Most HIV/AIDS mental health providers—and certainly almost all who work in institutions such as hospitals or community health and mental health centers—provide services that are paid for by federal programs. Two federal programs in particular have significantly shaped that care—the Ryan White Comprehensive AIDS Resources Emergency (C.A.R.E.) Act of 1990, reauthorized with modifications in 1996, and Medicaid.

The Ryan White C.A.R.E. Act was passed in 1990 to provide funding for HIV-related primary health care and support services. With other funding streams such as Medicaid supporting a variety of AIDS services, this legislation was designed to fill gaps and provide emergency assistance, to facilitate and engage new clients into care, and to foster “the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease,” in the words of the 1990 legislation.

The C.A.R.E. Act has enabled the creation of thousands of programs, including many HIV mental health programs, throughout the United States. Many of the programs described in this book came into existence because of these Ryan White funds, and the book’s foreword was written by the man who administered these funds until his retirement from government service in 1996.
The other major federal funding stream for HIV-infected persons is Medicaid (Title XIX of the Social Security Act Amendments of 1965). Medicaid annually pays for six times the amount of services funded by Ryan White.

While many working and middle-class persons with HIV disease may begin paying their mental health and medical bills with private insurance, toward the later stages of the illness they may choose or need to turn to Medicaid for assistance. Many persons with HIV/AIDS never had private insurance and have been entirely dependent on Medicaid to pay their medical and mental health costs. Medicaid covers 40 percent of all people with HIV, as many as 60 percent of adults living with AIDS, and 90 percent of all children with AIDS. In fiscal year 1994, Medicaid served approximately 56,000 persons with full-blown AIDS.

Why a Chapter on These Issues?

HIV/AIDS mental health care in the twenty-first century may be funded wholly differently than it has been in the early 1990s. Funding may be extremely limited, funding policies may be very constrictive, and policy debate may pit the needs of persons with AIDS against persons with other diseases. In contrast to the early 1990s, very lean times may be ahead.

As the epidemic shifts from one affecting primarily gay men to one striking substance abusers and, more generally, poor people in urban centers, these funding issues will be compounded by the pervasive media disinterest in AIDS and by the political contempt for poor people and urban centers.

This chapter is important because many readers of this book will be hoping to practice HIV/AIDS-related care as we approach and enter the twenty-first century. As you will discover, no practitioner can afford to ignore federal and state policy-making; the costs to your clients but also to you as a provider are too great!

This chapter examines the two major funding streams: Ryan White and Medicaid. In the section on Medicaid, the government program likely to be most transformed in the next decade, I extensively describe possible changes, including managed care and block grants, and their ramifications. In the last section, I suggest survival strategies on your part.

I write as a professional social worker, a gay man active in HIV/AIDS issues, a former director of five homeless shelters, a senior public policy
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analyst, and someone who has been active in federal and state policy-making as the director of government relations for an organization that represents more than 100 community mental health agencies. I urge you to know what may be ahead, and to act on it. Denial and/or avoidance are not adaptive coping mechanisms for today's — and tomorrow's — challenges.

The Ryan White C.A.R.E. Act

Understanding Ryan White

In 1990 Congress passed landmark AIDS/HIV legislation, the Ryan White Comprehensive AIDS Resources Emergency Act, which created a five-year federal program that eventually spent more than $2 billion for HIV-related services.

The results of the Ryan White stream were invaluable. With Ryan White support, states and localities have developed medical, mental health, and support services that promote early treatment and cost-effective care to individuals and families with HIV/AIDS. A recent study found that many Ryan White-funded programs in New York City were successful in engaging clients who would otherwise not have received care (Warren, Fullwood, Lee, & Salitan, 1995).

The initial authorization of the Ryan White legislation expired in September 1995, with funding ending early in April 1996. Because reauthorization was critical to the continued provision of vital HIV-related medical, mental health, and social services, advocates for HIV services were activated.

