

August 25, 2008

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower
ALBANY, N.Y. 12237

Jay Laudato
Director, Division of Managed Care
Office of Health Insurance Programs
New York State Department of Health
Corning Tower
ALBANY, N.Y. 12237

Re: **Mandatory Enrollment of HIV + Medicaid recipients in Medicaid Managed Care Plans**

Dear Ms. Bachrach & Mr. Laudato:

We, the undersigned organizations, write to you to raise significant concerns we have that the State of New York may soon require that most persons living with HIV/AIDS (PLWHAs) on Medicaid enroll into a managed care plan. Your office has already publicly stated the decision to move forward with mandatorily enrolling PLWHAs into Medicaid managed care. We ask you to slow the process to provide time for your office and the HIV/AIDS community to begin dialogue and to reach resolution on the serious issues that are presented here, and other concerns present in the PLWHA community of New York. While voluntary informed choice remains the best method for selection between fee for services, managed care, or HIV special needs plans, if enrollment must be mandated, then we seek to assure use of an enrollment process which safeguard the rights of the PLWHA's and recognizes the unique challenges faced by the PLWHA within the larger Medicaid population context. Therefore, we respectfully request that you meet with us so that we can discuss our concerns.

We are certain that you share with us the commitment that PLWHAs on Medicaid get the best possible care and treatment available. In this regard, we wish to work with

you and partner with you to ensure that HIV-positive Medicaid beneficiaries maintain their access to the best possible care.

According to Social Services Law, HIV positive individuals will not be required to enroll with a managed care program until program features and reimbursement rates are approved by the Commissioner of Health and, as appropriate, the Commissioner of Mental Health. The advocacy community has not seen evidence that Medicaid managed care plans are equipped to handle this medically vulnerable population.

Below are a number of concerns we have. We wish to discuss with you ways to resolve these issues before PLWHAs are required to join a managed care plan:

(1) Navigation of the enrollment process

All prospective Medicaid managed care enrollees are supposed to receive mandatory enrollment letters which explain that they will be automatically assigned to a managed care plan if they do not choose a plan or request an exemption. Experience shows that many clients do not receive these letters or do not understand them. Many recipients will not know they have been auto-assigned to a plan until they try to access care. As a result, enrollees with chronic illnesses often experience disruptions in and barriers to care. We strongly urge you to work with the HIV and Medicaid community to develop notices that are both eye-catching and easy to understand.

Considering that a significant number of HIV-positive Medicaid beneficiaries experience homelessness, are in emergency/transitional housing or are unstably housed, we remain concerned over how the Department is planning to provide outreach to these populations. The address that the local Social Service District may have for many beneficiaries is likely to be outdated and incorrect; merely sending a mailing to persons who are homeless or unstably will not adequately inform them of pending mandatory enrollment. Data from the Ryan White funded CHAIN study indicates that up to 30% of PLWHAs are homeless or unstably housed at any time, and that 52% of all PLWHAs have a history of homelessness or unstable housing.¹

The Department needs to revisit the possibility of “intelligent enrollment” rather than random auto-assignment. The Department should examine a recipient’s utilization data and auto-assign them to a plan that their providers participate with to avoid loss of services. In addition recipients should be “pre-coded” for exemptions based on the Department’s utilization data and service data held by other agencies such as OMRDD.

¹ Aidala, Angela, “Housing Need, Housing Assistance, and Connection to HIV Medical Care”, C.H.A.I.N., February 15, 2007 http://www.nyhiv.org/pdfs/chain/Housing_Medical%20Care%202007_05-02-07.pdf

The managed care plans and the enrollment broker (Maximus) must be prepared to handle populations with complex and unique service needs, including transgendered persons. The plans and Maximus must be prepared to identify health care providers who can meet the unique needs of the HIV population with complex and co-morbidity issues, including Hepatitis C, substance abuse and mental health issues. In addition, we cannot stress strongly enough the need to inform the plans and Maximus of the need to ensure confidentiality of HIV information.

(2) Need for public awareness campaign

As happened when the HIV Special Needs Plans (HIV SNPs) commenced voluntarily enrolling beneficiaries, a state-supported outreach campaign is needed to educate consumers on the options available to them. This campaign should include sessions on what it means to be enrolled in a health plan, what their health plan options are, who to contact to find out which plans the recipient's doctors participate with, what to do if their doctors do not all participate in the same network, how to make sure they do not lose access to vital services, how the exemption process works and how to navigate the process.

The State Department of Health must ensure proper training for enrollees and providers on the benefit package and billing issues. Frequently, clients are not able to access services because both they and providers are unaware of the difference between covered and carved out services and how to bill for those services. Clients and their providers must be educated on the bifurcated system (i.e., what is carved out) and must understand what services are supposed to be covered by their plan and what services are covered by fee-for-service Medicaid.

(3) Capacity, standards and access to care

The Department of Health AIDS Institute has already carefully thought out what standards of care should be required for the HIV-infected Medicaid population when they developed HIV Special Needs Plans. Each HIV SNP is required to meet a very stringent set of standards, all to ensure that PLWHAs receive the care and treatment they need and deserve. However, the State Health Department does not hold standard managed care plans to the same requirements for its HIV-positive enrollees that it does for the HIV SNPs. We believe it is crucial that standard Medicaid managed care plans be held to the same standards for care, treatment and access to services as the HIV SNPs are held to for its HIV positive clients.

To date, the State Department of Health has not provided any information on the number of HIV specialists in each of the standard Medicaid managed care plans. A basic and crucial issue that must be resolved before any HIV positive client is compelled to join a managed care plan is whether the plans even have the capacity to adequately serve the estimated 67,000 clients on Medicaid who are HIV positive. Does each and every plan have a sufficient number of HIV specialists in their plans? Are those specialists within reasonable distance from where large numbers of persons living with HIV on Medicaid reside? Once again, the standard managed care plans must be

required to meet the same capacity requirements as the HIV SNPs in order to ensure that PLWHAs will have sufficient access to medical providers who have knowledge in the treatment of HIV.

We strongly urge that the Department ensure that all Medicaid managed care plans have contractual agreements to include within their network of providers the Designated AIDS Centers within their catchment area and other medical facilities that have experience in treating persons living with HIV.

(4) Definition of case management

Additionally, the Department must develop a clear definition of the case management/ care coordination services that the plans are required to provide. Lack of access to these services puts medically vulnerable populations at risk of losing services. Currently plans have different standards for when case management/care coordination services are provided and what navigational assistance they provide. The Department must implement a uniform standard of case management/care coordination services to assist medically vulnerable populations with plan navigation.

In a meeting held with many HIV advocates in December 2007, the Department committed to having an on-going dialogue with the HIV community over this issue. We would like to meet with you as soon as possible to discuss these issues, especially before you proceed with the process of mandatorily enrolling PLWHAs into managed care. To arrange for a meeting, please contact Diane Spicer, Staff Attorney, Legal Aid Society at (212) 577-3390 or dkspicer@legal-aid.org or Matthew Lesieur, Director of Public Policy, New York AIDS Coalition at (212) 629-3075 ext. 108 or mlesieur@nyaidsc.org

Sincerely,