

SNiP TIPS

A Guide For Advocates To New York State's HIV Special Needs Plans

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Acknowledgements

The SNIIP Tips are the result of a year's work to make Medicaid managed care work better for people living with HIV/AIDS by ensuring that the community has a voice in the implementation of the HIV Special Needs Plans (HIV SNPs). These efforts were made possible by the generous financial support of the New York City AIDS Fund.

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Foreword

Why develop SNIIP Tips?

In New York State, Medicaid for people living with HIV/AIDS is changing. In April 2003, the New York State Department of Health began enrolling HIV-positive Medicaid beneficiaries into HIV Special Needs Plans, or HIV SNPs. Thousands of individuals are now making a very serious decision about whether to enroll in an HIV SNP, or to stay in the Medicaid fee-for-service program or a mainstream health plan.

Gay Men's Health Crisis (GMHC) is offering the SNIIP Tips as a tool to assist Medicaid beneficiaries who are deciding whether or not to join an HIV SNP, and to help them get care if they do join. The SNIIP Tips are an advocacy tool that will be placed in the hands of people living with HIV/AIDS and their advocates that will enable them to maximize the promise of managed care. Our goal is simply to make New York State's Medicaid managed care program work better for individuals living with HIV/AIDS.

How can you use the SNIIP Tips?

The SNIIP Tips are intended to empower Medicaid beneficiaries living with HIV/AIDS to take charge of their health care. One way to get this information into the hands of beneficiaries is by educating the frontline workers who are assisting individuals living with HIV/AIDS. Therefore, case managers, benefits counselors, and other client advocates are target audiences for the SNIIP Tips. Others will also find the SNIIP Tips informative and useful, including policy makers, researchers, health plans and providers, funders, and members of the media.

The SNIIP Tips cover a wide range of topics, including eligibility for the HIV SNPs, the ins and outs of the enrollment process, what to think about before choosing a plan, benefits available from the HIV SNPs, getting help from member services, and problem-solving. SNIIP Tips answer basic questions like: Who can enroll in an HIV SNP and who cannot? If my client joins a SNP, can she disenroll if she is not satisfied, or does she have to stay in? Can I keep seeing my same doctor if I join an HIV SNP? By knowing the answers to these questions, people living with HIV/AIDS will be able to make informed choices about joining a SNP.

While we believe the SNIIP Tips are comprehensive, undoubtedly many questions remain unanswered. If there is a question not answered, please call GMHC's Managed Care Consumer Assistance Program at 212/367-1125; TTY: 212/367-1199. Words in the glossary (Appendix I) are bolded the first time they are used. If you come across an unfamiliar term, more than likely you can find a definition of it in the glossary. Helpful phone numbers and names of all the HIV SNPs are listed in the resources section (Appendix II). Use Appendices III–VI for maximum time

frames for appointment availability, a list of who can and cannot enroll in the HIV SNPs, services that should be coordinated by the HIV SNPs, and information about accessing mental health and substance abuse services.

Finally, the SNiP Tips are a snap-shot of the HIV SNPs at a point in time. GMHC expects that New York State's HIV SNPs program will be improved over the coming months and years to better meet the needs of people living with HIV/AIDS. Look forward to updates from GMHC about changes in the program.

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An Introduction to HIV Special Needs Plans

An HIV Special Needs Plan, or HIV SNP (you can say it like “HIV snip”), is a new kind of Medicaid health plan for people with HIV/AIDS and their children. Right now, people with HIV don’t have to join an HIV SNP, but they can if they wish. If they don’t want to join an HIV SNP, they can remain in traditional Medicaid or pick a mainstream Medicaid health plan. Adults without HIV cannot join an HIV SNP.

What are Medicaid health plans?

Medicaid is a health insurance program for many people with low incomes. When it started, Medicaid was a **fee-for-service (FFS)** program. This means that the government paid **providers** like doctors, clinics, and hospitals, for each of the services they gave to people with Medicaid.

Recently, **managed care** principles have been increasingly applied to the Medicaid program. With managed care, the government pays a health plan a fixed amount for each Medicaid beneficiary who is a **member**. The Medicaid health plan then gives most of the member’s care. This change was made to save money and to give better care. Medicaid health plans that serve anyone, with or without HIV, are sometimes called **mainstream Medicaid health plans**.

In New York State, Medicaid managed care is becoming a **mandatory** program. People with Medicaid in some zip codes have to pick a Medicaid health plan. People who have HIV are **exempt** from mandatory managed care for now. This means they can join a plan or decide to stay in traditional fee-for-service Medicaid.

What are HIV SNPs?

HIV SNPs are a new type of Medicaid health plan. They are for people with HIV and their children. These health plans link medical and social services to meet the special needs of people with HIV.

How are traditional Medicaid, mainstream Medicaid health plans, and HIV SNPs different?

There are some similarities and several important differences.

1. **Benefits:** People in HIV SNPs and Medicaid health plans get all the same benefits as people in traditional Medicaid. Most of the benefits are given directly by the SNP, but others are given outside the SNP.
2. **Case management:** An HIV SNP links medical and social services to meet the special needs of people with HIV and their children. So, HIV SNP enrollees have **case managers** who help coordinate all of the medical and social services that members get.
3. **Providers:** In traditional Medicaid, people can see any provider who takes Medicaid.

Introduction

In an HIV SNP, enrollees can usually go only to providers who participate in the health plan. These providers make up the health plan's **network**.

4. **Primary Care Providers:** Members of an HIV SNP have one doctor who is a **primary care provider**, or **PCP**. The PCP coordinates the enrollee's medical care, and if the enrollee wants to see a specialist, she or he usually has to get a referral from the PCP. In an HIV SNP, all primary care providers are **HIV specialists**, which means they have training and experience in treating people with HIV/AIDS.
5. **Specialists:** People in traditional Medicaid can see any specialist who takes Medicaid. People in mainstream Medicaid health plans and HIV SNPs usually need a **referral** from their primary care providers and can only see specialists in the plan's network.

| | Traditional Medicaid | Mainstream Medicaid health plans | Medicaid HIV SNPs |
|--------------------------------------|--|---|---|
| Benefits | Standard package | Same, but some are given inside and some outside the plan | Same, but some are given inside and some outside the plan |
| Coordination of benefits | People coordinate their own benefits | PCPs coordinate enrollees' medical care | PCPs coordinate enrollees' medical care and case managers coordinate clinical and social services |
| Providers | People can see any provider who takes Medicaid | People can usually see only providers within their health plan's network | People can usually see only providers within their health plan's network |
| Primary Care Providers (PCPs) | No primary care providers | Primary care providers don't have to be HIV specialists | Primary care providers are HIV specialists |
| Specialists | People can see any specialist who takes Medicaid | People usually need a referral from their PCP to see a specialist, and can only see specialists in the plan's network | People usually need a referral from their PCP to see a specialist, and can only see specialists in the plan's network |

Does my client have to join an HIV SNP?

