

3. SPECIAL POPULATIONS

This chapter describes how special populations are served under The Partnership Plan, including provisions for education and outreach to such populations; inclusion of providers with qualifications and experience treating individuals with special needs; and evaluation and oversight mechanisms designed to monitor quality and access. This chapter is organized into two sections. The first section describes the special needs populations that are to be served through mainstream managed care plans, and the second describes the Special Needs Plans (SNPs) for people with HIV/AIDS.

Overview at the Outset of The Partnership Plan

New York's Medicaid population poses unique challenges in the implementation of a managed care program. Among the 3.6 million Medicaid beneficiaries, described here at the start of the program, are:

- 100,000 HIV+ individuals
- 100,000 individuals with Serious and Persistent Mental Illness
- an estimated 180,000 individuals with developmental disabilities
- roughly 57,000 foster children
- nearly 50,000 serious and chronic substance abusers
- a significant population of homeless individuals

These populations, many of which overlap, can benefit significantly from a managed care approach to health care delivery. The Partnership Plan offers two models of managed care: a mainstream MCO program offered through HMOs and PHSPs; and Special Needs Plans for persons with HIV.

New York has developed and implemented rigorous plan participation standards to ensure that mainstream MCOs have networks and quality management programs necessary to adequately serve populations with special needs. These plan participation standards are described in the Plan Qualification Guidelines document, which is available on the NYS DOH web site at www.nyhealth.gov.

Special Needs Plans incorporate traditional managed care principles but with highly specialized networks and outreach, prevention, and support programs. The remainder of this chapter describes each of the special needs populations served under these two managed care models.

Participation in Mainstream Managed Care Organizations

The following special needs populations may enroll and receive services through mainstream MCOs subject to the provisions described below:

Foster Care Children

Primary responsibility for the care of foster children falls to the local social services districts. In each district, children are placed either under the care of a voluntary agency, which provides services under contract with the local district, or are under the direct care of the local district. In accordance with State law, children who are under the care of a voluntary agency are excluded from participation in The Partnership Plan. These children will continue to receive medical services through the fee-for-service program. Local districts will be responsible for identifying these children for exclusion.

At the option of each local district, however, children under direct care may be eligible for enrollment in The Partnership Plan. Prior to enrolling eligible direct care children in The Partnership Plan, a local district is required to develop a plan that specifically addresses the following issues for this group of children:

- **Coordination of care:** Coordination of care for foster children can present unique challenges, as the children may have multiple “caretakers” -- the foster parent, local district, and/or birth parent, each of whom needs to be informed and involved in the health care of the child.
- **Enrollment:** The local district determines whether all contracted MCOs, or a subset of MCOs, will be eligible to enroll foster children. The district will also develop an enrollment plan which will describe who has responsibility for selecting the managed care plan, how education and outreach will be conducted, and the process for enrollment if it differs from the districts’ process for other enrollees.
- **Special Needs:** The district identifies any special health care needs of its foster care population and addresses how such needs will be met under managed care.

See Appendix 3.1 for the format of the foster care enrollment plan submitted by local social services districts. The Bureau of Program Planning has reviewed and approved each district’s plan for enrollment of foster children. Local districts may not enroll foster children in the mandatory program until their enrollment plan is approved by the State.

Dually Eligible (Medicare/Medicaid) Beneficiaries

Medicaid and Medicare dual eligibles may not enroll in a plan’s mainstream Medicaid managed care product. However, effective January 1, 2005, Medicaid and Medicare dual eligibles, meeting eligibility criteria, may, on a voluntary basis, enroll in plans qualified as Medicare/Medicaid Advantage Plans for most of their Medicare and Medicaid benefits. Plans qualified by the Department to participate in Medicaid Advantage must offer dually eligible persons a uniform Medicare Advantage Product and the supplemental Medicaid Advantage Product especially designed to wrap around the Medicare Advantage product, as described in Chapter 29.

Homeless Populations

The majority of the State's homeless population lives in New York City. In NYC, all homeless persons are exempt from participation.

The enrollment and benefits counselor pre-identifies homeless individuals in shelters using cross-matched data from the Shelter Care Information Management (SCIM) system, the HOME system (which contains data on family homes) and the Welfare Management System (WMS). Lists of homeless Medicaid beneficiaries in shelters are generated monthly. Individuals on these lists do not receive mandatory mailings, and therefore, must take a proactive step to enroll in Medicaid managed care. The updated homeless data file is used by the enrollment and benefits counselor as an edit before mailing auto-assignment confirmation letters, so that individuals who become homeless subsequent to receiving a mandatory packet are not auto-assigned. There may be a small number of remaining homeless shelter residents who have to self-identify because they entered a shelter after the most recent data match, and thus were not pre-coded. Homeless individuals in the shelter system are categorically eligible for disenrollment on an expedited basis and will receive care from the on-site providers or other Medicaid fee-for-service providers.

