The AIDS-Friendly HMO

An oxymoron? Not so fast. It may be the wave of the future.

August 1, 1999 By Chandler Burr

Kathie, an HIV positive AIDS educator in central New Jersey, had been receiving adequate care through Medicaid for some time. But she walked into a health care disaster in September 1996. Her occasional vaginal bleeding had worsened, so she hurried to her usual clinic, where she was suddenly told that the state had enrolled her in Harmony Health Plan, a health maintenance organization, or HMO. It took her three months to see a gynecologist, during which time she could barely leave her house. “I was bleeding clots as big as my hand,” she recalls. When she finally got to a doctor, he was afraid to examine her because of her HIV, finally giving her a shot of Lupron, a hormone reducer, which did nothing. She asked to go to a nearby cancer institute, but her HMO refused. On her next visit, she had to see a different doctor, completely unfamiliar with her case. It took another three months to get out of the HMO, at which point a gyn diagnosed her with Stage II cervical cancer. She immediately had to have her cervix, ovaries and uterus removed. “I finally had to save my own life from the HMO,” she says.

HMOs, first popularized in the 1980s to reduce costs, are notorious for providing poor care for complex, chronic diseases like AIDS. Today, with 86 percent of American workers already covered by HMOs, a new trend could compromise medical care for even more people with HIV: forcible placement of a state’s entire Medicaid population, people like Kathie, into HMOs. Activists and legislators across the country are trying to soften the effects through means ranging from a federal Patients’ Bill of Rights to a New York state rule that people with HIV must be allowed a specialist as their primary doctor. But in limiting the damage of HMOs, will these measures bloat costs as well?

A New Model for PWA Health Care

John Bartlett, MD, of Johns Hopkins University, may have a rather impressive solution. In 1995, in Bartlett’s state of Maryland, Medicaid costs were rising by 20 percent each year; Bartlett was well aware that Medicaid patients would soon be pushed into managed care. So in July 1997, he launched a Medicaid enrollment program at his clinic, a highly respected HIV practice at Johns Hopkins. He had created, in effect, an HIV HMO.

Bartlett turned the traditional HMO on its head. Instead of “cherry picking,” or choosing only healthy members—the standard approach for HMO solvency—Moore Options seeks out patients

with a complex and costly disease. Yet the company is turning a profit.

The crucial difference lies in a more logical way of disbursing Medicaid dollars, what's called a "risk-adjusted capitated rate." Medicaid reimbursements have traditionally been crude: just the total pot divided by the number of patients. "And you got that whether your patient was healthy or in the hospital most of time," says Liza Solomon, Maryland's AIDS director. With the old fee-for-service system, she says, states could neither control costs nor predict budgets.

So Bartlett decided to arrive at a dollar amount that would truly cover AIDS patient care. Colleague Richard Moore, MD, analyzed in the minutest detail the clinic's costs for Bartlett's AIDS caseload, and handed Bartlett a figure: $2,161 per PWA per month. Bartlett took it to the state—and the state, hoping for savings, agreed to it. Now, rather than the old, crude Medicaid rate, the clinic's HMO had a new, fine-tuned AIDS rate—enabling Bartlett to predict costs and reduce financial risk. Says Patty Engblom, program director for Moore Options, "In traditional managed care, you assign people a primary physician as a medical gatekeeper, and then you have administrative gatekeeping through restrictions to specialists and a limited pharmacy." Moore Options manages costs by keeping its patients healthy.

Michael Weinstein, president of the AIDS Healthcare Foundation, runs a similar program in Southern California called Positive Healthcare, available to almost any local PWA on Medicaid. Like Moore Options, Positive Healthcare has a direct contract with its state's Medicaid program and receives risk-adjusted AIDS reimbursements. The taxpayer hands Weinstein not only money but total oversight of each patient's care. Positive Healthcare, a nonprofit, is essentially a coordinator, taking a 10 percent administrative fee and distributing the rest to its six clinics and in-patient facilities.

Its Long Beach facility, the CARE Program of St. Mary's Hospital, is spacious and well kept. CARE provides everything a person with HIV would need, from pulmonary and gyn to case management and a dental clinic. The one thing CARE does not offer—residential care—Positive Healthcare supplies through its other facilities.

Such integration is crucial. Says Peter Reis, a Positive Healthcare administrator, "One of the big problems with Medicaid is there's no single entity tracking each patient. Positive Healthcare, on the other hand, is a closed system. We know exactly what everyone's doing, which is better medically for the patient and better economically for us."

Unlike traditional HMOs, where access to specialists is a struggle, Positive Healthcare and Moore Options operate solely with HIV specialists. There is no general practitioner serving as a gatekeeper. Yet what appears to be luxury is actually economy: AIDS data have shown a significant difference in mortality—and hospitalization costs—between patients seeing HIV specialists and those relying on generalists.

