HIV Special Needs Plans in the New York State Medicaid Program

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AMIDA CARE
HEALTH. ADVOCACY. CARE.

CONTENTS

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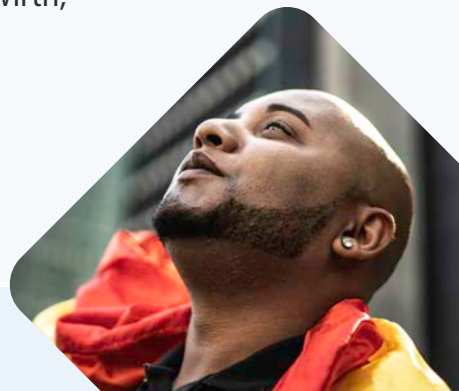
Any errors or omissions are the responsibility of the authors.



INTRODUCTION

"It takes more than just organizing medical services, you have to really engage the participant."

NEW YORK STATE'S HIV-SPECIAL NEEDS PLANS, OR SNPS, WERE DEVELOPED TO PROVIDE A HIGH LEVEL OF SPECIALIZED CARE COORDINATION FOR PEOPLE LIVING WITH HIV IN THE MEDICAID PROGRAM. From early in the epidemic, it had been apparent that people living with HIV would need a high level of support, both in obtaining medical services and in coordinating across medical and social service providers. Intensive inpatient care and related services were both expensive and complex, as was antiretroviral therapy once it became available. HIV-SNPs were designed to meet these challenges by focusing on intense coordination of the health care and social services that people living with HIV need to live healthy lives. Today, by increasing engagement with effective outpatient services, HIV-SNPs continue to improve health and reduce the use of costlier, facility-based care.

Today, 42% of Medicaid-eligible people living with HIV in New York City have enrolled in HIV-SNPs.[1] Together, three plans are serving a total of over 15,000 New Yorkers, most living with HIV and some who are HIV-negative but from populations placed at higher risk of infection.[2] The plans serve a unique role in the New York Medicaid program, as well as in the state's Ending the Epidemic Initiative.

This white paper details the history and current role of New York's HIV-SNPs, based on a review of peer-reviewed and general literature, as well as interviews with experts involved with SNPs at their inception, and those currently working in or with HIV-SNPs today (see Appendix 1). All italicized quotes in this white paper are from project interviews.

After detailing the development of SNPs and their evolution over time, the paper reviews the current HIV-SNP landscape, the services they offer, and available data on their impact. The paper concludes with a discussion of SNPs' role in ending the HIV epidemic in New York State, and of future challenges and opportunities for HIV-SNPs.

The History of New York's HIV-SNPs

HIV IN NEW YORK CITY

NEW YORK CITY WAS ONE OF THE EPICENTERS OF THE EARLY AIDS EPIDEMIC: by 1992, more than 17% of all adult AIDS cases in the U.S. and nearly a quarter of all pediatric AIDS cases in the US had been reported by health departments in the New York City metropolitan area.[3] The high prevalence of cases and resulting loss of life led to the creation of HIV clinics, community-based organizations, and activism in New York City.[4,5] However, many clinicians remained unfamiliar with the needs of people living with HIV (PLWH). Moreover, many PLWH faced high medical costs and inadequate insurance coverage, further limiting their ability to receive necessary care.[6] The high cost of HIV treatment and patients' inability to pay for care also caused financial challenges for health care providers, and many urban hospitals experienced or narrowly avoided bankruptcy due to uncompensated HIV care.[7]

To promote continuity of care and incentivize providers to treat HIV patients with high-cost health needs, the New York State Health Department AIDS Institute created a system of Designated Statewide AIDS Centers, hospital-based programs that are certified by the state to provide a continuum of care and services for people living with HIV. The Institute also played a major role in the development of enhanced Medicaid reimbursement for these Designated AIDS Centers, as well as a broad network of community health centers, including federally-qualified health centers, that offer HIV primary care for HIV-SNP members and other PLWH.

In addition to AIDS Centers, the AIDS Institute oversaw a number of innovative programs aimed at improving the health of PLWH, including prevention services, case management programs, counseling, quality improvement initiatives, home care and adult day programs, legal services, and more.[8]

After the introduction of highly active antiretroviral treatment (HAART) in the late 1990s, HIV began to transition into a chronic condition.[9] However, care remained costly and expensive, and PLWH continued to need responsive, integrated services.

INTRODUCTION OF MANAGED CARE IN NY MEDICAID

You can't force people into managed care and disrupt their treatment…One of my long term patients showed up in clinic one day and the front desk said, we can't see you, you're signed up with another plan. She had no idea she had signed up; she said somebody on the corner was giving out T shirts and she signed a piece of paper.

MULTIPLE INTERVIEWEES STATED THAT AS THE STATE PREPARED FOR MANAGED CARE OVER THE PRECEDING DECADE, THERE WERE CONCERNS THAT NON-SPECIALIZED MANAGED CARE PLANS WOULD NOT MEET THE NEEDS OF PLWH. Mainstream plans would not necessarily prioritize access to HIV expertise; include HIV-experienced providers in their networks; or include coverage and network access to providers who could address the histories of trauma, addiction, and poverty that many PLWH

New York HIV-SNPs Timeline

1996 — New York's Section 1115 Waiver is approved, enabling the state's Medicaid program to contract with Managed Care Organizations and establishing the HIV SNP program.

2003 — New York's first Medicaid Managed Care plans, including HIV SNPs, begin operation.

2011 — New York requires Medicaid beneficiaries with HIV to enroll in a managed care plan.

2013 — New York imposes a global cap on Medicaid spending.

2014 — New York allows HIV SNPs to enroll people experiencing homelessness, regardless of HIV status.

2017 — New York allows HIV SNPs to expand eligibility to people of transgender experience, regardless of HIV status.

experience. In addition, mainstream plans might be focused on saving money in the short term through limiting access to services even if those services might preserve health and lower costs for PLWH in the long term.

DEVELOPMENT OF HIV-SNPS

> *There isn't anybody systematically engaging with them and the 90 plus percent of their life when they're not using the health care system, and we want to have a system that does that.*

ANTICIPATING THAT THESE CHALLENGES WOULD ARISE FOR PLWH IN MAINSTREAM MCOS, THE AIDS INSTITUTE AND OTHER STAKEHOLDERS HAD BEGUN IN THE LATE 90s TO DEVELOP THE CONCEPT OF HIV-SNPS. They were designed as comprehensive plans tailored to PLWH that address not only HIV but also and the social, behavioral, and psychosocial factors that often accompany HIV. The HIV-SNP program built on the existing network of the AIDS centers, HIV primary care providers (PCPs), HIV Specialists, and HIV case managers to harness existing expertise in the HIV field, and facilitate the integration of community-based providers and networks and facilitate the integration of community-based providers and networks, incorporating fiscal responsibility for coordination.[10]

> *You're not alone…you know you don't have to suffer through … the uncertainty of everything. [SNPs were designed to] put in that care coordination so people didn't get lost in the fragmented world of healthcare and behavioral health services.*

New York State's Medicaid program officially introduced managed care plans, including HIV Special Needs Plans (SNPs), in 2003.[11] For PLWH who enroll in "mainstream" managed care plans, many of the concerns about how these plans would fall short were borne out:

1. PLWH often felt they knew more about HIV than their PCPs;
2. It was extremely difficult to get specialty care appointments;
3. Mental health and detox services were difficult to access; and
4. Many of the HIV providers used by PWHAs weren't in the various program's provider networks.[12]

SNPs IN THE MEDICARE PROGRAM

SNPs have grown to national prominence through the Medicare program, which adopted the model as a way to provide targeted services for people with special needs through a managed care plan. The Medicare Modernization Act of 2003 introduced the concept of SNPs at a national level and created three categories of plans which target individuals in different circumstances: D-Dual Eligible SNPs (D-SNPs) for those dually eligible in Medicaid and Medicare, Chronic Condition SNPs (C-SNPs) for enrollees with a severe or chronic disabling condition (including HIV), and Institutional SNPs (I-SNPs) for those in institutional settings.[14] Similar to other Medicare managed care plans, Medicare pays each SNP a per member, per month rate based on the plan's enrollment and adjustments for enrollees' health status.[15] Some research on Medicare SNP performance has found SNP enrollment to be associated with positive health outcomes and cost savings for diabetes patients,[16] end-stage renal disease patients,[17,18] and institutionalized patients.[19] However, one study found that D-SNP enrollees did not report better care coordination or plan performance than dual eligible people who enrolled in traditional Medicare[20]; another found that SNPs performed better than non-SNP Medicare Advantage plans on some measures but worse on others.[21]

During the early years of HIV-SNPs, word began to spread through the HIV community that they could better meet the needs of PLWH, and enrollment gradually increased. However, while enrollment in managed care remained voluntary, most PLWH remained in fee-for-service. By 2011, Medicaid enrollees statewide with HIV were required to enroll in a managed care plan, but they could choose between an HIV-SNP and a mainstream managed care organization.[13] According to multiple interviewees, this was when HIV-SNP enrollment dramatically increased.

