



The Legal Aid Society - Health Law Unit

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MEMORANDUM

Date: October 22, 2008
From: Rebecca Novick, Health Law Unit
To: AIDS Institute
Re: AIDS Institute Listening Forum Comments

Alan Levine
Chairperson of the Board

Theodore A. Levine
President

Steven Banks
Attorney-in-Chief

Lisa Sbrana
*Acting Supervising Attorney
Health Law Unit*

My name is Rebecca Novick and I am a Law Graduate in the Legal Aid Society's Health Law Unit. On behalf of the Legal Aid Society, I would like to thank the AIDS Institute for convening this Listening Forum to address consumer and provider concerns about mandatory enrollment of PLWHAs in Medicaid managed care and for allowing us to share our comments.

The Legal Aid Society's Health Law Unit (HLU) operates a state-wide Health Law Helpline and provides assistance to more than a thousand low-income health care consumers and advocates each year. In addition to providing direct representation and advice to consumers, our unit provides training and technical assistance to community-based organizations, legal services providers, and health care providers across the state. Our comments today are largely based on the experiences of our disabled clients in accessing their Medicaid services since mandatory enrollment of the SSI population began in 2005.

Outreach

We recommend that SDOH develop an enrollment process that acknowledges the particular challenges faced by those with complex health conditions. These individuals and their caregivers are often overwhelmed by the volume of mail they receive and are less likely than other populations to respond to mandatory enrollment letters. In addition, many PLWHAs are unstably housed or homeless, presenting additional challenges in reaching them through an enrollment mailing. A comprehensive outreach campaign for the education and training of beneficiaries, providers and health plans (including CBO outreach) is essential to ensure that enrollment efforts reach the HIV/AIDS population. This outreach should include specific information on how to respond to enrollment letters, what it means to be enrolled in a managed care plan, and most importantly, how to avoid interruptions in vital services which could present grave health care risks for this population.

Any successful outreach program must be given time to function effectively. Therefore, we recommend that the auto-assignment timeline be extended for the HIV/AIDS population so that beneficiaries and the providers who serve them have time to learn about managed care and make

educated decisions about plan enrollment. In addition, we recommend that the time in which enrollees can switch plans be lengthened and the “lock-in” period for new enrollees be shortened for the most vulnerable populations.

Enrollment

Instead of random auto-enrollment, SDOH should implement “intelligent enrollment” for individuals who do not select a plan in order to ease problems with transitional care and limit interruption of services. Another alternative to random auto-assignment is to only auto-assign PLWHAs into Special Needs Plans. SDOH has raised concerns about confidentiality with regard to this proposal. However, we are unsure of how this raises a confidentiality issue with providers who are already on notice of HIV status through current treatment or who will be made aware by mandatory enrollment generally.

In addition, we recommend that SDOH use the data it already has on enrollees to pre-code enrollees for automatic exemptions and exclusions such as homelessness.

Standards of Care

We also urge the Department of Health to enforce standards of care for all managed care plans providing services to the HIV/AIDS population. All managed care plans should be held to the same standards as HIV Special Needs Plans (SNPs), for which the AIDS Institute designed specific standards of care. If the Department plans to auto-enroll PLWHAs into mainstream managed care plans, it is essential that it demands of these plans the same standards of care that SNPs are required to provide.

Continuity of Care

Previously mandatorily enrolled populations have experienced termination of existing long term and specialty care for chronically ill individuals. Even with mechanisms in place to address this issue, including providing plans with Medicaid utilization data for new enrollees, many new enrollees with chronic illness have been shut out of critical health services. Plans must be held accountable when they fail to ensure continuity of care. Plan requirements for continuity of care should include completion and transmission of health risk screening forms to health plans and case managers. SDOH should provide oversight over the transitional care requirements of the Public Health Law.

We also urge SDOH to develop a strategy to improve coverage for enrollees who face a bifurcated service delivery system. When certain services are “carved out” of the managed care benefit package, enrollees and providers face an unusually complex system for which neither have been appropriately educated in the past. SDOH should acknowledge the difficulty for enrollees of accessing care through two entirely different systems, and design outreach and education efforts specifically around this issue. Enrollees with a bifurcated delivery system must receive case management and assistance with plan navigation and coordination of benefits.

One suggestion to alleviate problems with continuity of care upon enrollment is a Medicaid “wrap” which could be modeled on Medicaid’s wrap around Part D drug coverage during the initial enrollment period in January of 2006. This wrap would ensure that new enrollees do not lose access to vital medical services during the transition period.

Enrollee Rights and Plan Oversight

Medicaid recipients newly enrolled in managed care plans have been denied their due process rights when their existing services are terminated without notice and they are not informed of their right to appeal or to receive aid-continuing. Before the mandatory enrollment of PLWHAs, we strongly recommend that SDOH develop processes to ensure plans’ compliance with due process requirements.

In conclusion, we strongly urge SDOH to work cooperatively with providers, plans and especially beneficiaries to ensure that the specific challenges of mandatory enrollment for the HIV/AIDS population are addressed before mandatory enrollment is implemented. This is essential to avoid many of the problems associated with mandatory enrollment of other previously-exempt groups and prevent dangerous interruptions in the provision of care. To further this goal the SDOH should convene an HIV/AIDS stakeholders work group, as they have done when mandating other previously exempt populations, to assess the specific standards of care and outreach and enrollment processes needed to accommodate this vulnerable population. To inform their input the work group should study the quality of care and the experiences of other disabled populations mandated into managed care.