

THE PARADIGM SHIFT IN MEDICAID: WOMEN WITH HIV UNDER MANAGED CARE*

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I. INTRODUCTION

In *The Structure of Scientific Revolutions*, Thomas Kuhn rejects the concept of “development-by-accumulation,” which describes scientific advancement as based on a progression of ideas, each incorporating all that precede it, and ultimately yielding a new understanding.¹ He views scientific revolutions as “non-cumulative developmental episodes in which an older paradigm is replaced in whole or in part by an incompatible new one.”² Although Kuhn’s book addressed scientific revolutions, his concept of paradigm shifts has influenced many different fields of thought, and can be applied to the area of HIV/AIDS prevention and care.³

The delivery of publicly-funded health care is undergoing a paradigm shift. Historically, Medicaid operated under national fee-for-service systems. These systems focused on acute, episodic interventions with reimbursements for providers’ fees that were defined for specific services.⁴ Currently, however, Medi-

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1. See THOMAS KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS* 2 (1996).

2. *Id.* at 92.

3. See Malcolm Gladwell, *My Jaw Dropped*, *NEW YORKER*, July 8, 1996, at 32, 32.

4. See David M. Eddy, *Balancing Cost and Quality in Fee-for-Service Versus Managed Care*, *HEALTH AFF.*, May-June 1997, at 162, 163.

caid operates primarily under managed care plans.⁵ These plans consist of state-associated delivery systems that focus on cost control and care management; providers are paid a predetermined, or "capitated," dollar amount per patient to provide certain levels of care.⁶ This shift to capitated reimbursement necessarily affects the methods that women, including those with HIV, use to access primary health and specialty care.⁷

This Article addresses three issues of importance to the HIV/AIDS care of women under Medicaid managed care systems: changes concerning access to services women will face; how coordinated quality services will be delivered; and whether reimbursement rates will be sufficient to cover the costs of care.

II. THE PARADIGM SHIFT

This shift from fee-for-service care to managed care has been marked by two changes, both of which may have significant implications for the health care of women with HIV/AIDS. First, Medicaid has been decentralized, moving from a federally-driven system into a state-driven system.⁸ At the same time, Medicaid has been disconnected from general public assistance.⁹ Second, a growing number of states have opted for capitated managed care systems.

Three important statutes underlie the decentralization of Medicaid and its separation from general public assistance. The first is the Omnibus Budget Reconciliation Act of 1981 (OBRA).¹⁰ OBRA provides the legal flexibility for states to request permission to alter the required health care provisions for eligible individuals under publicly funded programs such as Medicaid.¹¹ As a result, states are able to expand coverage of eligible populations, alter benefits packages, and introduce managed care systems.

The second is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).¹² PRWORA abolished Aid to Families with De-

5. In 1993, there were 166 Medicaid managed care plans. See Suzanne Felt-Lisk & Sara Yang, *Changes in Health Plans Serving Medicaid, 1993-1996*, HEALTH AFF., Sept.-Oct. 1997, at 125, 128 ex.1. By the end of 1996, there were 355 managed care plans serving 7.7 million clients in 35 states. See *id.* at 127. In 1997, about 40% of all Medicaid beneficiaries were enrolled in managed care. See Sara Rosenbaum, *A Look Inside Medicaid Managed Care: A Study of Medicaid Contracts Sheds Light on the Program's Transition to Managed Care*, HEALTH AFF., July-Aug. 1997, at 266, 266. By the end of 1998, "half of all people enrolled in Medicaid programs are expected to be in managed care." HEALTH RESOURCES & SERVS. ADMIN. ET AL., HIV CAPITATION RISK ADJUSTMENT: CONFERENCE REPORT 1 (1997) [hereinafter HIV CAPITATION RISK ADJUSTMENT].

6. For a discussion of the differences between fee-for-service care and Medicaid managed care, see Eddy, *supra* note 4, at 165-70.

7. See generally CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE: SERVING WOMEN WITH HIV/AIDS (1997) (finding that women will be one of the groups most affected by shift to managed care) [hereinafter CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE].

8. See Kant Patel, *Medicaid: Perspectives from the States*, 7 J. HEALTH & SOC. POL'Y 1, 1-2, 7-17 (1996).

9. See *id.* at 1-2.

10. Pub. L. No. 97-35, 95 Stat. 357 (1981) (codified in scattered sections of 42 U.S.C.).

11. See 42 U.S.C. § 1396n (1994).

12. Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 8 U.S.C. and 42 U.S.C.).

pendent Children (AFDC),¹³ created the Temporary Assistance for Needy Families (TANF)¹⁴ block grant program, and gave states the authority to design their own public assistance programs.¹⁵ This statute is significant for the effects it has had on both the decentralization of Medicaid and its separation from general assistance. Under the old AFDC program, families that met the eligibility requirements automatically received Medicaid assistance according to prescribed federal regulations.¹⁶ Under the new TANF program, however, states are given discretion to determine levels of entitlements for welfare recipients, as well as eligibility requirements for receiving them.¹⁷ Because the TANF program does not enroll recipients automatically in Medicaid as the AFDC program had, former AFDC program recipients may no longer be eligible for Medicaid assistance.¹⁸ The reverse also may occur, as people may be eligible for medical assistance but ineligible for the TANF program.¹⁹

The third statute is the Balanced Budget Act of 1997 (BBA).²⁰ The BBA outlines instances in which a state may implement a Medicaid managed care program without first seeking a waiver from federal requirements.²¹ As a result, states have additional flexibility to structure their management of covered health care.²²

The second change resulting from the shift from fee-for-service to managed care is that a growing number of states have opted for capitated managed care systems. Under capitated managed care, providers receive a per-member per-month fee, rather than a procedure-based or service-based reimbursement.²³ Capitated fees cover expenditures associated with a prescribed package of bene-

13. The AFDC program was authorized in Title IV of the Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620, 627-29 (42 U.S.C. §§ 601-676 (1994)).