The NYC DOHMH, in conjunction with the Human Resources Administration and the enrollment and benefits counselor, educate operators of homeless shelters in the exemption policy and train them in assisting homeless clients in obtaining exemptions. Homeless persons who receive a mandatory enrollment packet may obtain exemption forms from any homeless shelter.

Homeless individuals in New York City who do not reside in shelters are also exempt from participation in Medicaid managed care but must self-identify and request an exemption. The State works with the City and with other local districts with significant homeless populations to develop outreach and education efforts specifically targeted to the homeless population. Outreach activities also include training for the staff of key community-based organizations and homeless services providers and the distribution of educational materials to charitable entities that serve the homeless, such as the Red Cross, Partnership for the Homeless, Catholic Charities, and H.E.L.P. The purpose of working with these organizations is centered on their important role in disseminating information to these populations about their health care options.

In local districts outside of New York City, homeless individuals are not enrolled unless the local district opts to allow them to enroll. Local districts are responsible for identifying homeless residents for exemption.

Individuals with Developmental Disabilities

Individuals with developmental disabilities who are not dually eligible are eligible to enroll in all managed care plans participating in The Partnership Plan. In its MCO qualification process, the State requires plans to demonstrate capacity to treat individuals with physical or developmental disabilities, specifically including the following:

- Guidelines and methods for the identification of persons at risk of, or having, chronic diseases or disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment and home health services.
- Case management systems to ensure that all required services are provided on a timely basis.
- Systems to coordinate service delivery with out-of-network providers, including behavioral health providers.
- Policies and procedures which allow for the continuation of existing relationships with out-of-network providers, when considered to be in the best interest of the member.
- Policies and procedures which either allow for specialist physicians to serve as primary care providers when it is considered to be in the best interest of the member; or allow for standing referrals to specialists/sub-specialists for members who require regular visits.

OMRDD undertakes outreach and educational efforts to advise persons with developmental disabilities of their options for health care delivery under The Partnership Plan, including their rights with respect to continuation of existing provider relationships and access to specialists, including policies on standing referrals. OMRDD conducts outreach and education activities directly with consumers and their families, and offers assistance with selection of and enrollment into a qualified managed care plan, when such assistance is requested. In addition, OMRDD provides technical assistance and training to OMRDD case managers and the voluntary agency service network. OMRDD also provides SDOH with materials to be used in training of all enrollment staff (LDSS or contracted) on issues related to this population. SDOH distributes these materials to the local districts.

While individuals with developmental disabilities are enrolled voluntarily for the same benefit package as other Medicaid enrollees, long term care services continue to be provided outside of managed care. Within the OMRDD service system, persons with developmental disabilities are assigned to the long term care service that best meets their needs after their situation has been assessed using an individualized planning process that takes into account functional impairment as well as medical conditions. OMRDD service coordinators coordinate service referrals with MCO primary care physicians to ensure that physicians are informed and knowledgeable about the long-term care services their patients are receiving outside of the managed care system.

OMRDD also provides information to all Partnership Plan MCOs regarding long-term care services and the process for initiating a referral to OMRDD.

Persons with Chronic Chemical Dependency Problems

Persons with chronic chemical dependency problems who do not have AIDS or are not dually diagnosed as seriously and persistently mentally ill or seriously emotionally disturbed are

generally required to enroll in mainstream managed care plans, unless they are receiving services provided by a residential alcohol or substance abuse or chemical dependence program or meet some other exemption criteria (see Chapter 2). These individuals receive treatment for their chemical dependence problems through MCOs along with all of their other needed acute health care, up to the limits imposed under the capitated benefit plan.

To ensure that all members have access to necessary chemical dependence services, all MCOs must demonstrate capacity to provide appropriate services for members with chemical dependence treatment needs. Specific requirements include:

- Inclusion of a full array of chemical dependence provider types in their networks, including licensed certified social workers, certified drug and alcohol counselors, and Office of Alcoholism and Substance Abuse Services- (OASAS-) licensed treatment providers.
- Availability of culturally and linguistically appropriate services, including therapy services.
- Methods for identifying persons requiring services, and encouraging self-referral and early entry into treatment. In particular, MCOs must have methods for referring pregnant women to OASAS for needed services that are beyond the capitated benefit package.
- Systems to coordinate service delivery between physical health, chemical dependence, and mental health providers.
- Participation in the local planning process to the extent required by the local social service district.
- Provisions for self-referral to any network provider for an initial chemical dependence assessment and evaluation for all inpatient detoxification, inpatient rehabilitation and treatment, or outpatient detoxification services, without a referral in any 12 month period.