HIV-SNPs: The Current Landscape

THE HIV-SNP MARKET IN NEW YORK

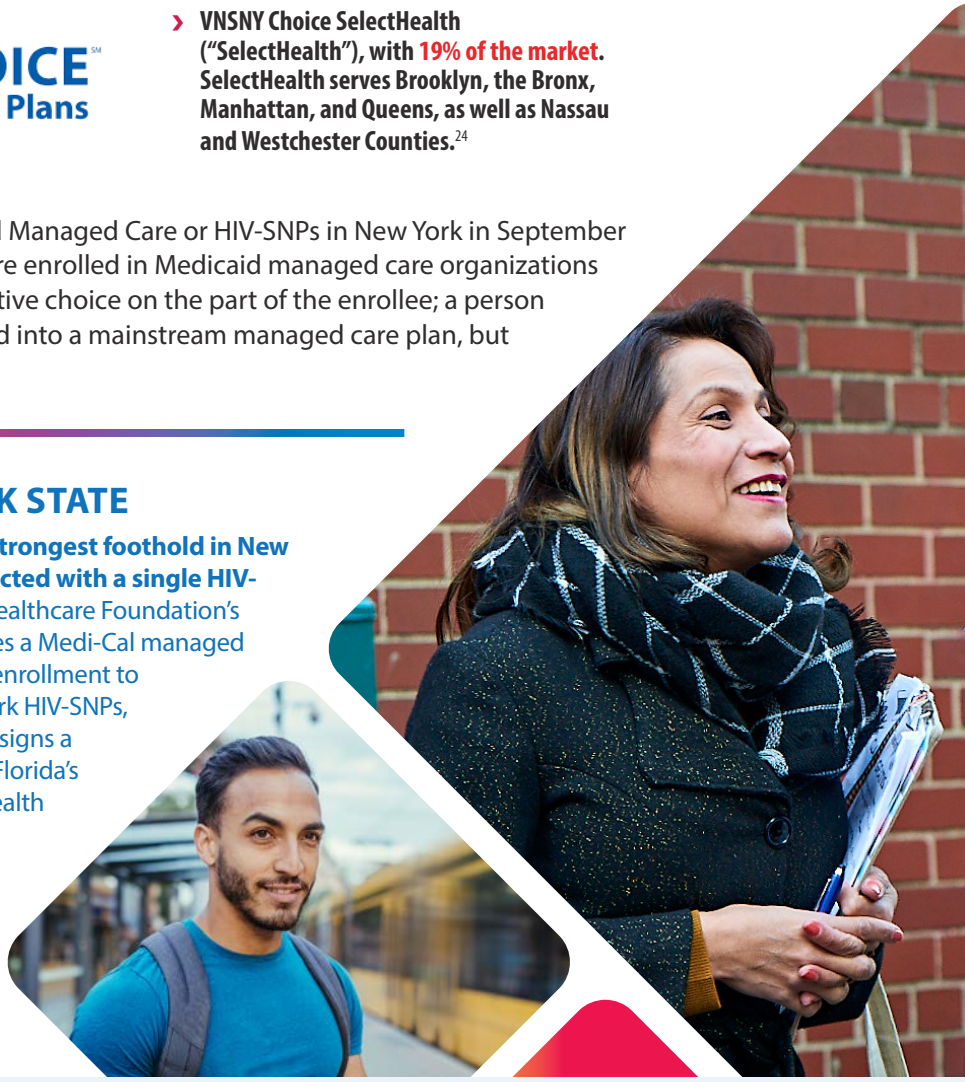
THREE HIV-SNPS ARE OPERATING IN NEW YORK STATE AS OF SEPTEMBER, 2021:

- **Amida Care, with 54% of the HIV-SNP market. Amida Care serves the five boroughs of New York City.**[22]
- **Metro Plus, with 27% of the market. Metro Plus serves Manhattan, Brooklyn, Queens, and the Bronx.**[23]
- **VNSNY Choice SelectHealth ("SelectHealth"), with 19% of the market. SelectHealth serves Brooklyn, the Bronx, Manhattan, and Queens, as well as Nassau and Westchester Counties.**[24]

Of the 36,400 people eligible for either Medicaid Managed Care or HIV-SNPs in New York in September of 2021, 42% are enrolled in HIV-SNPs; the rest are enrolled in Medicaid managed care organizations (MCOs).[25] Enrollment into a SNP requires affirmative choice on the part of the enrollee; a person newly enrolling in Medicaid will be auto-enrolled into a mainstream managed care plan, but can, if eligible, choose to switch to a SNP.[26]

HIV-SNPS OUTSIDE OF NEW YORK STATE

Although the Medicaid HIV-SNP model has the strongest foothold in New York City, several other jurisdictions have contracted with a single HIV-SNP plan or explored similar models. The AIDS Healthcare Foundation's Managed Care division, Positive Healthcare, operates a Medi-Cal managed care plan in Los Angeles, California. The plan limits enrollment to people with a prior AIDS diagnosis and, like New York HIV-SNPs, offers a network of PCPs that are HIV experts and assigns a registered nurse care manager to every member.[27] Florida's Medicaid program has contracted with the Clear Health Alliance plan, created in 2012,[28] which is a Medicaid SNP for PLWH. The plan offers case management, a network of clinicians that specialize in HIV care, vision care, non-emergency medical transportation, and rewards for meeting healthy behavior targets.[29]



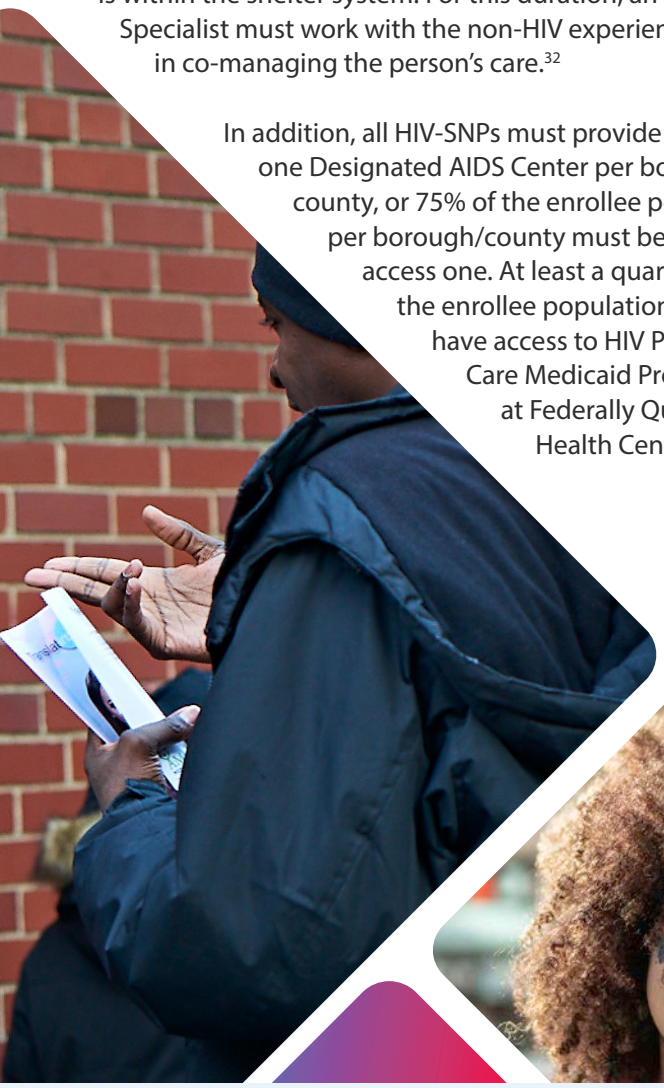
PROVIDER ACCESS REQUIREMENTS

THE CONTRACTS BETWEEN HIV-SNPS AND THE STATE ESTABLISH CERTAIN PROVIDER ACCESS REQUIREMENTS FOR THE PLANS.