14. Pub. L. No. 104-193, 110 Stat. 2105, 2112-13 (1996) (42 U.S.C.A. § 601 (West Supp. 1997)).

15. See 42 U.S.C.A. §§ 602, 603 (1997).

16. See 42 C.F.R. § 435.110(a) (1997).

17. See 42 C.F.R. § 430.0 (1997).

18. Another difference between the two programs involves funding limitations: while funding for AFDC increased in response to increased demand, the funding for TANF is fixed. See Greg J. Duncan & Gretchen Caspary, *Welfare Dynamics and the 1996 Welfare Reform*, 11 NOTRE DAME J.L. ETHICS & PUB. POL'Y 605, 608 (1997). When states have to cut corners in order to manage their limited funds, see Ann Marie Rotondo, *Helping Families Help Themselves: Using Child Support Enforcement to Reform Our Welfare System*, 33 CAL. W. L. REV. 281, 287 (1997), women with HIV/AIDS may feel the pinch.

19. See Laurence Lavin, *AIDS, Medicaid, and Women*, 5 DUKE J. GENDER L. & POL'Y 193, 200-01 (1998) (describing the "de-linking" of Medicaid eligibility from eligibility for TANF and how it has exacerbated already existing barriers to medical care). Additional provisions of the law spell out work requirements and payment limits for any state's recipients. See 42 U.S.C.A. § 1396u-1(b)(3) (West Supp. 1997).

20. Pub. L. No. 105-33, 111 Stat. 251 (1997) (amending portions of Personal Responsibility and Work Opportunity Reconciliation (Welfare Reform) Act, Pub. L. No. 104-193, 110 Stat. 2105 (1996)).

21. See *id.*

22. With the flexibility granted by the PRWORA and BBA, states could, among other things, expand services such as primary care case management, modify eligibility requirements such as the percentage above the poverty level at which individuals qualify for Medicaid, or mandate that Medicaid participants enroll in managed care.

23. See HIV CAPITATION RISK ADJUSTMENT, *supra* note 5, at 1.

fits for the client.²⁴ To change from a Medicaid fee-for-service plan to a capitated managed care plan, a state either must request a waiver under section 1915²⁵ or section 1115²⁶ of the Social Security Act, or must meet the requirements of the BBA.²⁷ Under the BBA, a state must write beneficiary protections, develop quality assurance standards, and assure that timely payment requirements are included in contracts.²⁸ Upon either receiving a section 1915(b) waiver approval or qualifying for an exemption, a state may mandate enrollment for eligible populations in managed care by county.²⁹ A section 1115 waiver offers a state additional freedom to modify Medicaid requirements, including rules on benefits, provider qualification and payment rules, and administrative requirements.³⁰

As states institute a wide variety of managed care plans³¹ for TANF and Supplemental Security Income (SSI)³² recipients, they must ensure that the per-member payments are sufficient to cover the needs of HIV/AIDS patients, fifty-three percent of whom are dependent on Medicaid.³³ Additionally, each state's Medicaid plan must be monitored to ensure that HIV care, regardless of the

24. See MARIA K. TODD, THE MANAGED CARE CONTRACTING HANDBOOK: PLANNING AND NEGOTIATING THE MANAGED CARE RELATIONSHIP 7-8 (1996).

25. See 42 U.S.C. § 1396n (1994).

26. See 42 U.S.C. § 1315(a) (1994).

27. See Pub. L. No. 105-33, 111 Stat. 251 (1997). For descriptions of the section 1115 waiver application procedure, see Vernellia Randall et al., *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 SETON HALL L. REV. 1069, 1073 n.22 (1996).

28. See Pub. L. No. 105-33, 111 Stat. 251 (1997); see also HCFA Urges States to Submit Draft Contracts for Review Before Expanding Managed Care, 6 Health Care Pol'y (BNA) 7, 7-8 (Jan. 5, 1998).

29. See Pub. L. No. 105-33, 111 Stat. 251 (1997); see generally John Holahan et al., *Insuring the Poor Through Section 1115 Medicaid Waivers*, HEALTH AFF., Spring 1995, at 199, 199-216 (analyzing five state waiver demonstration programs under Section 1115). For a listing of approved section 1915(b) waivers from January 1, 1997 through March 31, 1997, see *First Quarter 1997 Approved 1915(b) Waivers Report* (last updated June 18, 1997) <<http://www.hcfa.gov/medicaid/omc5.htm>>.

30. See 42 U.S.C. § 1315 (1994); see also SARA ROSENBAUM ET AL., CENTER FOR HEALTH POLICY RESEARCH, NEGOTIATING THE NEW HEALTH SYSTEM: A NATIONWIDE STUDY OF MEDICAID MANAGED CARE CONTRACTS Part I.2. (Kay A. Johnson ed., 1997); Lavin *supra* note 19, at 203 n.95 (describing specific waiver requests by Maine).

31. See Diane Rowland & Kristina Hanson, *Medicaid: Moving to Managed Care*, HEALTH AFF., Fall 1996, at 150, 150-52 (describing the dramatic increase in states' use of managed care programs).

32. See 42 U.S.C.A. § 1381 (1994); see also Alison Barnes, *The Policy and Politics of Community-Based Long-Term Care*, 19 NOVA L. REV. 487, 515 n.161 (1995) (noting that "[SSI] provides a guaranteed minimum income for individuals who are aged, blind, or disabled, who have insufficient workforce participation to be eligible for [Social Security Disability Income].").

33. See JEFFREY S. CROWLEY, NATIONAL ASS'N OF PEOPLE WITH AIDS, MAKING MEDICAID MANAGED CARE WORK: AN ACTION PLAN FOR PEOPLE LIVING WITH HIV 5 (1997) [hereinafter AN ACTION PLAN]. In addition, 90% of HIV-positive children are dependent upon Medicaid. See *id.*

variation under which it is provided, meets or exceeds treatment guidelines for women.³⁴

III. WOMEN LIVING WITH HIV/AIDS

HIV/AIDS is a growing concern for and among women in the United States.³⁵ Recent surveillance data suggest that between one-third and one-half of all HIV testing is performed on women between the ages of fifteen and forty-four.³⁶ According to the data, between 120,000 and 160,000 women are living with HIV in the United States;³⁷ in 1996 alone, 13,820 adult or adolescent women were diagnosed with AIDS,³⁸ more than seventy-nine percent of whom were women of color.³⁹ HIV/AIDS has emerged as a major health concern, particu-

34. See, e.g., Panel of Clinical Practices for the Treatment of HIV Infection, U.S. Dep't of Health & Human Servs., Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents (1997) (providing recommendations for the clinical treatment of HIV using antiretroviral therapies including the recently introduced protease inhibitors and non-nucleoside reverse transcriptase inhibitors) (on file with the Duke Journal of Gender Law & Policy). The Department of Health and Human Services issued a request for comments on these guidelines in June 1996. See Availability of Report of NIH Panel to Define Principles of Therapy of HIV Infection and Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults, 62 Fed. Reg. 33,417 (1997). Both of these sources also can be accessed at <<http://www.hivatis.org/upguidaa.html>>.

