

## **“Statewide Medicaid Managed Care for People Living with HIV/AIDS: New Developments Outside of NYC”**

The following Questions and Answers were prepared from questions submitted during June 16, 2011 webcast. The responses are current as of the date noted at the bottom of the page.

Additional questions can be submitted to: [HIVPCMP@health.state.ny.us](mailto:HIVPCMP@health.state.ny.us).

- 1. My understanding is that currently, the Medicaid Managed Care Plan reimburse for the care of HIV+ clients at the standard APG rates. Will this continue after October or will each facility need to re-negotiate its standard Medicaid rates (with that managed care organization) to take care of the enhanced needs of HIV+ clients?**

DOH does not participate in contract negotiations between plans and providers. Each health plan negotiates a contract with each facility or provider group. These contracts may include a fee schedule for specialty care or other monthly capitation for PCP. In general hospitals negotiate contracts that include fees for hospital providers. These contracts are periodically reviewed by the plan. Some contracts may be based on APG rates. HIV providers should contact the facility administrator responsible for negotiating clinic and provider rates as it can vary by plan.

- 2. Will the Medicaid managed care organizations be required to meet the standards of care for people living with HIV?**

Yes. The Plan’s provider network receives regular communication from the Plan in the form of provider newsletters and informational bulletins. These communications include DOH Standards, Policies and Recommendations. DOH measures plan performance on three HIV measures and posts those HIV QARR results on the DOH website

- 3. Will the pharmacy benefit continue as a carve-out?**

Beginning October 1, 2011, NYS will require health plans to provide the pharmacy benefit to all managed care members. This is a new change for all 2.9 million NYS health plan members. Until patients are enrolled in a health plan, coverage will continue to be Medicaid fee-for-service. There will be a Medicaid Update during the summer to address this important change. Patients already in health plans will continue to use their Medicaid card until their plan informs them of this change. Each plan will be responsible for identifying HIV and other populations with special transition needs to ensure continued access to needed medications.

**4. Will all HIV+ clients currently receiving straight Medicaid be expected to sign up for a Managed Care plan in October?**

Most HIV+ individuals have been or will be required to join a Medicaid Managed Health Care plan – however, not all persons with HIV will be required to join a plan. A variety of factors may exclude PLWHA from enrollment in Medicaid Managed Care at this time. Beneficiaries are excluded if they have Medicare and Medicaid in spend-down to qualify for Medicaid, or are enrolled in the HIV Uninsured Care Program or in a Long Term Home Health Care Program. Additionally, PLWHA are not required to join a plan unless they live in a (mandatory) county that requires their residents to join a plan.

**5. Will clients with Medicaid spend-down in order to qualify for Medicaid be given the option to sign up as well?**

Clients with Medicaid spend-down are excluded from joining a Plan at this time.

**6. Where will clients sign up for the Managed Care Plan?**

The answer depends of the person's county of residence. Persons with questions can call either their local county social services department or the New York Medicaid CHOICE HelpLine at 1-800-505-5678 or 1-888-329-1541 TTY/TDD. To determine if your county uses New York Medicaid CHOICE for enrollment, please visit:

[http://www.health.state.ny.us/health\\_care/managed\\_care/mmc\\_counties/maximus\\_with\\_ssi.htm](http://www.health.state.ny.us/health_care/managed_care/mmc_counties/maximus_with_ssi.htm)

**7. Many of our Adult Day Health Care Program (ADHCP) participants utilize Medicaid transportation to access the programs. Will they still be able to do this or will client's access to transportation depend on what managed care plan they choose?**

For clients participating in AIDS Adult Day Health Care program the expense for transportation to and from the program is included in the rate paid by the Medicaid program and would not be billed separately. The AIDS ADHCP benefit is carved out of the plan benefit, and is paid as a fee-for-service encounter (Rate Code 1850). Non-emergency medical transportation is an optional benefit and providers would need to check with plan on arrangements for this service for plan members. Note: All Medicaid plans in Monroe County include non-emergency transportation in the benefit at this time. (See response to questions 8 on the Medicaid Redesign Team proposal for establishing regional transportation vendors).

**8. How will the switch on October 1, 2011 to Medicaid Managed Care affect those clients who currently use Medicaid transportation to get to and from their HIV appointments and other specialty appointments?**

One Medicaid Redesign Team proposal included in the State's budget is to create regional transportation vendor agreements for Medicaid transportation services. These regional vendor contracts are being negotiated and rolled out by region. There will also be a Medicaid Update article alerting the providers of this change.

Transportation in the Hudson Valley is targeted to switch over to the vendor FROM the plan benefit package about January 1, 2012. At that time, the benefit will be managed through the vendor. Until this switch in January, 2012, for those enrolled in managed care, emergency and non-emergency transportation will be part of their managed care plan's benefit plan, and arrangements for transportation must be made through the plan. While all plans must cover emergency transportation not all plans in all counties in the Hudson Valley include non-emergency transportation. It is best to check with the plan. In Dutchess, Sullivan and Ulster counties non-emergency transportation continues to be a fee-for-service benefit so nothing changes until vendor arrangement in place. In Westchester County, currently all plans are responsible for the non-emergency transportation benefit. Managed care enrollees in the remaining counties should check with the plan for coverage.