First, in HIV-SNPs each enrollee's PCP must either be an HIV specialist (defined as meeting the criteria of at least of one of three HIV-focused professional bodies) or have specialty training in HIV care. HIV-SNPs must offer each enrollee a choice of at least three primary care providers (PCPs) within distance and travel standards, and will assign a PCP to enrollees who fail to select one. Enrollees are allowed to change PCPs within thirty days of their first appointment.[31]

Enrollees who are homeless and living with HIV may designate a shelter physician who may not have HIV experience or expertise as their PCP while the enrollee is within the shelter system. For this duration, an HIV Specialist must work with the non-HIV experienced PCP in co-managing the person's care.[32]

In addition, all HIV-SNPs must provide at least one Designated AIDS Center per borough/county, or 75% of the enrollee population per borough/county must be able to access one. At least a quarter of the enrollee population must have access to HIV Primary Care Medicaid Programs at Federally Qualified Health Centers.[33]



CARE COORDINATION

For far less than half of these people is HIV the biggest challenge they have in their life.

NEW YORK MEDICAID HIV-SNPS MUST DEVELOP AND IMPLEMENT AN INTERDISCIPLINARY CARE PLAN FOR EACH ENROLLEE.[34] According to our interviewees, care coordination in HIV-SNPs operates on the premise that if people are receiving treatment for behavioral health and substance use disorders, as well as addressing the social determinants of health through improving housing, employment opportunities, and transportation, they are significantly more likely to be able to adhere to treatment for HIV, which is supported by studies illustrating the effectiveness of intense case management.[35]

Do more for me than tell me to go to the doctor's office and take my pill.

Care coordination includes integrated care teams, in-house pharmacy teams, adherence support, wraparound services, and continual engagement in outpatient and preventative care. For people who need intensive services such as those with multiple chronic conditions, substance use or mental health challenges, SNPs employ health navigators and outreach workers.

This level of coordination is crucial because HIV-SNP enrollees have multiple and complex chronic conditions. For example, 55% of Amida Care members have psychiatric conditions, 42% have asthma or chronic obstructive pulmonary disease (COPD), 35% have depression, 25% have hypertension, and 24% have chronic opioid dependence.[36] Overall, the mainstream Medicaid risk score, per Optum, is 1.42, whereas the Amida Care average risk score is 7.28, and 33% of members have a risk score above 12.7.[37,38]

All the housing, nutrition, [and other] needs are profound, and you're gonna be hard pressed to find a physician who can you know capably take all that on herself or himself. I think it takes a village, and a SNP model really helps provide that village.

Care coordinators have regular contact with patients. For example, Amida Care works to provide tailored care and encourages treatment engagement through rewards programs to incentivize engagement in care, as well as a consumer advisory committee, phone calls after missed appointments, and active engagement with pharmacies to ensure that prescriptions are filled.[39,40] Increased care coordination and engagement also has a secondary effect of ensuring that people continue to use the HIV-SNPs' services and are not automatically disenrolled from Medicaid.

> *Amida Care actually contracts with several of its providers, so monthly they will receive a list .. of people who … over some period haven't had labs so that would indicate that they fallen out of care. [Providers] get that list and are paid by Amida Care to follow up with those people: find them, find out if they're in care. If they are in care, why haven't they been having labs taken; if they're not in care, working to engage them, whether in our care or care of another immediate care provider.*

SNPs can also have peer programs to provide extensive, personalized outreach to members:

> *Our peers sometimes make 50 attempts to find somebody. They don't succeed with everybody, but in many ways they become what I think has often been the key ingredient in consistent, successful care for the marginalized HIV population, which is a surrogate family. Somebody that they will trust, that they'll rely on when they have basically nothing else.*

When members with high risk scores are inconsistently or not engaged in care with providers, Amida Care will remain in contact with those providers to apprise them of treatment activity of the member. Should the member return to that provider, then the provider is ready to re-engage the member in care.

One interviewee noted that while many mainstream Medicaid MCOs offer care coordination for their members, HIV-SNPs' understanding and focus on the needs of PLWH is unique:

> *You could see the drop off that occurred in mainstream managed care [case management] because the focus and attention wasn't there, because the HIV population was so diluted amongst the entire membership to have that attention is not that common. Managed care plans go for [HIV case management], but it just doesn't occur as robustly. Because you don't have the vision from the HIV medical directors that are required to sort of set the pathway... knowing the all the issues of attrition, how you can work with providers, and how people fall through the cracks.*

EXPANDED ELIGIBILITY FOR HIV NEGATIVE POPULATIONS

EXPANDING ACCESS TO COVERAGE FOR THOSE AT RISK OF DEVELOPING HIV IS A CRUCIAL PART OF ENDING THE HIV EPIDEMIC, AND THE TRANSGENDER AND HOMELESS POPULATIONS ARE BOTH AT HIGH RISK OF DEVELOPING HIV AND CAN BENEFIT FROM CARE COORDINATION SERVICES.[41,42] Transgender people experience a high burden of HIV infection, with transgender women in particular experiencing very high rates.[43,44,45] Recognizing the importance of providing health care and supportive services to people at risk of HIV infection, New York State recently allowed HIV-SNPs to expand their membership to include HIV-negative individuals who are HIV negative and experiencing homelessness and/or are transgender. All three HIV-SNPs now enroll and provide tailored services for both populations.[46,47,48,49,50,51]

People experiencing homelessness are also at increased risk for HIV infection. In 2010, the rate of new HIV infections was found to be almost twice as high for people who experienced homelessness than for people with stable housing.[52,53] Individuals who are homeless are more likely to engage in high-risk behaviors associated with HIV infection and transmission, such as injection drug use, sharing or reusing needles, sex work, having multiple sexual partners, and engaging in unprotected sex.[54] In a study of young adults experiencing homelessness, over 50% of participants reported having unprotected sex within the past 30 days, and roughly 35% of homeless young adults reported they do not discuss HIV or sexually transmitted infections at all with their sexual partners.[55]

As discussed further below ("Housing Assistance"), SNPs have programs to address housing needs for both HIV-positive and HIV-negative enrollees.

VOCATIONAL TRAINING

EMPLOYMENT AND STABLE HOUSING ARE IMPORTANT FACTORS IN DETERMINING HIV SUPPRESSION, OUTCOMES, AND TRANSMISSION.[56,57]

To improve employment outcomes among beneficiaries, and fulfill their mission of advocacy, all three HIV-SNPs in New York have programs addressing employment.[58] Amida Care has created an employment program, the HIV Innovator Employment Project, for people living with HIV. This program includes six Federally Qualified Health Centers and one community-based organization, employing 35 enrollees.[59] Additionally, Amida Care has employed over 500 individuals since 2003 with jobs through workforce programs such as the Workforce Innovator Network (WIN), which trains members in marketable skills.[60] WIN coordinates with Housing Works and the Alliance for Positive Change to create meaningful employment opportunities for members. SelectHealth provides Behavioral Health Home and Community Based Services, which includes pre-vocational training, transitional employment services and training, and ongoing employment services.[61] MetroPlus also provides education support services, pre-vocational, and ongoing support for employment services.[62]

> *If people don't see vocational opportunity for themselves, they are far less likely to prioritize their healthcare…And we know from research that that things like being vocationally involved improve treatment adherence just generally. Part of it just has to do with having daily routines that you build your life around, including your health care.*

HOUSING ASSISTANCE

BOTH AMIDA CARE AND METROPLUS HAVE PROGRAMS ADDRESSING ACCESS TO HOUSING FOR MEMBERS BOTH WITH AND WITHOUT HIV. Amida Care's Homeless Outreach Management and Empowerment (HOME) program connects homeless members to housing providers, and monitors stability; 10% of Amida Care's members are in this program.[63] This program acknowledges that PLWH will struggle to manage their care and viral load if they do not have a stable home; members' quality of life improves with having stable housing, and their medical costs decrease. Since the HOME program began in 2016, 50 members have been stably housed, and 861 members are currently in the home program.[64] MetroPlus offers housing and support services for homeless members with HIV, and provides qualifying members with a Health Home Care Manager to assist with housing and food.[65,66]

NETWORK BREADTH

IN ADDITION TO HIV SPECIALIST PCPS, HIV-SNPs CAN OFFER STREAMLINED ACCESS TO NON-HIV SPECIALISTS, in part due to their ability to offer providers Medicare payment rates (which are typically higher than Medicaid rates):

> *We can refer people to specialists in the private offices. I had a guy who literally lived in a cardboard box, who joined the SNP and came in one day with some horrendous rash. The wait time in the dermatology clinic was three months. I got him an appointment through [the SNP] the next day.*

SNPs also work to ensure that their networks include providers who are geographically and culturally accessible to a range of patients.