In congressional debate, legislators acknowledged the different faces of AIDS and emphasized that AIDS is the leading cause of death among men and women ages twenty-five to forty-four (Dunlap, 1995; Seelye, 1995). "Not everybody who has AIDS gets it from sex or drug needles. But . . . more to the point, gay people who have AIDS are still our sons, our brothers, our cousins, our citizens. They're Americans, too. They're obeying the law and working hard. They are entitled to be treated like everybody else," asserted President Bill Clinton while speaking at Georgetown University (Seelye, 1995).

But opposition emerged. During the legislative process, several issues came to the fore:
• **AIDS-related allocations versus those for other illnesses.** "At the federal level, until recently the overlap between groups advocating for health care services for people with HIV/AIDS and groups advocating on general health care finance and insurance issues has been a null set" (Westmoreland, 1995, 273). Some leaders, however, have sought to capitalize on competition for limited dollars. Sen. Jesse Helms (R-NC) placed a "hold" on the reauthorization bill, saying that AIDS receives too much money in comparison to cancer and heart disease and maintaining that "we've got to have some common sense about a disease transmitted by people deliberately engaging in unnatural acts" (Seelye, 1995). In response, reauthorization supporters were quick to note that U.S. Public Health Service figures documented total annual federal funding for AIDS at $6 billion, far less than the $36.3 billion in outlays for heart disease and the $16.9 billion for cancer. Helms's opposition was viewed as a continuation of his homophobic opposition to HIV funding and his vested interests in heart disease.

• **Mandatory testing of newborns.** In the House of Representatives, reauthorization was stalled by a move to require mandatory HIV testing of newborns for states desiring C.A.R.E. Act funds. A positive test on the newborn would always reveal the HIV status of the mother. This was opposed by many public health officials and women's and feminist organizations, as well as by many people living with HIV and by AIDS advocates.

*Politics in the AIDS Community: Alive and Well*

Many observers would assume that AIDS advocates and health and human service professionals would unite as a powerful, political voice to facilitate reauthorization, but this has not been entirely true. The politics of limited resources, diverse needs, and coalition work, coupled with power imbalances, has served at times to splinter advocacy around Ryan White.

The CAEAR (Cities Advocating Emergency AIDS Relief) Coalition, a national alliance comprising localities and states that receive Ryan White monies, proved to be the ground where significant disagreement over AIDS policy and reauthorization strategy emerged. The group's original goals focused on increasing annual C.A.R.E. Act allocations in the first
five years of the legislation. During this period new cities qualified for more or additional funds, further complicating the group’s consensus decision-making process.

Individual localities, for example, disagreed about whether to pursue joint allocations for cities and states or to retain the 1990 legislation’s practice of providing individual streams to qualified localities and states. Single appropriation, some argued, would merge the resources of cities and states, yielding a robust, unified voice for future congressional appropriations debates. Funded states, some of which lacked funded localities, feared profound neglect. Another dispute emerged around using something called the Medicare Wage Index within the funding formula as a means for adjusting allocations on the basis of regional service costs, which some states felt favored areas with higher costs.

As usual, difficult times serve as opportunities to query the goals, methods, and membership of advocacy organizations, as inconvenient as it usually seems. The members of the CAEAR Coalition found themselves struggling with several additional issues, such as retention of its single-focus mission statement as well as methods to resolve disagreements about operating principles, which favored consensus and restricted individual members’ autonomy. Call it an inability to address these difficult issues, or an appropriate focus on reauthorization; either way, the coalition postponed addressing these issues until after reauthorization. The most obvious fallout of this dissension was that multiple points of view were expressed by AIDS advocates on Capitol Hill during the congressional debates. A divided constituency is more easily thwarted.

