··· PAPER PRESENTATION ···

Comprehensive HIV Services Under a Capitated Reimbursement System: AIDS Healthcare Foundation

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Abstract

The application of capitated managed care systems to Medicaid populations has increased as part of an effort to control healthcare costs. The difficulties of caring for people with HIV and AIDS in the Medicaid population is compounded by the issues of impoverishment and access to care. In this profile, we discuss the rationale for and planning involved with creating the AIDS Healthcare Foundation, a community-based program providing comprehensive and coordinated care for people with HIV and AIDS.

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The AIDS Healthcare Foundation (AHF, or the Foundation) is one of the largest community-based providers in the United States for care of persons with human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS), delivering more than 30,000 primary care medical visits annually. The foundation is based in Los Angeles County, California, where 35% of all reported AIDS cases in the state are located. This region is second only to New York City in the number of reported cases of AIDS by county or municipality. AHF has been providing direct medical care to persons with HIV/AIDS in Los Angeles County since 1987. Estimates indicate that another 67,000 residents have HIV, with only one third of these individuals receiving treatment. In the past decade, the AIDS epidemic in Los Angeles County has spread dramatically into communities of people of color. Between 1988 and 1998, the county Department of Health reports a dramatic decrease in new cases of AIDS among white individuals while the numbers of new cases among African American, Asian, and Latino groups have risen. Currently, only 34% of new cases involve white people, as opposed to 61% in 1988. Conversely, 23% of all new cases are reported in African American individuals, as opposed to 18% in 1988. Over the same time period, new cases among Latino people increased from 19% to 40% From 1998 to mid-1999, the number of new cases continued to increase for Latino and African American patient groups and decrease for white patients; for the 900 new patients in the AHF system during that time, 44% are Latino, 35% are African American, and 18% are white.

AHF currently operates 4 outpatient healthcare centers throughout the county, all of which are affiliated with major medical centers, and developed a capitated managed-care program called Positive Healthcare (PHC), which has become the trade name for their capitated plan. AHF also owns and operates 2 hospice/nursing facilities, both with a 25-bed capacity. In the first 10 years, AHF provided primary care to approximately 7700 patients cumulatively and currently maintains an active caseload of 3750 patients. AHF receives funding from the Ryan White CARE Act, Medicaid, Medicare, private insur-

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ers, and charitable donations. The budget for 1998 was $35 million.

More than 90% of patients in AHF's active caseload report incomes 200% below the federal poverty guidelines. Roughly 90% of the patients who are people of color have been diagnosed with AIDS and access care only after displaying symptoms of AIDS. Thirteen percent of AHF clients are female; four-fifths of these are people of color, with half of these patients being Latina. While 60% of AHF patients had an AIDS diagnosis 5 years ago, 32% of the current patient load has an AIDS diagnosis. Of the remaining patients, 31% have symptomatic HIV disease and 35% have asymptomatic disease. Of the active caseload, 25% are Medicaid recipients.

The Foundation is recognized not only for the size of its operations but also for its history of legislative activism and involvement with managed care. AIDS Healthcare Foundation was one of the first community-based organizations to recognize that capitated managed care reimbursement was fast becoming a de facto model for many Medicaid systems, given state efforts to control healthcare costs. AIDS Healthcare Foundation also recognized the potential this model had for affecting the way HIV/AIDS care could be delivered and financed.

While seeing the promise of managed care, AHF shared the concern of other treatment advocates that such programs might sacrifice quality to reduce HIV/AIDS-related costs or might fail to provide the kind of specialized services required by patients with HIV/AIDS.

These concerns prompted AHF to pursue state legislation to protect the rights of people with AIDS. In 1991, AHF sponsored state legislation to establish a pilot managed care program that included risk-adjusted rates for AIDS. In April 1995, PHC began delivering service to 107 initial enrollees. By these actions, AHF hoped to set a precedent for other providers by pioneering the development of a managed care system wholly appropriate to HIV-infected populations.

AIDS Healthcare Foundation built its managed care model on principles involving quality medical direction, overseeing, and clinical coordination. PHC is an integrated healthcare delivery system, complete with extensive medical and social case management, proactive treatment adherence, and thorough utilization review processes. Positive Healthcare provides comprehensive and coordinated care within a specialized framework, where specialists have the clinical and financial flexibility to care for patients rationally and systematically at a time of rapidly changing treatment paradigms.

