Ryan White CARE ACT Title II
Cost Containment Practices:
A State and National Perspective

Prepared By:
The Center for Public Policy Research and Ethics
The AIDS Institute
1-800-779-4898
www.theaidsinstitute.org

Prepared For:
The Bureau of HIV/AIDS
Florida Department of Health
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The AIDS Institute would like to thank the Florida Department of Health, Bureau of HIV/AIDS for their generous support. Also, this work would not have been possible without the cooperation and considerable efforts of the Florida Ryan White Title II consortia and Ryan White Title II administrators nationwide. The participants provided information that illustrated how the concepts and activities related to cost containment can differ considerably from consortia to consortia or state to state, yet also hold commonalities that can be used to share experiences, innovations, and expectations.
Executive Summary

This paper seeks to illustrate the types and extent of practices used by local Ryan White CARE Act Title II planning bodies and lead agencies within Florida to contain costs and determine how cost savings are used to maintain or enhance services. Included is an analysis of the guiding principles and assumptions such practices are based on, as well as the fiscal and programmatic outcomes of such practices. Cost containment activities found within Florida are compared to national trends in Ryan White CARE Act Title II programs. Study methods include survey instruments, follow-up interviews, and a review of local and national planning documents. Recommendations are presented regarding the improvement of the cost containment decision making process and practices within these programs.
The Ryan White Comprehensive AIDS Resource Emergency (CARE) Act was initiated in 1990 to provide a safety network for people living with HIV/AIDS. Reauthorized in 1996 and 2000, the CARE Act is a federal funding program administered through the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB). Overall funding is determined annually based on projections of the prevalence and incidence of HIV and AIDS in the United States. The Ryan White CARE Act currently serves over 500,000 people in the United States each year (Buchanan, 2002).

The CARE Act allocates funding through four "Titles" (I-IV) and one part, Part F. Each funding stream has a specific purpose and function through different, specific grantees (HAB Who is Eligible, 2003). Funding is allocated by the federal government and administered through a contract management system at HRSA.

Title I provides money to cities or city/county combinations disproportionately affected by HIV and AIDS, referred to as Eligible Metropolitan Areas. Title I grants are generally administered to service providers through the county or city government entity which submitted the application to HRSA for Title I funds. Title II funding is administered directly to state governments for a variety of services through county health departments and community based organizations.

The organization of the Title II system varies from state to state. Some have only a statewide planning body or localized consortia, while others have both a statewide body and local consortia. If a state uses localized consortia, then that state is required by HRSA to include agencies and community based organizations (CBOs) with a record of service to HIV populations and sub-populations, be representative of the same, and carry out an assessment of service needs within the geographic area to be served.

Lead Agencies within Florida, who are the grants’ administrative and/or fiscal agents for the health district areas applying for direct service funding, comprise the
state’s “consortia.” These agencies include CBOs and community health departments. Since the Florida HIV/AIDS planning community uses the term consortia (as opposed to consortium), the vernacular will be used throughout this work to maintain familiarity.

Title III funding is concerned with primary healthcare for underserved populations and people of low socio-economic status, applied for directly by health centers, health-planning councils, and other community based groups. Like Title III, Title IV grants are dispensed to public and private entities for services and research centered on women, youth, and children affected by and at risk for HIV.

Part F of the CARE Act is funding for Special Projects of National Significance (SPNS), which are intended to assist the development of system-wide solutions and impact the overall availability of healthcare services. Part F also funds the AIDS Education and Training Center Program, or AETC. AETC programs are designed to educate healthcare providers regarding healthcare practices for people with HIV and AIDS.

The Ryan White CARE Act, although a publicly funded system, is not an entitlement program like Medicare and Medicaid. Considered a "discretionary" program, it is not guaranteed to be refunded each year. Federal law mandates that Ryan White funding be the payer of last resort, meaning HIV caseworkers must first try to get People Living with HIV/AIDS (PLWHAs) Medicaid assistance or other non-Ryan White public funding. However, there are no federal regulations on eligibility for Ryan White funded services, except that a recipient is either HIV positive or an immediate caregiver of an HIV positive person. Each state or designated area under the CARE Act is responsible for determining their own requirements for eligibility and implementation.

Requirements for representation exist for the states, which must periodically convene a meeting of people living with HIV, representatives of grantees, providers, and public agency representatives for the purpose of developing a statewide, coordinated statement of need. The agency administering the grant is also required to engage in a public advisory planning process (HAB Tools for Grantees, 2003).

The guiding principles and assumptions these requirements are based on are provided by the Bureau of HIV/AIDS. They include: revising CARE systems to meet emerging needs, ensuring access to quality HIV/AIDS care, coordinating CARE Act
services with other health care delivery systems, and evaluating the impact of CARE Act funds and making needed improvements (HAB Guiding Principles, 2003).

Cost consideration, while a component of the CARE Act’s purpose, is not explicitly found within these principles. Although “evaluating the impact of CARE Act funds” may involve stated values, principles, strategies, or practices specifically related to containing costs, inter- and intra-state interpretations of “impact” differ considerably.

An examination of cost containment activities found within the Title II system in Florida and nationally was achieved through local and national research requests. Comprehensive planning documents from Title II statewide planning bodies and Florida consortia were analyzed for adherence to HRSA-directed requirements. Additionally, innovative practices, surveys, and follow-up interviews regarding the cost containment decision making process within these programs aided in the analysis and creation of the proposed recommendations.
The impetus for cost containment occurred long before the enactment of the Ryan White CARE Act of 1990. Whether initially to ensure patient revenue for clinics and providers, give health coverage to employees instead of increased wages, or even reduce mortgage defaults resulting from large medical expenses, revenue generation and cost containment have been central to insurance and managed care since 1910 (Kongstvedt, 2001). As broad values lead to less generalized principles, strategies, and finally specific practices, cost containment can currently be viewed as spanning three main levels.

At the system (topmost administration) level, wide-scale impact is gained through controlling supply via Certificate of Need (CON) regulation, controlling demand through managed care and the regulation of health insurance, and controlling costs through hospital rate setting (NCSL, 2003; Schneiter et al., 2002; KFF, 2002). Other methods include leveraging purchasing power through centralization and expansion, standardizing reporting requirements, and facilitating data exchange and coordination (National Governors Association, 2003).

