

Description of Program Changes to the Partnership Plan 1115 Demonstration Waiver (Project Number 11-W00114/2) and the Federal-State Health Reform Partnership (F-SHRP) (Project Number 11-W-00234/2)

I. Mandatory managed care enrollment of Medicaid beneficiaries with HIV/AIDS

Overview

One quarter (or 9,375) of all Medicaid managed care eligible HIV positive beneficiaries are voluntarily enrolled in either a mainstream managed care plan or one of three HIV Special Needs Plans (SNPs) that serve the metropolitan New York area. Of the estimated 52,000 Medicaid beneficiaries with HIV currently residing in New York City (NYC), 15,000 are excluded from Medicaid managed care due to their status as dually eligible for Medicare and Medicaid or because they are nursing home residents or meet other exclusion criteria

Upon approval of these amendments to the Partnership Plan and F-SHRP waivers, the State will begin enrolling HIV positive Medicaid beneficiaries into managed care plans. While mandatory enrollment will ultimately be implemented statewide, a phased-in process will start in NYC to enroll the approximate 27,500 individuals whose only known exemption from mandatory enrollment is their HIV status. If eligible, these beneficiaries may request another exemption such as homelessness. These individuals will have the option to enroll in one of twelve managed care plans currently serving Medicaid beneficiaries or one of three HIV Special Needs Plans (HIV SNPs) specifically designed to serve HIV positive beneficiaries and their families. To ensure a smooth transition from fee-for-service to managed care, DOH will implement the program on an incremental basis, by borough initially reaching out to 2,500 NYC HIV positive beneficiaries each month. Prior to implementing in any upstate county, there will be an assessment of the implementation experience in NYC as well as a determination by county of the network capacity to serve this population. Upstate roll-out would be regional as with the mandatory SSI expansion and would begin no sooner than one year from the NYC start-up.

Rationale

The State's decision to require mandatory managed care enrollment for HIV positive beneficiaries is consistent with the goals of the Partnership Plan. Fourteen years of data demonstrate that Medicaid beneficiaries enrolled in managed care plans receive better quality care than those in fee-for-service Medicaid. Studies of those who have voluntarily enrolled in managed care and other evaluations have repeatedly shown a steady improvement in quality of care and a dramatic improvement in chronic care disease management for those in Medicaid managed care plans. Based on this evidence, persons with HIV/AIDS and/or a chronic condition will receive better quality care in a managed care setting.

In fact, recent studies comparing the quality of care for HIV positive beneficiaries in Medicaid fee-for-service and Medicaid managed care show the following:

- HIV-specific quality indicators including antiretroviral treatment, viral load and immune system monitoring and cholesterol screening (for patients in ARV treatment) are equal to or better in managed care than fee-for-service.
- HIV-positive beneficiaries enrolled in managed care have fewer hospitalizations in general, and fewer hospitalizations for pneumonia (a potentially preventable complication) than their fee-for-service counterparts.
- People with HIV in managed care are also more likely to receive preventive health services such as cholesterol screening, mammography and cervical cancer screening than beneficiaries in fee-for-service.
- HIV-positive beneficiaries enrolled in SNPs report that they are highly satisfied with their care and had a more positive experience than their fee-for-service counterparts in several areas, including fewer interruptions in their relationship with providers, fewer barriers to care, access to more specialists, fewer problems communicating with their providers, and more favorable outcomes with problem resolution.

More than 90 percent of Medicaid beneficiaries with HIV have at least one other chronic condition – such as diabetes, a mental health condition, alcoholism and drug addiction - and are more likely to benefit from the coordination model of care offered under New York’s managed care program. DOH has been measuring the care delivered to patients with chronic diseases who are enrolled in health plans for 14 years. In that time, health plans have achieved a number of significant improvements in health outcomes and coordination of care among beneficiaries with chronic diseases, cardiovascular issues and psychiatric conditions.

- The percent of diabetics whose HbA1c level was poorly controlled dropped from 53 percent to 35 percent. A similar achievement was noted in the follow-up within 30 days after a hospitalization for a mental illness, where rates increased from 63 percent to 76 percent.
- Member satisfaction with health plans is routinely assessed. Data from a 2004 study showed that 88 percent of beneficiaries with a chronic illness would recommend their plan to family or a friend and 81 percent gave their primary care physician a high ranking.

Results from a recently completed study of newly enrolled SSI-eligible beneficiaries reveal that 95 percent feel the care they get from their doctor is as good as or better than it was in fee-for-service. They reported increased ease in making appointments and in

finding specialists. (In 2008, there were 6,500 physicians participating in Medicaid fee-for-service, but more than 13,000 available through Medicaid managed care plans.) A copy of the report will be available on the SDOH website.