The CAEAR Coalition was not the only national voice driving reauthorization. The Human Rights Campaign Fund (HRCF) commissioned a public opinion poll to study voter attitudes toward AIDS funding. HRCF hired the Terrance Group, a respected Republican polling firm, and Lake Research, a well-known Democratic pollster, to study Americans’ attitudes regarding government support of HIV/AIDS care, research, and prevention. In spring 1995, HRCF reported that broad nationwide support for AIDS funding exists among Democratic, Republican, and independent voters – 77 percent wanted to maintain or increase federal funding, with deep support in every region of the country and among all religious subgroups. Seventy-eight percent of those polled said that this is no time to retreat on the AIDS crisis, 56 percent said that they would be less inclined to vote for a member of Congress who voted against continued federal funding for AIDS care, and 45 percent said they be-
lieve the government is doing too little to respond to AIDS, including a plurality of the people who voted for Ross Perot in the 1992 presidential election (Human Rights Campaign Fund, Lake Research, & Terrance Group, 1995).

**C.A.R.E. Act Reauthorization**

Despite the fractionated AIDS advocacy, in 1996 the U.S. Congress passed the reauthorization of the Ryan White legislation that expired in September 1995. Given that Ryan White is discretionary spending (categorical grant funding for nonentitlement programs) and that discretionary spending has been under an overall cap since the Budget Act of 1990 (any new money must come from cuts to other existing programs), it is a small miracle that Congress and the President were able to agree on the expenditures that provide additional funding for Ryan White's drug assistance program, ADAP.

**Medicaid**

The Social Security Act Amendments of 1965 established the Medicaid program to provide health care to public assistance recipients and other qualified individuals. As an entitlement program, Medicaid benefits are available to any person who meets statutory eligibility criteria. The entitlement mechanism was originally created to reduce the disparities in medical care provided to the poor that existed among states and to distribute fairly the financial burden of such medical care.

The federal government has established mandatory services that must be covered by Medicaid and optional services that may be covered by Medicaid. Some states, such as New York, provide a comprehensive Medicaid program that includes medical services that extend well beyond the minimum mandatory level.

**Cost Shifting and Cost Containment**

The 1980s produced significant federal cutbacks for most public welfare services at the same time that need escalated and the number of individual billionaires increased conspicuously (Fabricant & Burghardt, 1992). As a result, states were forced to reduce services, restrict eligibility, find ways of shifting expenses to other entities, or undertake some combination of
these. Many states succeeded in decreasing their financial responsibility by shifting mental health expenditures to the federal government and to localities by converting services to Medicaid reimbursement. These arrangements parceled the largest financial responsibility for mental health services to the federal government (50–80 percent), then to the states (25–10 percent) and, last, to local communities (25–0 percent).

Despite the Medicaidization of mental health services, many states’ fiscal responsibilities continued to grow as total expenditures grew. In New York, for example, total mental health expenditures increased from $2.7 billion in 1986 ($1 billion Medicaid) to roughly $4 billion ($2 billion Medicaid) by the end of 1993 (New York State Office of Mental Health, 1993). Consequently, many states engaged in a set of cost-containment practices, including:

• **Utilization reviews**: States set regulatory standards for record keeping and services. Payment is withheld if an agency fails to meet standards.

• **Medicaid utilization threshold systems**: States impose an annual limit on outpatient mental health services. In 1993 New York set a limit of forty visits and sought to reduce the threshold to thirty visits a year later. Agencies must submit paperwork to secure authorization for additional reimbursable visits.

• **Diagnostic related groups (DRGs)**: Using groupings of specific “health” conditions, a standard maximum number of visits/services or maximum payment is predetermined. Providers, namely hospitals, can make money if they decrease the number of visits or the length of stay while collecting the standard payment. While psychiatry is excluded, this cost containment measure can create significant psychosocial issues related to premature or poor discharge planning.

• **Uniform case records**: States create recordkeeping requirements, including progress and contact notes, which can be reviewed to determine inappropriate or overextended services.

• **Certificates of need**: To operate new (and sometimes expanded) programming, states require agencies to file lengthy proposals and secure certificates of need. The state limits funding for new certificates, thereby limiting development of new programs.
The Future of Cost Containment: Medicaid Managed Care

Now into the second decade of the AIDS pandemic, many states have filed federal Medicaid waivers to convert traditional Medicaid fee-for-service systems into state-run managed-care programs. The individual state programs have the potential to alter dramatically the health and the mental health care systems for persons living with HIV and AIDS.