The program (specific service line) level involves management leverage, such as limiting eligibility; reducing benefits; increasing cost-sharing; reviewing utilization; prevention; education; reducing fraud, abuse, and waste; reducing organizational processes and paperwork through consolidation; pooled purchasing; increasing coordination; and shifting care to community settings (Randall, 1993; Schwenk, 1999).

At the practice level where services are performed, controls directed and managed by the program level include prior authorizations; financial risk shifting and/or financial incentives to providers; requiring second opinions for major procedures; provider feedback; and increasing appropriate use of services through follow-up and education (Randall, 1993; Schwenk, 1999; Gaynor et al., 2001).

When compared with the managed care industry as a whole, public service delivery systems such as Medicare, Medicaid, and the CARE Act contain important similarities and differences. Increasingly, both public and private healthcare systems are creating chronic illness disease management models rather than focusing on expensive, episodic, tertiary care (Gordis, 2000). Public and private service delivery, therefore,
requires a long-term management focus. Both are also impacted by legislation, however, the structure, requirements, and burdens for their programs and services are quite distinctive.

Public programs such as Medicare, Medicaid and the CARE Act, each maintaining legislatively mandated populations, have eligibility requirements producing far less selective risk pools than those of Managed Care Organizations (MCOs). MCO fiscal solvency is in part dependent upon leveraging “healthy” versus more costly “sick” patients. Those receiving public services must meet certain financial and/or health related criteria. Individuals often comprising the public program risk pool, due to various factors such as education level, poverty, and inconsistent access to healthcare, are significantly less healthy than individuals that are gainfully employed and privately insured.

An MCO also has options that are not available to public systems. For example, an MCO can withdraw from a regional area (i.e., allow policies to expire without renewal) if expenditures cross a predetermined cost-benefit threshold. It can also centralize processes much easier, since community representation is not required. Public programs do not possess this freedom. If eligibility criteria are met, public programs, with few exceptions, cannot refuse coverage.

A similarity between public and private can be found within the values of each system. Values of the managed care system are centered on “containing or reducing costs and increasing client satisfaction and the health or functional status of the individual” (Pew Health Professions Commission, 1995). Similarly, CARE Act services are “intended to reduce the use of more costly inpatient care, increase access to care for under-served populations, and improve the quality of life for those affected by the epidemic” (HAB Purpose of the CARE Act, 2003). As the CARE Act language broadens the scope beyond cost per se, other variables must be discussed for overall context.

The “iron triad” model of healthcare is reflected by both public and private systems, where access, quality, and cost are interdependent (Sultz and Young, 2001). Changing one invariably affects the other two, which can necessitate trade-offs at the system, program, and practice levels. Quality management models such as Total Quality Management (TQM), Continuous Quality Improvement (CQI), and Total Quality Care
(TQC) seek to prevent such trade-offs by continuously evaluating the values, guiding principles, goals, strategies, plans, and specific actions in order to improve quality, increase access, and reduce (and/or contain) costs (Longest, 2001).

A U. S. General Accounting Office study of quality initiatives for the Malcolm Baldrige National Quality Award cited decreased costs as a benefit of CQI. CQI is “the reciprocal of the traditional cost containment initiatives that were prevalent during the 1970s and 1980s,” where health services organizations narrowly “focused on increasing the ratios of outputs to inputs.” CQI moves beyond this definitional view of efficiency by focusing on “improving both process and output quality versus simply reducing costs” (Dictionary.com, 2003; Longest 2001).

These differences and similarities are instructive when discussing cost containment practices, because there are limits to what each program can implement due to fiscal, programmatic, and legal constraints. Cost containment, then, is both a component and result of quality management initiatives; at once both an affective element requiring the collection, analysis, and evaluation of accurate and timely data, as well as an effective end result.
Findings: Comprehensive Plans

A request was sent to each state Title II contact (See Appendix for contact lists) provided by both the Health Resources and Services Administration (HRSA) and the National State and Territorial AIDS Directors (NASTAD). These Title II contact lists provided by HRSA and NASTAD are the most current available. However, problems occurred in the contact information accuracy, such as address and/or personnel mobility. Every effort was made to find the most appropriate department and contact person in each state.

The request for the comprehensive plans developed by the states’ administrative and planning bodies remained dependent upon the voluntary responses of Title II staff. Through reading these plans, The AIDS Institute garnered major themes and practices employed by the different state representatives in relation to cost containment practices. The following analysis and summary was completed, adhering to cost containment theories and guidance provided by the public and private sector literature review.

State Title II Comprehensive Plans

Cost containment at the state level falls within four main categories: funding reallocation or cost sharing, consolidation, coordination, and evaluation. Although the terms efficiency and effectiveness are used throughout the statewide Title II Comprehensive Plans, they are omitted from analysis when used without qualification.

As described by the collective comprehensive plans, reallocation of funds involves eliminating or reducing funding for programs designed to assist people with HIV/AIDS in areas that are tangential and supportive to their health. These can include services such as transportation, substance abuse counseling, and home health care.

For example, Michigan describes the goal of its home health care program as “ensuring that home and community based care services are available in order to reduce hospitalizations for persons living with HIV disease” (Michigan DCH, 2003). The cost savings realized from such reductions are an important lead-to effect, since hospital care accounts for the second largest HIV patient expenditure after antiretroviral medications.
(Saag, 2002). Another effect is stated in Pennsylvania’s plan: “access to and provision of needed substance abuse and mental health services is critical to prevent further HIV transmission” (Pennsylvania DOH, 2003).

With limited funding, programs with a higher priority for direct impact are supported with funding streams previously targeted to tangential services. Washington’s plan describes how an adult residential chemical dependency service and an incarceration-to-community transition program were discontinued to “support the increasing cost of ADAP medications and an increase in client enrollment/utilization” (Washington DOH, 2003).

Funding movement can also occur within a program in the form of client-level cost sharing or co-payments. For example, health insurance premiums partially paid by a Washington state Title II program began requiring a co-payment in 2003.

