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Issues - Medicaid

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Better Coordination Between Ryan White and Medicaid

Problem: The HHS Inspector General has recently pointed out that Medicaid managed care organizations and Ryan White programs do not adequately coordinate the services they provide to persons with HIV/AIDS.

Solution: The IG recommended that HCFA and HRSA disseminate technical assistance and guidance on strategies Medicaid programs can use to establish appropriate managed care contracts for needed medical services and costs related to these services. HRSA and HCFA have begun to meet on these issues. The agencies could provide states with model contract language requiring coordination between Ryan White and Medicaid providers.

Discussion: Although Ryan White providers and Medicaid MCOs often serve the same population, they often do not coordinate services. For instance, the medical providers are often not aware of the Ryan White services, such as nutrition counseling and supplements, psycho-social services, home attendant care and case management, that the person is also getting. These social services, however, can help to support clients' ability to access health care and comply with health maintenance routines. Better coordination could result in better drug compliance and higher quality health care.

Higher Quality of HIV/AIDS Care in Medicaid

Problem: A recent study by the Agency for Health Care Policy and Research (AHCPR) has found that HIV+ persons with Medicaid received significantly inferior health care compared to privately-insured persons. African-Americans, Latinos and women also received inferior care compared to whites and men.

Solution: Medicaid providers should be providing care based on the HHS guidelines on combination therapy that were released last year. HCFA and the States should ensure through contracting with managed care organizations or through direct contact with providers that all providers who serve the HIV+ population are aware of and adhere to the guidelines. Providing more services to HIV+ Medicaid recipients could impact the Medicaid baseline.

Discussion: At a time when it is possible to diminish radically the mortality and morbidity associated with HIV, this study suggests that Medicaid is not providing as high quality care to the HIV+ population as the insured population receives, even taking into account CD+4 lymphocyte counts. For instance, while only 13% of privately insured persons had one or more emergency room visits without an associated hospitalization, almost one third of Medicaid recipients had such an ER visit. Likewise, while 28% of privately insurance patients did not receive protease inhibitors, almost one half of Medicaid beneficiaries did not. Differences in outcomes and quality between Medicaid recipients and private insured persons may occur between HIV-negative persons as well.

HCFA currently estimates that there are 50,000 asymptomatic persons who know their status plus 41,000 persons who are asymptomatic and do not know their status on Medicaid. Most of these people would be women eligible through the AFDC/TANF program. Providers should be

encouraging all at risk women to be tested for HIV.

Consumer Bill of Rights Could Improve Care for HIV+ Persons

Problem: Although privately insured HIV+ persons had the best health care access indicators in the AHCPR study, many privately insured persons are still not receiving adequate care. From the study, it is unclear whether the lack of adequate care is related to limited insurance coverage for appropriate care or poor provision of care by health providers.

Solution: Just as government employees in the Federal Employees Health Benefits program (FEHBP) have a guarantee to high quality care through the adaption of the Consumer Bill of Rights, all private employees and members of health plans should have a guarantee of high quality care consistent with the Consumer Bill of Rights.

Discussion: The President's Consumer Bill of Rights calls for improvements in the quality of managed care that would enhance care for persons with HIV. For instance, the Consumer Bill of Rights requires that consumers with complex or serious medical conditions have direct access to qualified specialists. Consumers who are undergoing treatment for a chronic condition, such as AIDS, at the time they involuntarily change health plans or when a provider is terminated by a plan should be able to continue to see their original specialty provider for up to 90 days. Consumers should have the right to considerate, respectful care and should not be discriminated against based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

Reductions in AIDS Deaths Vary by Race and Gender

Problem: AIDS death rates for women and African-Americans have not fallen as dramatically as have AIDS death rates for men and for whites -- possibly because women and African-Americans may not be receiving the same quality and/or amount of care as men and whites.

Possible Solutions:
Exactly what improvements would be most efficient is not yet clear from the data, but there are some potential starting points.

- Address the inexperience of many physicians by better disseminating HHS clinical practice guidelines, or by referring patients to more experienced doctors.
- Imposition of some "quality of care" standard among Ryan White grantees.
- Use Ryan White's AIDS Education and Training Center component to identify and address gaps in physicians' knowledge of care for HIV/AIDS.
- Increase awareness in community of benefits from early intervention.

Data:
CDC AIDS data show that death rates have not fallen as dramatically among women and blacks as they have among whites and men.

Change in AIDS Deaths, 1995 to 1996

Demographic Group	% Change
Men (28,293 deaths in '96)	-25%
Women (6,654 deaths in '96)	-10%
White (13,320 deaths in '96)	-32%
Black (14,893 deaths in '96)	-13%
Hispanic (6,355 deaths in '96)	-20%

Merck data show that "women and minorities are more likely to be HIV symptomatic than white men when starting HIV treatment", and "a smaller proportion of women and minorities than white men are treated by the most experienced physicians."

Access to Combination Therapy May Vary By State

Problem: Some Southern and Western states tend to have waiting lists for ADAP and/or combination therapy.