In the case of children, a school counselor or similar source may also initiate a referral to an MCO provider. Information on the right to self-refer is included in each MCO's member handbook. MCOs are also required to make available to their members a listing of all behavioral health providers in their network.

Participation in Special Needs Plans

Special Needs Plans have been developed under The Partnership Plan as a way of addressing the particular needs of the HIV/AIDS population.

People with HIV/AIDS

Eligibility: All Medicaid managed care eligible persons infected with HIV, whether symptomatic or asymptomatic, and their related children up to the age of nineteen, will be eligible to enroll in an HIV Special Needs Plan if available in their area.

Whether or not HIV SNPs are available in their area, HIV-positive individuals may voluntarily elect to enroll in mainstream managed care plans. (The State has certified all MCOs currently under contract as qualified to serve persons with HIV/AIDS based on the criteria specified in the MCO RFP/Plan Qualification Guidelines).

SNP Requirements: Specific requirements for SNPs are contained in the Medicaid Managed Care Act passed by the New York State Legislature and signed into law in October 1996 and are reflected in the HIV SNP Contract.

The following is an overview of the SNP Program Design:

SNP networks are drawn from providers who have developed clinical and program expertise in this field and are already serving persons with HIV and their families. This permits the Special Needs Plans to offer a host of coordinated ambulatory and institutionally & community-based services that conform to the current standards of care and clinical guidelines established by the State Department of Health's AIDS Institute, thereby ensuring appropriate treatment. SNPs are required to furnish services in settings designed to provide primary care and aggressive early and acute interventions, in conjunction with long-term therapies. SNPs have formal linkages or contracts with community based agencies providing case management, supportive and enabling services, and outreach and prevention activities.

Six plans were approved in April of 2000 through a competitive procurement process. Five of these plans were certified, and the SNP program became operational in summer 2003. Two of the five certified plans withdrew from the program in 2005, leaving three operational plans.

HIV SNPs are responsible for the formation of networks of health, psychosocial and ancillary service providers that meet the complex needs of SNP members. SNPs offer a comprehensive, integrated continuum of services. At a minimum, SNP networks include providers capable of delivering the full array of services provided through Medicaid.

- Inpatient hospital
- Outpatient clinic
- Physician
- HIV pre- and post-test counseling
- HIV prevention education
- Laboratory

- Mental health
- Chemical dependence
- Emergency room
- Medical case management
- Care coordination/case management
- Home health (acute, short-term)
- Private duty nursing
- Radiology
- Diagnostic
- Eye care
- EPSDT
- DME

Family planning is a required capitated benefit for HIV SNPs¹. SNP Enhanced Services include Care and Benefits Coordination, HIV Prevention, Risk Reduction, and Treatment Adherence. SNP networks must integrate existing HIV service providers and community organizations into their networks whenever possible. SNPs must demonstrate to the Department of Health that the network providers have appropriate HIV expertise and training.

SNPs are required to perform many of the administrative functions of a mainstream MCO, including encounter reporting, claims processing, and member services. SNPs, like mainstream managed care plans, may retain the services of a management contractor, or third party administrator, to establish and perform administrative and management functions for the plan.

Outreach and Education

¹ SDOH negotiated special terms and conditions with one HIV SNP (Fidelis) for an alternative method for providing Family Planning services. These terms and conditions require that an agreement is secured with a "SDOH-designated Family Planning Contractor" to provide family planning services to Fidelis enrollees. Special monitoring, compliance and quality assurance are established to ensure prospective, new and current enrollees are provided information and access regarding availability of Family Planning services through the designated contractor as well as through free-access.

The DMCPE and the AIDS Institute developed materials for extensive outreach and educational efforts to advise HIV positive persons including, on an ongoing basis, any enrollees newly diagnosed with HIV infection or AIDS, of their options for health care services, following the development of HIV SNPs. The AIDS Institute will train/or arrange training for providers, the LDSS, and marketing/enrollment agents in the use of these materials.

The AIDS Institute, in collaboration with the local districts, conducted the following:

- Regional informational sessions for HIV/AIDS providers and advocacy organizations will be held to provide detailed information about the AIDS/HIV SNP.
- Training sessions for all education and enrollment staff (contracted or County-employed), including hotline operators.

