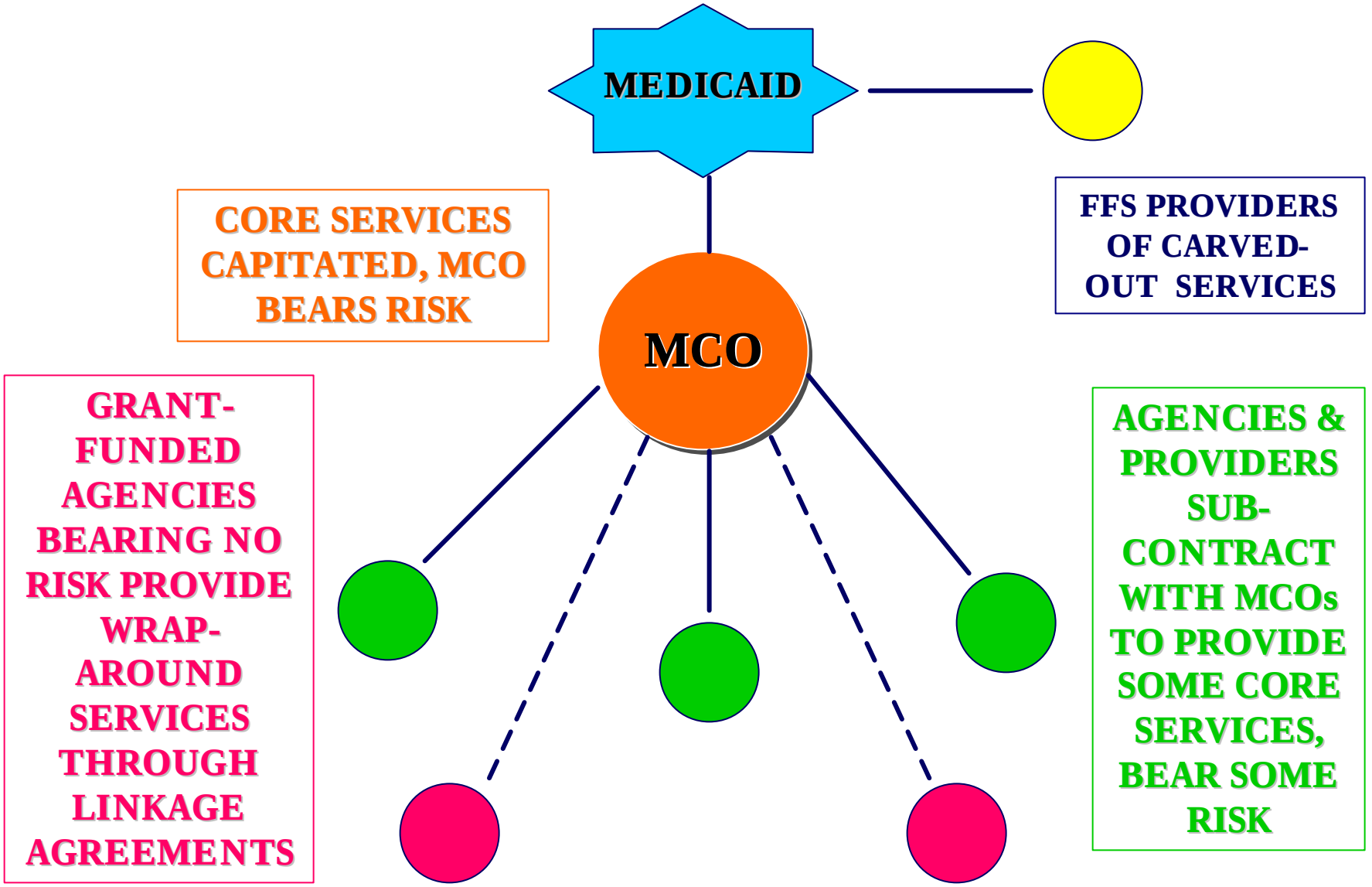
PLAN SELECTION CRITERIA

- Established provider network
- Geographic coverage
- Sufficient capacity & accessible services
- Acceptable marketing, enrollment, grievance, & disenrollment procedures
- Established quality assurance program
- Fiscal solvency
- Established administrative & governance structure
- Meets State managed care licensure criteria

