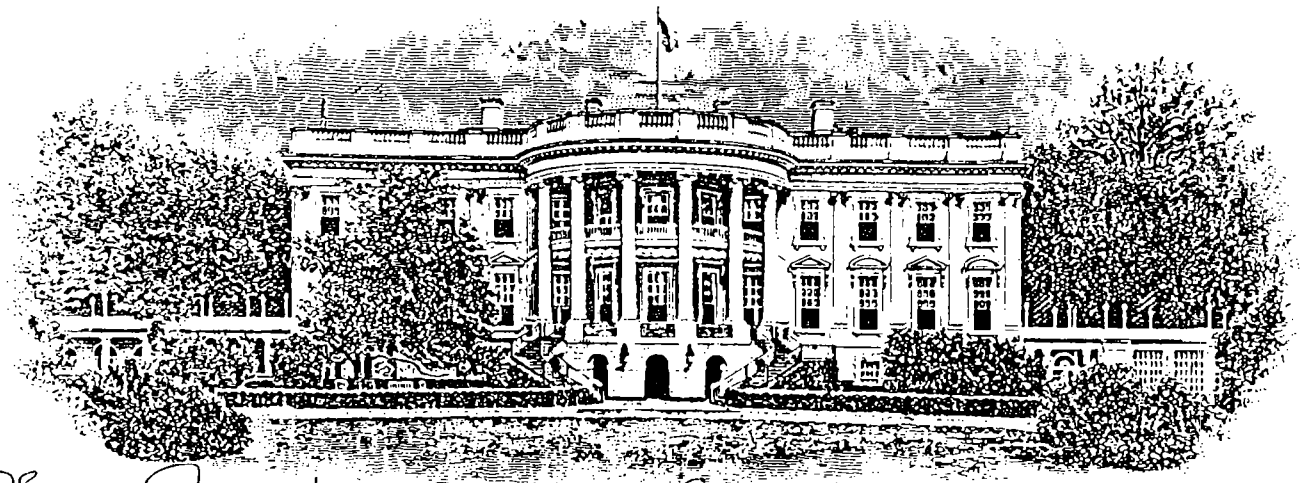
The White House



PS – Thanks for the fax Friday night
PPS – I'll be at the 11-1 rollout mtg.

DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Joanne Pokaski

FAX NUMBER: _____

TELEPHONE NUMBER: _____

FROM: Diana Fortuna

TELEPHONE NUMBER: _____

PAGES (INCLUDING COVER): C+3

COMMENTS: Not a rush – can you share this w/ LV + see how much of it is doable and/or desirable? Thanks. (Maybe LV could deal directly w/ Jeff Levi if she wanted? He is Patsy Fleming's deputy – What do you think?)

a)E

Call HCFA → get reaction

Diana - give me a call on this — Thanks, Jeff

THE WHITE HOUSE

WASHINGTON

February 15, 1995

MEMORANDUM FOR CAROL RASCO

FROM: Jeff Levi

SUBJECT: Medicaid managed care waivers

Attached is a long-promised series of questions that might be raised in reviewing state Medicaid waiver applications with an eye to protecting people with HIV (or any other chronic disease). These are as broad as possible and reflect the input of a number of key consumer organizations working on this issue in the HIV community. There are no guarantees that people with HIV will always be protected -- but if these questions are satisfactorily answered, the chances are improved and the mechanisms will be in place to identify and possibly remedy problems as they arise.

Please let me know how we can follow up on this -- we are getting a number of inquiries from AIDS groups wondering how the waiver process will evolve in the coming months.

I've also attached for your information a proposed A-19 that was submitted by HHS at our request to OMB that would permit use of Ryan White funds to develop a managed care model for people with HIV. I'm not sure this will be welcomed on the Hill, but I think we can find other ways to encourage existing Ryan White grantees to further develop these models. (I met today with a Ryan White grantee who has developed a managed care model -- using Ryan White funds for outpatient services and Medicaid for inpatient -- who has reduced the average cost per patient to $93 per month while maintaining a high standard of care. I'm still looking into the protocol and checking this out -- but these are the kinds of examples that we need to gather to make our case that managed care can be done well and cost effectively for people with HIV, and then using them, in turn, as standards in judging waivers.)

not attached (unless you want it)

6321090

Questions for review of Medicaid managed care waiver applications:

Does the application adequately consider the needs of people with chronic diseases and disabilities and does it demonstrate how these needs will be addressed?

- Did the community hearings on the proposal show evidence of outreach to people with chronic diseases and disabilities. (In other words, did they reach the SSI population, not just the more homogenous AFDC population?)