> *Special network developers are constantly reaching out - a new pharmacy, a new physician or new psychiatrist, a new whatever on the medical side …reaching a particular community, like in the Asian community in central Queens.*

INCLUDING PLWH IN LEADERSHIP

> *Don't make me call some 1-800 number where I'm an anonymous person.*

To some extent, all three HIV-SNPs in New York include or solicit feedback from members living with HIV in leadership or development of plan policies to more accurately and efficiently meet the needs of the beneficiaries.[67,68,69] For example, Select Health invites enrollees to participate in advisory committees, including the Member Advisory Committee and the Behavioral Health Committee.70 MetroPlus Health includes a consumer member on the Board of Directors,[71] and Amida Care includes two plan members on the board of directors, as well as on board committees such as the Audit Committee and Quality Management Committee.[72] Amida Care has also developed a Member Advisory Council, which holds Town Hall meetings throughout New York to solicit feedback and questions from plan members.[73]

HIV-SNPs' Impact on the Medicaid Program

HIV-SNPS' WORK HAS YIELDED A NUMBER OF KEY LESSONS FOR THE MEDICAID PROGRAM, BOTH IN THE STATE AND MORE BROADLY.

THOUGHTFUL BENEFIT DESIGN FOR PLWH CAN REDUCE HOSPITALIZATIONS, ER VISITS, AND COSTS

MOST MANAGED CARE PLANS, IN ANY MARKET, CONTROL COSTS BY DENYING OR LIMITING ACCESS TO EXPENSIVE TREATMENTS AND DRUGS. HIV-SNPs have shown that engaging with the prescribing provider to understand the rationale behind the prescriptions and, when needed, approving more expensive modalities of treatment, can result in a healthier patient who requires less intensive and expensive hospital care. HIV-SNPs have somewhat higher pharmacy costs per enrollee with HIV than mainstream plans, but their approach has led to savings in inpatient and other medical costs. Pairing effective formulary design with focused treatment adherence services and incentives has led to improved health and high levels of viral suppression even among marginalized populations.

A 2009 Lewin Group study of per capita inpatient costs for HIV-SNP enrollees found a 26%-38% reduction in inpatient costs compared to pre-enrollment.[74] Inpatient costs were 32-45% lower in HIV-SNPs compared to Medicaid FFS, pharmacy expenses were slightly higher, and all other medical costs are 0-10% lower in HIV-SNPs. This same study's best estimate of the HIV-SNP program impact on Medicaid was a savings of $4.2 million, or 3.3% of expenses in 2008.[75]

Between 2008 and 2016, Amida Care estimated that their services led to a 74% reduction in hospitalizations, 34% reduction in hospital length of stay, and a 63% decline in emergency room visits, all totaling $150 million in savings to New York State Medicaid.[76,77] The organization believes that these savings occurred largely due to tailored and coordinated care that keeps people with significant care needs healthier than they would be in a mainstream managed care organization.

Ultimately, HIV-SNPs' approach illustrates that managed care can be used to improve the quality of care for PLWH. As one interviewee noted regarding the impetus behind the development of HIV-SNPs, "Fee for service just pays for whatever happens to happen, and that's not good enough." When managed care is paired with adequate rates, strong quality standards such as those developed by the AIDS Institute, intensive care coordination, and significant protections for enrollees, plans can actively assemble a strong system of support for each member.

A significant role in improving treatment outcomes is by decreasing what one interviewee described as the impact of "churn," the phenomenon of enrollees losing Medicaid eligibility or switching plans during a relatively short time period. When an insurance plan assumes that enrollees will not be with the plan for a long time, it may prioritize short-term savings. For example, if an enrollee drops out of HIV care, a plan will save money in the short term, even though the person's health may decline and long-term costs may rise. At Amida Care, where care coordination teams work to reduce the number of enrollees leaving the plan, the annual turnover rate is 11%, compared to a national average of 25%.[78,79]

INTENSIVE SUPPORT AND INCENTIVE APPROACHES CAN IMPROVE TREATMENT ADHERENCE

PHARMACY COSTS ARE, FOR THE TIME BEING, INCLUDED ("CARVED INTO") IN THE HIV-SNPS AND ALL MCOS' BENEFIT PACKAGE. Interviewees asserted that this has important implications for treatment adherence. A 2008 study found that the proportion of people filling at least one prescription per month was higher after enrollment into an HIV-SNP compared to enrollment in a Medicaid FFS plan, and long-term analysis found a slight increase in pharmacy costs, indicating higher treatment adherence.[80]

SNPs' pharmacy benefit teams work closely with health care to coordinate members' care for chronic conditions, access to medication, and treatment adherence. Pharmacy care management uses real-time data to monitor whether a patient is consistently filling essential prescriptions. If a barrier to care arises at the pharmacy, the pharmacy benefit team intervenes to ensure that members can access treatment when they need it. By working closely with patients and providers, SNPs use pharmacy data to spot trends, avoid potentially life-threatening drug-on-drug interactions and ensure uninterrupted access to care.[81]

HIV-SNPs can use targeted, evidence-based approaches to supporting treatment adherence. Amida Care's Live Your Life Undetectable program, introduced in 2018, was modeled off of an earlier program developed by Housing Works. Housing Works' Undetectables program, initiated in 2014, leveraged a client-centered model of care, as well as cash incentives of $100 quarterly for achieving undetectable viral loads of less than 50 copies/ml. This program reported a 15% increase of undetectable rates of HIV, from 67% to 82%. Additionally, there was a 23% increase in the proportion of clients virally suppressed at all times assessed, from 39% to 62%.[82]

Amida Care's program similarly encourages members with HIV to achieve and maintain viral suppression through offering cash incentives of $100 quarterly for achieving viral suppression of less than 200 copies/ml and engaging in support services.[83] As of June 2020, 2,783 clients were enrolled in this program.[84]

The cash incentives don't work by themselves; they work because they help harness people to focus on other sets of interventions.

PHARMACY BENEFIT CARVEOUT

In 2020, New York enacted legislation to carve the pharmacy benefit out of the managed care program, transitioning the benefit back to fee for service. While this transition has been delayed by two years (to April 2023),[85] according to multiple interviewees, the impact on HIV-SNPs would be significant and negative, as HIV-SNPs depend heavily on the pharmacy carve-in to be financially stable. Interviewees assert that the pharmacy carve-in allows HIV-SNPs to negotiate lower payments to pharmacies, allowing for more revenue to divert to care coordination. In addition, interviewees noted that the potential carveout of pharmacy from the state's managed care program could threaten this coordinating role, particularly for PLWH enrolled in HIV-SNPs.

SERVING THE TRANSGENDER COMMUNITY REQUIRES MORE THAN HIV CARE

SERVING THE TRANSGENDER COMMUNITY MEANS UNDERSTANDING THEIR LIVED EXPERIENCE AND ADDRESSING THE HEALTH NEEDS THEY PRIORITIZE. Since passage of the ACA, insurance policies have broadly become more inclusive of gender-affirming care, including prescription hormone therapy, mental health counseling, voice therapy and procedures like mastectomies, breast augmentation and genitalia surgeries.[86] However, transgender people experience major barriers in the healthcare system, including discrimination, untrained providers, and payment issues, that hinder access to all types of healthcare.[87]

HIV-SNP eligibility was expanded to include transgender people who are HIV-negative, primarily because this population experiences such a high risk of HIV. However, instead of treating transgender people only as potential "vectors," the plans have strived to meet health and social needs holistically, with a strong emphasis on gender-affirming services. Their benefit design and care coordination approach should serve as a model for how all Medicaid MCOs reach and serve their transgender enrollees.