The Patient Perspective

So what do patients think? David Burns, 40, who tested positive in 1983, had spent several years in what he calls “nightmare” battles with a traditional HMO. With Positive Healthcare, he is overwhelmed by the difference. “They’re wonderful. I’ve had everything: CMV, hepatitis C, throat cancer where I’ve been treated by radiation, shingles,” he says. “Cytovene for my CMV was $1,745 per month when it first came out, and they covered it.” He is enrolled in the AIDS Drug Assistance Program, but Positive Healthcare covers costs beyond ADAP dosage caps. “They even covered Viagra after we stopped my testosterone treatment,” he says, sounding a bit stunned. “They pay for everything.”

Burns says he still has to be attentive, confirming followups and referrals to avoid waits. But he decided against a move to Florida because of Positive Healthcare and even volunteers at the group’s research center “to give back to them.”

Clients seem equally impressed by Moore Options. (Neither of these new HMOs has yet been independently evaluated.) About two years ago, when Maryland forced all of its Medicaid recipients into HMOs, Baltimore PWA Michael Willis, 38, panicked. He had read about the horrors of HMOs—“how you never have a personal relationship with a doctor, how they shunt you from place to place.” But he says Moore Options breaks the mold: “When I call my doctor at 1 pm. Friday, he calls back by 1:30. Some of my PWA friends in other HMOs don’t even have a number to call their doctor.”

Even with this high standard of care, both operations are economically viable. Positive Healthcare receives $1,140 per patient per month, less than Baltimore’s allotment because the Los Angeles AIDS rate doesn’t cover hospital stays. For that, the state reserves $657 per patient each month, and Positive Healthcare gets half of whatever money goes unused. Positive Healthcare has been so good at keeping people healthy and out of hospitals that this figure has been substantial: In 1998, the state kicked back about $140 per patient each month in savings. According to state audits over the past three years, Positive Healthcare is treating AIDS at about 15 percent less than fee-for-service medical providers.

Taking the Show on the Road

Could this model work elsewhere? The answer is a bit tricky. HIV HMOs are most viable in AIDS epicenters, cities with a high concentration of both HIV clients and specialists. Even then, it’s not easy to persuade states to offer a correct risk-adjusted rate—and no program can survive with insufficient reimbursement.

Baltimore’s risk-adjusted rate for AIDS, slightly higher than the rest of the state, is $2,161 per patient per month. By comparison, Pennsylvania’s non-adjusted Medicaid rate is $664, and Michigan’s, $120. “If you’re a provider in Pennsylvania and you have a great AIDS program,” says Bartlett, “it’s a financial disaster.” The problem is data. Most states can’t adopt risk-adjusted rates because they lack the kind of numbers that Bartlett has, which detail real-world AIDS costs.

And any change in reimbursement rates or Medicaid management requires political will. Maryland

had to apply for a federal waiver to change its Medicaid system, and before launching the program, Bartlett and state officials had to hold town meetings across the state. But given that half of all Americans with AIDS rely on Medicaid, the cost containment potential is enormous. Adjusted reimbursement rates, combined with coordinated, expert care, could help shrink costs for dozens of other complex and costly illnesses.

This possibility is rapidly becoming a reality across the country. Positive Healthcare just began operations in Florida, now that the state's Medicaid program has switched to managed care for, initially, AIDS, diabetes and hemophilia. And in Massachusetts, which is moving to put everyone on Medicaid into HMOs, Com-munity Medical Alliance (CMA) of Boston applies the Positive Healthcare model not just to AIDS but to other complex conditions, such as multiple sclerosis. Like Positive Health-care and Moore Options, CMA saves money by keeping people out of hospitals—a track re-cord that's attracted the interest of large for-profit providers like Blue Cross of California, which is now studying just how cost-effective AIDS managed care can be. The model is even gaining legal support. Weinstein's group recently filed a suit over rate-setting practices and won an agreement that the state would reimburse a "reasonable" rate to enable a high standard of care.

These developments are a good sign for PWAs. In 1995, New York Gov. George Pataki proposed mandated enrollment of people on Medicaid into HMOs. Since then, AIDS advocates and state planners have been working together to create new health care structures and decide how to finance them. Partly through their advocacy, New York switched to risk-adjusted reimbursement, and bids to create HIV "Special Needs Plans" are due from providers in September. (At press time, a federal waiver made HMO enrollment optional for people with AIDS in New York City.)

As more people on Medicaid are pushed into HMOs and watch their access to specialists and decent care shrink, they will need to look to new health care models for solutions. Michael Weinstein and John Bartlett would argue that their HMOs are so responsive to patients' needs that they don't merit the term—which has become, after all, almost derogatory. "I'd never go to an HMO," says David Burns innocently (he's a Positive Healthcare member). "They're scary."

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