The term managed care refers to a variety of arrangements between the state and private corporations that manage an array of services. Most state plans recognize some combination of the following categories of managed-care models:

- **Full-risk capitation**: Organizations receive a per-patient (per capita, or capitation) payment to provide a comprehensive set of benefits to enrollees and assume full financial risk. Enrollees select one of the organization's affiliated physicians as their primary care doctor, and all specialist services (mental health, substance abuse), hospital admissions, and other services must be approved by this provider/gatekeeper. Since the primary care provider's group pays, out of its capitation income, for most specialty services, providers or organization “gatekeepers” may be reluctant to make or approve the referral.

- **Partial-risk capitation**: A group of physicians agrees to provide a limited set of primary-care services to the enrollees in exchange for a monthly capitation payment. As with full-risk capitation, the patient selects a doctor to serve as a primary care provider, and that physician must approve all referral services and hospital admissions. Unlike the situation with full-risk capitation, however, the group of primary-care physicians bears no financial risk for the cost of services it does not provide directly. This model usually asks primary-care physicians to manage special care services but does not put them at financial risk for the cost of these services.

- **Enhanced fee-for-services**: An individual physician agrees to serve as primary-care provider and as case manager for referral services but assumes no financial risk. Instead, the physician is paid under a fee-for-service schedule that includes additional payment for the responsibility for managing special care services.

It should be emphasized that the documented cost-savings benefits of managed care as described in the literature are based almost exclusively

**Potential Benefits of Full-Risk Capitation Plans**

From a client perspective, managed care promises greater access to health care and greater continuity of care, because a single physician or a small group is available to provide primary care and to coordinate other services. Theoretically, the patient has a clearly identified and readily available source of care when a problem arises. He or she is not obliged to seek out an appropriate specialist or clinic (and pay out-of-pocket) or forced to utilize emergency rooms because of a lack of relationship with a regular provider. In addition, there is evidence that members of capitation plans are more likely to receive preventive services such as immunizations, checkups, and periodic screening than are patients in fee-for-service relationships. This is related to the financial incentives built into capitated systems, which focus on preventing disease, thereby avoiding costly hospitalizations.

The principal drawback, from a client's perspective, is the requirement that initial contacts be restricted to a primary-care physician selected from the plan's "preferred physicians" network. This restriction on freedom of choice is typically redressed in two ways. First, patients are given a choice of plans and of physicians within plans. Second, patients who are dissatisfied with their chosen physicians may be reassigned to another physician within the plan or may disenroll from that plan and opt for another.

Equally important are the benefits that managed care promises taxpayers — those who pay for medical and mental health care covered by Medicaid. Numerous studies have demonstrated that full-risk capitation plans provide health care of competitive quality and at a significantly lower cost. The cost savings estimates are generally in the range of 20 to 40 percent. The savings are achieved in two basic ways. First, and most significant, is a much lower rate of acute hospitalization and shortened average lengths of stay. Second, these plans conserve resources by limiting use of referral specialists and emergency rooms. Hospital inpatient and emergency room use (most costly services) by the Medicaid population, for example, is higher in New York City than the national average. To the extent managed care shifts health care away from inpatient units and emergency rooms, it may be possible to save money.
State managed-care plans represent blueprints for a monumental restructuring of the mental health and AIDS primary-care systems, with the most relevant application to the health maintenance organization (HMO) industry (full-risk capitation) as differentiated from other managed-care models.