35. See generally Risa Denenberg, *The Community: Mobilizing and Accessing Resources and Services*, in WOMEN, CHILDREN, AND HIV/AIDS 251, 251 (Felissa L. Cohen & Jerry D. Durham eds., 1993); Susan Cu-Uvin et al., *Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome Among North American Women*, 101 AM. J. MED. 316 (1996) (describing the rapid increase in the incidence of AIDS among women). Women now represent almost 20% of the AIDS cases in the United States, see Centers for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *Update: Trends in Aids Incidence—United States, 1996*, 46 MORBIDITY & MORTALITY WKLY. REP. 861, 865 tbl.3 (1997), a proportion that has doubled since 1990, see Tedd V. Ellerbrock et al., *Epidemiology of Women with AIDS in the United States, 1981 through 1990: A Comparison with Heterosexual Men with AIDS*, 265 JAMA 2971, 2972 (1991) (noting that in 1990 women represented approximately 10% of the reported adult AIDS cases).

36. See Tracey E. Wilson et al., *HIV-Antibody Testing: Beliefs Affecting the Consistency Between Women's Behavioral Intentions and Behavior*, 26 J. APPLIED PSYCHOL. 1734, 1735 (1996). Many women, however, do not discover that they are infected with the virus until they arrive at an emergency room, a physician's office, or a hospital for care. See Pascale M. Wortley et al., *HIV Testing Patterns: Where, Why, and When Were Persons with AIDS Tested for HIV?*, 9 AIDS 487, 490 (1995) (finding that many persons diagnosed with AIDS between 1990 and 1992 were not tested until they were admitted to an acute care facility).

37. See John M. Karon et al., *Prevalence of HIV Infection in the United States, 1984 to 1992*, 267 JAMA 126, 128 tbl.1 (1996). Like other sexually transmitted diseases, HIV infection transmits more easily to women than to men. See Timothy P. Flanigan et al., *Update of HIV and AIDS in North America*, 79 MED. & HEALTH, RHODE ISLAND 180, 180 (1996). While the most common mode of HIV transmission among women remains intravenous drug use, recent data from states with confidential HIV infection reporting indicate that heterosexual contact has surpassed intravenous drug use as the most frequent source of infection for women. See CENTERS FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T OF HEALTH & HUMAN SERV., NO. 2, HIV/AIDS SURVEILLANCE REPORT 12 tbl.5 (1996) [hereinafter HIV/AIDS SURVEILLANCE REPORT 1996]; see also Pascale M. Wortley & Patricia L. Fleming, *AIDS in Women in the United States: Recent Trends*, 278 JAMA 911, 912 (1997). These data are representative of only 29 states with confidential HIV infection reporting. See HIV/AIDS SURVEILLANCE REPORT 1996, *supra*, at 35 tbl.27.

38. See HIV/AIDS SURVEILLANCE REPORT 1996, *supra* note 37, at 10 tbl.3.

39. See *id.* at 12 tbl.5. Moreover, of those females diagnosed with AIDS through December 1996, over 70% were under the age of forty. See *id.* at 16 tbl.9.

larly among young African-American and Latina women⁴⁰—women who historically have constituted healthy and, therefore, low-cost populations when compared to the Medicaid population as a whole.

Despite the high number of women with HIV/AIDS, the clinical care that women receive has been developed through research conducted primarily with men.⁴¹ However, significant differences exist in the health care needs of women based on gender, behavior, modes of transmission, and gynecological conditions.⁴² For example, certain opportunistic infections occur more frequently in women than in men. Moreover, gynecological conditions associated with HIV disease can complicate the treatment of women.⁴³ Pregnancy also raises unique complications for HIV care;⁴⁴ the introduction of effective treatments, such as zidovudine to prevent vertical transmission of HIV from mother to fetus, requires early detection of the disease, more frequent medical visits, and an increased use of pharmaceuticals.⁴⁵

Furthermore, early studies found that HIV disease progressed more quickly in women than in men from the time of diagnosis;⁴⁶ more recent clinical research has offered findings that indicate that gender differences in disease progression

40. See Cu-Uvin et al., *supra* note 35, at 316 (finding that almost 75% of women with AIDS in the United States are African-American or Latina, although they comprise only 20% of American women).

41. See Catherine A. Hankins & Margaret A. Handley, *HIV Disease and AIDS in Women: Current Knowledge and a Research Agenda* 5 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 957, 957-58 (1992); HEALTH RESOURCES & SERVS. ADMIN., U.S. DEP'T HEALTH & HUMAN SERVS., HIV/AIDS WORK GROUP ON HEALTH CARE ACCESS ISSUES FOR WOMEN 63 app. D (1993) [hereinafter DHHS HIV/AIDS WORK GROUP]; R. Ancello-Park & I. De Vincenzi, *Epidemiology and Natural History of HIV/AIDS in Women*, in HIV INFECTION IN WOMEN 1, 8 (Margaret A. Johnson & Frank D. Johnstone eds., 1993).

42. See Marge Berer & Sunanda Ray, *HIV/AIDS-related Illnesses, Effects on Women's Health, Treatment and Care*, in WOMEN AND HIV/AIDS: AN INTERNATIONAL RESOURCE BOOK 14, 15-31 (Marge Berer & Sunanda Ray eds., 1993); Jeanette R. Ickovics & Judith Rodin, *Women and AIDS in the United States: Epidemiology, Natural History, and Mediating Mechanisms*, 11 HEALTH PSYCHOL. 1, 1-16 (1992).

43. See Cu-Uvin et al., *supra* note 35, at 318-20. For example, the occurrence of candida esophagitis and extensive chronic ulcerative disease secondary to herpes simplex are gender related. See *id.* at 318 tbl.1, 319.