Amida Care's expansion to include HIV negative transgender members emphasized providing access to PrEP for HIV prevention, and 25% of transgender HIV negative members in Amida Care are on PrEP to prevent HIV.[88] However, Amida Care's broader goal is to address transgender member's health more broadly, by focusing on all of their health and social needs.[78]

> *For transgender women, whether it's pitching PrEP for those who are HIV negative or viral suppression for those who are positive, there's this sense that all you care about is my HIV and pushing AIDS drugs. This isn't really that you care about me, it's that you care about me not being a vector. I think that's a very common perception in in the transgender community. The only way to really overcome that perception is to show something different, that we actually do care about you as a person, and one of the things that we know is that for many transgender people, whether it's just getting regular access to hormones or actually going through with gender affirming surgery, that those issues are paramount. If we're not able to help people address those issues, helping them focus on their other health care issues is always going to fall to the side.*

While in general, Medicaid plans may have inconsistent or unclear policies about which procedures are medically necessary vs. cosmetic, HIV-SNPs' expertise in transgender health leads to clear, gender-affirming policies. Of Amida Care's transgender members, 20% received gender affirming surgery within their first year of enrollment, and 65% received surgery by year 3 in the plan.[89] In total, the plan has helped over 1,100 members access gender-affirming surgery, with the average member accessing multiple surgeries.

One interviewee explained that the longer transgender members are engaged in care, the longer they have time to stabilize underlying conditions and become eligible and able to receive gender affirming surgery. The viral suppression rates for HIV-positive transgender enrollees in Amida Care is 94%, compared to the national viral suppression rate of 65% for transgender women and 72% for transgender males.[90,91]

HCV COINFECTION CAN BE EFFECTIVELY, AND COST-EFFECTIVELY, ADDRESSED

Amida Care reports that an integrated care team managing patients co-infected with HIV and Hepatitis C improved hepatitis C virus (HCV) repression rates and saved $6.12 million.[92] To achieve this cost savings and improved repression, Amida Care developed its own prior authorization process for Hepatitis C drugs, given the high cost of these drugs and the high rate of co-infection with Hepatitis C and HIV.[93] Among other Medicaid plans and the state's FFS program, treatment was withheld until patients developed advanced liver disease. Amida Care advocated for the opposite approach, treating PLWH who were also HCV positive regardless of liver disease status. According to an interviewee, because Amida Care had conducted HCV testing for all PLWH, as is clinically indicated, they were able to treat Hepatitis C aggressively and early and remained committed to treatment for people who were reinfected or who required treatment adherence assistance.[94]

HIV-SNPs' Role in Ending the HIV Epidemic

HIV-SNPS ARE PLAYING A KEY ROLE IN THE STATE'S PLAN TO END THE HIV EPIDEMIC. While most states are unlikely to develop their own SNP models, lessons drawn from HIV-SNPs' work can help inform efforts to end the epidemic across the entire country.

HIV-SNPS AND NEW YORK STATE'S ENDING THE EPIDEMIC PLAN

The HIV-SNPs are really great partners with the health department in terms of advancing the state's priorities in battling the AIDS epidemic.

NEW YORK'S ENDING THE EPIDEMIC (ETE) INITIATIVE WAS LAUNCHED IN 2014 TO SUBSTANTIALLY REDUCE THE NUMBER OF HIV INFECTIONS BY THE END OF 2020 AND ACHIEVE THE FIRST-EVER DECREASE IN HIV PREVALENCE IN THE STATE. This three-point plan includes efforts to (1) identify persons with HIV who remain undiagnosed and link them to health care; (2) link and retain persons with diagnosed HIV infection in health care to maximize the likelihood of virus suppression so they remain healthy and prevent further transmission of the virus; and (3) facilitate access to pre-exposure prophylaxis (PrEP) for high-risk HIV-negative persons to prevent future viral infection and transmission.[95] The state set goals to reduce the rate at which persons diagnosed with HIV progress to AIDS by 50% and reduce the number of new HIV infections from 3,000 to 750 per year by the end of 2020. The department of health estimated that this would result in medical cost savings of $804.4 million from averting 2,250 HIV infections.[96]

Although progress has been disrupted by the COVID-19 pandemic, the Governor announced at the end of 2020 that New York has made significant advances in ETE. In 2019, the number of new HIV infections fell to 1,700, an all-time low for the state.[97] Since the start of ETE, the incidence of HIV has declined each year, with a 38% decrease over that time period.[98] Also, 83% of individuals with new diagnoses were connected to care within 30 days of being diagnosed, and 89% of PLWH in care were virally suppressed.[99,100]

From the start, New York's Ending the Epidemic Blueprint recognized that sufficient access to health care through SNPs is essential to ending the HIV epidemic, as the Blueprint's main goals of linking people to care, improving viral suppression, and prevention efforts are all supported by HIV SNPs.[101] The Ending the Epidemic Blueprint included recommendations to add NYS SNPs to the state's Marketplace in the first quarter of 2015; today, all three HIV SNPs are listed on the state Marketplace website and consumers can search by HIV SNP as a plan type.[102] This helps ensure that all HIV-positive Medicaid recipients and those requesting transfers from mainstream Medicaid plans are aware of and can enroll in HIV-SNPs. An Ending the Epidemic committee also recommended expanding SNPs to include preventative services.[103] The expansion of HIV SNP eligibility to include transgender and homeless HIV negative populations accomplished this by improving HIV prevention services through increasing access to PrEP and nPEP.[104]

The state's Ending the Epidemic plan also recommended that SNPs expand their scope to include comprehensive HIV preventive services, including PrEP and nPEP.[105] Ending the HIV epidemic in New York will require increasing the number of Medicaid beneficiaries taking PrEP from 6,000 to 30,000.[106] This will require a range of innovations, including decreasing prescription refills by longer supplies of PrEP, and removing prior authorization requirements for PrEP. Amida Care recommends that, to end the HIV epidemic, health plans should build in automatic levers to test for HIV and facilitate conversations with patients about PrEP.[107]

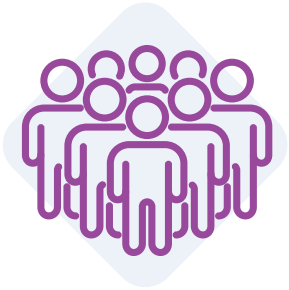
If the government wants to end the epidemic, I can't imagine not using, and maximizing the use of, special needs plans in the city of New York.

FURTHER LESSONS FROM HIV-SNPS FOR ENDING THE EPIDEMIC

WHILE THE HIV-SNPS HAVE PROVIDED VALUABLE CONTRIBUTIONS TOWARD ETE IN NEW YORK CITY, THEIR WORK HAS ALSO YIELDED KEY LESSONS FOR THE RESPONSE ACROSS THE STATE AND THE COUNTRY.

It is feasible to effectively serve and retain PLWH who are often considered the most "hard to reach" within the broader healthcare system:

Interviewees noted that SNPs serve people who are often alienated from mainstream care, such as people experiencing substance use disorder or homelessness. By recognizing that patients have needs beyond the medical setting that can be met through a range of behavioral and social services, SNPs have illustrated that other plans and providers should not simply "give up" on engaging and serving the subset of people living with HIV.



Ending the Epidemic requires meeting the needs of aging PLWH:

The population of PLWH is growing older. Nationally, from 2013 to 2017, the number of PLWH over age 65 almost doubled.[108] People aging with HIV are likely to have at least two other chronic conditions in addition to HIV; by 2030, 33% of PLWH aged 50 to 60, 50% of PLWH aged 60 to 70, and two thirds of PLWH over age 70 will have multiple comorbidities.[109] PLWH over age 50 experience significant rates of multi-morbidity, polypharmacy, and significant healthcare costs.[110,111] This increase in older people with HIV, particularly with comorbidities, will lead to what some have termed a "silver tsunami" in multimorbidity and polypharmacy for PLWH.[112]

People living with HIV for years tend to experience a range of medical comorbidities with risk driven by both age and HIV, including some cancers, lung disease, bone loss, and cardiovascular disease.[113] In addition, people who are diagnosed with HIV at older ages are more likely to be diagnosed at a later stage of disease.[114]

New York's "mature" epidemic means that HIV-SNPs in the state are already experienced serving an aging patient population with multiple complex conditions in addition to HIV. Of over 107,000 New Yorkers living with diagnosed HIV/AIDS,[115] 59% are 50 or older,[116] compared to 51% nationwide.[117]

Amida Care is already reporting increased costs for non-HIV related care, particularly among members over age 50; most inpatient admissions in Amida Care are no longer due primarily to HIV.[118] HIV-SNPs' model of care coordination for HIV polypharmacy and comorbidities can help guide other payers and providers as they face similar trends around the country.