The second type of cost containment activity employed by the states is consolidation, where usually one organization assumes the similar activities of multiple organizations. For example, consolidating the administration of the Washington insurance program into the state’s Department of Health is expected to “result in cost savings due to the economy of scale benefit” (Washington DOH, 2003). This benefit is gained from multiple factors, such as standardization and the elimination of duplication. Michigan is similarly consolidating the “needs assessment activities previously conducted by regional care consortia” in order to gain increased standardization (Michigan DCH, 2003).

Eliminating duplication can also be gained via coordination and collaboration among programs. One of Washington’s objectives is to “establish strong relationships with other Titles to maximize utilization of funds without duplicating services.” Title II leadership plans to accomplish this by “working together on the development of the Statewide Coordinated Statement of Need (SCSN), meeting on a regular basis to discuss issues that affect all Titles,” and by “encouraging strong linkages regarding training opportunities” (Washington DOH, 2003). South Carolina similarly supports collaboration as a strategy for overcoming cost barriers for both HIV positive individuals and the state’s consortia (South Carolina DHEC, 2003).
Pennsylvania officials state that a coordinated, integrated effort among referral systems, prevention, care and treatment, and supportive services should be included to develop targeted, effective, sustained delivery of “ongoing, lifelong prevention and care and support systems for those at risk and already infected.” Interestingly, the plan also cites the planned development of “quality management and evaluation methodologies to measure the effectiveness of HIV/AIDS care and support programs” (Pennsylvania DOH, 2003).

Evaluation is integral to cost containment, because desired outcomes and goals are meaningless without measures and timely, accurate data. Funding allocations for CARE resources in Michigan, for example, were based on a funding model comprised of “data from its Uniform Reporting System, epidemiology, existing funding, and a ruralness factor.” Requests for Proposals (RFPs) were “issued for adherence, access, and monitoring activities based on best practices.” Recommendations were made by an ad-hoc work group primarily consisting of PLWH/As (Michigan DCH, 2003).

**Florida Title II Consortia Comprehensive Plans**

All thirteen 2003 Florida Title II Consortia Comprehensive Plans were reviewed for cost containment practices (Florida Consortia, 2003). Due to the sharing of one lead agency by two consortia, the total number of possible responses is one less than the total number of consortia that exist. Because consortia are not specifically required to report cost containment activities, abstraction and synthesis is based on indirect criteria found within three specific sections of the plans, such as cost and outcome effectiveness, efficiency, data use, and evaluation.

Section five of the plans is entitled “Prioritization Setting and Resource Allocation.” This section contains some direct language related to cost containment, which were reflected in a “Decision-Making Principles” table asking consortia to provide a checkmark to indicate usage of the listed principles. Principle three illustrates, “Priorities should contribute to strengthening the agreed-upon continuum of care, including providing primary health care, limiting duplication of services, and minimizing the need for hospitalization.” All of the consortia indicated usage of the principle.
Another formatted table is entitled, “Data/Information Used for Priority Setting and Allocation of Funds.” Consortia are asked to indicate their use of the given data types, along with the month/year currency. A category header within the table is “Service Cost Data,” with a listing of the data types: unit costs for each service, known or estimated; cost-effectiveness data, if available; percentage of Ryan White funds spent on women, infants, children and youth (WICY); and Other. Less than half of the plans indicated using all of the given data types.

Also within section five is Priority Setting Criteria. Consortia are again asked to provide a checkmark indicating their use of the given criteria. The second listed is “Quality, cost effectiveness, and outcome effectiveness of services, as measured through outcomes evaluation, quality management programs, client surveys and other evaluation methods.” Nearly all consortia indicated use of this criteria.

Within section six is “Shared Values/Guiding Principles,” where consortia are asked to fill in or list their responses. Open-ended responses range from general statements concerning “cost effectiveness” to specific tasks within two major, strategic areas: treatment partnering and coordination.

The partnering of people living with HIV/AIDS with their service providers to maintain their health and well being was cited by several plans. Shared responsibility and resource maximization are factors that result from this process, which includes service delivery planning.

Another type of partnering beyond the service provision level is program-level coordination. This involves prevention, early intervention, and community resources not necessarily funded by Ryan White Title II. One plan stated that an objective of coordination is to eliminate duplication by conducting joint provider meetings and request for proposal processes among Titles I and II, as well as collaborating on joint contract monitoring of provider agencies.

The final section of the comprehensive plans is “Quality Management and Evaluation.” Consortia are asked to describe methods used in their area to achieve three related purposes required by the CARE Act Amendments of 2000. When asked to describe how they evaluate costs and cost benefits of services provided, responses include reports by way of planned quality management initiatives, comparing costs to
usual and customary costs (Medicaid, Blue Cross, etc.), and looking for the low-cost provider of standardized, minimum services. One consortia describes analyzing trends, utilization data, re-allocations, and over- and/or under-utilization of allocations in determining the funding of service categories in conjunction with the needs assessment activities.

The collection and use of timely and accurate data for prioritization is important to cost containment because it is through sufficient data that evaluation of progress and priority of allocations can be determined. Terminology and theories such as efficiency, effectiveness, and elimination of duplication seems to have filtered to local areas, yet descriptions of their usage are not required and lack a qualitative dimension. Examples such as coordination and collaboration are provided and can be useful in determining specific practices, such as making comparisons with other systems and analyzing trends within data. However, practices vary widely between areas. Overall, the comprehensive plans focused on recognition and confirmation, such as yes and no, rather than functional descriptions, such as how and why. These items point toward the need to survey consortia representatives for specific practices in addition to successes and failures.
Findings: Surveys

Methodology

Surveys given to Title II Florida consortia Lead Agencies and state directors gained information regarding the structure, planning process, and feasibility of cost containment practices within their areas. The responses from these surveys, in addition to the ideas presented in the literature review and comprehensive plans, form the AIDS Institute, Center for Public Policy Research and Ethics recommendations.