- Is the plan sensitive to the special health needs of the chronically ill? Is it permitted, for example, that a specialist serve as gatekeeper? Is extended pre-authorization for specialty care permitted?

- Does the plan demonstrate an adequate mix of providers to meet the needs of people with chronic diseases and disabilities? Has the state done a demographic profile of its Medicaid population to determine what services will actually be needed?

- Does the plan include FQHCs and reimburse them at the FQHC higher rate? (This is critical to assuring adequate services for more costly patients with disabilities or chronic diseases.)

Is the ongoing monitoring, evaluation, and governance of the plan sensitive to the needs of people with chronic diseases and disabilities?

- Does the plan, as part of its evaluation, track people with chronic diseases as well as healthy people, including the special care and service needs of sicker people?

- Does the plan assure that a diverse representation of people in the plan will be part of its governance and evaluation (including those with disabilities and chronic diseases)? Will appropriate technical assistance be provided to all patient participants to assure that this is full participation?

- Does the plan, in doing economic profiling of facilities (or individual physicians) to find points of higher cost, make allowance for those physicians or facilities that have a disproportionate share of higher cost patients (e.g., a physician whose practice is primarily HIV infected patients)?

Does the application assure appropriate consumer protections for people with chronic diseases and disabilities within the plan?

- Does the plan assure a right of appeal by the consumer and/or the provider to utilization review decisions? Is this assured in an expeditious manner?

- Is there a requirement that, within a given time period, an orientation about the plan and what benefits are available, is provided to all participants in the plan -- not just those seeking care?

- Where there is more than one managed care plan being offered, is there due process to get out of a plan if a patient feels the plan is not meeting his/her care needs?

- Are provisions made to assure continuity of care by a provider during the transition to the new system? In other words, can a current Medicaid patient remain with his/her provider even if that provider is not chosen for the managed care plan?

Special notes:

- Any application that does not assure coverage of prescription drugs becomes irrelevant to people with HIV. This is the most important benefit -- and one that saves the greatest cost.

- The best way to assure quality protection is if the managed care plan has a mix of populations (i.e., is not exclusively Medicaid patients).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Use of Funds for Capitation Programs

Amend Title XXVI, Part A, of the Public Health Service (PHS) Act (Ryan White CARE Act), Section 2604 to allow funds allocated for primary care to be used for capitated programs, including an amount no greater than 10% for hospitalization costs as a component of section 2604 (c), for those individuals who are not eligible for Medicaid or other payment.

Current Law: Title XXVI, Part A, Section 2604 allows for the use of funds for outpatient and ambulatory health and support services for individuals and families with HIV disease, inpatient case management services, and up to 10% inpatient personnel needs (2604 (c)).

Proposal: Add a provision to allow funds to be used for capitated programs, including a limited percentage of funds for inpatient hospitalization costs for those who are not eligible for Medicaid. Amend section 2604 (c) to cover capitated hospitalization costs under the 10% limitation for inpatient personnel needs as part of a capitation proposal that covers inpatient and outpatient services. Emphasize language that requires utilization of all other potential sources of payment, particularly Medicaid.

Rationale: Capitated systems of care are increasingly being utilized by the public and private health sector as a more cost effective way to provide health care services than through fee-for-service. Medicaid programs in several states are being modified to increase enrollment of clients in capitated systems. Because the current Ryan White legislation does not provide for use of Part A funds for inpatient care, grantees have not been able to use capitated systems for persons with HIV/AIDS. Use of Ryan White funds to pay capitated rates would encourage the use of the most cost-effective providers and provider groups to serve persons with HIV/AIDS, and provide an opportunity to evaluate the cost effectiveness and quality of care delivered. Use of capitated systems of care may include coverage of the full continuum of health care services for enrollees, and provide an opportunity to integrate community-based support services as well.

It is necessary to limit the amount of funds a grantee could use for hospitalization under capitated plans because of the adverse impact this could have on resources available for other services. As the current legislation requires, grantees must utilize outpatient Medicaid reimbursement and other public and private insurance coverage for both inpatient and outpatient care where clients are eligible, and could utilize grant funds for only those services provided under the capitated plan that have no other source of payment. Grantees would be required to demonstrate collaboration between Medicaid and the capitated plan in their grant application. Language in Section 2604 (c) would need to be revised to allow for capitated inpatient care up to 10% level.

Effect on Beneficiaries: Planning councils could establish as a priority for funding capitated systems of care from which persons with HIV/AIDS could choose to receive their care. Capitated plans could be expected to provide a comprehensive array of health care and support services to each enrollee, coordinate service delivery to clients, and provide information on the inpatient utilization and cost of HIV care services for people with HIV/AIDS.

Contact Person: Anita Eichler, 301-443-9091