Conclusion

SEVERAL FACTORS CONVERGED IN NEW YORK STATE TO MAKE HIV-SNPS POSSIBLE: a concentrated epidemic with many affected lives in New York City; a Medicaid program with robust eligibility parameters; and, in the AIDS Institute, a government agency committed to aligning the evolving payment landscape with the needs of people living with HIV. The epidemic, and the Medicaid system, have evolved extensively over time. But the HIV-SNPs continue to play an important and distinct role in their lives of their enrollees and in the state's efforts to end the epidemic.

SNPs have illustrated that people with complex health and social needs can be served with high-quality medical services, through careful benefit design and access to needed services that improve health and result in savings in costly complications. The have also demonstrated that addressing housing insecurity, poverty and other social determinants of health can aid in improving care and wellbeing, both for PLWH and people and communities placed at high risk. SNPs' years of experience in serving people living with HIV, as well as communities who are placed at higher risk for infection, has yielded crucial lessons for the Medicaid program and for ending the HIV epidemic in New York and nationally.

APPENDIX 1: PROJECT INTERVIEWEES

Jay Dobkin, MD, Chief Medical Director, VNSNY CHOICE/SelectHealth

Ira Feldman, Former Deputy Director, NYS AIDS Institute at New York State Department of Health

Joe Kerwin, Deputy Director, Medicaid Policy and Health Care Financing, NYS AIDS Institute at New York State Department of Health

Charles King, Chief Executive Officer, Housing Works, Inc.; Amida Care Board Member

Joel Menges, Chief Executive Officer, The Menges Group

Sanjiv Shah, MD, Chief Medical Officer, MetroPlus

Arthur Webb, President, Arthur Webb Group; Amida Care Board of Directors

APPENDIX 2: REFERENCES

1. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
2. Recipients Enrolled in Mainstream Medicaid Managed Care by County, Plan, Aid Category, and NYSoH. June 2021. https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2021/docs/en06_21.pdf
3. National Research Council (US) Panel on Monitoring the Social Impact of the AIDS Epidemic; Jonsen AR, Stryker J, editors. The Social Impact Of AIDS In The United States. Washington (DC): National Academies Press (US); 1993. 9, The HIV/AIDS Epidemic in New York City. Available from: https://www.ncbi.nlm.nih.gov/books/NBK234564/
4. National Research Council (US) Panel on Monitoring the Social Impact of the AIDS Epidemic; Jonsen AR, Stryker J, editors. The Social Impact Of AIDS In The United States. Washington (DC): National Academies Press (US); 1993. 9, The HIV/AIDS Epidemic in New York City. Available from: https://www.ncbi.nlm.nih.gov/books/NBK234564/.
5. Goddard A. The History of AIDS: A Timeline. New York Historical Society. https://aids.nyhistory.org/timeline/. Accessed July 2021.
6. National Research Council (US) Panel on Monitoring the Social Impact of the AIDS Epidemic; Jonsen AR, Stryker J, editors. The Social Impact Of AIDS In The United States. Washington (DC): National Academies Press (US); 1993. 9, The HIV/AIDS Epidemic in New York City. Available from: https://www.ncbi.nlm.nih.gov/books/NBK234564/.
7. Padamsee TJ. Fighting an Epidemic in Political Context: Thirty-Five Years of HIV/AIDS Policy Making in the United States. *Social History of Medicine*, 2018;33(3):1001-1028. https://doi.org/10.1093/shm/hky108.
8. New York State Department of Health, AIDS Institute. The New York State Department of Health AIDS Institute, July 30, 1983–July 30, 2008: 25 Years of Leadership, Service and Compassion. https://www.health.ny.gov/diseases/aids/providers/reports/docs/aids_institute_25-years.pdf. Published May 2010. Accessed July 2021.
9. National Institutes of Health (NIH), National Institute of Allergy and Infectious Diseases (NIAID). Antiretroviral Drug Discovery and Development. https://www.niaid.nih.gov/diseases-conditions/antiretroviral-drug-development. Updated November 26, 2018. Accessed July 2021.
10. Ira Feldman, M. P. A., Cruz, H., DeLorenzo, J., Hidalgo, J., Hope Plavin, M. P. A., & Whitaker, J. (1999). Developing a managed care delivery system in New York State for Medicaid recipients with HIV. *The American journal of managed care*, 5, 1457-1465.
11. Laufer, F., Menges J, Schutze M, Zhang D. Evaluation of New York's HIV Special Needs Plan Program: Cost and Usage Impacts. The Lewin Group. In collaboration with the AIDS Institute, New York Sate Department of Health. November 6, 2009. https://www.health.ny.gov/diseases/aids/general/resources/snps/docs/hiv_snp_research_paper.pdf
12. Doug Wirth, "HIV Special Needs Plans (SNPs): A New Health Care Option in New York." The Body Positive (Dec. 1, 2006). Available at https://www.thebody.com/article/hiv-special-needs-plans-sn-ps
13. Medicaid Managed Care for People with HIV and AIDS. New York State Department of Health. Revised: November 2017. https://www.health.ny.gov/health_care/managed_care/living_with_hiv/
14. Amida Care attempted to create a D-SNP but was unsuccessful.
15. Centers for Medicare and Medicaid Services (CMS). Special Needs Plans. https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans. Updated November 13, 2019. Accessed July 2021.
16. Cohen R, Lemieux J, Schoenborn J, Mulligan T. Medicare Advantage Chronic Special Needs Plan boosted primary care, reduced hospital use among diabetes patients. *Health Aff (Millwood)*. 2012;31(1):110-119. doi:10.1377/hlthaff.2011.0998.
17. Powers BW, Yan J, Zhu J, et al. The Beneficial Effects Of Medicare Advantage Special Needs Plans For Patients With End-Stage Renal Disease. *Health Aff (Millwood)*. 2020;39(9):1486-1494. doi:10.1377/hlthaff.2019.01793
18. Becker BN, Luo J, Gray KS, et al. Association of Chronic Condition Special Needs Plan With Hospitalization and Mortality Among Patients With End-Stage Kidney Disease. *JAMA Netw Open*. 2020;3(11):e2023663. Published 2020 Nov 2. doi:10.1001/jamanetworkopen.2020.23663.
19. McGarry BE, Grabowski DC. Managed care for long-stay nursing home residents: an evaluation of Institutional Special Needs Plans. *Am J Manag Care*. 2019;25(9):438-443.
20. Haviland AM, Elliott MN, Klein DJ, Orr N, Hambarsoomian K, Zaslavsky AM. Do dual eligible beneficiaries experience better health care in special needs plans?. *Health Serv Res*. 2021;56(3):517-527. doi:10.1111/1475-6773.13620
21. Grace SC, Elliott MN, Giordano LA, Burroughs JN, Malinoff RL. Health-related quality of life and quality of care in specialized medicare-managed care plans. *J Ambul Care Manage*. 2013;36(1):72-84. doi:10.1097/JAC.0b013e31826746dc
22. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
23. SelectHealth VNSNY Choice. Provider Search. Last updated July 14 2021. https://providersearch.vnsnychoice.org/#/results?plan=sh&type=ALL
24. MetroPlus Health. Provider and Pharmacy Directory. 2021. https://eastmainsiteprodsa.blob.core.windows.net/cms/metroplusmvc12/media/member/provider%20directories/2021jul_medicaid_providerdirectorykingsrichmond.pdf
25. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
26. New York State Department of Health. MRT Demonstration Section 1115 Quarterly Report and Annual Report. November 2020. https://www.health.ny.gov/health_care/medicaid/redesign/reports/2019_pp_annual_rpt.htm
27. Positive Healthcare. Positive Health Care California. N.D. https://positivehealthcare.net/california/phc/
28. Matheson J. Clear Health Alliance: Debut of the for-profit HIV/AIDS special needs plan. Recon Strategy. https://reconstrategy.com/2012/07/clear-health-alliance-debut-of-the-for-profit-hivaids-special-needs-plan-2/. Published July 16, 2012. Accessed July 2021.
29. Clear Health Alliance. https://www.clearhealthalliance.com/florida/home.html. Accessed July 2021.
30. New York State AIDS Institute, HIV Special Needs Plan Model Contract. https://www.health.ny.gov/diseases/aids/general/resources/snps/docs/hiv_special_needs_plan_model_contract.pdf
31. Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan/Health and Recovery Plan Model Contract. March 1 2019. https: www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
32. Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan/Health and Recovery Plan Model Contract. March 1 2019. https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
33. Medicaid Managed Care/Family Health Plus/ HIV Special Needs Plan/Health and Recovery Plan Model Contract. March 1 2019. https: www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
34. Medicaid Managed Care/Family Health PLus/ HIV SPecial Needs Plan/Health and Recovery Plan Model Contract. March 1 2019. https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
35. See, e.g., Brennan-Ing M, Seidel L, Rodgers L, Ernst J, Wirth D, Tietz D, et al. (2016) The Impact of Comprehensive Case Management on HIV Client Outcomes. PLoS ONE 11(2): e0148865. doi:10.1371/ journal.pone.0148865
36. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
37. "Providing Access to Health Services to People of Transgender Experience: A Medicaid Case Study". Presentation at 2019 USPATH Meeting. September 3-8, 2019. On file with George Washington University.
38. Email from Doug Wirth to Naomi Seiler (July 6, 2021).
39. Amida Care. Healthy Rewards Program. www.amidacareny.org/for-members/earn-healthy-rewards/
40. Amida Care. Member Advisory Council. www.amidacareny.org/for-members/member-voices/
41. HIV.Gov. Who Is at Risk for HIV? Is the Risk of HIV Different for Different Groups? May 27 2020. https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/who-is-at-risk-for-hiv#:~:text=By%20race%2Fethnicity%2C%20Blacks%2F,significant%20risk%20for%20getting%20HIV
42. Thakarar K, Morgan JR, Gaeta JM, Hohl C, Drainoni ML. Homelessness, HIV, and Incomplete Viral Suppression. *J Health Care Poor Underserved*. 2016;27(1):145-156. doi:10.1353/hpu.2016.0020
43. Amida Care. Breaking Barriers to Transgender Health Care: A report on health challenges and solutions for the transgender community. March 2019. https://www.amidacareny.org/wp-content/uploads/ac-whitepaper_FINAL.pdf
44. UCLA Williams Institute School of Law. How Many Adults Identify as Transgender in the United States? June 2016. https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/
45. Centers for Disease Control and Prevention. HIV and Transgender People: HIV Diagnosis. Last reviewed July 14, 2021. https://www.cdc.gov/hiv/group/gender/transgender/hiv-diagnoses.html
46. VNSNY Choice SelectHealth. Why Choose Select Health? www.selecthealthny.org/enroll-in-the-plan/why-choose-selecthealth/
47. Amida Care. Homelessness. https://www.amidacareny.org/homelessness/
48. MetroPlus. Partnership in Care Member Handbook. Revised November 2018. https://eastmainsiteprodsa.blob.core.windows.net/cms/media/mbr-18-283-pic-member-handbook-11-19-18.pdf
49. MetroPlus Plans. Partnership in Care (PIC) HIV-SNP. Last updated June 23 2021. https://www.metroplus.org/Plans/nyc-care-other/pic
50. VNSNY Choice SelectHealth. Why Choose Select Health? https://www.selecthealthny.org/enroll-in-the-plan/why-choose-selecthealth/
51. Amida Care. Be Yourself: The Health Plan for Individuals. https://www.amidacareny.org/transgender-landing-page/
52. Denning, P. & DiNenno, E. (2010). Communities in crisis: Is there a generalized HIV epidemic in impoverished urban areas of the United States?. *Centers for Disease Control and Prevention*.
53. Evidence into Action: Housing is HIV Prevention and Care. Policy Paper from the North American Housing and HIV/AIDS Research Summit Series. September 21 - 23 2011. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/key_resources/housing_and_supportive_services/evidence_into_action_housing.pdf