44. See DHHS HIV/AIDS WORK GROUP, *supra* note 41, at 13-16.

45. See Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 NEW ENG. J. MED. 1173, 1178-79 (1994) (describing decreased risk of vertical transmission in pregnant women taking zidovudine); Josephine A. Mauskopf et al., *Economic Impact of Treatment of HIV-Positive Pregnant Women and Their Newborns with Zidovudine*, 276 JAMA 132, 136-38 (1996); cf. Evans McMillion, Note, *The Case Against Mandatory HIV Testing of Pregnant Women: The Legal and Public Policy Implications*, 5 DUKE J. GENDER L. & POL'Y 227, 228-44 (1998) (arguing against the mandatory HIV-testing of pregnant women).

46. See Ann B. Williams, *The Epidemiology, Clinical Manifestations and Health-Maintenance Needs of Women Infected with HIV*, NURSE PRACTITIONER, May 1992, at 27, 32-34.

may result from women's lack of access to HIV care.⁴⁷ This may cause significant differences in how HIV affects women and men, as women repeatedly report difficulties in accessing services,⁴⁸ ranging from a lack of knowledge of available services to the lack of resources to secure them.⁴⁹

Women with HIV disease face numerous obstacles to the procurement of essential services.⁵⁰ Because HIV/AIDS correlates with poverty,⁵¹ and women are more likely than men to be poor, uninsured, or underinsured,⁵² women are more likely to receive insufficient medical care.⁵³ Medical appointments may leave patients waiting for hours, yet result only in a schedule of tests and a handful of unaffordable prescriptions.⁵⁴ Moreover, if an infected woman also is responsible for an infected child, the medical needs of both must be met.⁵⁵ The medical setting in which a mother receives care, however, may not be structured to accommodate a mother and child together.⁵⁶ Language and cultural differences can complicate further the struggle many women experience in acquiring

47. See Ancello-Park & De Vincenzi, *supra* note 41; Howard L. Minkoff & Jack A. DeHovitz, *Care of Women Infected with the Human Immunodeficiency Virus*, 266 JAMA 2253, 2253-58 (1991); Richard Rothenberg et al., *Survival with the Acquired Immunodeficiency Syndrome*, 317 NEW ENG. J. MED. 1297, 1300 tbl.2 (1987). Similarly, the use of new pharmaceuticals such as protease inhibitors requires routine and frequent access to medical services. See Steven G. Deeks et al., *HIV-1 Protease Inhibitors: A Review for Clinicians*, 277 JAMA 145, 151-52 (1997). But see Beverly E. Sha et al., *HIV Infection in Women: An Observational Study of Clinical Characteristics, Disease Progression, and Survival for a Cohort of Women in Chicago*, 8 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUMAN RETROVIROLOGY 486, 494 (1995) (noting that in their study, insurance status, as an indicator of access to health care, did not influence the survival time of women with AIDS).

48. See, e.g., CENTER FOR WOMEN POLICY STUDIES, "WE KNOW WE'RE NOT ALONE": THE VOICES OF WOMEN LIVING WITH HIV/AIDS IN THE METROPOLITAN DC AREA: A CONTENT ANALYSIS OF FOCUS GROUPS WITH AFRICAN AMERICAN, LATINA, AND WHITE WOMEN 4-24, 39-52 (1997) (discussing the difficulties HIV-positive women face in accessing health care and housing) (unpublished manuscript on file with the *Duke Journal of Gender Law and Policy*).

49. See DHHS HIV/AIDS WORK GROUP, *supra* note 41, at 5-20.

50. See Kathleen A. Ethier et al., *For Whose Benefit? Women and AIDS Public Policy*, in WOMEN AND AIDS: COPING AND CARING 207, 216-19 (Ann O'Leary & Loretta Sweet Jemmott eds., 1996); see generally Greg Rubin, *Confronting Obstacles*, in WOMEN, POVERTY, AND AIDS: SEX, DRUGS, AND STRUCTURAL VIOLENCE 279, 279-98 (Paul Farmer et al. eds., 1996); Jeffrey Selbin & Mark Del Monte, *A Waiting Room of Their Own: The Family Care Network as a Model for Providing Gender-Specific Legal Services to Women with HIV*, 5 DUKE J. GENDER L. & POL'Y 103, 116-19 (1998).

51. See Ethier et al., *supra* note 50, at 216.

52. See *id.*

53. See *id.* One study found that more women than men received Medicaid, and that this was a critical factor in compromising women's access to care and the quality of that care. See *id.* at 218.

54. See Gloria Weissman et al., *Women Living with Drug Abuse and HIV Disease: Drug Abuse Treatment Access and Secondary Prevention Issues*, 27 J. PSYCHOACTIVE DRUGS 401, 402-03 (1995).

55. See Patricia Antonello, *The Voices of Women with HIV Infection*, in PRIMARY CARE OF WOMEN AND CHILDREN WITH HIV INFECTION: A MULTIDISCIPLINARY APPROACH 1, 3-4 (Patricia Kelly et al. eds., 1995). Even infants who are not infected with HIV require medical care and general care, posing another problem for infected mothers. See *id.*

56. See Darlene Shelton et al., *Medical Adherence Among Prenatal HIV Seropositive, African American Women: Family Issues*, 11 FAM. SYS. MED. 343, 348 (1993) (describing the difficulties of medical adherence for a woman who must take care of her small children).

care.⁵⁷ In addition to these obstacles to basic care, women infected with HIV also may have additional needs such as HIV education, case management,⁵⁸ and the provision of social services such as housing, transportation, public assistance, psychological health services, support groups, nutrition assistance, pastoral care, child care, and legal services.⁵⁹

An additional layer of complexity arises from the fact that HIV is rarely an isolated problem for infected women. HIV-positive women come from diverse social, cultural, and economic backgrounds, and many struggle with domestic violence, poverty, homelessness, or inadequate housing.⁶⁰ Furthermore, because a large percentage of identified HIV-positive women are intravenous drug users, many women also may need drug treatment and mental health services.⁶¹ These complex health and social needs of women with HIV must be considered as the states determine their Medicaid reimbursement fees for managed care plans and define the eligible populations for Medicaid coverage.