ORGANIZING HIV SERVICES IN MANAGED CARE SETTINGS

- Training & experience of clinical staff & their willingness to treat HIV-infected patients
- Ability to rapidly disseminate new therapeutic approaches & provide on-going training
- Contractual relationships with HIV specialists & social support programs
- Up-to-date quality assurance programs
- Attitudes of other patients treated in same settings & communities in which services are provided
- Adequacy of capitation rate setting system to cover current & anticipate future HIV costs
- Confidentiality, disclosure, & privacy
- Case finding & outreach

FINANCING & DELIVERY OF HIV SERVICES IN A MEDICAID MANAGED CARE ENVIRONMENT



CHALLENGES TO SETTING HIV CAPITATION RATES

- It is difficult to identify the claims of HIV infected recipients
- Historical service utilization data may be:
  - unavailable for all planned services,
  - based on a small number of patients,
  - heavily influenced by high or low cost users,
  - unable to account for "case-mix,"
  - untimely
- Historical data on service costs may be:
  - based on inefficiently operated programs,
  - offset by other grant funding streams,
  - or reflect cross-subsidization of programs
- "Carved out" services (e.g., drugs and diagnostics) may influence medical management in unplanned ways

HIV RISK ADJUSTERS

- Age and gender
- Source of insurance (i.e., can risk be spread across several payers)
- Spectrum of HIV disease (i.e., HIV asymptomatic, symptomatic, AIDS)
- Surrogate clinical markers (i.e., CD4 count, viral load)
- Other clinical co-morbidities (i.e., other chronic diseases, substance abuse, mental illness, tuberculosis)
- Psycho-social co-morbidities (i.e., poverty, homelessness)

WHY PARTICIPATE IN MANAGED CARE?

- Enhance the quality, accessibility, coordination, and continuity of care for managed care members with HIV
- Ensure your agency's ability to access HIV-infected populations enrolled in managed care plans so your agency can offer them grant-funded prevention and psychosocial services
- Improve your agency's likelihood of financial survival
- Diversify your agency's client and income base
- Influence the governance and policy making process within managed care plans
- Adopt sound business practices used by managed care plans to improve your agency's products and more efficiently use scarce resources

ADVERSE SELECTION

Attracting members who are sicker than the general population

- **This results in higher than budgeted expenses for the plan**
- **MCOs may avoid enrolling individuals who are sicker than the "average" patient**
- **Some MCOs may avoid enrolling HIV-infected individuals because of their relatively high treatment cost**

Improved Integration of HIV Care Networks: One Way To Meet The Challenge

Integrated service delivery systems are:

- **Entities that directly provide or support provision of integrated health care and social support services to a defined population**
- **Networks offer comprehensive services and has a centralized structure that coordinates and integrates services provided by member organizations and clinicians participating in the network (Shortell, 1996)**

INTEGRATED SERVICE DELIVERY SYSTEMS

- Adopt local strategic, systemic planning that focuses on the greater good of the care delivery system, not individual organizational self-interest
- Planning emphasizes purposeful development of care models that reflect local needs
- Blend funding sources to maximize revenue
- Adopt uniform eligibility standards, with higher income individuals making contributions through sliding fee scales
- Establish a core minimum service package, regardless of payer
- Provide one-stop shopping where feasible

INTEGRATED SERVICE DELIVERY SYSTEMS

- Use provider assignment and utilization management to reduce duplicated services or unnecessary care
- May use prospective global budgeting, capitation payments, and other strategies to control costs
- Cost containment may be achieved through enrollment or benefit caps, negotiated prices for drugs or other services, and efficiencies in service delivery and administrative costs
- Reinvest revenue gained from an efficient system by expanding the number of individuals served or increasing the benefits provided

Center for Integrated HIV Care Networks (CIHCN)