Public Input

In addition to the required public notice in the newspapers (see Appendix 1), the SDOH has and will continue to reach out to health plans, HIV/AIDS advocates, providers and other stakeholders in order to help inform the implementation process. Valuable input has been gained with regard to enrollment policies, lock-in requirements, case management requirements, choice period, outreach and education, provider training and information sharing with health plans.

The Division of Managed Care (DMC), the AIDS Institute, the New York City Department of Health/Mental Hygiene (CDOH/MH) and the Division of Health Care Access and Improvement (HCAI) are soliciting input from providers and community organizations that specialize in the care of the HIV/AIDS population including HIV Special Needs Plans (HIV SNPs). A comprehensive education plan targeting all contracted organizations serving HIV was developed and is in process. Multiple training sessions are scheduled for hospitals, community health clinics/designated AIDS centers (DAC) sites, Medicaid providers, public health offices, community based organizations and community services societies, HIV/AIDS Service Administrations (HASA), adult homes, home care providers, managed care organizations, mental health and substance abuse providers, correctional health-transitional care, Department of Homeless Services, the Division of HIV services and advocacy groups.

At a meeting of the Managed Care Plan Operational Issues Work Group in July, 2008, and a public meeting of the Medicaid Managed Care Advisory Review Panel in August, 2008, the Division of Managed Care (DMC) discussed the proposed implementation of mandatory enrollment of the HIV positive population. The AIDS Institute recently met with HIV SNPs to discuss operational issues related to expanding enrollment such as expanding network capacity.

On September 3, 2008, in New York City, staff from the DMC and the AIDS Institute listened to the concerns of HIV/AIDS advocates. Attendees provided the State with input that will help in the development of the implementation process and were advised to submit additional questions and comments to OMCmail@health.state.ny.us. This email address will be monitored regularly and answers to the questions as well as other relevant information will be posted on the SDOH website.

On October 6, 2008, staff from the DMC, the AIDS Institute and New York City met with 90 individuals who are HIV+ to obtain their input into this process. State and City staff gave presentations about mandatory enrollment. After the presentations, attendees were able to ask questions and offer suggestions. There was a positive response from attendees about the session.

Description of Key Program Features:

Beneficiary and Provider Education and Outreach

Mirroring the process used to enroll the SSI population, there will be several mailings including a general mandatory announcement letter to the target population. This will be followed by regular consumer specific mailings, starting with the initial mandatory notice packet and multiple reminders all with the message to take action. As stated above, notices will be sent at the rate of 2,500 letters per month. Mailings will start in one borough and proceed to the next borough as mailings are completed.

SDOH is working with New York Medicaid Choice to revise enrollment materials to reflect mandatory enrollment for the HIV population and include expanded information on the availability of HIV Special Needs Plans. The brochures and enrollment forms, as well as the plan lists included in the educational packets, will be revised.

A notice will be sent to all providers who treat HIV patients to explain mandatory managed care enrollment and solicit their assistance in answering beneficiary questions, including information about all of the plans with which they participate. In addition, an information update was submitted for publication in an upcoming Medicaid Update to alert all Medicaid providers of the change. To complement these written alerts, numerous provider training sessions will be held by the DMC, the AIDS Institute, and the CDOH/MH.

There will be an expansion of New York Medicaid Choice outreach staff to additional HIV/AIDS Services Administration (HASA) sites. In addition, SDOH, CDOH and Maximus will work with community-based organizations that are primarily utilized by HIV positive consumers.

Enrollment/Default Enrollment

Eligible persons will be able to enroll in any SNP in the borough in which they live or work. If an HIV SNP is not available in a borough, beneficiaries will be allowed to enroll in a SNP in another borough. The period for individuals to choose a managed care plan will be consistent with current policy for all other Medicaid populations. Those who do not choose a plan during the 60 or 90 day choice period will be assigned to a mainstream health plan using the standard auto-assignment algorithm. HIV positive beneficiaries will not be auto-assigned to an HIV SNP because of confidentiality concerns.

Persons with HIV/AIDS may transfer from a mainstream health plan to an HIV SNP or from an HIV SNP to a mainstream plan at any time. This decision was made to accommodate individuals who join either of the two options and decide the alternative would better address their needs. For those in a mainstream plan who believe they could benefit from the enhanced services of a SNP, there is the opportunity to transition to such a plan. And, for those who join a SNP but would prefer to be part of a mainstream plan, they can transfer into a mainstream plan. However, after the grace period, beneficiaries must have a good cause reason to change from one mainstream plan to another

mainstream plan or from one HIV SNP to another HIV SNP during the nine month lock-in period.

Networks, Access to Care and Continuity of Care

Virtually all major providers who serve HIV positive beneficiaries in Medicaid fee-for-service are enrolled in at least one mainstream managed care plan. This is in part because SDOH has always required managed care plans to comply with specific requirements for ensuring access to HIV-specific services within their networks and by providing quality assurance guidance and direction on coordination with community resources.