57. See generally Johanna Daily et al., *Women and HIV Infection: A Different Disease?*, in WOMEN, POVERTY, AND AIDS, *supra* note 50, at 125, 125-44 (illustrating, through the stories of two women, how women with language and cultural differences require medical services that build in specific language and cultural support); see also Dawn F. Smith & Janet S. Moore, *Epidemiology, Manifestations, and Treatment of HIV Infection in Women*, in WOMEN AND AIDS, *supra* note 50, at 1, 18 (noting the additional difficulties faced by "non-English-speaking, low-literacy, and drug-using women" in receiving appropriate HIV treatment).

58. One source has defined case management as follows:

A patient-centered process which has been used to augment and coordinate existing care systems. Its goals are to access health and mental health care for patients; provide or obtain social support services; and, empower patients, family members, and significant others. The means of achieving these goals include providing education; creating connections between careseekers and caregivers; promoting active participation of the patient, family, and significant others in developing care plans; and acknowledging and complementing the important support given by family and significant others.

CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE, *supra* note 7, at 13 (citation omitted).

59. See Mardge H. Cohen & Patricia Kelly, *HIV Disease in the Primary Care Setting*, in PRIMARY CARE OF WOMEN AND CHILDREN WITH HIV INFECTION, *supra* note 55, at 9, 9-18; see also CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE, *supra* note 7, at 9 ("Of particular importance in assuring access to medical care are 'enabling services,' such as transportation and case management (coordination of care) . . ."); cf. DARLENE SHELTON ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., HIV/AIDS HEALTH CARE, UTILIZATION & MEDICAL ADHERENCE ISSUES AMONG HIV SEROPOSITIVE AFRICAN AMERICAN WOMEN IN MIAMI: THE ROLE OF THE FAMILY AND THE EXTENDED KINSHIP NETWORK 23 (1993) (exploring influences on health care utilization, and reporting the importance of access to transportation and child care, family support, and possible pregnancy or substance abuse); Selbin & Del Monte, *supra* note 50, at 116-19.

60. See Carol Levine & Machele Harris Allen, *Social Interventions in the Care of Human Immunodeficiency Virus (HIV)-Infected Pregnant Women*, 19 SEMINARS IN PERINATOLOGY 323, 324 (1995).

61. See HIV/AIDS SURVEILLANCE REPORT 1996, *supra* note 37, at 12 tbl.5 (noting that 45% of women reported with AIDS through 1996 were intravenous drug users); see also Weissman et al., *supra* note 54, at 401-02.

IV. CAN RESEARCH HELP?

States' experience with Medicaid managed care for elderly and disabled beneficiaries is not extensive.⁶² As of 1996, only five states had more than one year of experience with mandated Medicaid managed care systems for individuals with disabilities: Arizona, Oregon, Tennessee, Utah, and Virginia.⁶³ Another eleven states voluntarily had operated similar programs for a year or more, but fewer than twenty percent of the eligible Medicaid populations were enrolled.⁶⁴

Given the few states involved and the limited coverage that exists for individuals with disabilities in those states, there is little information available on managed care plans for women with HIV.⁶⁵ Research on the effects of managed care on disabled populations with private insurance, however, can provide some insight as to what can be expected for the Medicaid-funded care of women with HIV. A study of 12,997 health maintenance organization (HMO) patients suffering from at least one of five diseases—arthritis, asthma, epigastric pain/ulcer, hypertension, or otitis media—identified a strong correlation between the severity of illness and the frequency of health resource utilization.⁶⁶ Especially applicable to the care of women with HIV is the finding that limitations on reimbursement for pharmaceuticals were associated with increased numbers of ambulatory and emergency room visits, and a greater number of hospitalizations.⁶⁷ This finding has significant implications for the future health care of women with HIV/AIDS. Because it is expected that pharmaceuticals will become one of the more expensive facets of HIV care,⁶⁸ managed care plans may consider limiting coverage for HIV pharmaceuticals and associated tests. If women with HIV/AIDS anticipate that the costs of pharmaceuticals might exceed reimbursement levels, they will be likely to reduce their use of such pharmaceuticals and, therefore, suffer a gap in care.⁶⁹ While managed care plans may save money in the short run, in the long run they would lose money, as such a strategy would tend to increase opportunistic infections, as well as overall medical costs.

Another potential disadvantage of managed care may surface if health plans receive the same reimbursement rates for both sick and healthy clients.

62. See CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE, *supra* note 7, at 8; U.S. GEN. ACCOUNTING OFFICE, MEDICAID MANAGED CARE: SERVING THE DISABLED CHALLENGES STATE PROGRAMS 4-5, 24-25 (1996). While only a few states have *long-term* experience with Medicaid managed care, Medicaid managed care has become very widely-used in recent years. See Sara Rosenbaum, *A Look Inside Medicaid Managed Care: A Study of Medicaid Contracts Sheds Light on the Program's Transition to Managed Care*, HEALTH AFF., July-Aug 1997, at 266, 266 (noting that in 1997, nearly 40% of all Medicaid beneficiaries were enrolled in managed care).

63. See U.S. GEN. ACCOUNTING OFFICE, *supra* note 62, at 4, 24-25.

64. See *id.*

65. See CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE, *supra* note 7, at 8-9.

66. See Susan D. Horn et al., *Intended and Unintended Consequences of HMO Cost-Containment Strategies: Results from the Managed Care Outcomes Project*, 2 AM. J. MANAGED CARE 253, 259-60 (1996).

67. See *id.* at 259.

68. See CALIFORNIA DEP'T OF HEALTH SERVS., MEDI-CAL STUDIES, NO. 5, AIDS: DEMOGRAPHICS AND EXPENDITURES FOR PERSONS WITH AIDS 1980-94 18, 19 tbl.10, 21 tbl.11 (1996).

69. Cf. Richard D. Moore & John G. Bartlett, *Combination Antiretroviral Therapy in HIV Infection: An Economic Perspective*, 10 PHARMACOECONOMICS 109 (1996) (finding combination drug therapy to be superior to monotherapy, and associated with a three-year increase in average lifespan).

These plans will suffer financially if they enroll large numbers of HIV-positive clients due to the high costs of their care.⁷⁰ Research shows that in managed care systems, both risk adjustment for HIV/AIDS and the use of HIV/AIDS medical specialists as primary care physicians⁷¹ can assist in increasing access to quality care for women.⁷² Risk adjustment procedures base capitation rates on the insured's individual health status and recent health care expenditures.⁷³ This technique can be beneficial especially for people with chronic illnesses such as HIV/AIDS, whose patterns of health care expenditures are more predictable than those of the general population.⁷⁴ Risk adjustment methods, therefore, can assure that providers receive adequate per-member per-month reimbursement for care.⁷⁵ Additionally, access to specialists for primary care assures appropriate treatment, which can prevent costly hospitalizations and opportunistic infections.