Center for Health Services Research & Policy

George Washington University

School of Public Health & Health Services

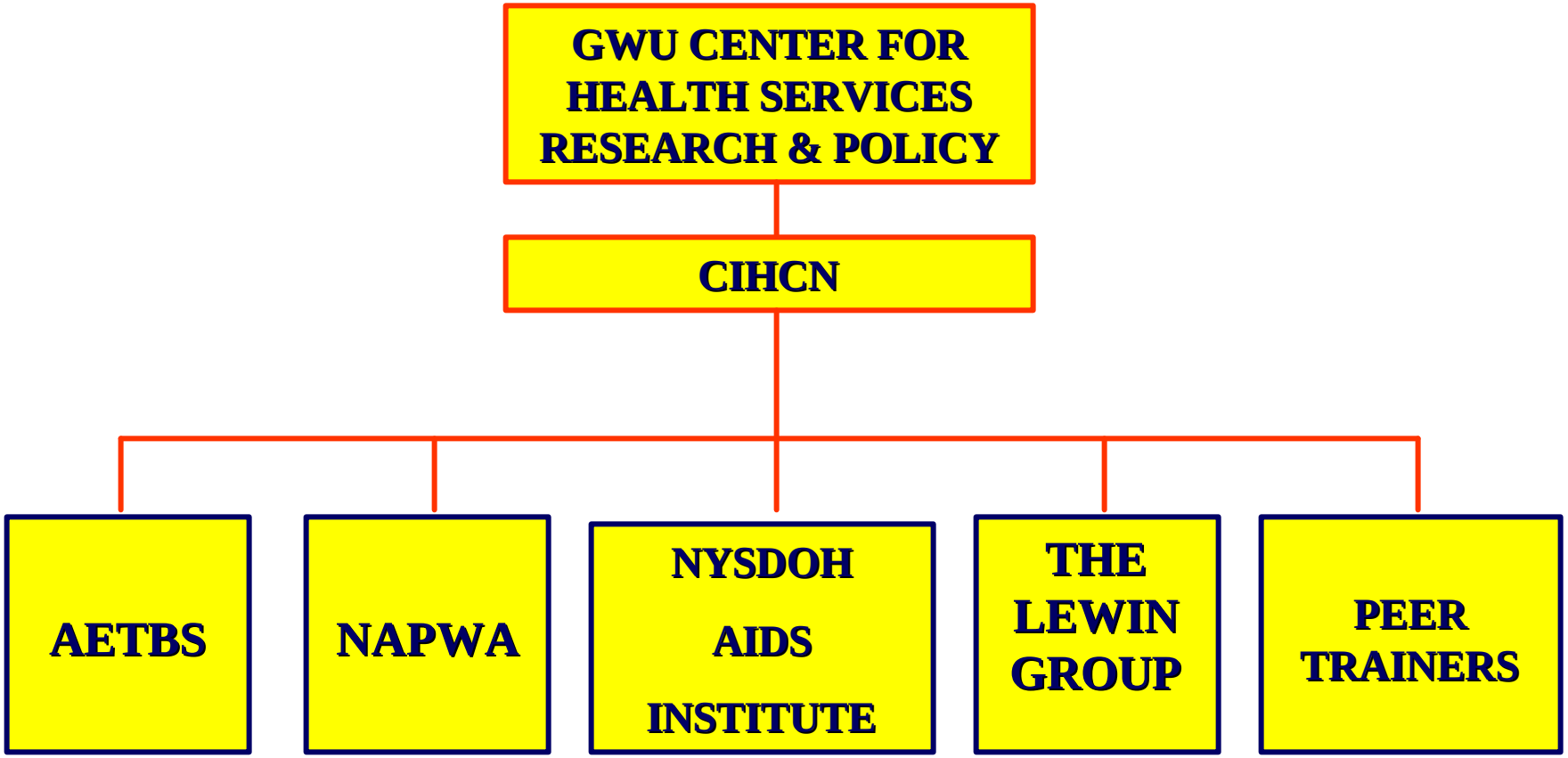
CIHCN'S GOALS

- **Demonstrate the feasibility of integrating traditional, community-based HIV providers to improve the quality, capacity, and coordination of HIV care by:**
  - **Reengineering the HIV care continuum based on a managed care model**
  - **Adopting sound business practices**
  - **Optimizing HIV care resources**
  - **Minimizing organizational redundancy**
  - **Enhancing linkages among ASOs**
  - **Integrating Medicaid, CARE Act, and other funding streams**