··· MEDICAID AND MANAGED CARE IN CALIFORNIA ···

California's Medicaid program, Medi-Cal, provides healthcare coverage for more than 5 million women, children, elderly, and disabled people. Between 1980 and 1996, enrollment in the Medi-Cal program doubled and costs more than tripled. California now spends more than $15 billion a year on Medi-Cal services. To control costs, the state is engaged in a comprehensive effort to expand managed care services to Medi-Cal recipients, using 19 of the 1915b waivers of the Social Security Act. Over the past several years, the state has steadily increased its commitment to large-scale expansion of managed care within Medi-Cal.

The largest and most comprehensive effort in this regard is a program called the Two-Plan Model, which has been implemented in 12 of California's largest counties. In these designated counties, the Department of Health Services contracts with 2 managed care plans. The first, awarded through competitive bidding, is a commercial health plan. The second is a locally initiated, publicly sponsored plan developed jointly by local government, clinics, hospitals, physicians, and other Medi-Cal providers. Enrollment in 1 of the 2 plans is mandatory for most Medi-Cal recipients who live in these counties, have no share of cost, and receive coverage through the Temporary Assistance to Needy Families program (formerly Aid to Families with Dependent Children). Other patients who may join one of the managed care plans voluntarily with no share of cost include the elderly and those who are blind or physically disabled, including AIDS-disabled.

Several Medi-Cal beneficiaries are exempt from mandatory enrollment, including:

- Recipients of any age who receive SSI;
- Recipients with complex or high-risk medical conditions who are in a treatment relationship with a provider who is not affiliated with the Two-Plan Model programs;
- Children in foster care; and
- Native Americans who qualify for services at a Native American health clinic.

Some patients should not be enrolled in the Two-Plan Model Program, including:

- Recipients of care in a skilled nursing facility;

- Recipients who are accepted for case management in the AIDS waiver program;
- Recipients requiring a major organ transplantation; and
- Recipients with a share of cost.

In November 1997, the state of California made special risk-adjusted AIDS rates available to Two-Plan Model managed care organizations, offering them financial protection in the event of voluntary enrollment of beneficiaries. The 1998 county rates range from $1000 to $1070 per member per month (PMPM) for all Medi-Cal services except new drug therapies, while the effective rate for these services at AHF is $1797 PMPM, or $1140 PMPM for all services except inpatient, and $657 PMPM in an inpatient risk pool.

··· PROJECT DESCRIPTION ···

Project Genesis

Shortly after beginning to provide primary medical care to Medi-Cal beneficiaries with AIDS, AHF recognized that the Medi-Cal fee-for-service system was inefficient, leading to the provision of fragmented, episodic care. At the same time, the State Medi-Cal program, attempting to control costs, began moving towards a capitated managed care reimbursement system. Initial plans were not clear as to how this new system would be structured, the population it would encompass, and the provisions that would be available for persons with chronic or disabling conditions such as HIV/AIDS.

From a patient-care perspective, a more coordinated and organized approach was necessary. AIDS Healthcare Foundation believed that any new model must contain provisions allowing specialty providers to act as primary care providers. In addition, diagnosis-based risk-adjusted rates should be included in the model to protect specialized providers and health plans from the competitive disadvantage arising when these providers, because of their reputation for excellence in treating patients with high-cost conditions, attract a disproportionate share of patients with higher-than-average healthcare utilization needs.

In 1991, AHF began discussions with the California Department of Health Services about developing a special capitated Medicaid managed care program for people with AIDS. Initial discussions were not productive, given that the state had neither the desire nor the infrastructure to facilitate such a program at that time. Thus, another avenue would have to be pursued. In September 1991, AHF helped facilitate state legislation to allow an AIDS-specific primary care case management program (PCCM). In 1992, the legislation was passed and signed by the governor.

AHF spent most of 1993 preparing the PCCM application, which was submitted to the state in February 1994. The final contract was signed in March 1995. PHC began operation on April 1, 1995. As with all PCCMs, AHF is subject to having the state Department of Health Services oversee the clinical and financial operations and ensure that all services covered under Medi-Cal are available and accessible to enrollees.

To further the development of the capitated care model, AHF used a 5-year grant received in October 1994 from the Health Resources Services Administration (HRSA) Special Projects of National Significance (SPNS) Program. Funding was allocated for important data gathering and for the clinical, administrative, and financial preparations needed to develop a national managed care model and capitated reimbursement system.