Additional studies have found that preventive and screening services are provided more frequently to clients in HMOs than to those in fee-for-service programs.⁷⁶ While screening for HIV/AIDS was not included in the studies,⁷⁷ Medicaid managed care may be able to identify HIV-positive women more quickly by providing earlier testing, diagnosis, and linkages to treatment.

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act's Special Projects of National Significance (SPNS) Program⁷⁸ is testing models of capitated care to examine the tension between HIV health care delivery under Medicaid managed care and fee-for-service plans, and to assess the possibilities for delivering appropriate care to women with HIV/AIDS. Six individual projects are examining the provision of managed HIV/AIDS services in different

70. See William J. Aseltyn et al., *HIV Disease and Managed Care: An Overview*, 8 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUMAN RETROVIROLOGY S11, S19-S20 (Supp. 1 1995).

71. Research has shown that physicians with specialized HIV/AIDS knowledge are more likely than other practitioners to prescribe appropriate pharmaceuticals and provide state-of-the-art care. See Mari M. Kitahata et al., *Physicians' Experience with the Acquired Immunodeficiency Syndrome as a Factor in Patients' Survival*, 334 NEW ENG. J. MED. 701, 704-05 (1996).

72. See generally HIV CAPITATION RISK ADJUSTMENT, *supra* note 5. An example of a successful risk adjustment policy is Maryland's Medicaid managed care program, HealthChoice, which has developed a capitated model based on these two methods. See *id.* at 20. Maryland's Department of Health and Public Hygiene has agreed to supplemental payments for HIV care. See *id.* In addition, Hopkins AIDS-Medicaid Capitated Care HMO at Johns Hopkins University will provide AIDS care to Medicaid recipients. See LAWRENCE BARTLETT & PATRICIA RUTH HITZ, KAISER FAMILY FOUND., *DELIVERING HIV CARE IN A MANAGED CARE ENVIRONMENT: ISSUES AND STRATEGIES* (1996). Moreover, to ensure the solvency of the plan, the new, high-cost AIDS medications are excluded from the capitation arrangement and paid for on a fee-for-service basis. See HIV CAPITATION RISK ADJUSTMENT, *supra* note 5, at 21.

73. See HIV CAPITATION RISK ADJUSTMENT, *supra* note 5, at 3.

74. See *id.*

75. See *id.*; TONY DREYFUS ET AL., KAISER FAMILY FOUND., *USING PAYMENT TO PROMOTE BETTER MEDICAID MANAGED CARE FOR PEOPLE WITH AIDS* 4 (1997).

76. See Amy B. Bernstein, *Women's Health in HMOs: What We Know and What We Need to Find Out*, 6 WOMEN'S HEALTH ISSUES 51, 55-58 (1996).

77. See generally *id.* at 51-59.

78. See 42 U.S.C.A. § 300ff-101 (West Supp. 1997). The SPNS Program is authorized under Part F of the CARE Act to support the development and evaluation of innovative and replicable models for delivering health and support services to people with HIV. See *id.*

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arenas, including community-based settings, university-based medical center settings, and community health center settings.⁷⁹ Each health care project is either fully or partially-capitated.⁸⁰ To date, only one project evaluation, that of the Visiting Nurses Association of Los Angeles, a not-for-profit home care agency, has reached a sufficient stage to report results.⁸¹ These early results show improved patient medical condition and increased patient satisfaction with the care received,⁸² and research indicates that similar home care programs decrease overall costs.⁸³

At the same time, research shows that women with HIV require more costly and continuous care than the healthier women who constitute the majority of TANF program recipients on Medicaid.⁸⁴ This raises an important issue for women enrolled in Medicaid managed care plans—access to coordinated care.⁸⁵ It remains to be seen whether, under the new system, HIV-positive women who are Medicaid recipients will have access to the full range of services they need, including care for HIV, opportunistic infections, and related gynecological infections.⁸⁶

V. THE NEW FEDERAL ROLE

The states' movement to Medicaid managed care is changing the historical roles of many federal agencies. In order to be positioned properly to safeguard vulnerable and underserved populations, the agencies must be responsive to the realities of the health care market where fee-for-service plans, partially-capitated managed care plans, and fully-capitated managed plans exist concurrently.⁸⁷

79. The six projects are funded at the following institutions: the Johns Hopkins University, the East Boston Neighborhood Health Center, the AIDS Healthcare Foundation, the Visiting Nurses of Los Angeles, and the New York State AIDS Institute, see BARTLETT & HITZ, *supra* note 72, at app. C, and Duke University Medical Center, see SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE (SPNS) PROGRAM, U.S. DEP'T HEALTH & HUMAN SERVS., PARTNERSHIP STEERING COMMITTEE GRANT PROJECT ABSTRACTS 8 (1997) [hereinafter GRANT PROJECT ABSTRACTS].

80. See GRANT PROJECT ABSTRACTS, *supra* note 79, at 2-3.

81. See generally David A. Cherin et al., *The Transprofessional Model: Blending Intents in Terminal Care of AIDS*, 17 Q. HOMECARE J. (forthcoming Mar. 1998) (manuscript on file with the *Duke Journal of Gender Law and Policy*).

82. See *id.* (manuscript at 26-27).

83. See *id.* (manuscript at 4).

84. See CENTER FOR WOMEN POLICY STUDIES, MEDICAID MANAGED CARE, *supra* note 7, at 8-9.

85. Cf. Tami Mark & Curt Mueller, *Access to Care in HMOs and Traditional Insurance Plans*, HEALTH AFF., Winter 1996, at 81, 82-83 (finding that HMO patients complained of more unmet health care needs than patients in traditional plans); see also *supra* notes 58-59 and accompanying text.

86. See generally AN ACTION PLAN, *supra* note 33; see also U.S. GEN. ACCOUNTING OFFICE, MEDICAID: STATES' EFFORTS TO EDUCATE AND ENROLL BENEFICIARIES IN MANAGED CARE 18-19 (1996); cf. Shelton et al., *supra* note 56, at 23.