No. HIV SNPs are **voluntary** now. This means that people with HIV who have Medicaid can either stay in traditional Medicaid, pick a mainstream Medicaid health plan, or pick an HIV SNP. They won't lose their Medicaid benefits if they don't join an HIV SNP.

Sometime in the next few years, HIV SNPs may become mandatory. This means that people with HIV who get Medicaid may have to pick an HIV SNP or a mainstream Medicaid health plan and won't be able to stay in traditional Medicaid. But some groups of people, like homeless people, will still be able to stay in traditional Medicaid if they want to.

Who HIV SNPs are for

Who can join an HIV SNP?

HIV Special Needs Plans are for people with HIV who have Medicaid. They don't have to have AIDS or be sick. If they want to, people with HIV can also enroll their children up to the age of 19, whether or not the children have HIV. HIV negative spouses and partners cannot be enrolled in the HIV SNP.

Some people are **excluded** from joining a Medicaid health plan, including HIV SNPs. This means that they can't join a mainstream Medicaid health plan or an HIV SNP. Excluded groups include people who get both Medicaid and Medicare, people who have to **spend down** to be eligible for Medicaid, and people who are eligible for New York's Family Health Plus program. Please see Appendix IV for a full list of excluded groups.

Does my client need Medicaid to stay in an HIV SNP?

Yes. Even if people switch from traditional Medicaid to an HIV SNP, they have to remain enrolled in Medicaid to stay in the health plan. Your clients in HIV SNPs will still need to meet all the guidelines for Medicaid, including **recertification**.

SNiP Tip: Your clients can ask their HIV SNP case managers for help with staying enrolled in Medicaid.

Do people with HIV and Medicaid have to join HIV SNPs?

No. **Right now people who have HIV don't have to join an HIV Special Needs Plan or any other Medicaid health plan.** They can decide to stay in traditional Medicaid, join a Medicaid health plan, or join an HIV SNP. No one is required to join an HIV SNP.

SNiP Tip: Remember, your clients can receive general enrollment information about HIV SNPs by calling New York Medicaid Choice at 1-800-505-5678. For all other questions, call GMHC's Managed Care Consumer Assistance Program at 212/367-1125; TTY: 212/367-1199. (See Appendix II, "Resources.")

Will my client ever be required to enroll in an HIV SNP?

Maybe. Sometime in the next few years, HIV SNPs may become mandatory. If this happens, people with HIV will have to pick an HIV SNP or a mainstream Medicaid health plan. But some groups, like homeless people, will still be **exempt** from mandatory enrollment. They will be able to stay in traditional Medicaid if they want to. When these changes happen, people will be told and might need more information about HIV SNPs.

How to Enroll

Joining an HIV SNP is voluntary for now. If a person with HIV decides not to join an HIV SNP, he or she won't lose Medicaid benefits.

How can my client prepare to enroll in an HIV SNP?

First of all, **advise your clients to keep their Medicaid cards**. Even once they join an HIV SNP, they will need the card to get some services, including prescription drugs and family planning services from any Medicaid provider. (See page 11, "Benefits.") They might also need their cards to get public benefits, like food stamps.

Also, if your client has a doctor he or she would like to continue seeing, advise him or her to ask that doctor:

- ✓ If he or she participates in the HIV SNP's network;
- ✓ The name of the HIV SNP he or she participates in; **and**
- ✓ If he or she can still take new patients through that HIV SNP.

Verify with New York Medicaid Choice what your doctor told you. If the doctor isn't available through the HIV SNP, your client may want to think twice about joining.

SNiP Tip: At a minimum, be sure your clients check with both the doctor and New York Medicaid Choice in New York City to see if their current doctor has room for new SNP patients. Be aware that sometimes New York Medicaid Choice will tell your client that a doctor can accept new patients, when in fact he or she cannot. And sometimes the doctor can take on patients, even if he or she is officially "full."

How does the enrollment process work?

Once HIV SNPs are up and running, everyone with Medicaid living in the areas covered by the HIV SNPs will get a letter about them. The letter will explain what HIV SNPs are and will tell people that if they have HIV, they and their children can join one. This letter will be sent to every Medicaid beneficiary. Getting the letter does **not** mean your client has HIV.

Your client can call a phone number in the letter to get an enrollment package. Two types of enrollment packages will be available. People with traditional Medicaid will get information and an enrollment form for the HIV SNP. Someone already in a Medicaid health plan will get information, a disenrollment form for the mainstream plan, and an enrollment form for the HIV SNP.

If more than one SNP is available in your area, your client will be able to pick one on the enrollment form. In New York City, there will be seven HIV SNPs to choose from. On the form, your client will need to choose an HIV SNP to enroll in. (See Appendix II, "Resources," for a listing.)

Your client might also sign up with a sales marketer from a specific HIV SNP. Advise your clients that they don't have to sign up this way if they don't want to join or if they want to get more information from other sources first.

After your client chooses an HIV SNP, he or she should call the SNP to find out what information they need to verify their HIV infection. **The HIV SNP must verify the client's HIV infection before the enrollment process can be completed.** They don't need to do this for uninfected children or for newborns whose HIV status is still unknown.

Once your client has called the HIV SNP, enrollment materials should be completed and mailed to New York Medicaid Choice.

SNiP Tip: Remember, the enrollment will not be completed until your client's HIV infection has been verified. Contact the member services department of the chosen HIV SNP to learn how this is done.

After New York Medicaid Choice processes your client's enrollment materials, the following notices will come in the mail:

- ✓ An **initial notification letter**, telling your client about the rights and responsibilities of people in the HIV SNP
- ✓ An **enrollment confirmation notice**, which gives the starting date of enrollment, the name of the HIV SNP, and the names of all family members who are being enrolled

If your client is excluded from joining, she or he will get a **notice of denial of enrollment**, which includes information on how to argue against this decision through a fair hearing. (See page 20, "Solving Problems II: Fair Hearings.")

SNiP Tip: Advise your clients to keep all written materials they get if they decide to join an HIV SNP, including all materials related to enrollment. Tell your clients to use their enrollment confirmation notice to get care from the SNP until their membership card arrives.

Claudia joined an HIV SNP. She is pregnant and she picks a primary care provider for her baby before she gives birth. She picks a doctor who speaks Spanish and has an office near her home. Her son is born on November 13. His starting date for coverage is November 1, the first day of his month of birth.

How does newborn enrollment work?

Newborn babies who are not in an excluded category (see Appendix IV for complete listing of eligible and excluded groups) will be automatically enrolled in the mother's HIV SNP. Enrollment starts the first day of the child's month of birth.

Enrolled pregnant women will want to pick a primary care provider (PCP) for the baby before the baby is born. If a parent hasn't chosen a PCP for her newborn, the HIV SNP will assign a PCP to the infant within 2 days of being told of the birth by the hospital.

Parents can set up an appointment with the infant's PCP right after birth. Within 14 days of finding out about the birth, the HIV SNP has to send a member ID card to the parents along with a letter confirming the infant's enrollment and explaining how to get care. A parent can ask for disenrollment of a newborn baby, or of any child, at any time. (See page 22, "Leaving an HIV SNP.")