The development of the survey for the Title II representatives and the Florida consortia was created in response to both the literature review and the analysis of the comprehensive plans. Major topics identified for further study were related to planning and administrative body structure, familiarity with the term cost containment, the priority given to cost containment practices within the respondent’s Title II system, existing cost containment practices at different levels, the feasibility of cost containment practice examples, and the various internal or external pressures that might have caused the development and employment of cost containment practices. With all of these specific questions, the surveys were constructed to elicit information related to these topics and utilized a variety of quantitative and qualitative measures. Questions were constructed to test the validity of related questions using a variety of scales, multiple choice, and open-ended questions. The information gathered was then formed into recommendations. This information could be utilized by Florida Title II grantees as well as HRSA staff dealing with the grantees.

To send out the surveys to the Florida consortia, The AIDS Institute (TAI) obtained a current list of Lead Agency contacts. These contacts were the most appropriate, since they have the most up-to-date fiscal knowledge of their area. Each contact received an email and fax copy, along with a cover letter explaining the intent and deadline of the survey. Follow-up requests were conducted one week prior to the requested deadline. TAI staff also ensured anonymity to respondents, as no names or specific locations were provided in the survey’s findings. Voluntary response, in this case, implied consent.
To send out the surveys to the states, the Title II representative contact lists mentioned previously were again utilized. Survey targets were sent the survey electronically and by fax, along with a cover letter explaining the intent and deadline of the survey. Again, follow-up requests were made one week prior to the deadline. TAI staff promised anonymity to respondents, ensuring that no names or specific locations would be provided in the survey’s findings. Again, voluntary response implied consent. Final copies of the study will be sent to all respondents nationwide and within Florida.

**State Survey Findings**

Nineteen of the state surveys were returned, representing a 38% response rate. The respondents represented an adequate blend of states with both large and small HIV incidence rates. For planning and/or administration of the Title II structure within their state, eight respondents indicated having a singular, state-wide body, three indicated having a system of localized bodies (e.g., consortia), and eight employed both.

All but three Title II representatives indicated familiarity with “cost containment.” When asked to describe their interpretation of the term, responses were reflective of the “iron triad” model, adding considerations for quality and access in addition to “high volume, low cost” efficiency measures. Additional statements included references to being the payer of last resort, administrative simplification, standardization of grant materials, statistical reporting, and not having duplication.

The priority level for cost containment was rated as “moderate” in six of the states and “high” in thirteen. All but one respondent indicated cost containment was a component of other initiatives such as quality management, rather than a singular or “stand alone” initiative.

When asked to describe the cost containment practices that exist at the administrative level, respondents indicated the prior elimination of regional consortia and the associated centralized planning that resulted. Also included were enhanced training (i.e. technical assistance) and communication with contractors, Medicaid, and other state and local entities, screening for other service delivery systems, prior authorization for payment of services, standardization of statistical and narrative reports, the elimination of
paperwork, and matched data across consortia to identify and address service duplications.

At the services/program level, respondents indicated an annual cap on expenditures per client, the use of a review committee for expenditure approval, case management for services and referrals to other non-HIV specific services, enrollment of eligible individuals in charity care, requiring second opinions on certain dental procedures, and capping the maximum allowable amount of certain services per client.

Three survey questions asked for the degree of impact cost containment practices had on quality, access, and expenditures in the consortia Title II program in 2003. A scale ranging from “very negative” to “very positive” impact is provided for each, as shown in the following table:

### State Ratings of Quality, Access, and Expenditures

<table>
<thead>
<tr>
<th></th>
<th>Very Negative</th>
<th>Slightly Negative</th>
<th>None</th>
<th>Slightly Positive</th>
<th>Very Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Access</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Expenditures</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0</td>
<td>3</td>
<td>12</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

Negative responses across all three areas, comprised of “very negative” or “slightly negative,” totaled three, while positive responses, alternately comprised of “slightly positive” or “very positive,” totaled 29. The balance of the impact on all three measures, therefore, is very slanted toward the positive side of the scale. Respondents who indicated “don’t know” totaled five for quality, three for access, and four for expenditures. Within each strata, access is more balanced toward “slightly negative” than either quality or expenditures.

Asked to describe their measures for quality, respondents indicated rate of use, the reimbursement delay, CD4/viral load monitoring, Public Health Service (PHS) guideline therapies, adherence and prevention measures, prescribing patterns, and measures for overtime, processes, satisfaction, and impact.
If either “slightly” or “very” positive responses were indicated in terms of access, quality, and expenditures, an open-ended probing question asked for a description of how benefits were used to improve the consortia’s administration, services, and/or programs. Descriptions of increased services to a larger number of clients are said to have been accomplished by way of increased engagement with other community-based agencies, the elimination of pre-authorization of medical expenses, increased education to providers, and facilitation of data exchange for best practice dissemination.

The documentation of this process is then reported as being contained within monthly, quarterly, and annual reports. Specific studies were cited per state and have been conducted regarding cost effectiveness, quality assurance, and service denials.

The reasons for which cost containment practices were developed were asked of the states, with the opportunity to describe other means. As shown in the table below, “Reduced funding” received eight responses, while Health Resources and Services Administration (HRSA) HIV/AIDS Bureau requirements received fifteen. One respondent indicated utilization of quality management practices in addition to HRSA mandates.

The methods by which cost containment practices were developed received 17 responses for “administrative review within the state,” seven responses for “state contract process/needs assessment,” one response for “local contract process/needs assessment,” and three responses for “state and local contract process/needs assessment.”

**State Reasons and Methods for Cost Containment Development**
The majority of the State Title II representatives indicated being “proactive” for cost containment practices, while two indicated being “reactive.” This was in contrast to more open-ended questions where responses identified funding reductions and additional HRSA requirements. Because “reactive” has a negative connotation, it was less likely respondents were willing to choose it over “proactive.”

When asked to describe what the HRSA HIV/AIDS Bureau could undertake to assist with identifying, planning, or implementing cost containment practices, several responses described technical assistance for determining which expenditures were appropriate or not appropriate in relation to Public Health Service (PHS) guidelines regarding HIV care. Sharing proven best practices for cost containment and requiring all titles of the CARE Act to share data were also mentioned.