Positive Healthcare Clinical Delivery Model

Prior to beginning service on April 1, 1995, AHF hired professionals with experience in AIDS care utilization management (UM) and quality assurance. AHF developed a UM program that includes treatment protocols for best practice, a drug formulary, and standardized laboratory tests and panels. AHF established clinical capacity standards of 1 registered nurse (RN) case manager per 150 patients and 1 physician and 1 mid-level provider per 500 patients.

To ensure coordinated care, AHF assigns an RN case manager to each PHC client. The case manager monitors the overall care plan established by each patient's primary care physician and interdisciplinary team. This team includes a provider (physician, nurse practitioner, or certified physician's assistant), a mental health clinician (psychiatrist, psychologist, or clinical social worker), medical assistants, and social service benefits counselors. The team collaborates on the monitoring and evaluation of both of the individual care plans as well as on the aggregated quality indicators. This collaboration enables the identification of high-risk, problem-prone, high-cost, and high-volume conditions and respond with reconfigured care plans that are designed to better meet the medical and psychosocial needs of the patients.

The RN case manager navigates the patient through all stages of care, acting as liaison to the physician/mid-level provider, coordinating the vari-

ous components of care, and teaching the enrollee how to cope with the disease and live as independently as possible. The RN case manager also communicates regularly with all providers who deliver care, services, and products to the patient. While a physician/mid-level provider makes decisions for care, the RN case manager makes sure that the goals of the treatment plan are met. The case manager advises providers of adjustments to be made to the care plan.

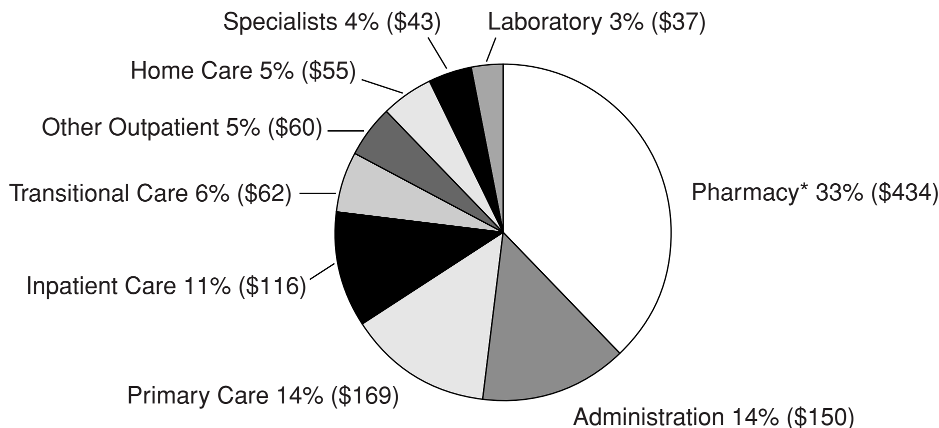
Financial Issues

Prior to launching PHC, AFH needed to be prepared to assume financial risk for the cost of medical care for AIDS patients. AHF conducted an extensive financial planning and review process using data from patients with CD4 counts of less than 200. The review used internal and market costing structures to analyze internal cost and utilization in determining unit medical costs for AIDS patients. The variables that were examined include: primary and specialty physician services, ancillary services, hospital inpatient and outpatient services, home health and skilled nursing services, administrative overhead and insurance requirements, and capitalization requirements.

Using the information gathered, AHF was able to make enrollment forecasts, revenue forecasts, and cash flow projections. AHF then developed a comprehensive business plan for PHC. AIDS Healthcare Foundation then was properly prepared to negotiate network contracts with hospitals and specialty providers and to negotiate an appropriate capitation contract with the state of California.

The capitated Medicaid managed-care contract for AFH is with the California Department of Health Services (DHS). The initial contract rate of $1107 PMPM was determined prospectively by the State using 1994 fee-for-service claims data for Medi-Cal AIDS patients in Los Angeles County. The claims were grouped into 5 major cost categories (home health, pharmacy, physician services, ancillary services, and other outpatient costs) to determine PMPM costs by category and in the aggregate, with 95% of the aggregate figure offered to AHF as a PMPM capitation (Figure). This guaranteed the State savings of 5%. The initial contract required that AHF provide PHC enrollees access to all Medi-Cal covered services, with the exception of hospice, dental, and long-term care. The current contract in effect through December 1999 includes a rate of $1140 PMPM for all Medi-Cal covered services except inpatient care, with drug treatment protocols introduced after December 1995 carved out. In addition, patients who are HIV-positive but not diagnosed with AIDS currently do not have a capitated rate.