SNiP Tip: Your client's decision about whether to sign up his or her children for the HIV SNP, or keep a newborn in the plan, can depend on several things. Questions to think about include:

- ✓ Does my client want case management services for his or her HIV-positive child?
- ✓ Is the child's current doctor part of an HIV SNP?
- ✓ Parents and HIV-negative children cannot join different SNPs. However, the HIV-positive parents of HIV-negative children can join a SNP and keep the child in traditional Medicaid or in a mainstream Medicaid health plan.

Can my client appeal decisions about enrollment?

Yes. It's a good idea to check first with whomever your client sent the enrollment materials to, to see if the problem can be solved easily. In New York City contact New York Medicaid Choice. If this doesn't fix the problem, your client can ask for a fair hearing to appeal any decision related to enrollment and eligibility issues. (See page 20, "Solving Problems II: Fair Hearings.") For more information about fair hearings, please contact GMHC's Managed Care Consumer Assistance Program at 212/367-1125; TTY: 212/367-1199. (See Appendix II, "Resources.")

Starting Out

What information will my client get from the HIV SNP after joining?

Once a person joins an HIV SNP, the plan will send:

1. A **medical provider directory** that includes all participating providers by specialty and a list of facilities, including Designated AIDS Centers for the county or borough in which the enrollee lives.
2. An **ID card** that includes the name of the enrollee's clinic (if they go to one), the name and phone number of the PCP, the member services toll-free number, and the 24-hour toll-free number that enrollees can use to get services when the PCP isn't available. The card does not say "Special Needs Plan," "SNP," "HIV," or "AIDS." This ID card has to be sent within 14 days of the enrollment date. Enrollees should ask the plan how to use their enrollment confirmation notice or another document to get services before they get their ID card.
3. A **member handbook**, which the HIV SNP has to send within 14 days, explains how the HIV SNP works and highlights enrollee rights and responsibilities.

Also, the HIV SNP has to contact your client in person, by phone, or by mail within 15 days of joining. The staff has to tell your client about the plan, and find out if your client has any special medical, social, or communication needs. The HIV SNP will also help your client pick a primary care provider if he or she hasn't already.

SNiP Tip: In addition to the HIV SNP member ID card, advise your client to keep their regular Medicaid cards. They will need them to get some services including pharmacy benefits, non-network family planning services, and non-network tuberculosis diagnosis and treatment. (See page 11, "Benefits.")

What help can the HIV SNP's member services department give?

Each HIV SNP has to operate a toll-free member services hotline during regular business hours. There might be a separate line for complaints and utilization review inquiries. (See page 17, "Solving Problems I: Complaints and Appeals.") There also has to be a hotline that can take calls or give instructions outside of normal business hours.

Enrollees can call member services for any reason including:

- ✓ Explanations of how to get services
- ✓ Help in picking or changing PCPs
- ✓ Help in making appointments
- ✓ Questions about complaints, appeals, and fair hearings (See page 17, "Solving Problems I: Complaints and Appeals," and page 20, "Solving Problems II: Fair Hearings.")
- ✓ Explanation of anything in the member handbook

What kinds of translation and interpretation services are available for my clients who don't speak English or who have special communication needs?

If enough people in an area speak a language other than English, the HIV SNP has to provide written materials in that language. Also, the plan and participating providers must have interpreters for people who don't speak English, if not in person, then at least by telephone.

Written materials might only be available in English and Spanish. People who are not comfortable in either of these languages can decide to have someone help them understand written materials. They can also get interpretation services for appointments and for phone calls. But, they may also decide not to join the plan if they can't get a PCP who speaks their language or if they are not comfortable without written materials in their language.

The plan and participating providers must have services in place for communicating with people who have visual, hearing, speech, physical, or developmental disabilities. These include Braille or audiotapes, TTY access, and American Sign Language.

SNiP Tip: Call the HIV SNP member services hotline with questions about getting care in a language that is best for your client. The plan's PCP should speak your client's language, or have staff that can translate medical terminology.

How can my client pick a primary care provider?

Advise your client to pick a **primary care provider** right after joining if he or she did not pick one during the enrollment process. All HIV SNP primary care providers are **HIV specialists**. This means they have experience and training in treating people with HIV. (For non-infected children, the PCP doesn't have to be an HIV specialist.)

SNiP Tip: Advise your clients to pick a primary care provider (PCP), instead of letting the plan pick one. Choosing a PCP gives your client more control over their health care. Clients should set up an appointment with their PCP right away. Tell the PCP about on-going treatment needs when setting up the appointment.

The plan has to offer enrollees a choice of at least three PCPs. If your client does not pick a PCP within 30 days of being told of enrollment, the HIV SNP will automatically pick a PCP for your client.

Enrollees can decide to have one PCP for the whole family if they're all members, or different PCPs for different members. Women can pick an OB-GYN (obstetrician/gynecologist) in addition to a PCP.

SNiP Tip: Your clients may want to think about what matters most to them in a primary care provider. Different things may matter more to different people. Some questions that they might think about include:

- ✓ Do I want a PCP that I already know?
- ✓ Do I want a PCP very close to my home?
- ✓ What are the PCP's office hours?
- ✓ Does the PCP speak my language or have staff that does?
- ✓ Is the PCP familiar with my culture?

Can my client keep seeing a non-network provider?

Usually, the HIV SNP will allow enrollees to see providers only within the plan's network. But, in two situations new enrollees can keep seeing a health care provider who isn't part of the network for up to 60 days after joining. The non-participating provider has to agree to follow the plan's rules and charge only the amount the plan normally pays. This can happen if:

1. The enrollee has a life-threatening disease or condition, or a degenerative and disabling disease or condition including HIV; **or**
2. The enrollee has reached the second trimester of pregnancy by the starting date of enrollment. In this case, the transitional period will include care directly related to the delivery for up to sixty days after the birth.

How long does my client have to wait to visit HIV SNP providers?

These first visits have to be made available to enrollees within the time periods listed. (See Appendix III for time frames on other types of visits.) Your client can call Member Services if he or she has any trouble getting these first appointments:

| Type of visit | Appointment has to be available |
|---|---|
| First visit for enrollees with on-going treatment needs | Within 7 days of request if medically necessary |
| First family planning visit | Within 2 weeks of request |
| First prenatal visit | Within 3 weeks during first trimester Within 2 weeks during second trimester Within 1 week during third trimester |
| First PCP office visit for newborns | Within 48 hours of leaving the hospital |

SNiP Tip: Advise your client to do these things at the first PCP visit:

- ✓ Bring a list of symptoms
- ✓ Bring a list of medications
- ✓ Take notes on what the PCP says
- ✓ Ask questions if anything is unclear
- ✓ Ask how the PCP will connect with other providers
- ✓ Ask how the PCP will work with the case manager
- ✓ Ask when the next appointment will be

Benefits

What benefits do HIV SNPs offer?

People in HIV SNPs get all the same services as traditional Medicaid. Most of these services, like primary care visits, are paid for by the plan and have to come from network providers.