State representatives were provided with a table containing ten items and were asked to indicate if they were currently done, planned to be done, or not feasible. Responses are found within the following table:

**Cost Containment Items and Stages of Development**

<table>
<thead>
<tr>
<th>Cost Containment Items</th>
<th>Currently Done</th>
<th>Plan to be Done</th>
<th>Not Feasible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized reporting requirements</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Facilitation of data exchange for best practices</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Reduced administrative processes and paperwork</td>
<td>9</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Increased coordination between HIV/AIDS programs</td>
<td>14</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Increased coordination between non-HIV/AIDS programs</td>
<td>8</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Prior authorizations</td>
<td>9</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Analyzing service and expenditure data for cost-efficiency</td>
<td>9</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Required second medical opinions for major procedures</td>
<td>1</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Increasing appropriate use of services through patient follow-up and education</td>
<td>7</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Leveraging purchasing power through centralization</td>
<td>7</td>
<td>3</td>
<td>2</td>
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The most common cost containment items currently being done are “standardized reporting requirements and “increased coordination between HIV/AIDS programs.” The majority of the states were planning several items mentioned in the table, however the greatest number identified “increased coordination between non-HIV/AIDS programs,” as their top choice. They indicated that “prior authorizations” and “requiring second medical opinions for major procedures” were not feasible.

The final question regarding what cost containment practices they would employ if given unlimited resources (e.g., time, staff, funding) found that state Title II representatives wanted standardization of care payments through a better understanding of unit cost of services, better linking of prevention to the care continuum, and an increased review of adherence and compliance. Significant attention was given to better linking to Medicare and Medicaid programs, with the ability to bill either program retroactively for services rendered. Similarly, more frequent verification of eligibility was cited as a desired method, given unlimited resources. Additional suggestions included reviewing the feasibility of a “tiered approach” for reimbursement of client services based on their Federal Poverty Level (FPL) and better verification of patient eligibility. Finally, creating a more reasonably priced insurance pool for HIV+ individuals through collaborations with private insurers was suggested.

**Florida Consortia Survey Findings**

Eleven of thirteen consortia surveys were returned, representing an 85% response rate. Nearly all lead agency representatives responded that they are familiar with the term “cost containment” as it relates to Title II programs within the Ryan White CARE Act. Descriptions of their interpretation of the term mainly focused on the usage efficiency of limited funding (i.e., providing maximum services at the lowest possible cost). However, some included effectiveness (i.e., goal actualization) and the consideration of access and quality. One response described cost containment as an “evaluation process with determined effectiveness factors (measurement outcomes) and best practices.”

Cost containment priority levels consisting of none, low, moderate, or high were given a “high” by nearly two thirds (seven) of the respondents, while “moderate” was
selected by those remaining (four). Also, cost containment is a component of other initiatives (e.g., quality management) in all of the consortia, as opposed to a singular or “stand alone” initiative.

Descriptions of the cost containment practices at the administrative level were centered on negotiating the lowest service provision rate with the Medicaid rate set as the target, formulating utilization guidelines, and reducing service and planning effort duplication. Responses also included collaboration with other Ryan White programs, evaluating service unit indicators, and continuing with an attempt to create a universal data collection system.

Service or program level practices were centered on interagency agreements (i.e., Memoranda of Agreement). Others described collaboration between service providers to reduce duplication; using preferred providers; service limitations; electronic data collection; and vendor management through monitoring and CQI programs.

Three questions asked for the degree of impact cost containment practices had on quality, access, and expenditures in the consortia Title II program in 2003. A scale ranging from “very negative” to “very positive” impact is provided for each, as shown in the following table:

<table>
<thead>
<tr>
<th></th>
<th>Very Negative</th>
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<th>Slightly Positive</th>
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<td>1</td>
<td>9</td>
<td>2</td>
<td>5</td>
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Respondents indicating negative responses, comprised of “very negative” or “slightly negative,” totaled ten, while positive responses, alternately comprised of “slightly positive” or “very positive,” totaled seventeen. The balance of the impact on all three measures, therefore, is slanted toward the positive side of the scale. However, while quality and expenditures are more positive, access is slightly more negative.
If either “slightly” or “very” positive responses were indicated, an open-ended probing question was then asked for a description of how benefits were used to improve the consortia’s administration, services, and/or programs. Descriptions of increased services to a larger number of clients were said to have been accomplished by way of performance outcome monitoring, expansion of such monitoring, and administrative review constancy.

The documentation of this process is then reported as being contained within monitoring reports; local monitoring files; reports provided to planning bodies; weekly budgeting reviews; and meeting minutes. A lack of consistency or reliability was also indicated.

Internal and external reasoning or methods for which cost containment practices were developed were asked of the consortia, with the opportunity to describe other means. As shown in the table below, “administrative review” and “local planning contract process/needs assessment” both internal processes, were selected by nine and eight respondents, respectively. Although all of the open-ended responses described external factors such as an increased number of clients but not funding, increased provider fees, and an increased in the number of services being requested. Responses indicating the external means “reduced funding” and “Florida Department of Health, Bureau of HIV/AIDS requirements” received a total of seven responses combined. No consortia indicated “not applicable.”

**Consortia Reasons and Methods for Cost Containment Development**

![Consortia Reasons and Methods for Cost Containment Development](image)
Consortia indicated cost containment practices nearly equally “proactive” or “reactive” at six and five, respectively. While reacting to external changes, consortia noted they were simultaneously developing proactive cost containment practices in anticipation of future changes.

When asked to describe the assistance the Florida Department of Health, Bureau of HIV/AIDS could undertake with identifying, planning, or implementing cost containment practices, several responses mentioned standardization of state practices and data collection. Technical assistance and shared practices for these items were also included, in addition to more direction specifically regarding the needs assessment and increased awareness to consortia areas’ differing needs.