Figure. Distribution of Costs for Service Categories, 1998



*This figure does not include an amount for protease inhibitors. With these included, the cost would increase by $500 per member per month.

Under both of these contacts, all inpatient services provided to PHC enrollees are paid directly by the DHS, although the contracts allow for AHF to benefit financially if inpatient costs for PHC patients are lower than other Medi-Cal AIDS patients in Los Angeles County. The incentive program, known as Savings Sharing, was designed to encourage providers to deliver efficient managed healthcare through gate-keeping, case management, and a well-developed utilization management function to reduce unnecessary fee-for-service (FFS) costs. The basic concept is to estimate what would have been spent on these beneficiaries in an FFS system and pay the plans a percentage (eg, 50% as written in AHF's initial contract) of the savings. The Savings Sharing program is effectively as an inpatient risk pool, which is reconciled semi-annually for AFH.

Benefits Package

Positive Healthcare enrollees have access to all services covered by Medi-Cal, including primary and specialty physician care, pharmacy, inpatient and outpatient hospital care, home health/infusion drugs/durable medical equipment, laboratory and other ancillary services, medical case management, and skilled nursing/hospice care. Service exceptions include dental care, services in a state or federal hospital, inpatient psychiatric services, and inpatient services in a county hospital for the treatment of tuberculosis, chronic, medically uncomplicated narcotism, or alcoholism.

Positive Healthcare requires healthcare service case management, but not social services case management. AHF has informal linkages with many AIDS social service agencies, and AHF case managers and social workers refer clients to these support services.

Network Development

AIDS Healthcare Foundation has developed a network that includes in-house services and outside contracted services interwoven in order to provide a full array of services to its clients.

Primary Care and Specialty Physician Consults. AIDS Healthcare Foundation operates 6 healthcare centers staffed by 15 full-time physicians and 6 midlevel providers. AIDS Healthcare Foundation also has contracts with part-time medical specialists in selected disciplines. Most patients receive primary care as well as some specialty medical care. AIDS Healthcare Foundation has signed contracts with 3 private physician practices to expand its own primary care network. In addition, AHF clients have access to professionals in medical specialty fields, such as dermatology, oncology, gynecology, ophthalmology, proctology, pulmonology, rheumatology, gastroenterology, neurology, cardiology, pain management, orthopedics, otorhinolaryngology, and surgery. The UM Department actively assesses specialty service quality and appropriateness.

Clinical Case Management. AIDS Healthcare Foundation has 6 full-time equivalent RN case managers. To improve delivery of case management, AHF has centralized case management activities to encourage communication among case managers and facilitate the exchange of information related to resources and a patient's condition. Working as part of a multidisciplinary team, case managers are able to prioritize their efforts and give the highest level of attention to patients with the most acute disease.

Mental Health and Social Services. A full-time psychiatrist and 2 half-time psychologists head the AHF mental health program. In addition, 5 full-time social workers are available for the clinical program and 2 for the skilled nursing facilities. Patients have the option of accessing mental health services through an in-house program or choosing an outside professional from a panel of specialists. PHC pays for 3 visits to a psychiatrist or psychologist per month, or up to 6 visits in a crisis situation.

In addition, AHF has contracts with providers for pharmacy, inpatient care, hospice and chronic care, and home care. Through AHF case management and linkages with social service agencies, AHF clients have access to information and assistance on insurance and other benefits, residential referrals, legal assistance, substance abuse programs, transportation assistance, grocery assistance, and home meal delivery.

Medi-Cal patients with AIDS are also eligible for the state's AIDS Medi-Cal waiver program. The program allows contracted agencies to bill Medi-Cal for services administered to eligible beneficiaries; these services include case management, in-home skilled nursing, attendant and homemaker care, psychosocial counseling, and transportation.

Enrollment and Marketing

Enrollment in PHC is voluntary. Eligibility for PHC is limited to individuals on Medi-Cal who have been diagnosed with AIDS and have no copay. AIDS Healthcare Foundation has 3 full-time enrollment personnel who are trained and certified by the state. The enrollment in PHC as of January 1999 was 485 members. Given current enrollment trends and the movement of the state toward mandatory enroll-

ment of Medi-Cal beneficiaries into managed care systems, the Foundation expects to add another 250 members by December 2000.