How can my client get specialty care?

When the PCP can't give care that the enrollee needs or when your client wants to see a specialist, the PCP will give your client a **referral**. A referral is a piece of paper with information including the name of the specialist. These specialists are usually network providers, but if the plan does not have an appropriate provider in the network, the plan has to pay for a non-network specialist.

After getting a referral, enrollees are supposed to get appointments with specialists within 4 to 6 weeks. They can contact member services if they have trouble getting an appointment.

Leilani has HIV and Parkinson's Disease. She wants to have her neurologist as her primary care provider so that she can see him without a referral. Since her neurologist isn't an HIV specialist, he will work with an HIV specialist to make sure she gets the care she needs.

SNiP Tip: Advise your client to hold onto the referral even after the appointment with the specialist in case there is a disagreement with the plan later.

Enrollees who need lots of care from specialists can get a **standing referral**. This will allow them to see the specialist for a certain number of visits or a certain length of time without getting a new referral from the PCP each time.

An enrollee with a **chronic illness** in addition to their HIV can get a special referral that will make a non-HIV specialist the coordinator of the enrollee's primary and specialty care. Enrollees can call the HIV SNP's member services to find out how to get standing and special referrals.

How can my client get emergency care?

People in HIV SNPs can get emergency care from any provider inside or outside the network without a referral or prior approval. An emergency is a medical or behavioral condition that a person with an average knowledge of health thinks will cause serious harm without care right away. Even if the situation does not turn out to be an emergency, the plan has to pay for the care if it was reasonable for the person to think that it was an emergency. This is called the **prudent layperson standard**. This applies to both medical and behavioral emergencies.

One night Jose has bad chest pains. He is afraid that he is having a heart attack and calls an ambulance to go to the Emergency Room. The doctors find that Jose wasn't having a heart attack. But, because it was reasonable for him to think that it was an emergency, he did the right thing in going to the Emergency Room.

SNiP Tip: Sometimes your client will need “urgent care” which is different from “emergency care.” Urgent care is for non-emergency conditions that will harm your client’s health if not treated within twenty-four hours. For example, PCP (pneumocystis carinii pneumonia) is a condition that requires urgent care to prevent rapid and life-threatening progression of the disease. If your client needs urgent care, have her call the primary care provider right away. An appointment should be offered the same or the next day.

What other services can my client get outside the network?

There are some services that HIV SNP enrollees can get from any Medicaid provider using their Medicaid card. A referral from the PCP or approval from the plan is not necessary to access these services. These include prescription drugs, treatment for tuberculosis, some mental health and substance abuse services, and family planning and reproductive health care.

How can my client get family planning and reproductive health services?

Enrollees can get family planning and reproductive health services from any Medicaid provider, whether or not the provider is a part of the plan’s network. **They don’t need a referral from the PCP or approval from the plan.** If the provider is outside of the network, your client will need to show her Medicaid card. The plan has to tell all enrollees of childbearing age of this right and has to give them lists of in- and out-of-network reproductive health and family planning providers.

Andrea likes her new HIV SNP primary care provider. But she wants to continue getting birth control pills and condoms from the clinic in her neighborhood. She likes the staff there and is more comfortable asking them questions about family planning. Andrea can use her Medicaid card to get contraceptives and other family planning services from the clinic. She doesn’t need a referral from her primary care provider.

Family planning and reproductive health services include:

- ✓ Birth control
- ✓ Emergency contraception
- ✓ Pregnancy testing and counseling
- ✓ Abortion
- ✓ Pap smears
- ✓ Pelvic and breast exams
- ✓ STD testing and treatment
- ✓ HIV testing and counseling

These services include all necessary education and counseling. When necessary, family planning services include screening, diagnosis, and treatment for sexually transmissible diseases, sterilization services, and screening for pregnancy.

SNiP Tip: Minors have the same right to get family planning services in HIV SNPs as adults. The plan has to keep all information about family planning confidential for both adult and minor enrollees. Tell your teenage clients that their parents or guardians won't be told if they get family planning services.

How Can My Client Get Mental Health and Substance Abuse Services?

Enrollees can **self-refer** for one mental health assessment from a network provider in any calendar year. This means they can get this assessment without a referral or prior authorization. Enrollees can also self-refer for one chemical dependence assessment for inpatient detoxification, inpatient rehabilitation or outpatient detoxification services. All enrollees will get a list of participating mental health and substance abuse providers from the plan, including a list of children's mental health specialists. Please see Appendix VI for a complete listing of mental health and substance abuse services.

Enrollees who want a chemical dependence assessment for any alcohol and/or substance abuse outpatient treatment services, except outpatient detoxification services, must use their Medicaid benefit card to go to any provider that takes Medicaid.

SNiP Tip: People who need on-going mental health and/or substance abuse services can get help from the HIV SNP's case management system. In some areas, HIV care and substance abuse care will be available in the same place. Your clients can ask their case managers to help them find this kind of site if they need these services.

How to Get Medical and Social Services from the HIV SNP

How easy will it be for my client to get medical services?

Providers have to be easy for enrollees to reach. HIV SNP plans should offer enrollees a choice of three primary care providers not more than 30 minutes away in urban areas or 30 minutes/30 miles in non-urban areas. The standard is 30 minutes/30 miles for specialty care, hospitals, mental health, lab, and X-ray providers.

If they want to, enrollees can pick network providers who are outside this range, if they can pay for and arrange transportation themselves. Otherwise, non-emergency transportation is covered through the HIV SNP or on a fee-for-service basis using the client's regular Medicaid card.

HIV SNP plans must have medical services available 24 hours a day, seven days a week. If your client can't reach his or her PCP (or OB-GYN for pregnant women), he or she can call the plan's 24-hour toll-free number for services. This number may be the same or different from the member services line.

Appointments have to be available to enrollees at least as quickly as shown in the chart in Appendix III, and enrollees shouldn't have to wait more than an hour at appointments. If your client has been having trouble getting an appointment or waiting at a provider's office, he or she can file a complaint. (See page 17, "Solving Problems I: Complaints and Appeals.")

SNiP Tip: If your client needs help and can't reach his or her PCP, he or she can call the plan's 24-hour toll-free number at any time for help getting care. Remember, if it's an emergency your client does not need to contact the plan before getting care.

How does the HIV SNP's case management system help enrollees get services?

One of the goals of the HIV SNPs is to link medical and social services for members. This is done by **case managers**. Your client in an HIV SNP will be assigned a case manager who will:

- ✓ Work with the PCP to coordinate medical care
- ✓ Make sure the member knows about plan services
- ✓ Figure out what the member needs and develop a care plan
- ✓ Check the quality of care that the member gets
- ✓ Arrange social services for enrollees

Please see Appendix V for a list of social services that the case manager can help coordinate. These include many different services like drug treatment, domestic violence help, and nutritional services. Most of these services are not given by the HIV SNP itself. These services have been **carved-out** of the benefit package the HIV SNP is paid to deliver. Many of them will be given by community-based organizations that your client may already be connected with.