Consortia were provided with a table containing ten items and were asked to indicate if they were currently done, plan to be done, or are not feasible. Nine of the eleven respondents completed the table, as shown in the following table of findings:

### Cost Containment Items and Stages of Development

<table>
<thead>
<tr>
<th>Cost Containment Items</th>
<th>Currently Done</th>
<th>Plan to be Done</th>
<th>Not Feasible</th>
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<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Facilitation of data exchange for best practices</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Reduced administrative processes and paperwork</td>
<td>3</td>
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<td>1</td>
</tr>
<tr>
<td>Increased coordination between HIV/AIDS programs</td>
<td>6</td>
<td>1</td>
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<tr>
<td>Increased coordination between non-HIV/AIDS programs</td>
<td>3</td>
<td>3</td>
<td>0</td>
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<tr>
<td>Prior authorizations</td>
<td>4</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Analyzing service and expenditure data for cost-efficiency</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Required second medical opinions for major procedures</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Increasing appropriate use of services through patient follow-up and education</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Leveraging purchasing power through centralization</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
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</table>
The most common cost containment items currently being done were “increased coordination between HIV/AIDS programs,” “standardized reporting requirements,” “prior authorizations,” “analyzing service and expenditure data for cost-efficiency,” and “increasing appropriate use of services through patient follow-up and education.” No consortia noted “leveraging purchasing power through centralization,” and only one stated “requiring second medical opinions for major procedures.”

The remaining respondent that did not indicate “increased coordination between HIV/AIDS programs” detailed that they planned to do so, and no consortia planned to have “prior authorizations” or “required second medical opinions for major procedures.”

The majority of respondents indicated that the second medical opinion requirement is not feasible, and none indicated the non-feasibility of increased coordination between both HIV/AIDS and non-programs, the analysis of service and expenditure data for cost-efficiency, or increasing appropriate service use through patient follow-up and education.

The final question regarding what cost containment practices they would employ if given unlimited resources (e.g., time, staff, funding) found that consortia wanted more bargaining power; more intensive technical assistance; clear expectations of reporting and contractual requirements; a single point of entry system; a more focused recruitment of the provider base; a Disease Management prototype for the Title II system; an area-wide data collection system; and, most commonly, expansion of core and ancillary services.
Recommendations

The following recommendations were developed according to data gathered from both the comprehensive plans and respondent surveys. The recommendations are divided into three sections relating to state Title II programs and their managing representatives at HRSA, the Florida consortia, and the Florida Department of Health, Bureau of HIV/AIDS. The final category relates to recommendations that can be utilized by both the states and the Florida consortia, as well as the general financing of publicly funded healthcare systems.

State Title II Programs

The AIDS Institute recommends that the Health Resources and Services Administration, HIV/AIDS Bureau:

♦ Create a process for the sharing of “best practices” for cost containment between states.

♦ Create a shared exchange of data between all Titles of the Ryan White CARE Act at the state and national level, while maintaining the integrity of private contract negotiations and client confidentiality.

♦ Provide technical assistance in the developing/interpreting of unit of cost fee system for interested states.

♦ Provide technical assistance in interpreting “HIV relevant services” for inclusion into the care continuum.

♦ Allow states to retain flexibility in organizing local and/or statewide planning bodies to better serve their communities while requiring viable community input into the process.

♦ Create and/or publicize standardized quality measures nationwide to facilitate cross-state comparisons and monitoring.

♦ Facilitate better linkages between Ryan White Title programs nationwide through contract language and/or better collaboration between contract managers for the different Titles funded through HRSA.
Facilitate better linkages between Ryan White Title programs, Medicaid, and Medicare through active collaboration with the Centers for Medicare & Medicaid Services.

**Florida Consortia**

The AIDS Institute recommends that the Florida Department of Health, Bureau of HIV/AIDS:

♦ Facilitate the sharing of best practices between consortia.
♦ Facilitate the standardization of data collection.
♦ Create clear expectations of reporting and contractual requirements.
♦ Facilitate training for and/or assist local consortia in provider recruitment, including recruitment models not traditional to the Ryan White system.
♦ Facilitate better linkages between Ryan White Title programs in Florida by collaborating more closely with administrative bodies for Title I, III, and IV.
♦ Facilitate better linkages between Ryan White Title programs, Medicaid, and Medicare by enhancing communications with the Agency for Healthcare Administration (AHCA).
♦ Require consortia to monitor impacts of cost containment on access, quality, and expenditures.
♦ Require consortia to report relevant cost containment practices in annual or semi-annual reporting.
♦ Create standardized measures for quality for consortia to use while tracking their cost containment practices.

**Ryan White Title II Programs and Public Healthcare Systems**

♦ Create an award for Quality achievements based on the Baldrige Award for Ryan White systems. This could be created at either the Florida state level or within HRSA’s structure.
♦ Encourage the HIV/AIDS service community to shift its thought paradigm and consider prevention as an integral part of the care continuum.

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**Conclusion**
When reviewing cost containment practices in the Ryan White care system, the differences between public and private systems must be considered. Healthcare-based cost containment theory was developed largely by the private insurance industry and can be very instructive to publicly funded healthcare systems. However, public systems such as Medicaid and the Ryan White care system are uniquely constructed and cannot employ some of the strategies developed by the private insurance industry. Administrators and service providers must remember these facts while choosing and/or creating cost containment practices. For example, annual caps per client and caps on service categories may contain costs, but they may also lead to future cost inefficiencies due to resulting treatment and service gaps that cause episodic, expensive, tertiary care.

Administrators and service providers overwhelmingly identified information sharing as a key gap in much of the information provided. This may seem to be a very simple and standard function, yet it seems to be overlooked. Much can be learned from peers, and lives can be saved when failures or successes are shared between programs. Frequently, communications such as these can be overlooked in the tumult of providing services and administering programs. However, with a few small changes to make information sharing transparent and fluid between programs, a great benefit could be created for service providers, administrators, and consumers.

Administrators and service providers must maintain cost containment practices as part of an entire system of quality management. Administrators should look to contract requirements that they manage to include evaluation of quality management criteria so that it will be reportable and possible to monitor. They must take into account factors such as access and quality of services. Any changes made to service systems due to cost containment analyses must not cut so deep as to paralyze a system specifically designed to serve the under- and uninsured, and therefore, neediest citizens. If services or access to services suffer because of implemented changes and programs fail to meet goals set by authorizing legislation, then cost containment practices become incidental. We must not rip the safety net provided by the Ryan White Care system, the payer of last resort, for those that are most in danger of having inadequate and inconsistent access to healthcare.
References


Michigan Department of Community Health (DCH), Division of HIV/AIDS-STD (2003).