AIDS Healthcare Foundation seeks to maximize enrollment of its active caseload, focusing on successful management of the patient's public benefits. In the last 12 months, PHC has worked to qualify as many eligible AHF clients for Medi-Cal as possible while maintaining the benefits of existing clients to avoid disenrollment.

The AHF enrollment coordinator, in conjunction with the directors of Clinical Services and Nursing, has developed a system to evaluate patient status with respect to the 1987 and 1993 definitions of AIDS by the CDC. The system relies on the participation of AHF benefits counselors to secure any and all benefits for which a patient is eligible.

Positive Healthcare also provides information about the program through its healthcare centers to educate the public about its merits. These actions have successfully increased enrollment.

AIDS Healthcare Foundation has begun targeting all AIDS patients in Los Angeles County who are eligible for Medi-Cal. To expand enrollment, PHC has identified the sources of its referrals, including word of mouth by enrollees in PHC, RN case managers and social case managers for patients with AIDS, hospital discharge planners, primary care providers, managed care providers for patients who do not have AIDS, AIDS service organizations, AIDS outreach specialists, HIV testing/counseling sites, and AIDS advocates.

Positive Healthcare is currently reaching out to its referral sources in a marketing campaign. The goal is to increase program visibility in affected communities by increasing publicity, such as advertising in selected publications, billboards and bus benches and making appearances at local health fairs. In addition, AHF is launching community outreach efforts by offering free Continuing Education Unit seminars to discharge planners from large hospitals to acquaint them with the latest treatments for HIV/AIDS and make them aware of PHC. AIDS Healthcare Foundation also is developing free continuing education conferences for AIDS caregivers. AIDS Healthcare Foundation is sponsoring patient/member bring-a-friend luncheons in each clinic, working with medical staff at contracted hospitals to acquaint them with PHC and encourage referrals.

AIDS Healthcare Foundation also is working with the Department of Health Services to send mailings to new Medi-Cal recipients in selected zip code areas, place brochures about HIV/AIDS in DHS eligibility offices, and leverage existing relationships with referral sources, such as the Los Angeles-based AIDS social service agencies.

Medi-Cal has been the singular payer source for PHC in the past and will continue to be an important factor in future expansion. Positive Healthcare's capitated program has allowed the DHS to reduce costs and project expenditures. For the first 3 years of the program, costs for PHC have averaged 15% less than the Medi-Cal fee-for-service AIDS population in Los Angeles County. Positive Healthcare enrollees have received specialized care and expressed strong satisfaction with their care.

Beyond its marketing activities, PHC has begun securing additional referrals by contracting with medical groups and independent practice associations that have large caseloads of Medi-Cal beneficiaries. Currently under Medi-Cal FFS, these medical groups are paid at substantially below-market rates. Under the PHC plan, medical groups receive about $150 PMPM to deliver AIDS specialty primary care. Consequently, many providers have shown a strong interest in contracting with the plan.

Outcomes

From 1995 to 1998, the length of hospital stay decreased by 17%. About 88% of those enrollees responding to the patient satisfaction survey reported to be satisfied or more than satisfied with the program, with 44% rating the plan as excellent. In addition, from the beginning, average per month costs for PHC members have been about 15% lower than for equivalent FFS populations in Los Angeles County.

··· CONCLUSION ···

Since beginning operations in April of 1995, PHC has worked with the California DHS to develop a capitated contract, develop an integrated HIV/AIDS care system, attract a critical mass of enrollees, and build an extensive network of relationships with specialty providers.

AIDS Healthcare Foundation has succeeded in implementing a streamlined continuum of care that has proven to be more effective and efficient than the FFS model, with most of the savings having been achieved through careful patient care management and the reduction of fragmentation of services.

For a capitation system to work, it must provide compensation to plans and providers who attract high-risk, high-cost patients. Inadequate compen-

sation mechanisms will undermine access to care and the capacity of providers to manage patient care.

One of the most important features of PHC is being a closed health network, limiting the access of patients to care providers, which allows AHF primary care physicians to completely direct and control care plans for their patients.

AIDS Healthcare Foundation has found that all payers in California, including state Medicaid programs, have as much interest in reducing costs as they do in providing quality care. Consequently, providers looking to develop a disease-specific, risk-based capitated program that includes risk-adjusted rates must demonstrate the capacity to deliver these services and the ability to effectively measure cost savings and quality improvement. To do this, managed care organizations must have appropriate information systems with the capacity to provide standardized data needed to interpret profits and losses, assess compliance with quality management programs, and link costs with utilization.