SNiP Tip: Encourage your clients to be very active in seeking help from their HIV SNP case managers. Some case managers may call their clients a lot and be very prompt in coordinating services, but others may be very busy. Your clients can call their case managers anytime to ask questions or to get help in coordinating services.

What can my client do if a provider leaves the HIV SNP network?

If a health care provider leaves the network, in some cases patients can decide to continue to see the provider for a temporary period instead of switching to a new provider right away.

This period lasts for 90 days for most enrollees, starting from the date the plan tells the enrollee that the provider is leaving the network. If the enrollee has entered the second trimester of pregnancy, the transitional period will cover medical care directly related to the delivery for up to 60 days after the birth.

The non-participating provider has to agree to follow the plan's rules and charge only the amount the plan normally pays.

How can my client switch to a different primary care provider?

HIV SNP enrollees can change their PCP until 30 days after their first appointment with the PCP without giving an explanation. After thirty days, enrollees can change their PCP every six months without an explanation. The plan has to process these requests and tell enrollees the date of change within 45 days. The plan has to switch your client by the first day of the second month after the request.

Your client can change PCPs anytime for **good cause**. These reasons are considered "good cause":

1. Your client can't get an appointment with the PCP within the time limits; (See Appendix III)
2. Your client moves, so that the PCP is outside the distance standards;
3. Your client and PCP agree that it's in your client's best interests to switch; **or**
4. Your client's PCP leaves the network or becomes unavailable for another reason.

Willie asks to change his PCP on September 13. The plan has to switch him by November 1, the first day of the second month after the request. Willie should call the HIV SNP member services line to make sure the plan has switched him before he starts seeing the new PCP.

Getting Medical and Social Services

Sameer joins an HIV SNP and picks a PCP out of the directory. He picks him because his office is on the Lower East Side, close to where Sameer lives. He meets with the PCP once and decides that he isn't comfortable with him. Sameer contacts the plan within 30 days and switches to another PCP. If he wants to change again without "good cause," he can only do so every 6 months.

The plan has to process these requests within 15 days. If the enrollee doesn't pick a new PCP within 30 days of one of these events, the plan has to assign a new PCP.

The plan can also assign a new PCP if:

1. The enrollee needs special care for a chronic or acute condition, and the enrollee and plan agree on a change in PCP;
2. The enrollee has behaved disruptively toward the PCP and the PCP has tried to accommodate the enrollee; **or**
3. The enrollee has taken legal action against the PCP.

In any of these situations, the plan has to first give your client a chance to pick a new PCP.

Solving Problems I: Complaints and Appeals

If your client has a problem with the plan, he or she can go through the plan's complaint and appeal process, the Medicaid fair hearing process, or both. A plan can't penalize an enrollee for filing a complaint or asking for a fair hearing. (See also page 20, "Solving Problems II: Fair Hearings.")

SNiP Tip: For help with appeals or fair hearings, you or your client can contact the Managed Care Consumer Assistance Program at GMHC at 212/367-1125; TTY: 212/367-1199.

How can my client file a complaint?

A **complaint** is any concern the enrollee tells the plan about. Complaints are sometimes called **grievances**. Complaints can be made at any time about any concern with the HIV SNP, its benefits, employees, or providers. Examples include rude treatment at the PCP's office and denials of benefits.

An important example of when your client might want to file a complaint is when he or she gets a notice of a negative decision from the plan. Whenever the HIV SNP denies your client a referral, denies or reduces benefits or services, or decides that a requested benefit isn't covered by the plan, the plan is supposed to give written notice to the enrollee. The notice has to tell your client how to make verbal and written complaints and the information that the plan will need to make a decision.

If your client is concerned about a referral or a plan-covered benefit, he or she can make a complaint over the phone. The plan has to have a toll-free number for this, and has to tell your client.

All other complaints have to be in writing. If your client wants to make a written complaint, he or she can either write a letter or use a form supplied by the plan.

If your client makes a complaint by phone and the plan solves the problem to your client's satisfaction right away, the plan does not have to send anything in the mail to your client.

If the complaint isn't resolved over the phone, the plan has to resolve the complaint within the following time frames:

- 🕒 Within 24 hours if a delay would "significantly increase" the risk to the enrollee's health
- 🕒 Within 15 days after getting all necessary information for cases about non-urgent referrals or benefits
- 🕒 Within 30 days of the receipt of all necessary information for all other cases

Complaints and Appeals

In all non-urgent cases, the plan has to send the enrollee written notice of the complaint within 15 days of getting it. They also have to send contact information for the person handling the complaint.

The plan's written response about the complaint has to explain:

- ✓ The decision
- ✓ Procedures for filing an appeal, including forms
- ✓ Fair hearing rights (See page 20, "Solving Problems II: Fair Hearings.")
- ✓ The enrollee's option to contact the State Department of Health (DOH)

If your client does decide to complain to the New York State Department of Health, he or she can call 1-800-206-8125 or write to:

NYS Department of Health
Bureau of Certification and Surveillance, Corning Tower
Albany, NY 12237

SNiP Tip: If your clients make complaints in writing, advise them to keep a copy of everything sent, and to mail everything "return receipt requested." If they make a complaint by phone, advise them to keep notes on the conversation, including what they said, who they talked to, and the date and time. Also, advise your clients to keep all mail they get from the plan about the complaint and any appeals.

How can my client appeal a plan's decision?

If your client isn't satisfied with the plan's decision about the complaint, he or she has 60 days to file an **appeal**. An appeal is made by writing a letter or using a form provided by the plan. Advise your client to keep a copy of the appeal and to send it "return receipt requested."

The HIV SNP has to send written acknowledgement of the appeal within 15 days, including how to contact the person handling the appeal. The SNP also has to say what additional information it needs to make a decision. The plan has to decide on the appeal and inform the enrollee of the outcome within the following time frames:

- 🕒 Within one day if a delay would significantly increase the risk to an enrollee's health; **or**
- 🕒 In all other cases, within 30 days of getting all necessary information.

Once the plan makes a decision, it will send a notice to your client. The notice will include the reasons for the appeal determination, the medical explanation, a notice on fair hearing rights (if applicable), the right to contact the New York State Department of Health with the complaint, and information on how to further appeal.

What if the plan says a treatment isn't "medically necessary"?

If the plan says that a treatment or service your client wants isn't "medically necessary," your client can ask for a **utilization review**. The process is similar to an appeals process.

Enrollees with life-threatening or disabling conditions or diseases, like HIV, can also ask for an **external appeal** when one or more covered services have been denied as experimental or investigational. All enrollees can ask for an external appeal if services were denied as not medically necessary. An external appeal can be requested after the enrollee has been denied under the initial internal utilization review procedure or when both the enrollee and plan agree to skip the internal procedure. However, an external appeal must be filed *before* the internal utilization review procedure has been completed.

An external appeal has to be filed within 45 days of the final negative decision from the plan. To get an application for an external appeal, contact the New York State Department of Insurance at 1-800-400-8882 or **www.ins.state.ny.us**, or call the plan's member services hotline.