Some state plans exclude certain populations, such as the psychiatrically disabled (persons with major mental illness who receive SSI disability benefits) from managed-care plans. Persons diagnosed with major mental illness often represent the vast majority of recipients of mental health services and create the vast majority of mental health expenditures. Most state plans, however, bestow blank-check authority on the HMO industry to treat the health and the mental health needs of people living with HIV/AIDS, receiving Aid to Families with Dependent Children (AFDC) or Home Relief (local aid to mostly single poor adults, which some localities require to be repaid). Often states mandate that all incidental behavioral managed-care services (mental health and substance abuse) be included within the HMO capitated rate. Interestingly enough, some states have suggested that “incidental use” be defined as less than thirty out-patient visits and sixty inpatient days within a one-year period. This position has no clinical foundation. Most states, under pressure from the nonprofit provider groups and AIDS advocates, have more appropriately defined “incidental use.”

Nationally, the majority of persons living with HIV/AIDS, families receiving AFDC, and adults receiving Home Relief grants who also receive mental health services are served by voluntary nonprofit mental health clinics in their own communities. These clinics would be most severely affected by a state’s managed-care plans. While collaboration with the HMO industry to develop managed-care and special-care (mental health, substance use, mental retardation, AIDS/HIV) service delivery models is appropriate, often the terms laid out in state plans appear to provide the HMO industry carte blanche, without significant state oversight. Further analysis yields what I consider to be significantly inadequate public policy with real potential to overwhelm people’s lives, foster significant underutilization, and increase long-term overall costs.

Often state plans fall significantly short of satisfying their managed-care policy objectives. When governors and legislatures set out to develop and implement statewide Medicaid managed-care programs, they often base their agenda on five specific goals:
— **Goal 1**: To ensure that managed-care programs offer Medicaid recipients as wide a choice of primary care and other medical service providers as possible.

For Medicaid recipients, the choice of a managed care provider will be based largely on an individual's primary needs at the time of enrollment—medical needs, most likely. Mental health needs, however, may develop or become apparent after the individual has enrolled in a plan, long after the opportunity to assess his or her unique needs in making a provider choice. For mental health services, this situation will result in little or no choice at all—a result of serious consequence. For Medicaid recipients with mental health needs (especially HIV-related), there are many unique aspects of treatment affecting choice of provider, including cultural competence and the availability of service in an individual's own community. Many plans are silent on or have completely ignored these issues.

— **Goal 2**: To promote more rational patterns of medical and health service utilization by Medicaid recipients.

Rational patterns for mental health service utilization are very different from what would be considered rational utilization patterns for medical and health services. Unlike other health care, psychiatric diagnosis is not a reliable predictor for length, frequency and intensity of treatment. Assessment and treatment of mental health disorders is not linear; many factors (as expressed by an integrated biopsychosocial/spiritual model for treatment of mental health disorders) affect the scope, length, frequency, and success of treatment, often leading to unpredictable and uneven patterns of usage. While many psychiatric disorders have a biochemical basis, their onset, course, and prognosis are uniquely affected by social, economic, and individual psychological factors. Also, to nonmental health care professionals, psychosocial, psychological, psychiatric, and medical conditions are often confused, even unrecognized. It is precisely for this reason that, when Medicare and Medicaid established diagnostic related groups to implement prospective payment systems for inpatient care, psychiatric conditions were exempted.

In addition, unlike the traditional medical model where consumers are often passive recipients of service, effective mental health treatment requires the consumer to take an interactive and dynamic role. To address unique issues and special needs, the
community-based mental health system has devoted itself for many years to developing a specialized service delivery system that includes the many elements that seek to ensure quality care. Those elements include state licensing of providers, regulatory requirements for mental health service, quality assurance, treatment documentation and utilization review, procedural and substantive standards for mental health treatment planning and ongoing treatment plan updating, networks to enhance continuity of care, and innovative program models. State Medicaid managed-care plans propose delivery systems for mental health services that are largely un- or underregulated or that simply omit many of these critical elements.