In addition, all mandatory mailing packets sent to Medicaid consumers include a brochure that describes the HIV SNPs, and a postage paid card that can be returned to New York Medicaid CHOICE to request additional, more detailed, information about the HIV SNPs. Consumers who request additional information, either by calling the HelpLine, or by returning the postage-paid card, are sent an informational packet specific to HIV SNPs that includes information about the SNPs and how to enroll.

HIV SNP Access and Quality Assurance Activities

Establishing HIV-specific standards for access and quality assurance/quality improvement was a critical step in the development of Special Needs Plans. The AIDS Institute's review agent, IPRO, conducts on-site reviews at each SNP for HIV SNP Program-specific requirements. HIV SNP-specific QARRs have been developed by the AIDS Institute in collaboration with the SNP Quality Committee.

Compliance with Federal Statutes

MCOs are contractually obligated to comply with all applicable Federal statutes, including all statutes related to non-discrimination such as Title II of the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Title III of the Americans with Disabilities Act prohibits discrimination on the basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation. A public accommodation is a private entity that owns, leases or leases to, or operates a place of public accommodation. Places of public accommodation identified by the ADA include, but are not limited to, stores (including pharmacies) offices (including doctors' offices), hospitals, health care providers, and social service centers.

Additionally, Title II of the ADA requires that public programs, when viewed in their entirety, must be readily accessible to people with disabilities. MCOs participating in The Partnership Plan are contracted agents of the State and local governments and therefore have Title II responsibilities for program accessibility. New York City convened a Workgroup for the purpose of drafting ADA compliance guidelines to assist MCOs in assessing their ability to meet their responsibilities. Members of the Workgroup included staff from: CDOH-HCA, SDOH DMCPE, MCOs, advocacy groups, and the NYC Mayor's Office for People with Disabilities. Draft guidelines for MCO compliance with the ADA were developed following input from the Workgroup. All MCOs, as well as all local districts, public health units and other interested parties were sent the draft ADA guidelines for comment. The document served as a template for the drafting of similar guidelines for MCOs participating in The Partnership Plan in upstate counties.

Additionally, MCOs are required to submit information on the providers within their networks who are wheelchair accessible. Provider network data for Medicaid are submitted to NYS DOH on a quarterly basis. This information must also be available to potential enrollees through provider directories or through the member services department.

To ensure compliance with the ADA, all MCOs applying to initiate service, as part of the Plan Qualification process, an ADA Compliance Plan. The ADA guidelines are included in the an appendix to the MMC/FHPlus contract. The ADA Compliance Plan must list the MCOs program site(s) and describe in detail how the MCO intends to make its services, programs and activities readily accessible to and usable by individuals with disabilities, including but not limited to people with visual, auditory, cognitive or mobility disabilities, at such site(s). In the event a particular program site is not readily accessible to and usable by people with disabilities, the MCO will include in its Compliance Plan a description of reasonable alternative means and methods that result in making the services, programs and activities accessible. The MCO must abide by the Compliance Plan and implement any action detailed in the Compliance Plan to make the services, programs and activities accessible to and usable by individuals with disabilities.

The State has developed guidelines for ADA compliance, and these guidelines are included as Appendix H of the MMC/FHPlus contract. . The Model contract is available at www.nyhealth.gov/health_care/providers/index.htm.

The State provided, as part of the Plan Qualification process, technical assistance workshops to assist MCOs in evaluating their programs, services, and activities regarding ADA compliance; in taking appropriate steps to measure access and ensure program accessibility; and in making reasonable alternative means and methods of program and services available to persons with disabilities.

As part of the Plan Qualification review process, the State and the LDSS review each MCO's ADA Compliance Plan for comprehensiveness and appropriateness. ADA Compliance Plans must include: satisfactory methods for evaluation of the overall level of compliance of MCOs; and reasonable alternative means and methods proposed to make programs, services and activities available. As part of the total MCO response in the Plan Qualification process, each MCO's ADA Compliance Plan becomes part of the managed care contract.

The State includes ADA Compliance monitoring in its surveillance activities.

Provider Education and the Identification of Persons with Special Needs

Chapter 26 includes a description of the requirements in place to ensure that MCOs are appropriately screening and identifying certain high-need persons and referring them, as necessary, for specialized care and treatment.

3. SPECIAL POPULATIONS (FHPlus)

With respect to FHPlus, enrollment in HIV SNPs (and mental health SNPs should they be reauthorized) is precluded until such time as one or more SNPs applies and is approved by the State and CMS to offer the FHPlus benefit package.