SNiP Tip: Your clients can name someone else to represent them in an appeal process if they are not comfortable dealing with the process themselves. This can be a friend, family member, or advocate. The plan can tell your client how to name a representative for this purpose.

Solving Problems II: Fair Hearings

What is a fair hearing?

A fair hearing is a state process for settling disputes.

SNiP Tip: For help with appeals or fair hearings, you or your client can contact the Managed Care Consumer Assistance Program at GMHC at 212/367-1125; TTY: 212/367-1199.

Roberto's plan sends him a notice that they are going to stop paying for a service he feels he needs. If he wants to, he can ask for a fair hearing right away, in addition to or instead of going through the plan's complaint and appeal process.

When can my client ask for a fair hearing?

Enrollees can ask for a fair hearing by telephone from the state Office of Administrative Hearings (OAH) for the following reasons:

- ✓ Local Medicaid office decisions about enrollment, disenrollment, or eligibility
- ✓ Denial, termination, reduction, or suspensions of benefits by the plan (including when a provider thinks a service is necessary and the plan disagrees)
- ✓ Provider denials of care that the plan agrees with and that have gone through the internal appeals process
- ✓ The plan's failure to respond promptly to a request for services

If the dispute is about services that the enrollee wants, he or she has to have written notice of a negative decision from the plan before requesting a fair hearing. **A fair hearing has to be about the health plan's decision, not a provider's.** So, if a doctor denies services, the patient has to go through the HIV SNP's internal appeals process. If the HIV SNP agrees with the doctor, the patient can then ask for a fair hearing.

Stacey's doctor won't give her a treatment she needs. She complains to the plan and the plan agrees with the doctor. She appeals this decision and the plan still agrees with the doctor. She can now ask for a fair hearing if she wants to, in addition to or instead of asking for an external appeal.

How does the fair hearing process work?

At the fair hearing, the plan or local Medicaid office will give evidence to support its side. If no one from the plan appears, the plan has to send written material to OAH and to the enrollee at least three business days before the scheduled hearing.

If the client is homebound, he or she can ask for a phone or written hearing, or choose a representative to go to the hearing for them.

The plan has to follow the decision made by OAH at the fair hearing. If the decision involves a service that was originally denied and the enrollee wins, the plan can give the service or pay

for the service by a non-network provider. If the enrollee has also pursued an external appeal, the decision at the fair hearing is the one that counts.

Will my client's disputed benefits be cut off during the fair hearing process?

To keep a disputed service from being reduced or cut off, your client has to ask for **aid continuing**. To get this, he or she has to ask for the fair hearing within ten days of finding out that the service is supposed to end or be reduced. If your client gets aid continuing, this means the plan has to continue to give the disputed services until the fair hearing process is done or until the treatment is over.

Can my client pursue both an appeal (or utilization review) and a fair hearing?

Yes. If your client's complaint is one that can be addressed through both processes, he or she can pursue a complaint and appeals procedure (or utilization review), a fair hearing, or both. Both processes can be started right away; enrollees don't have to go through the whole appeals process before asking for a fair hearing.

What are the differences between a fair hearing and the appeals (or utilization review) process?

In situations when your client may be able to choose between the plan's appeals or utilization review process and a fair hearing, or both, you will want to be able to tell them about the differences.

First of all, as discussed above, the process you can pick depends on the type of problem:

- ✓ If the problem has to do with eligibility for joining an HIV SNP, or enrollment and disenrollment issues, your client can ask only for a fair hearing.
- ✓ If the problem has to do with a provider's decision, your client has to start with the complaint and appeals process.
- ✓ If the problem has to do with a plan denial, reduction, or termination of benefits, your client can start with the complaint and appeals process and/or ask for a fair hearing.
- ✓ If the problem has to do with a plan denial based on medical necessity, your client can ask for a utilization review and/or a fair hearing.

Sarah's HIV SNP tells her she can't get a treatment she has been receiving. They send her a written notice. She calls the HIV SNP to file a complaint. The plan determines that she can't get the service. Sarah has 60 days to file an appeal. She can also ask for a fair hearing at any point in the process because the problem is a termination of a benefit. But she has to ask for it at least ten days before the service is going to be reduced if she wants to get aid continuing.

SNiP Tip: It is important to remind your clients that only a fair hearing has the possibility of aid continuing. If your client is worried about a benefit being reduced or cut off, asking for a fair hearing and for aid continuing can help prevent this.

Leaving an HIV SNP

How can my client leave the HIV SNP when he or she wants to?

HIV SNP enrollees can decide to **disenroll** at any time. By disenrolling, they can switch to traditional (fee-for-service) Medicaid, a mainstream Medicaid health plan, or another HIV SNP. Disenrollment normally happens the first day of the month after the request. But people in HIV SNPs can request an **expedited disenrollment**, which is faster. Expedited disenrollment requests must be processed within seven days. Adverse decisions about disenrollment can be appealed through the fair hearing process. (See page 20, “Solving Problems II: Fair Hearings.”)

Luc joined an HIV SNP, but he has decided that he doesn't like being in a health plan. He wants to return to traditional Medicaid as quickly as possible because he needs services from his old doctor who's not in the plan's network. Because he lives in Brooklyn, he calls the New York Medicaid Choice hotline and asks for an expedited disenrollment.

To disenroll within New York City, enrollees can call New York Medicaid Choice at 1-800-505-5678. Outside of New York City, they can call the local Medicaid office. If your client experiences problems disenrolling, call GMHC's Managed Care Consumer Assistance Program at 212/367-1125; TTY: 212/367-1199.

SNiP Tip: Advise your clients to think about how their leaving the plan will affect their children's membership. Parents and guardians are advised to disenroll non-HIV-infected children when they leave the plan. If the parent or guardian dies, non-HIV-infected children are disenrolled at recertification. In both cases, HIV-positive children can remain in the plan. Remember, a parent can disenroll their newborn baby or child without leaving the plan themselves.

What can my client do if he or she becomes ineligible for Medicaid?

The HIV SNP can disenroll members for a number of reasons:

1. The enrollee is not Medicaid-eligible anymore;
2. The enrollee meets the exclusion criteria for HIV SNPs (see page 3, “Who HIV SNPs are for”); **or**
3. The enrollee hasn't come for treatment or case management appointments for a period of three months after joining, or for a period of six months once a treatment program has been started.

If a beneficiary is disenrolled from the plan because of losing Medicaid eligibility and then becomes eligible again within three months, she or he will be automatically re-enrolled in the HIV SNP, if the HIV SNP has room.

SNiP Tip: If your client is disenrolled from the HIV SNP because he or she has lost Medicaid eligibility, you may need to help him or her apply for other sources of health coverage, like New York State's AIDS Drugs Assistance Program. Contact GMHC at 212/367-1225; TTY: 212/367-1199 for advice.

How will my client know when he or she is out of the HIV SNP?