— **Goal 3: To ensure quality of care within managed-care programs.**

First, the managed-care industry’s knowledge base and experience is grounded in the delivery of general medical services, not in comprehensive HIV/AIDS or mental health services. Second, the population it has historically served is the white middle class, not the Medicaid population. The mental health needs of individuals who have relatively stable employment, work environments with often generous benefits, and social supports are vastly different from those of the Medicaid population. Third, the managed-care treatment model is based on the delivery of service through narrowly defined channels, is often of a short-term nature, and does not integrate multiple systems. The mental health needs of the Medicaid population, especially those living with HIV/AIDS, dictate integration and coordination among a whole array of service delivery systems to address needs such as assistance with housing, entitlements, family interventions, crime/victimization, and protective or permanency planning services. Over many years, the community-based mental health system has been uniquely designed to address these needs. Why do states and the federal government assume that the managed-care industry would supply the same quality service as the community-based mental health system? Certainly, experience has not led to this assumption. Health care reform initiatives implemented by 1993 show that no state has a demonstrated model for successfully incorporating AIDS health and mental health issues into its managed-care program.

— **Goal 4: To enhance access to and availability of mainstream medical care and services by Medicaid recipients.**
Issues regarding how to provide enhanced access for primary health care are very different from the issues that must be addressed in order to enhance access to mental health care. Most state plans do in fact attempt to address access to health care for the Medicaid population, although most ignore issues of access to mental health care and substance abuse treatment and the added stressors associated with HIV/AIDS. Persons seeking mental health treatment in the general health care system often face stigma and discrimination, lack of coordination with other systems, and geographic, racial, and cultural isolation. Non-full-capitation models would offer equal access to health care without gerrymandering the entire mental health system and potentially jeopardizing access to mental health care. A health-care-only managed-care model would also achieve this goal. Yet many states refuse to explore models other than full capitation.

—Goal 5: To establish cost-effective managed care programs.

Some state plans have facilitated cost-effective managed-care programs by integrating medical and mental health care within one program. Other programs’ cost savings may be attributed to limited mental health service delivery motivated by the financial incentive to underserve and/or failure to provide mental health services due to unrecognized need. Furthermore, many plans fail to address factors that may neutralize anticipated cost savings. Do state plans, for example, take into account the nature of the Medicaid population’s utilization patterns, the fluidity of acute episodes of crisis, the likelihood that this population will move in and out of enrollment, and the probability that the Medicaid population may not change the way it has traditionally accessed mental health services? Whatever the reasons for anticipated cost savings, this mystery remains: Why do states overwhelmingly select full capitation to address the goal of cost savings? Why aren’t new and innovative services, split capitation, global budgeting, or other cost-controlling mechanisms discussed with the existing nonprofit mental health sector before undertaking massive restructuring that benefits profit-making enterprises?

In sum, this analysis suggests that many managed care plans fall short of meeting the goals I have enumerated. In fact, the issue of competition among HMOs may further impede attainment of these goals by creating an environment where health rates are quoted so low in order to secure a
contract that ultimately payments for special care, such as psychiatric and psychological services, will be used to offset health cost overruns.

Are we sure of the efficacy and validity of the HMO model, or are we experimenting with the mental health needs of people with HIV, poor people, and persons of color? This experimentation risks the potential collapse of the existing nonprofit community-based mental health system. This analysis suggests that managed-care planning often has very little to do with providing the special-care services that are needed for the Medicaid population and everything to do with accommodating reimbursement systems, creating profit incentives to underserve, and political expediency.

**Federal Block Grants: A New Fiscal Reality**

Finally, it seems probable that federal block grants will be debated for some time, threatening a shift of federal health dollars to states to spend as they see fit in terms of who will receive what services.

Traditionally defined, block grants merge multiple federal funding streams (encompassing a wide array of services) into one funding stream that is less than the fiscal sum of its individual parts. They are administered by states, rather than by federal agencies, permitting great discretion and flexibility with minimal oversight.

Block grants differ from entitlement and categorical programs in several ways. Unlike entitlement programs, block grants are capped funding streams (that is, a maximum amount of money is dictated) that do not reflect changes in population need. Moreover, federal programs funded through block grants have broader programmatic objectives with fewer specifics than entitlement and categorical programs, and they eliminate federal minimum eligibility, service, and provider choice requirements.