Appendices

Appendix A

Lead Agency Contacts

**Area 1:** Lutheran Services Florida, Inc. NW 4610 West Fairfield Dr
Pensacola, FL 32506
(850) 453-2772
**Contacts: Beth Deck or Karen Faggioni**

**Area 2A:** Bay AIDS Services and Information Coalition, Inc.
PO Box 805
Panama City, FL 32402
(850) 785-1088
**Contact: Frank Dean**

**Area 2B:** Big Bend Cares, Inc.
1375 Cross Creek Circle
Tallahassee, FL 32301
(850) 656-2437
**Contacts: Lorraine Elder or Susan Stevens**

**Area 3/13:** North Central Florida Health Planning Council, Inc
18 NW 33 Court
Gainesville, FL 32607
(352) 955-2264
**Contacts: Edith Orsini or Karen Klubertanz**

**Area 4:** Jewish Family & Community Services, Inc.
6261 Dupont Station Court East
Jacksonville, FL 32217
(904) 394-5734
**Contact: Mark Rubens**

**Area 5/6/14:** Hillsborough County Health & Social Services
412 E. Madison Street, Suite 1105
Tampa, FL 33602
(813) 272-6935
**Contacts: Aubrey Arnold or Kathey LaRoche**

**Area 12:** Health Planning Council of Northeast Florida, Inc.
101 S. Palmetto Ave.
Daytona Beach, FL 32114
(386) 323-2046
**Contacts: Joyce Case or Laurie Bilello**

**Area 7:** Heart of Florida United Way
1940 Traylor Blvd.
Orlando, FL 32804
(407) 323-2046
**Contacts: Natalie Thornhill or Emery Ivery**
Area 8: Health Planning Council of Southwest Florida, Inc.
9250 College Parkway, Suite 3
Ft. Myers, FL 33919
(941) 433-6700
Contacts: Patricia McGrain or Ed Houck

Area 9/15: Treasure Coast Health Council, Inc.
4125 W. Blue Heron Blvd., Suite 229
Riveria Beach, FL 33404
(561) 844-4220
Contacts: Kim Lucas or Lisa McWhorter

Area 10: Broward County Health Department
800 E. Broward Blvd., Suite 401
Ft. Lauderdale, FL 33301
(954) 467-4774
Contact: Lisa Agate

Area 11A: Miami-Dade County Health Department
1350 NW 14th Street, Bldg 7, 3rd Floor
Miami, FL 33125
(305) 377-5022
Contact: Evelyn Ullah

Area 11B: Monroe County Health Department
The Gato Building
1100 Simonton Street
Key West, FL 33040
(305) 377-5022
Contact: Cindy Francisco

Area 12: Health Planning Council of Northeast Florida, Inc.
101 S. Palmetto Ave.
Daytona Beach, FL 32114
(386) 323-2046
Contacts: Joyce Case or Laurie Bilello
<table>
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<th>State</th>
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<tr>
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<td>NASTAD Reference: Jane Cheeks</td>
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<td>HRSA Reference: Lola Thrower</td>
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<td>California</td>
<td>NASTAD Reference: Vanessa Baird Waker</td>
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<td>Connecticut</td>
<td>NASTAD Reference: Dr. Richard Melchreit</td>
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<td>Delaware</td>
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<td>NASTAD Reference: Ronald Lewis</td>
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<td>HRSA Reference: Lawrence Frison</td>
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<td>NASTAD Reference: Barbara Wallace</td>
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<td>Maryland</td>
<td>Dr. Liza Solomon</td>
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<td>Kevin Cranston</td>
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<td>Ohio</td>
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<tr>
<td>Texas</td>
<td>Casey Blass</td>
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<td>Jodie Pond</td>
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<td>Vermont</td>
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<td>Casey Rily</td>
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<td>West Virginia</td>
<td>Loretta Haddy</td>
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<tr>
<td>Wisconsin</td>
<td>Sheila Guilfoyle</td>
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<tr>
<td>Wyoming</td>
<td>Kurt Galbraith</td>
</tr>
</tbody>
</table>
Appendix B
Title II Cost Containment Survey: Title II State Programs

1. State:

2. Your name:

3. Your title:

4. In your state, what governmental agency does the Title II program reside (e.g. State Department of Health, State Department of Human Services)?

5. For planning and/or administration of the Title II service structure, your state has (Select only one):

   A singular state-wide body (describe):

   A system of localized bodies (e.g. consortia) (describe):

   Both (describe):

   Neither (describe):

6. Are you familiar with the term “cost containment” as it relates to Title II programs within the Ryan White CARE Act?  Y  N

7. If yes, describe your interpretation of “cost containment:”

8. On the scale below, rate the priority level for “cost containment” for your state (Select only one):

   No Priority  Low Priority  Moderate Priority  High Priority
9. “Cost containment” for your state is a (Select only one):
   □ Singular or “stand alone” initiative
   □ Component of other initiatives
     (e.g., quality management)
   □ Not applicable

10. Describe the cost containment practices that exist at the administrative level for your state:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

□ Not applicable

11. Describe the cost containment practices that exist at the services/program level (e.g. contracted agencies or individuals) for your state:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

□ Not applicable

12. On the scale below, rate the degree of impact cost containment practices had on the quality of Title II programs in 2003 (Select only one):

Very negative  Slightly negative  No  Slightly positive  Very positive
impact          impact          impact          impact          impact

□ Don’t know

13. On the scale below, rate the degree of impact cost containment practices had on access in Title II programs in 2003 (Circle only one):

Very negative  Slightly negative  No  Slightly positive  Very positive
impact          impact          impact          impact          impact

□ Don’t know

14. On the scale below, rate the degree of impact cost containment practices had on the expenditures for Title II programs in 2003 (Circle only one):
15. If a slightly or very positive impact resulted in the areas of quality, access, or expenditures, describe how the benefits were used to improve Title II administration, services and/or programs:

_____________________________________________________________________
_____________________________________________________________________

☐ Don’t know

16. How was this documented?

_____________________________________________________________________
_____________________________________________________________________