54. Logan, J. L., Frye, A., Pursell, H. O., Anderson-Nathe, M., Scholl, J. E., & Korthuis, P. T. (2013). Correlates of HIV risk behaviors among homeless and unstably housed young adults. *Public health reports (Washington, D.C. : 1974)*, 128(3), 153–160. doi.org/10.1177/003335491312800305
55. Logan, J. L., Frye, A., Pursell, H. O., Anderson-Nathe, M., Scholl, J. E., & Korthuis, P. T. (2013). Correlates of HIV risk behaviors among homeless and unstably housed young adults. *Public health reports (Washington, D.C. : 1974)*, 128(3), 153–160. https://doi.org/10.1177/003335491312800305
56. Maulsby, Catherine H., et al. "A scoping review of employment and HIV." *AIDS and Behavior* 24.10 (2020): 2942-2955.
57. Aidala AA, Wilson MG, Shubert V, et al. Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *Am J Public Health*. 2016;106(1):e1-e23. doi:10.2105/AJPH.2015.302905
58. Amida Care. Employing Consumer Workers: A Vital Strategy to End the HIV/AIDS Epidemic in New York State. March 2020. https://www.amidacareny.org/wp-content/uploads/ac-wp-work-V10-digital-1.pdf
59. Amida Care. Employing Consumer Workers: A Vital Strategy to End the HIV/AIDS Epidemic in New York State. March 2020. https://www.amidacareny.org/wp-content/uploads/ac-wp-work-V10-digital-1.pdf
60. Amida Care. Employing Consumer Workers: A Vital Strategy to End the HIV/AIDS Epidemic in New York State. March 2020. https://www.amidacareny.org/wp-content/uploads/ac-wp-work-V10-digital-1.pdf
61. VNSNY CHOICE Health Plans SelectHealth. New York State HIV Special Needs Plan Member Handbook. Approved 11/8/2019. www.selecthealthny.org/wp-content/uploads/2020/07/SelectHealth-Member-Handbook_Oct-2019.pdf
62. MetroPlus. Partnership in Care Member Handbook. Revised November 2018. eastmainsiteprodsa.blob.core.windows.net/cms/media/mbr-18-283-pic-member-handbook-11-19-18.pdf
63. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
64. Email from Doug Wirth to Naomi Seiler (July 6, 2021).
65. MetroPlus Health. HIV/AIDS Support Services. MetroPlus Good4You. Last updated January 1 2021. www.metroplus.org/good4you/hiv-resources
66. MetroPlus. Partnership in Care Member Handbook. Revised November 2018. https://eastmainsiteprodsa.blob.core.windows.net/cms/media/mbr-18-283-pic-member-handbook-11-19-18.pdf
67. Amida Care. Board of Directors. Accessed 8/24/2021. https://www.amidacareny.org/about-us/our-leadership/board-of-directors/
68. Choice SelectHealth. Member Handbook. Revised October 2019. https://www.selecthealthny.org/wp-content/uploads/2020/07/SelectHealth-Member-Handbook_Oct-2019.pdf
69. MetroPlusHealth. Board of Directors. Accessed 8/24/2021. https://www.metroplus.org/about-us/board-directors
70. Choice SelectHealth. Member Handbook. Revised October 2019. https://www.selecthealthny.org/wp-content/uploads/2020/07/SelectHealth-Member-Handbook_Oct-2019.pdf
71. MetroPlusHealth. Board of Directors. Accessed 8/24/2021. https://www.metroplus.org/about-us/board-directors
72. Amida Care. Provider Manual: Amida Care Health Plan. September 2018. https://www.amidacareny.org/wp-content/uploads/AC-Provider-Manual-9.10.18.pdf
73. Amida Care. Member Voices - Member Advisory Council. https://www.amidacareny.org/for-members/member-voices/
74. Laufer, F., Menges J, Schutze M, Zhang D. Evaluation of New York's HIV Special Needs Plan Program: Cost and Usage Impacts. The Lewin Group. In collaboration with the AIDS Institute, New York Sate Department of Health. November 6, 2009. https://www.health.ny.gov/diseases/aids/general/resources/snps/docs/hiv_snp_research_paper.pdf
75. Laufer, F., Menges J, Schutze M, Zhang D. Evaluation of New York's HIV Special Needs Plan Program: Cost and Usage Impacts. The Lewin Group. In collaboration with the AIDS Institute, New York Sate Department of Health. November 6, 2009. https://www.health.ny.gov/diseases/aids/general/resources/snps/docs/hiv_snp_research_paper.pdf
76. "Providing Access to Health Services to People of Transgender Experience: A Medicaid Case Study". Presentation at 2019 USPATH Meeting. September 3-8, 2019. On file with George Washington University.
77. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
78. Sugar S, Peters C, De Lew N, Sommers B. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. Assistant Secretary for Planning and Evaluation: Office of Health Policy. April 12 2021. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
79. Amida Care Overview. 02/12/21. PowerPoint on file with George Washington.
80. Laufer, F., Menges J, Schutze M, Zhang D. Evaluation of New York's HIV Special Needs Plan Program: Cost and Usage Impacts. The Lewin Group. In collaboration with the AIDS Institute, New York Sate Department of Health. November 6, 2009. https://www.health.ny.gov/diseases/aids/general/resources/snps/docs/hiv_snp_research_paper.pdf
81. Communication from Shakira Croce, Amida Care (Sept. 13, 2021).
82. Gambone, Gina, and Anna Thomas-Ferraioli. "Integrating a Multi-level ART Adherence Program into HIV Care Management." https://targethiv.org/sites/default/files/RWNC2020/15596_Gambone.pdf
83. Piscatelli N. Amida Care Viral Load Suppression Member Incentive Program. October 11 2018. https://www.amidacareny.org/wp-content/uploads/Program-Announcement-Primary-Care-Providers-1004-Website.pdf
84. Gambone, Gina, and Anna Thomas-Ferraioli. "Integrating a Multi-level ART Adherence Program into HIV Care Management." https://targethiv.org/sites/default/files/RWNC2020/15596_Gambone.pdf
85. New York State Department of Health. Medicaid Pharmacy Program. Revised May 2021. https://health.ny.gov/health_care/medicaid/redesign/mrt2/pharmacy_carve_out/
86. Lisa Gillespie, "Transgender health a big opportunity for health systems." *Modern Healthcare* (Aug. 17, 2021). https://www.modernhealthcare.com/safety-quality/transgender-healthcare-grows-insurance-coverage-expands
87. Id.