CIHCN'S GOALS

- **Enhance the ability of integrated HIV care networks to compete successfully as managed care organizations and network providers by improving the HIV care system through partnerships**
- **Enhance the ability of Medicaid and other managed care systems to serve HIV-infected individuals through contracting with HIV-experienced networks**

CIHCN'S PARTNERS



ONSITE TECHNICAL ASSISTANCE MODEL

Network

- Network readiness and environmental assessment
- Network strategic planning and identification of network providers
- Product development
- Financial risk assessment and development of risk assignment strategies
- Network financing, integration of funding streams, and capitalization
- Network formation and governance
- Administrative structure development

ONSITE TECHNICAL ASSISTANCE MODEL

Network

- MIS development
- Marketing plan and materials development
- Managed care contract development and negotiation
- Quality assurance program development and implementation
- Ongoing cost and utilization assessment
- Start-up and ongoing technical assistance
- Ongoing evaluation

ONSITE TECHNICAL ASSISTANCE MODEL

AIDS Service Organizations

- ASO board and staff training
- Strategic planning
- Administrative, capacity, financial, and MIS assessment
- Unit cost development
- Utilization management
- Product development
- Infrastructure development

ONSITE TECHNICAL ASSISTANCE MODEL

Consumers and Network Members

- Consumer education regarding managed care and integrated networks
- Consumer input into program design, marketing materials, and grievance process
- Network member education
- Member satisfaction assessment

ONSITE TECHNICAL ASSISTANCE MODEL

State Policymakers

- Policy and financing
- Rate setting
- Managed care contract specification development
- Legislative analysis and development

MICHIGAN

- **Service Area: Detroit, Ann Arbor, Ypsilanti, Lansing, Flint, & adjoining counties**
- **Lead Agency: AIDS Partnership Michigan (Detroit)**
- **Other Network Members: AIDS Consortium of Southeast Michigan (Detroit), HIV/AIDS Resource Center (Ypsilanti), Wellness AIDS Services (Flint), Lansing Area AIDS Network (East Lansing), CARES (Kalamazoo)**
- **Service Model: Case management**
- **Estimated Patients Served: Unclear**
- **Managed Care Saturation: High**
- **Funding Sources: Title I, II, IV, HOPWA, SAMSHA, CDC, State, foundations**

TA Requested:

- Identifying “best practices” for network development
- Strategic planning
- Bringing HIV clinical providers into the network
- Network administrative structure development
- Rate setting
- Unit cost development
- Business plan development
- Marketing
- Outcomes measurement

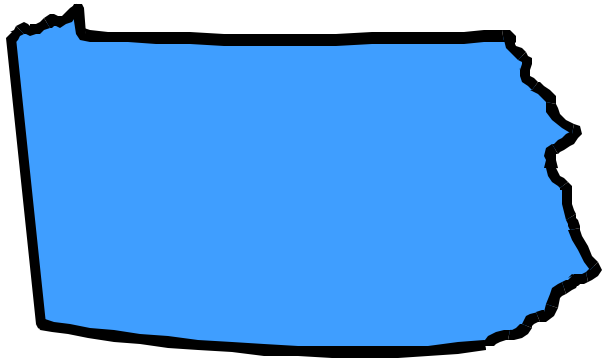
Other TA Identified By Reviewers:

- Medicaid managed care HIV program development

MICHIGAN

PENNSYLVANIA

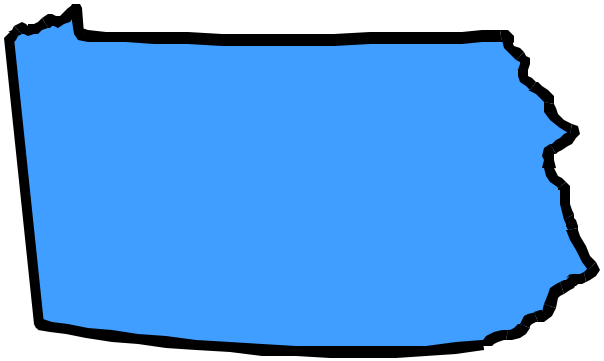
- Service Area: Lehigh Valley & Capital Region
- Network: LinkCare
- Lead Agency: AIDSNET (Title II consortium)
- Other Network Members: Lehigh Valley Hospital, AIDS Services Center, AIDS Outreach, Easton Hospital, St. Luke's Hospital, Berks AIDS Network, Behavioral Health Choices, Family Health Council of Central PA, AIDS Planning Coalition of South Central PA, Pinnacle Health System, Community Psychological Center,
- Service Model: Integrated clinical, case management, & support services
- Estimated Patients Served: ± 1,000
- Managed Care Saturation: High within year
- Funding Sources: Title II, III, HOPWA, State, foundations



TA Provided Or Planned:

- Business plan & administrative structure development
- Network governance
- Financial risk assessment & network financing
- MIS
- Product development & marketing
- Managed care contracting
- Quality assurance program development and assessment
- Unit cost & utilization assessment
- Evaluation
- Policy development regarding HAB payer of last resort, case management reimbursement, & managed care HIV service coverage

PENNSYLVANIA



NEW YORK CITY

- **Service Area: New York City boroughs of Brooklyn & Staten Island**
- **Lead Agency: SIBRO**
- **Other Network Members: Brooklyn AIDS Task Force, Discipleship Outreach Ministries, Dr. Jordan Glaser, Project Hospitality, Richmond Home Needs Services, Staten Island AIDS Task Force**
- **Service Model: Integrated clinical, case management, & support services for adults**
- **Estimated Patients Served: ± 1,500**
- **Managed Care Saturation: Growing rapidly in Medicaid population**
- **Funding Sources: Medicaid, Titles I, II, III, CDC, HOPWA, State, City**

NEW YORK CITY

TA Provided Or Planned:

- Business planning
- Network infrastructure development
- Funding sources for capacity development
- Governance and revenue distribution
- MIS
- Unit costing and sub-capitation rate setting
- Quality assurance
- Program evaluation
- Outcomes research
- Training
- Funding stream integration

A Network Readiness & Environmental Assessment Are Used To Develop A Technical Assistance Plan & Budget

METHODS

- **Self-assessments by network providers**
- **On-site assessments**
- **Interviews with policymakers, consumers, & other key stakeholders**
- **Interviews with managed care plan staff**
- **Funding & service profiles**
- **Supplemental information**

ONSITE TECHNICAL ASSISTANCE MODEL

State Policymakers

- Policy & financing
- Rate setting
- Managed care contract specification development
- Legislative analysis & development

ONSITE TECHNICAL ASSISTANCE MODEL

Network

- Identification of best practices used by HIV & other networks
- Network readiness & environmental assessment
- Network strategic planning & identification of network providers
- Product development
- Financial risk assessment & development of risk assignment strategies
- Network financing, integration of funding streams, & capitalization
- Network formation & governance
- Administrative structure development

ONSITE TECHNICAL ASSISTANCE MODEL

Network

- MIS development
- Marketing plan & materials development
- Managed care contract development & negotiation
- Quality assurance program development & implementation
- Ongoing cost & utilization assessment
- Start-up & ongoing TA
- Ongoing evaluation

ONSITE TECHNICAL ASSISTANCE MODEL

AIDS Service Organizations

- ASO board & staff training
- Strategic planning
- Administrative, capacity, financial, & MIS assessment
- Revenue enhancement
- Unit cost development
- Utilization management
- Product development
- Infrastructure development

ONSITE TECHNICAL ASSISTANCE MODEL

Consumers & Network Members

- Consumer education regarding managed care & integrated networks
- Consumer input into program design, marketing materials, & grievance process
- Network member education
- Member satisfaction assessment

TECHNICAL ASSISTANCE MATERIALS TO BE PREPARED BY CIHCN

- Policy briefs & options papers
- Network readiness & environmental assessment tools
- On-site training modules
- Prototype TA materials
- Model contract specifications
- Quality measures & improvement practices
- Methods for assessing the impact of integrated HIV care networks on delivery of HIV care
- Data collection tools, analytic plans, & model reports