**9. With auto-assignment, how does the health plan get chosen?**

Managed Care Plans with acceptable quality performance measures will be eligible for auto enrollments.

**10. Currently, a plan in our County does not provide bus passes for patients, stating they will reimburse patients after the appointment. That is very difficult for many of our patients who do not have the money for regular bus transportation. Will that change?**

The transportation standard referenced in the question is the policy of that specific plan. However, if a member has a medical need that warrants an alternate mode of transportation, or if they need a bus pass in advance of the visit, the enrollee should contact the member services department of the plan and request an exception. Please note, this needs to be done IN ADVANCE of the appointment so the plan has ample time to get the bus pass to the enrollee.

**11. With regard to rural counties in central and northern NY State, will the Managed Care Programs cover across numerous county lines, for example, even 2-3 counties away?**

All plans in mandatory counties in Central and Northern New York have service areas that include several counties. This is true of most Medicaid managed care plans. To determine which counties are covered by any plan, please visit:  
[http://www.health.state.ny.us/health\\_care/managed\\_care/pdf/cnty\\_dir.pdf](http://www.health.state.ny.us/health_care/managed_care/pdf/cnty_dir.pdf)

**12. How will health plans improve access to home health aide care for HIV positive individuals?**

All health plans include Home Health Services ordered by a provider and provided by agencies that are either a Certified Home Health Agency (CHHA) or a Licensed Home Care Agency (LHCSA). This includes home health aide services as appropriate. Effective August 1, 2011, health plans will be required to include personal care services as a covered benefit. This has been a carved-out benefit. Plans must have contracts with and networks that include home health service providers.

**13. Will NY Medicaid Choice be available for clients who are in LDSS covered counties for basic questions, or will all assistance need to go through the county?**

In LDSS covered counties, Medicaid recipients should be directed to their own county representatives – however, if NY Medicaid Choice received a call, they could answer general questions.

**14. Could you please share links to information on plans and participating providers?**

[http://www.health.state.ny.us/health\\_care/managed\\_care/pdf/cnty\\_dir.pdf](http://www.health.state.ny.us/health_care/managed_care/pdf/cnty_dir.pdf)

**15. Will there be any co-pays?**

There will be co-pays for medications for plan members and fee-for-service patients. There will be no additional co-pays for Medicaid managed care members. Some co-pays exist in Medicaid fee-for-service that are not assessed to plan members.

**16. After October 1, 2011, what happens with individuals who reside outside of a mandatory county. Are they exempt from the managed care requirements?**

Medicaid beneficiaries are not required to join a plan unless they live in a “mandatory county” that requires their residents to join a plan. They will continue to receive the Medicaid benefit with no change at this time. In the future, DOH expects the number of mandatory counties to increase.

**17. What if a client adamantly refuses to choose a plan based on beliefs that this is a way for government to control health care choices? What can I tell him/her?**

Enrolling in a managed care plan is not intended to limit choices – however, it IS a response to the need to control costs of the Medicaid program. The NYS legislature has accepted several recommendations from the Medicaid Redesign Team. Enrolling several currently exempt Medicaid eligible populations into Medicaid Managed Care is one of the proposals. If the person refuses to join a plan, they will be auto-assigned. Auto-assignment can be problematic for the patient if the patient’s care providers are not part of the plan’s provider network.

**18. Are individuals with cancer/receiving chemo excluded from having to choose an MMC plan?**

Some individuals with chronic medical issues can request 6-month exemption if their care is with a specialist provider not participating in any managed care plans. Health plans must permit a new enrollee to continue an ongoing course of treatment during a transitional period of up to sixty (60) days from the effective date of enrollment if the new enrollee has an existing relationship with a non-participating health care provider, elects to continue to receive care from the non-participating provider, and has a life-threatening disease or condition or a degenerative or disabling disease or condition. Transitional care services must be provided for up to 60 days

or until the plan has assessed the member's needs and an approved treatment plan is put into place.

**19. If the county where patients reside does not use the New York Medicaid CHOICE, should we be contacting the county to find out how they are going to roll this out or will it just be based on the County recertification date? Will there be designated staff or staff added at LDSS offices to assist with enrollment?**

Counties who are not using New York Medicaid CHOICE will be responsible for enrollment of their county's residents. You should contact your county Department of Social Services to confirm how and when clients will be notified. Questions or concerns regarding local Medicaid recipients should be directed to the designated LDSS Medicaid managed Care contact.

**20. Will plan members be required to choose a pharmacy?**

No one will have to choose one pharmacy. It is anticipated on October 1, 2011 the pharmacy benefit will be a covered plan benefit. At that time, program members will have to use pharmacies within the plan's pharmacy network.