88. Amida Care. Providing Access to Health Services to People of Transgender Experience: A Medicaid Case Study". Presentation at 2019 USPATH Meeting. September 3-8, 2019.
89. Amida Care. "Providing Access to Health and Services to People of Transgender Experience: A Medicaid Case Study". USPATH Meeting presentation. September 3-8 2019.
90. The Centers for Disease Control and Prevention. HIV and Transgender People: Viral Suppression. Last reviewed July 14 2021. https://www.cdc.gov/hiv/group/gender/transgender/viral-suppression.html
91. Amida Care. "Providing Access to Health and Services to People of Transgender Experience: A Medicaid Case Study". USPATH Meeting presentation. September 3-8 2019.
92. Leach T, Moore J, Rambaran S, Leach E, Cohn J, Olivo N, Ernst JA. New Hepatitis Drugs in a Medicaid Special Needs Population - A Preliminary Report. https://www.amidacareny.org/wp-content/uploads/New-Hepatitis-Drugs-Medicaid-SNP-2.pdf
93. Fatehi E, Rambaran S, Leach T, Ng K, Alao O, Ernst J. A Medicaid Hepatitis C Prior Authorization Program Outcomes Evaluation. https://www.amidacareny.org/wp-content/uploads/Medicaid-HepatitisC-Prior-Authorization-1.pdf
94. Leach T, Ernst JA, Wirth D, Rambaran S, Moore J, Leach E, Cohn J, Olivo N. How a Medicaid HIV Special Needs Managed Care Plan in NYC Achieved Cost Savings and Successful Clinical Outcomes. https://www.amidacareny.org/wp-content/uploads/Special-Needs-Managed-Care-Plan-1.pdf
95. New York State Department of Health. Ending the AIDS Epidemic in New York State. Revised July 2021. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/
96. New York State Department of Health. Get Tested Treat Early Stay Safe End AIDS. 2015. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf
97. New York State. On World AIDS Day, Governor Cuomo Announces New York State has "Bent the Curve" on the HIV Epidemic. December 1 2020. https://www.governor.ny.gov/news/world-aids-day-governor-cuomo-announces-new-york-state-has-bent-curve-hiv-epidemic
98. New York State. On World AIDS Day, Governor Cuomo Announces New York State has "Bent the Curve" on the HIV Epidemic. December 1 2020. https://www.governor.ny.gov/news/world-aids-day-governor-cuomo-announces-new-york-state-has-bent-curve-hiv-epidemic
99. ETE Dashboard Ending the AIDS Epidemic. ETE Metrics: NYS Progress to End the AIDS Epidemic by the End of 2020. Data as of June 2020. https://etedashboardny.org/metrics/
100. ETE Dashboard Ending the AIDS Epidemic. ETE Metrics: NYS Progress to End the AIDS Epidemic by the End of 2020. Data as of June 2020. https://etedashboardny.org/metrics/
101. New York State Department of Health. Get Tested Treat Early Stay Safe End AIDS. 2015. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf
102. New York State of Health. NYS Provider & Health Plan Look-Up. https://pndslookup.health.ny.gov/providers/health_plan. Accessed July 2021.
103. Ending the Epidemic Task Force Committee Recommendation. Encourage all Performing Provider Systems (PPSs) to Adopt DSRIP Domain 4 HIV/AIDS Projects. N.d. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/crs/cr19.pdf
104. Amida Care. A Pandemic + An Epidemic: COVID 19's Impact on New York's Plan to End the HIV Epidemic. October 2020. https://www.amidacareny.org/wp-content/uploads/ETE-COVID_Issue-Brief_10-2020.pdf
105. New York State Department of Health. Get Tested Treat Early Stay Safe End AIDS. 2015. https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf
106. Amida Care. A Pandemic + An Epidemic: COVID 19's Impact on New York's Plan to End the HIV Epidemic. October 2020. https://www.amidacareny.org/wp-content/uploads/ETE-COVID_Issue-Brief_10-2020.pdf
107. Amida Care. A Pandemic + An Epidemic: COVID 19's Impact on New York's Plan to End the HIV Epidemic. October 2020. https://www.amidacareny.org/wp-content/uploads/ETE-COVID_Issue-Brief_10-2020.pdf
108. Mascolini M. Multimorbidity in people with HIV using ART in the US: Projections to 2030. Conference on Retroviruses and Opportunistic Infections. March 6-10, 2021. https://natap.org/2021/CROI/croi_25.htm
109. Mascolini M. Multimorbidity in people with HIV using ART in the US: Projections to 2030. Conference on Retroviruses and Opportunistic Infections. March 6-10, 2021. https://natap.org/2021/CROI/croi_25.htm
110. Maciel RA, Klück HM, Durand M, Sprinz E. Comorbidity is more common and occurs earlier in persons living with HIV than in HIV-uninfected matched controls, aged 50 years and older: A cross-sectional study. *Int J Infect Dis*. 2018;70:30-35. doi:10.1016/j.ijid.2018.02.009
111. McGettrick P, Barco EA, Mallon PWG. Ageing with HIV. *Healthcare (Basel)*. 2018;6(1):17. Published 2018 Feb 14. doi:10.3390/healthcare6010017
112. Althoff KN. The Silver Tsunami: Projecting multimorbidity, polypharmacy, and healthcare costs for those aging with HIV in the US. Johns Hopkins University. https://grantome.com/grant/NIH/R01-AG053100-01.
113. CDC, "HIV and Older Americans" (Updated Aug. 9, 2021). https://www.cdc.gov/hiv/group/age/olderamericans/index.html
114. HIV.gov, "Growing Older with HIV" (Updated May 17, 2021). https://www.hiv.gov/hiv-basics/living-well-with-hiv/taking-care-of-yourself/aging-with-hiv
115. New York State Department of Health, Bureau of HIV/AIDS Epidemiology, AIDS Institute. New York State HIV/AIDS Annual Surveillance Report for Persons Diagnosed through December 2019. October 2020. https://health.ny.gov/diseases/aids/general/statistics/annual/2019/2019_annual_surveillance_report.pdf
116. New York City Department of Health and Mental Hygiene. HIV Surveillance Annual Report, 2019, Table 3.1. https://www1.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2019.pdf
117. Centers for Disease Control and Prevention. HIV and Older Americans. August 9, 2021. https://www.cdc.gov/hiv/group/age/olderamericans/index.html.
118. Correspondence with Amida Care. 8/23/2020.

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