87. Many federal agencies, including the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Agency for Health Care Policy Research (AHCPR), the Health Care Financing Administration (HCFA), and the Health Resources and Services Administration (HRSA) have been involved with HIV/AIDS since the beginning of the epidemic in the early 1980s.

Due to the decentralization of Medicaid, the separation of general public assistance from medical care, and the growth of capitated Medicaid managed care, the federal government's role in health care delivery may shift. Instead of setting rates for fee-for-service reimbursements, the federal government likely will perform the functions of oversight, enforcement of approved state waivers, and monitoring of exempt state plans. Moreover, in order to ensure compatibility with state Medicaid managed care systems, the federal government will need to re-examine targeted HIV/AIDS funding streams such as the Ryan White CARE Act⁸⁸ and the Centers for Disease Control and Prevention (CDC) prevention cooperative agreements.⁸⁹

One challenge facing these agencies involves the use of clinical trials. The participation of managed care recipients in clinical trials has become a point of negotiation and discussion at the NIH and the FDA.⁹⁰ Clinical trials allow women with HIV to gain access to new medications, while at the same time testing the effectiveness of new treatments in women.⁹¹ Historically, managed care networks have sponsored research on the outcomes and effectiveness of

The CDC provides a system of surveillance to monitor and prevent the outbreak of disease, and supports research into disease and injury prevention. See Dep't of Health & Human Servs., *DHHS: What We Do* (visited Nov. 15, 1997) <<http://www.hhs.gov/about/profile.html>>.

The FDA ensures that drugs are safe and effective. See Food & Drug Admin., *Frequently Asked Questions* (visited Feb. 4, 1998) <<http://www.fda.gov/opacom/faqs/genfaqs.html>>.

The NIH is the world's premiere research organization; it is involved with 30,000 projects nationwide. See Office of AIDS Research, *General Information* (visited Feb. 4, 1998) <<http://www.nih.gov/od/oar/DSCPFRAM.HTM>>. The NIH has an Office of AIDS Research (OAR) that is responsible for the scientific, budgetary, legislative, and policy elements of the NIH's AIDS research program. See *id.*

The AHCPR is the lead agency in charge of supporting research designed to improve the quality of health care, reduce its costs, and broaden access. See Agency for Health Care Policy Research, *About AHCPR* (visited Feb. 4, 1998) <<http://www.ahcpr.gov/about/about.htm>>.

The HCFA is the agency that administers the Medicare and Medicaid programs. See Health Care Fin. Admin., *What is HCFA?* (visited Feb. 4, 1998) <<http://www.hcfa.gov/about.htm#whatis>>. With at least 50% of those living with AIDS receiving their health coverage through Medicaid, the HCFA is the largest single payer of direct medical services for people living with AIDS. See U.S. Dep't of Health & Human Servs., *Fact Sheet: Medicaid and Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection* (visited Feb. 4, 1998) <<http://www.hcfa.gov/medicaid/obs11.htm>>.

The HRSA provides funding for medically underserved populations. See U.S. Dep't of Health & Human Servs., *supra*. It consists of 643 community and migrant health centers and 144 primary care programs, and serves 8.1 million Americans a year. See *id.* HRSA also provides services to people with AIDS through the Ryan White CARE Act programs. See *id.*

88. See 42 U.S.C. § 300ff-101 (1994), as amended by 42 U.S.C.A. § 300ff-101 (West Supp. 1997).

89. See 42 U.S.C. § 247c (1994); OFFICE OF MANAGEMENT & BUDGET, EXECUTIVE OFFICE OF THE PRESIDENT, 1997 CATALOGUE OF FEDERAL DOMESTIC ASSISTANCE § 93.940, at 1253-54 (31st ed. 1997). Through this program, 65 states, localities, and territories receive funds to implement community HIV prevention programs. See Helen Schietinger et al., *Community Planning for HIV Prevention: Findings from the First Year*, 10 AIDS & PUB. POL'Y J. 140, 140 (1995).

90. See *HMO-Based Research Programs Form New Research Network; Lewin-VHI Managed Care Report Released*, "The Blue Sheet" (F-D-C Reports, Inc.) 4, 4-5 (Feb. 21, 1996) [hereinafter "The Blue Sheet"].

91. See generally Anna C. Mastroianni, *HIV, Women, and Access to Clinical Trials: Tort Liability and Lessons from DES*, 5 DUKE J. GENDER L. & POL'Y 167, 168-69, 186-91 (1998) (calling for increased enrollment of women in clinical trials).

FDA-approved treatments rather than participating in federally-sponsored clinical research.⁹²

A second challenge that the federal health agencies face concerns the review and monitoring of state waivers of fee-for-service plans. While current federal efforts have focused on initial state waiver review, discussions also are underway with respect to ongoing efforts to monitor the states' progress in implementing Medicaid managed care, including whether states have been able to maintain access to medical services and to assure appropriate treatments such as obstetrical care for women with HIV.⁹³ For HRSA in particular, both waiver review and monitoring move the agency beyond its traditional role of funding health services for vulnerable populations⁹⁴ to one of assuring the availability of quality health care.⁹⁵ While most of the criteria used for waiver review apply to all individuals living with HIV, some, such as coverage for gynecological care, are unique to women.⁹⁶ The review of state waivers and subsequent monitoring efforts will require the federal agencies to focus on the quality and accessibility of HIV/AIDS services by managed care plans, including enrollment procedures and post-enrollment support, benefit designs, payment systems, patient satisfac-

92. See "The Blue Sheet", *supra* note 90, at 5.

93. HCFA and HRSA are holding a series of staff meetings to better coordinate HIV care among Medicaid and Ryan White CARE Act programs. See HUMAN RESOURCES & SERVS. ADMIN., MANAGED CARE STRATEGIC PLAN: RYAN WHITE CARE ACT PROGRAMS 6 (1997).

94. See HIV CAPITATION RISK ADJUSTMENT, *supra* note 5, at 65 app. D.

95. See HUMAN RESOURCES & SERVS. ADMIN., STRATEGIC PLAN: 1998-2003 2 (1997) (stating that the assurance of quality health care is HRSA's vision for the future).

96. Examples of what is covered in HRSA reviews include:

To what extent will a PCCM [primary care case management] model disrupt provider-patient relationships, or limit choice of provider and access to experienced HIV care, specialty care, treatments and services for Medicaid beneficiaries with HIV/AIDS?