The general rationale behind block grants is a desire to decrease the number of unfunded mandates on states and localities and to increase local programmatic flexibility. Despite this underlying policy rationale, block grants often require localities to meet complex programmatic requirements and to finance programs without increased federal assistance. While block grants have been an integral part of federal aid for the last twenty years, the current scope of block grant discussions represents a fundamental shift in the fiscal relationship among the federal, state, and local governments.

The effect of block grants on HIV/AIDS mental health funding may
look something like this: An agency sensitive to community needs, such as the need for additional HIV/AIDS mental health care, may currently seek money from several federal funding streams, thereby piecing together a package of care that responds to the special needs of its patients. If a Medicaid block grant system is enacted, those various federal funding streams will not be available to tap. In fact, state legislators and administrators may dictate usage of the pooled money, likely not responding to the needs of special Medicaid populations.

**Tools for Advocacy**

By now the careful reader has realized that policy-making in Washington and in state capitals significantly affects mental health practice and client care. The following suggests several responses:

- **It is not sufficient just to practice. At minimum, you must keep informed about HIV and about mental health policy issues.**
  
  You should also be involved in policy-making. Otherwise you run the risk of having the service delivery system, which includes your practice, reshaped or redirected without your participation. Public policy affects your practice and your client’s care.

  — Push your professional organizations to represent your needs in Washington and at state capitals.
  
  — Engage (I didn’t say lead) in grass-roots community organization and advocacy.

- **Don’t negate the involvement of your clients in advocacy because you fear an inappropriate use of your professional power or interference with the therapeutic relationship.**

  Staff and supervisors must resolve this dilemma. When in doubt, why not ask your clients? It is fundamental that all helping relationships foster client empowerment. This requires knowledge and information sharing (forms of power) to promote the client’s self-voice.

- **Do not wait for requests for funding proposals (RFPs) to land on your desk.**

  You should be involved in the process so that you can shape the RFPs. The optimal method is by having a continuing good relationship with agencies that affect your work. In this relation-
ship, project officers and others will tell you what is occurring within the agency and will help you lobby for funding for your projects. If you do not have that relationship yet, then learn how agencies that affect you develop funding priorities. Then, when the priority-creation process is about to start, visit the decision makers and tell them what your clients need.

- **In the realm of practitioner accommodations, clinicians must become proficient with a world of short-term, cognitive-behavioral, and outcome-based modalities.**

  This does not mean you must forgo long-term therapies. However, you need to become knowledgeable and skillful in using short-term interventions to meet specified goals. You must also learn to live with HMOs' case managers, who are likely to try to get the most bang for very little buck.

  Clinicians must also prepare for "case management" that focuses on moving the client to less intensive services and demonstrating outcomes, rather than case management that focuses on getting customized services for clients.

- **Agencies need to assess their ability to compete in the managed-care environment.**

  Materials are readily available for such assessments. Consult, for example, the Center for Substance Abuse Treatment's (1994) Managed Healthcare Organizational Readiness Guide and Checklist.

  Agencies that offer only one service or a lot of that one service (horizontal integration) are not attractive to managed-care companies unless they represent a niche or serve a cultural/ethnic/linguistic or other identified special population. HMOs are interested in multilayer services that are in place and intensive enough to prevent hospitalization (one-stop shopping).

- Agencies should reach out to HMOs or other networks seeking contracts.

- Agencies must study their management information systems to determine their ability to gather and report data concurrently (real time, this week/month), not retrospectively. Consequently, infrastructure is critical, and agencies will need to build, buy, or lease it.
Conclusion

People living with HIV/AIDS already face incredible obstacles in accessing medical care, maintaining quality of life, and often simply surviving. While many politicians on the left and the right agree on the need to enact positive reforms, proposals to dismantle the Medicaid system are of grave concern to people living with AIDS, their care partners, friends and families, health and mental health providers, and, ultimately, local communities and state governments.

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