After your client has disenrolled from the HIV SNP, New York Medicaid Choice will send the enrollee a notice of disenrollment including the date of disenrollment. New York Medicaid Choice also has to send notices if the enrollee's Medicaid coverage is ending and/or if the enrollee's eligibility for the HIV SNP is ending.

SNiP Tip: When a person is disenrolled for any reason, the HIV SNP has to give a discharge plan (see Glossary) to the person and the PCP within 15 days of the request for or notice of disenrollment. This plan has to say how the person will get care during the transition. Advise your clients to call member services if they don't get this plan within 15 days.

Appendix I

Glossary

Aid continuing: A method to continue getting a benefit during a fair hearing process.

Appeal: The process a member uses to ask a plan to reconsider a decision.

Carved-out: Services in fee-for-service Medicaid that are not included in the HIV SNP prepaid benefits package. Carved-out services can be accessed by SNP enrollees with their regular Medicaid card without HIV SNP pre-authorization.

Case manager: Someone who coordinates medical and social services for SNP members.

Chronic illness: An illness that someone has for a long time like asthma, Parkinson's Disease, or HIV.

Complaint: A concern that a member expresses to a plan. A "complaint" is also called a "grievance."

Discharge plan: A plan for how a member will get care once he or she is disenrolled from the plan.

Disenrollment: Leaving the plan.

Enrollment confirmation notice: A letter that tells a new member the starting date of coverage, the name of the HIV SNP, and all family members who are enrolled.

Excluded: Groups that can't join an HIV SNP or another Medicaid health plan.

Exempt: Groups that don't have to join a Medicaid health plan, but can if they want to.

Expedited disenrollment: A process for people who want to leave a plan quickly.

External appeal: A process a client can use when a plan says a service is experimental, investigational, or not medically necessary.

Fair hearing: A state process for settling disputes about Medicaid.

Fee-for-service: The traditional Medicaid system where the government pays providers for each service they give patients.

FFS: See Fee-for-service.

Good cause: A reason that allows a person to switch PCPs at any time.

Grievance: Another word for Complaint.

HIV SNP: HIV Special Needs Plan

HIV Special Needs Plan: A new type of Medicaid health plan specially designed for people with HIV and their children.

HIV specialist: A doctor with a certain amount of training and experience in treating people with HIV.

Initial notification letter: A letter that describes an HIV SNP to someone who has sent in enrollment materials.

Mainstream Medicaid health plan: A managed care plan for people with Medicaid that serves anyone, whether or not they have HIV.

Managed care: A system where the government pays a plan for each member enrolled, and the plan provides all or most of the person's care.

- Mandatory:** When people have to join a mainstream Medicaid health plan or an HIV SNP.
- Medicaid:** The government health insurance program for people with low incomes.
- Member:** Someone who is enrolled in a Medicaid health plan. In this guide, “enrollee” has the same meaning as “member.”
- Network:** The group of doctors, clinics, and hospitals that participate in a certain plan.
- Notice of denial of enrollment:** A letter that tells people that they cannot enroll in an HIV SNP.
- Notice of disenrollment:** A letter that tells people when their membership in an HIV SNP ends.
- PCP:** Primary Care Provider
- Primary care provider:** The doctor who coordinates a person’s medical care in an HIV SNP and provides referrals to specialists.
- Provider:** A doctor, hospital, or clinic.
- Prudent layperson standard:** The rule that HIV SNPs have to pay for medical care if it was reasonable for the member to think it was an emergency, even if it turns out not to be.
- Recertification:** The process of showing that you are still eligible for Medicaid. This process is also called “redetermination.”
- Referral:** Permission from the PCP that allows a person in an HIV SNP to see a specialist.
- Self-refer:** When a person in an HIV SNP can go directly to a service without getting a referral.
- Spend-down:** A way some people with higher incomes can qualify for Medicaid if they have high medical expenses.
- Standing referral:** A type of referral that lets someone see a specialist for a certain number of visits or a certain amount of time.
- Utilization review:** The process a member can use if a plan denies a service and says it is not medically necessary.
- Voluntary:** When people can choose to join an HIV SNP or “mainstream” managed care plan, but don’t have to.

Appendix II Resources

For information and help resolving problems with HIV SNPs:

| | |
|--|----------------|
| GMHC Managed Care Consumer Assistance Program | 212/367-1125 |
| TTY | 212/367-1199 |
| New York State Department of Health (complaints) | 1-800-206-8125 |

HIV SNP Member Services:

In the near future, six HIV SNPs will be operational. They are listed below with their member services phone numbers. For up to date information about which HIV SNPs are available in a specific geographic area, please go to www.health.state.ny.us/nysdoh/hiv aids/snps/plans.htm.

| | |
|---|----------------|
| CommunityCare Partners, Inc. (Not ready to enroll members) | |
| Fidelis Care New York Healthier Life | 1-888-FIDELIS |
| HealthFirst PHSP, Inc. | 1-800-905-5445 |
| MetroPlus Health Plan Partnership in Care | 1-800-303-9626 |
| NewYork-Presbyterian System SelectHealth, LLC. | 1-866-469-7774 |
| VidaCare | 1-800-556-0689 |

For assistance with HIV SNP enrollment and disenrollment:

| | |
|--|----------------|
| New York Medicaid Choice | 1-800-505-5678 |
| Outside NYC, Nassau County, Suffolk County | 1-800-732-9503 |

For questions about HIV/AIDS and clinical trials:

| | |
|--|----------------|
| New York State HIV/AIDS Hotline | 1-800-541-AIDS |
| Spanish | 1-800-233-SIDA |
| TDD | 1-800-369-AIDS |
| New York City HIV/AIDS Hotline (English and Spanish) | 1-800-TALK-HIV |
| AIDS Clinical Trial Information Service (ACTIS) | 1-800-874-2572 |

For help with medications, medical care and home health care for people who are insured or uninsured:

| | |
|--|-----------------|
| ADAP (AIDS Drug Assistance Program) | 1-800-542-AIDS |
| TDD | 1-518-459-0121 |
| Family Health Plus (free health insurance for low income adults) | 1-877-934-7587 |
| TTY: | 1-877-898-5849 |
| Child Health Plus (free or low-cost health insurance for children) | 1-800-698-4KIDS |

Additional Resources:

| | |
|--|----------------|
| NYS Partner Assistance Program | 1-800-541-AIDS |
| NYC Partner Notification | 1-212/693-1419 |
| Toll-free | 1-888-792-1711 |
| Social Security Administration | 1-800-772-1213 |
| NYS Domestic Violence Hotline | 1-800-942-6906 |
| Spanish | 1-800-942-6908 |
| TDD | 1-800-810-7444 |
| Americans with Disabilities Act (ADA) Information Line | 1-800-514-0301 |
| TDD | 1-800-514-0383 |