Possible Solutions: If the access problems in these States are driven by resource levels, then finding more resources -- either from individuals, companies, the State or local governments or the Federal government -- is probably the only way to address the problems.

We could seek to increase the contributions made by the States. States with AIDS cases greater than 1% of the national total[1] are currently required to provide State resources equal to 50% of the Title II grants (which include ADAP), but States can meet this requirement with "in kind" contributions such as facilities and staff. States could be required to increase the match they make to ADAP grants, or could be required to make their matching contributions in cash. This has been discussed in the past, and would be fairly controversial, but it is worth thinking about.

Increased funding for Title II and ADAP would help, but because these funds are distributed by formula, increases to them are unlikely to have a large impact in the States with problems. We could increase funding for Title III, which makes grants directly to clinics, and target the funds to States with access problems. We could also propose changes to the Title II and ADAP formulas, but these are unlikely to occur quickly.

Discussion: Nationwide, States provided 30% of the funds used by ADAPs in FY 1997. States that AIDS Action lists as having waiting lists for combination therapy contributed 20% of ADAP funds in their State -- less than the national average for ADAP.

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[1] CDC estimates that 242,000 people were living with AIDS in 1996, and that 641,000 total cases had been reported by the end of 1996. The law imposes the matching requirement on States whose AIDS cases are "in excess of 1 percent of the aggregate number of such cases" -- it is unclear whether this refers to living persons or all AIDS cases.

Insurance Continuation

Problem: States cannot use ADAP funds to pay premiums for clients' health insurance, even when that health insurance would cover combination therapy, and the cost of the premiums is less than the cost of buying the drugs directly.

Solution: Let States use ADAP funds to pay for health insurance when the insurance is the cheapest way of providing access to combination therapy, and when clients cannot afford to pay for such insurance themselves. As in any other public insurance program, the public insurance may be substituting for private insurance that people would have purchased if the public insurance was not available -- a phenomen known as "crowd-out." Policy could be proposed which would reduce the level of crowdout.

Discussion: The FY 1999 President's Budget included appropriations language signaling support for this idea, but this language has been viewed by the community as inadequate to give States the authority they need. The House Labor/HHS Appropriations Subcommittee report says States should have the flexibility to do insurance continuation.

Cost of Drugs

Problem: Ryan White grantees and Medicaid programs may be spending more than they have to for AIDS drugs.

Solution: Ensure these activities use the minimum price available to them by making maximum use of HHS 340B program and Medicaid rebates and discounts.

Discussion: We do not have much evidence to suggest that significant savings are available through cost minimization efforts. However, given the high cost of combination therapy drugs, small percentage reductions in the prices paid for these drugs could result in large dollar savings. HHS is already publishing a rule that would allow States to use a rebate program to capture the savings from this program (now currently available only as a discount).

Chuck Brain

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until it's over
AIDS ACTION

April 9, 1998

Secretary Donna E. Shalala
Department of Health and Human Services
615F Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

VIA FACSIMILE - URGENT

Dear Secretary Shalala:

On behalf of AIDS Action Council and the 2400 AIDS service organizations we represent, I urge you to immediately request a rehearing of the Desario case before the full Second Circuit Court of Appeals by the filing deadline of April 10th (Desario v. Thomas. No. 97-6027, U.S. Court of Appeals, 2nd Circuit, February 24, 1998). In addition, we respectfully request that the Health Care Financing Administration immediately communicate with state Medicaid programs about the appropriate use of lists; the legal obligation of Medicaid programs to provide medically necessary services to all Medicaid beneficiaries; and the illegality of discrimination against Medicaid recipients based on diagnosis and condition.

The recent decision of the three judge panel of the Second Circuit Court of Appeals poses an immediate threat to the quality and scope of health care of Medicaid recipients living with HIV/AIDS and other chronic and costly health care conditions in all of the states governed by the 2nd Circuit. Since one of these states, New York, is the home to more living AIDS cases than any other state, the ramifications of the decision for the AIDS community are profound. This decision undermines the fundamental principles of the Medicaid statute and erodes the very value of the Medicaid entitlement.

As you are well aware, Medicaid is the major source of health care for men, women and children living with HIV/AIDS and is often the only health care available to these individuals. You are also well aware that life-prolonging but costly drugs are dramatically reducing the mortality and morbidity associated with AIDS. AIDS Action joined the Clinton Administration in opposing the efforts of the Congressional Republican leadership to block grant the Medicaid program and to eliminate the benefit and quality protections available to Medicaid recipients. This court decision, if allowed to stand, would allow state Medicaid programs to deny vital services, including life-saving drug treatments, to eligible beneficiaries solely on the basis of cost. It would be tragic of the major victory of preserving the Medicaid program was undermined by a bad court decision.

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Please take action on the Desario case before a precedent is set that will threaten the gains the nation has made in fighting the AIDS epidemic and will jeopardize the health and lives of people with HIV/AIDS who depend upon the Medicaid program.

Sincerely,

Daniel Zingale
Executive Director

cc: Nancy-Ann Min DeParle
Chris Jennings
Kevin Thurm
Sandra Thurman
Eric Goosby
Dr. Peggy Hamburg
Richard Socarides