....

Are there plans for ongoing meetings between Medicaid staff and the State AIDS Director, health plan management, medical directors, HIV infected beneficiaries and family members, providers, and advocacy groups? How will these stakeholders participate in the monitoring of the utilization of HIV services, HIV-related quality of care, and health outcomes for PLWH [people living with HIV], including asymptomatic HIV-infected beneficiaries?

....

To what extent does the proposal indicate awareness of the incidence and prevalence of AIDS and HIV-infection among Medicaid beneficiaries within categorical populations? Is there recognition that the TANF population may contain substantial numbers of PLWH, including asymptomatic PLWH, who require early intervention delivered by experienced HIV-care providers?

....

What additional provisions are to be made during enrollment to assist PLWH who may be homebound, unable to understand procedures (they may have mental disabilities), or are not aware of the critical need for responding/or unable to respond in the required time frames?

HEALTH RESOURCES & SERVS. ADMIN., MEDICAID MANAGED CARE WAIVERS AND POPULATIONS WITH SPECIAL HEALTH CARE NEEDS: KEY ISSUES OF SPECIAL CONCERN TO PEOPLE LIVING WITH HIV INFECTION (PLWH) 1-5 (draft working paper June 13, 1997) (on file with the *Duke Journal of Gender Law & Policy*).

tion, the quality of clinical care (such as gynecological care for women), and patient grievance procedures.⁹⁷

A third challenge that the federal agencies face involves supporting the development of new models of HIV/AIDS care to respond to local differences in populations affected by the epidemic, as well as evaluating differences in state policies.⁹⁸ Currently, the SPNS program⁹⁹ funds the development of six such capitation models,¹⁰⁰ each located in states that applied for, and in some instances, received, section 1115 waivers.¹⁰¹ These programs are investigating risk adjustment rates for HIV, linkages between health care and appropriate support services for women, and the integration of health care for mothers and their children.¹⁰²

A final challenge for the federal government is the reexamination of its targeted HIV/AIDS funding streams. When the Ryan White CARE Act¹⁰³ was formulated, state Medicaid programs were primarily fee-for-service reimbursement programs. Most CARE Act funds are distributed by grantees based on service needs and on a state's ability to reach underserved populations. Notices of contract awards by eligible metropolitan areas (EMAs) and by states provide a lump sum calculated from a line-item organizational budget that includes personnel, administrative overhead, and contract and/or subcontract dollars.¹⁰⁴ Because the paradigms of health care delivery have changed, this method of allocating funds will need to be reassessed if the health care providers who receive these funds participate in Medicaid managed care. One suggested method for future funding would link awards to the rate of return on CARE Act "investments" using health outcome measurements and/or improvements in the quality of life of clients.¹⁰⁵ In addition, direct funding of services for women and children living

97. See OFFICE OF INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., MEDICAID MANAGED CARE AND HIV/AIDS (1997) (unpublished draft on file with authors). At the same time, HCFA has undertaken a number of monitoring efforts, see James P. Hadley & Linda F. Wolf, *Monitoring And Evaluating the Delivery of Services Under Managed Care*, HEALTH CARE FINANCING REV., Summer 1996, at 1, 1-4, but none is specifically HIV-related, see generally Elizabeth A. McGlynn, *Choosing Chronic Disease Measures for HEDIS: Conceptual Framework and Review of Seven Clinical Areas*, in MANAGED CARE AND CHRONIC ILLNESS: CHALLENGES AND OPPORTUNITIES 18 (Peter D. Fox & Theresa Fama eds., 1996).

98. See Ryan White CARE Act Amendments of 1996, 42 U.S.C.A. § 300ff-101 (West Supp. 1997).

99. See 42 U.S.C. § 300ff-101; *supra* text accompanying note 78.

100. See *supra* note 79 and accompanying text.

101. The most comprehensive and complex model is New York's section 1115 waiver which, with the accompanying state legislation, authorizes the creation of Special Needs Plans (SNP) for Medicaid recipients who are HIV-positive. Recipients can choose to receive care either from a general HMO or from an SNP. SNPs are HMOs certified by the state to provide comprehensive and capitated health services to HIV-positive persons eligible for Medicaid. In return for agreeing to provide comprehensive HIV care, the HMO becomes eligible for risk-adjusted reimbursement. See New York Health Care Reform Act of 1996, N.Y. PUB. HEALTH LAW § 2807-f (McKinney Supp. 1997-1998). For further information on section 1115 waivers, see discussion *supra* notes 25-30 and accompanying text.

102. See generally HIV CAPITATION RISK ADJUSTMENT, *supra* note 5.

103. See 42 U.S.C. § 300ff-101 (1994).

104. See WALTER MOREAU, U.S. DEP'T. OF HEALTH & HUMAN SERVS., TOOLS AND STRATEGIES TO ASSURE THE COST AND OUTCOME EFFECTIVENESS OF CARE ACT SERVICES 34 (1997).

105. See *id.* at 6.

with HIV/AIDS may need to be reconfigured based upon the services and populations covered by Medicaid managed care.

VI. CONCLUSION

The paradigm shift from fee-for-service to managed care encompasses many changes, including changes in emphasis from acute, episodic interventions to preventive care, changes in access to care for the populations to whom care is delivered, and changes in the cost reimbursement mechanisms. While some specific aspects of the paradigm shift, such as the coverage of pharmaceuticals, are important to all individuals living with HIV/AIDS, others, such as the access of TANF recipients to specialty care and children's health care, particularly are significant for women given women's complex care and treatment needs. Furthermore, the supportive services that would be included in a comprehensive continuum of care, which traditionally may not have been viewed as included in health care, such as the provision of housing, or follow-up after substance abuse treatment, must be provided if medical treatment is to be effective.

The complexity of the new Medicaid managed care plans and the differences among states in eligibility and coverage make the federal health agencies' monitoring of states' coverage of HIV/AIDS care critical. In order for Medicaid managed HIV/AIDS care to benefit women, and especially for women of color, federal agencies and providers of HIV/AIDS care will have to collaborate to ensure that each state's plan is able to deliver affordable, accessible, and quality care. Otherwise, notwithstanding the opportunities afforded by the paradigm shift, cost containment principles will be achieved at the expense of individuals' health care.