Appendix III Time Frames for Appointment Availability

| Type of care: | Appointment has to be available: |
|---|---|
| Emergency | Immediately |
| Urgent medical or behavioral problems | Within 24 hours of request |
| Non-urgent “sick” visit | Within 48–72 hours of request, as clinically indicated |
| Routine (non-urgent) preventive appointment | Within 4 weeks of request |
| Specialist referral (non-urgent) | Within 4 to 6 weeks of request |
| Initial prenatal visit | Within 3 weeks during first trimester Within 2 weeks during second trimester Within 1 week during third trimester |
| Adult (older than 21) baseline and routine physicals | Within 4 weeks of enrollment |
| Well Child Care | Within 4 weeks of request |
| In-plan initial family planning visits | Within 2 weeks of request |
| In-plan mental health or substance abuse follow-up visits (after emergency or hospital discharge) | Within 5 days of request |
| In-plan, non-urgent mental health or substance abuse visits | Within 2 weeks of request |
| Initial PCP office visit for newborns | Within 48 hours of hospital discharge |
| Provider visits to make health, mental health, and substance abuse assessments for the purposes of making recommendations regarding a recipient’s ability to work, when requested by local social services district | Within 10 days of request by enrollee |

Appendix IV

Eligible and Excluded Groups

Eligible Groups:

- Singles and childless couples who get cash assistance and Medicaid or who get only Medicaid
- Low-income families with children who get cash assistance and Medicaid or who get only Medicaid
- TANF recipient families who get Medicaid
- Pregnant women with income at or below 200% of the federal poverty level for their household size
- Children aged 1 or below whose family income is at or below 185% of the federal poverty level for their household size
- Children aged 1 through 5 whose family income is at or below 133% of the federal poverty level for their household size
- Children aged 6 through 19 whose family income is at or below 100% of the federal poverty level for their household size
- Transitional Medical Assistance beneficiaries
- Supplemental Security Income (SSI) and Supplemental Security Income Related (Medicaid only)

Excluded Groups:

- People who are dually-eligible for Medicaid and Medicare
- People who are only eligible for Medicaid through income spend-down
- People who are eligible for Family Health Plus
- People who are already enrolled in comprehensive private health care coverage that is determined to be “cost-effective” by the local social services district
- People who live in state-operated psychiatric facilities or in state-certified or voluntary treatment facilities for adolescents or children
- People who live in Residential Health Care Facilities at the time of enrollment, and enrollees whose stays in such a facility are classified as permanent at the time of entry
- People enrolled in managed long-term care demonstrations
- Medicaid-eligible infants living with incarcerated mothers
- Infants who weigh less than 1200 grams at birth or infants under 6 months who meet the criteria for SSI or the SSI-related category
- Foster children in the placement of a voluntary agency
- Youths in the care and custody of the commissioner of the NYS Office of Children and Family Services
- Certified blind or disabled children living or expected to be living apart from the parents for 30 days or more

Appendix IV: Eligible and Excluded Groups

People expected to be Medicaid eligible for **less than six months**, except for pregnant women

Foster children in direct care [discretion of local social services district]

People receiving **long-term care services** through Long Term Home Health Care programs or Child Care Facilities (except ICF services for the Developmentally Disabled)

People who are eligible for Medicaid **only for TB-related services**

People in State Office of Mental Health licensed **family care homes**

People in the **Restricted Recipient Program**

People with a “**County of Fiscal Responsibility**” code of 97, 98 or 99

People admitted to a **hospice program** at the time of enrollment

People receiving **family planning services who are not otherwise eligible for Medicaid** and whose income is 200% or less of the federal poverty level

Appendix V

Coordination of Services

The HIV SNP has to coordinate enrollee care with:

- The court system (for court-ordered evaluations and treatment)
- Providers of health care for the homeless
- Providers of services for victims of domestic violence
- Family planning clinics, community health centers, migrant health centers, rural health centers
- WIC, Head Start, Early Intervention
- Programs funded through the Ryan White Care Act
- Prenatal Care Assistance Program (PCAP) providers
- Local government agencies responsible for public health, mental health, mental retardation or substance abuse
- Specialized providers of long-term care for people with disabilities
- Other relevant entities that give services out-of-network.

Through case management, linkage agreements, and contracts, the HIV SNP has to coordinate care with these service providers:

- HIV/AIDS Social Service Providers
- Community-based providers offering HIV case management services, including non-intensive psychosocial case management
- Providers of individual and/or group HIV prevention and risk reduction education, counseling, and services
- Organizations that give treatment education to support and promote adherence to treatment guidelines
- Organizations that give substance abuse treatment readiness assessment, counseling, and referrals
- Organizations providing substance abuse assessments
- Harm reduction and needle exchange providers
- Programs and providers that offer mental health assessments
- Programs that offer counseling and assistance with partner/spouse notification
- Permanency planning and transitional service providers
- Community education providers
- HIV clinical education initiative providers
- Providers of housing and supportive services for the homeless
- Providers of services for victims of domestic violence, including shelters
- Providers of services to migrants
- Providers of nutritional services
- Programs that offer transportation to supportive services
- Providers of legal services

Appendix VI

Access to Mental Health and Substance Abuse Services¹

The following services are available from **HIV SNP** network providers²:

Inpatient hospital-based and outpatient detoxification

Inpatient voluntary and involuntary hospital admissions for mental health services and alternative levels of care from psychiatric hospitals

Outpatient in-home, office or community-based mental health services delivered by New York State Office of Mental Health (NYS OMH) providers or other providers of mental health services

Inpatient treatment and rehabilitation for alcohol and substance abuse

The following services are available **outside** of the HIV SNP provider network. These services are carved out. HIV SNP case managers should help coordinate carved-out mental health and substance abuse services for enrollees. HIV SNP enrollees will need to use their regular Medicaid card to access care.

Outpatient clinic services (under the supervision of a physician) for alcohol or substance abuse, except outpatient detoxification.

Methadone maintenance treatment

Medically supervised substance abuse services

Alcoholism outpatient rehabilitation services

Residential drug abuse and alcoholism treatment programs

Psychiatric rehabilitation, day treatment, and partial hospitalization services

NYS OMH community residences and family treatment programs

Intensive case management for individuals who are seriously and persistently mentally ill (SPMI).

New York State Office of Mental Retardation and Developmental Disabilities (NYS OMRDD) services.

1 For the HIV negative children of HIV SNP enrollees who receive Supplemental Security Income (SSI), all mental health and substance abuse services, except for detoxification services, will be accessed on a fee-for-service basis using the regular Medicaid card.

2 Please be aware that for HIV positive SSI Medicaid beneficiaries enrolled in mainstream health plans, all of the in-network services listed below, except for detoxification services, can be accessed on a fee-for-service basis from out-of-network providers. If an HIV positive SSI Medicaid beneficiary chooses to enroll in an HIV SNP, these same services will only be available from providers participating in the HIV SNP.

Notes

Notes

Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. Our mission is to reduce the spread of HIV disease, help people with HIV maintain and improve their health and independence, and keep the prevention, treatment and cure of HIV an urgent national and local priority. In fulfilling this mission, we will remain true to our heritage by fighting homophobia and affirming the individual dignity of all gay men and lesbians.

For information about our educational materials, please call GMHC Publications: 212/367-1205. For all other information, please call the Hotline or visit our website.

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