☐ Not applicable

17. For what reason(s) or by what method(s) were your cost containment practices developed? (Select all that apply)

☐ Administrative review within the state
☐ State contract process/needs assessment
☐ Local contract process/needs assessment
☐ State and local contract process/needs assessment
☐ Not applicable
☐ Other
(describe):

_____________________________________________________________________
_____________________________________________________________________

18. For what reason(s) or by what method(s) were your cost containment practices developed? (Select all that apply)

☐ Reduced funding
☐ Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) requirements
☐ Not applicable
☐ Other (describe):
19. Cost containment practices in your state are (Select only one):
   - [ ] Proactive
   - [ ] Reactive
   - [ ] Not applicable

20. Describe the activities the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) could undertake to assist you in identifying, planning, or implementing cost containment practices:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
21. From the following list, select which items are currently done, plan to be done, or are not feasible in your state (Check all that apply within each column):

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<th>Plan to be done</th>
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</tr>
<tr>
<td>[ ] Increasing appropriate use of services through patient follow-up and education</td>
<td>[ ] Increasing appropriate use of services through patient follow-up and education</td>
<td>[ ] Increasing appropriate use of services through patient follow-up and education</td>
</tr>
<tr>
<td>[ ] Leveraging purchasing power through centralization</td>
<td>[ ] Leveraging purchasing power through centralization</td>
<td>[ ] Leveraging purchasing power through centralization</td>
</tr>
</tbody>
</table>

22. Please provide any additional comments regarding the feasibility of the items provided in the previous question (#19):

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

23. Given unlimited resources (e.g., time, staff, funding), what cost containment practices would you employ within your state?

_____________________________________________________________________
_____________________________________________________________________

_____________________________________________________________________
Appendix C
Title II Cost Containment Survey: Florida Consortia

1. Consortia area:_______________________________________________________

2. Lead Agency Name:___________________________________________________

3. Are you familiar with the term “cost containment” as it relates to Title II programs within the Ryan White CARE Act?   Y    N

4. If yes, describe your interpretation of “cost containment:”
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

___ Not applicable

5. On the scale below, rate the priority level for “cost containment” in your consortia (Circle only one):

No Priority               Low Priority                Moderate Priority               High Priority

6. “Cost containment” in your consortia is a (Check only one):

___ Singular or “stand alone” initiative
___ Component of other initiatives (e.g., quality management)
___ Not applicable

7. Describe the cost containment practices that exist at the administrative level (e.g., Lead Agency, planning body) in your consortia:
____________________________________________________________________
____________________________________________________________________

___ Not applicable

8. Describe the cost containment practices that exist at the services/program level (i.e. contracted agencies or individuals) in your consortia:
____________________________________________________________________
____________________________________________________________________

___ Not applicable
9. On the scale below, rate the degree of impact cost containment practices had on the quality of the Title II program in 2003 in your consortia (Circle only one):

Very negative impact  Slightly negative impact  No impact  Slightly positive impact  Very positive impact

___ Don’t know

10. On the scale below, rate the degree of impact cost containment practices had on access in the Title II program in 2003 in your consortia (Circle only one):

Very negative impact  Slightly negative impact  No impact  Slightly positive impact  Very positive impact

___ Don’t know

11. On the scale below, rate the degree of impact cost containment practices had on the expenditures for the Title II program in 2003 in your consortia (Circle only one):

Very negative impact  Slightly negative impact  No impact  Slightly positive impact  Very positive impact

___ Don’t know

12. If a slightly or very positive impact resulted in the areas of quality, access, or expenditures, describe how the benefits were used to improve the administration, services and/or programs.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

___ Not applicable

13. How was this documented?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
14. For what reason(s) or by what method(s) were your cost containment practices developed? (Check all that apply)

<table>
<thead>
<tr>
<th>Internally</th>
<th>Externally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative review</td>
<td>Reduced funding</td>
</tr>
<tr>
<td>Local planning contract</td>
<td>Florida Department of Health</td>
</tr>
<tr>
<td>process/needs assessment</td>
<td>Bureau of HIV/AIDS requirements</td>
</tr>
</tbody>
</table>

Not applicable

Other (describe):_______________________________________________________
____________________________________________________________________
____________________________________________________________________

15. Cost containment practices in your consortia are (Check only one):

___ Proactive
___ Reactive
___ Not applicable

16. Describe the activities the Florida Department of Health Bureau or HIV/AIDS could undertake to assist you in identifying, planning, or implementing cost containment practices?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
17. From the following list, select which items are currently done, plan to be done, or are not feasible in your consortia (Check all that apply within each column):

<table>
<thead>
<tr>
<th>Currently done</th>
<th>Plan to be done</th>
<th>Not feasible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized reporting requirements</td>
<td>Standardized reporting requirements</td>
<td>Standardized reporting requirements</td>
</tr>
<tr>
<td>Facilitation of data exchange for best practices</td>
<td>Facilitation of data exchange for best practices</td>
<td>Facilitation of data exchange for best practices</td>
</tr>
<tr>
<td>Reduced administrative processes and paperwork</td>
<td>Reduced administrative processes and paperwork</td>
<td>Reduced administrative processes and paperwork</td>
</tr>
<tr>
<td>Increased coordination between HIV/AIDS programs</td>
<td>Increased coordination between HIV/AIDS programs</td>
<td>Increased coordination between HIV/AIDS programs</td>
</tr>
<tr>
<td>Increased coordination between non-HIV/AIDS programs</td>
<td>Increased coordination between non-HIV/AIDS programs</td>
<td>Increased coordination between non-HIV/AIDS programs</td>
</tr>
<tr>
<td>Prior authorizations</td>
<td>Prior authorizations</td>
<td>Prior authorizations</td>
</tr>
<tr>
<td>Analyzing service and expenditure data for cost efficiency</td>
<td>Analyzing service and expenditure data for cost efficiency</td>
<td>Analyzing service and expenditure data for cost efficiency</td>
</tr>
<tr>
<td>Required second medical opinions for major procedures</td>
<td>Required second medical opinions for major procedures</td>
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</table>

18. Please provide any additional comments regarding the feasibility of the items provided in the previous question (#17):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

19. Given unlimited resources (e.g., time, staff, funding), what cost containment practices would you employ within your consortia?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________