SDOH has provided health plans with a list of providers who serve the HIV positive population, including the number of patients that they service for plan use in augmenting their networks.

State law and the Medicaid managed care contract require health plans to ensure that enrollees have access to transitional care and specialty care. Health plans must have procedures in place that ensure new enrollees continuity of care regardless of provider status (participating or non participating) and must permit a new enrollee to continue a course of treatment during a transitional period of up to 60 days. The procedures should include a mechanism to ensure receipt of medically necessary services authorized under Medicaid fee-for-service until a managed care approved plan can be put in place. Plan policies with their participating providers must provide a mechanism to secure prior authorization within reasonable timeframes and not disrupt a course of treatment during the process.

Benefit Package

The benefit package for HIV positive individuals who join a mainstream managed care plan is the same as it is for all Partnership Plan and F-SHRP enrollees. For beneficiaries in the Partnership Plan, services carved out from managed care include but are not limited to: prescription medications, targeted case management, AIDS adult day health care services, some mental health and substance abuse services, HIV resistance tests, personal care, and hospice services. In addition to the above mentioned services, mental health and chemical dependence benefits will be provided through Medicaid fee-for-service for SSI beneficiaries included in the F-SHRP waiver.

The benefit package for the HIV SNPs is the same as the benefit package for mainstream managed care plans, except that the plan benefit includes mental health and substance abuse services for enrollees with HIV/AIDS, including SSI beneficiaries.

Special Terms and Conditions Changes Required

HIV positive individuals should be removed from the list of exempt populations in the Terms and Conditions of both waivers.

Budget Neutrality

The budget neutrality savings analysis already includes HIV positive beneficiaries enrolled in managed care as well as those receiving services through Medicaid fee for

service. Thus, the mandatory enrollment of HIV fee-for-service beneficiaries to managed care does not impact budget neutrality.

II. Twelve Months Continuous Coverage

Overview

New York State has been working toward simplifying Medicaid eligibility rules for consumers and eligibility workers in local departments of social services. Simpler eligibility rules will help with the State's goal of ensuring that all children and eligible adults have access to, enroll in and remain enrolled in affordable health insurance coverage.

Rationale

In 2007, revisions were made to Chapter 58 of the New York State Social Services Law to provide continuous coverage for certain Medicaid beneficiaries and Family Health Plus enrollees for a period of twelve months from the date of initial eligibility and subsequent redetermination of eligibility. This proposal will provide stability and continuity of coverage and care to adults in the same way that it has for children on Medicaid.

Description of key program features

- Individuals enrolled in the Family Health Plus program and certain individuals in Medicaid will be eligible for a total of twelve months of continuous coverage from the initial determination of eligibility and from the date of any subsequent determination of eligibility.
- Individuals eligible for Medicaid only after deducting the amount of incurred medical expenses equal to the amount of monthly income over the applicable standard will not be eligible for continuous coverage.
- Consumers will no longer be required to report changes of income and resources between authorization periods.
- Family members will now be eligible for 12 months of continuous coverage. Previously, children were only entitled continuous coverage in Medicaid.

Special Terms and Conditions Changes Required

A new term and condition should be added to the "Eligibility Section" in each waiver that reads:

Individuals enrolled in the Family Health Plus program and individuals in the following Medicaid categories will be eligible for a total of twelve months of continuous coverage from the initial determination of eligibility and from the date of any subsequent determination of eligibility (this does not apply to individuals who have available monthly income in excess of the medically needy income level and spend down to become eligible for Medicaid):

- Single individuals and childless couples in Medicaid;

- ADC-related children (aged 19 - 21);
- Parents and caretaker relatives living with dependent children under age 21;
- Qualified pregnant women; and
- SSI-related population including individuals eligible under 1634 (c) and (d) of the Social Security Act and all individuals eligible for Medicaid under Section 249E of PL 92-603 and Section 503 of PL94-566, who are not eligible for long-term care services.

In addition, the State requests any necessary expenditure authority needed to receive financial participation for this amendment.

Appendix 2 contains a chart that crosswalks the State Plan categories to the eligibility groups in the STCs. Appendix 3 contains the original public notice for 12 months continuous coverage.

Budget Neutrality

It is estimated that between 5,000 and 5,600 recipients will be affected by this initiative over a four year period. Based on these projections and using the agreed upon budget neutrality With Waiver PMPMs and associated trend factors, this amendment is expected to generate additional With Waiver expenditures of \$45 million for the Partnership Plan Waiver and \$800,000 for the F-SHRP Waiver for the period October 1, 2009 through September 30, 2013. Therefore, there are sufficient waiver savings to cover the expected additional cost and this proposal has minimal impact on budget neutrality. Appendix 4 contains the budget neutrality impact analysis.