



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 19, 2017

Mr. Eliot Fishman
Director, State Demonstrations Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
Department of Health & Human Services
7500 Security Blvd, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Mr. Fishman:

At this time, New York State would like to formally withdraw the following pending amendment proposals to our Section 1115 Medicaid Redesign Team Demonstration:

1. Criminal Justice (submitted 9/30/16)
2. Ending the AIDS Epidemic (submitted 12/1/16)

As New York continues to explore ways to improve and strengthen the healthcare delivery system, we may resubmit these proposals in the future. We look forward to continuing to work with the Centers for Medicare and Medicaid Services on New York's other healthcare reform initiatives. If you have any questions, please contact Kalin Scott of my staff at 518-474-3018.

Sincerely,


Jason A. Hergerson
Medicaid Director
Office of Health Insurance Programs

cc: Deborah Steinbach, CMS
Angela Garner, CMS
Michael Melendez, CMS
John Guhl, CMS
Kalin Scott, NYS DOH
Priscilla Smith, NYS DOH



Department of Health

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SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 1, 2016

Mr. Eliot Fishman
Director
Center for Medicaid and CHIP Services (CMCS)
Center for Medicare and Medicaid Services
7500 Security Blvd., Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Mr. Fishman:

Pursuant to the terms of New York State's Medicaid Section 1115 Demonstration Medicaid Redesign Team Plan (11-W-00114/2), the State is required to seek Federal approval of any amendments. In accordance with this requirement, the New York State Department of Health (NYSDOH) is submitting this request to the federal Centers for Medicare & Medicaid Services (CMS) to amend the 1115 Waiver, seeking the following changes:

The NYSDOH is requesting to advance the initiative to end AIDS as an epidemic in New York State. The goal of the initiative is to decrease new HIV infections to the point where, by the end of 2020, New York State will achieve a reduction in HIV prevalence for the first time. The plan includes three priorities:

1. Identify persons with HIV who remain undiagnosed and link them to health care.
2. Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.
3. Facilitate access to Pre-Exposure Prophylaxis (PrEP) for persons who engage in high risk behaviors to keep them HIV negative.

In October 2014, a 63-member Ending the Epidemic (ETE) Task Force was established by Governor Andrew M. Cuomo to advise the NYSDOH on achieving the goals of the plan to end the epidemic. The Task Force reviewed nearly 300 recommendations submitted online and received during regional forums held throughout the state and attended by more than 800 individuals. The Task Force developed *The 2015 Blueprint to End AIDS* – a plan comprised of 30 Blueprint recommendations related to the three-point plan as well as additional recommendations related to minimizing new HIV infections, inhibiting disease progression, and addressing social determinants of health.

The goal of this program is to advance the ETE effort. Additional investment is required to drive HIV below epidemic levels in NYS. This effort will involve expansion of programs associated with the plan to end the epidemic, including:

- Testing, including expanding HIV testing to identify persons with HIV who are undiagnosed and link them to care as well as screening persons with HIV for hepatitis C virus (HCV) to identify persons with HCV and link them to care and treatment.

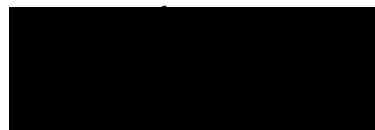
- Access to pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) services for persons at high risk to keep them HIV negative.
- Linkage to and retention in care initiatives for persons with HIV who are not in care and not virally suppressed in order to improve health, achieve viral suppression, and prevent further transmission, as well as linkage to HCV care and treatment programs for persons co-infected with HCV.
- Programs that address the social determinants of health to facilitate access to and retention in care, including services for persons at risk for and with STDs; services targeted to men who have sex with men (MSM), including young MSM and MSM of color; services targeted to transgender populations; condom education and promotion to prevent the spread of HIV; and examination of “sentinel events,” such as diagnoses in injecting drug users and AIDS mortality, in order to identify and address the health-related and contextual factors associated with such events.
- Health care workforce development to ensure the availability of quality care and services for persons with HIV and HCV via an expert workforce of clinicians and peers.

All programs and services are consistent with the recommendations in *The Blueprint*.

Approval of the waiver amendment will improve the health of New York Medicaid members living with HIV and prevent transmission of HIV, bringing New York State toward its goal of reducing new HIV infections to the point where, by the end of 2020, HIV prevalence in New York State will be reduced for the first time. New York requests that CMS approve a \$45 million investment into these programs, funded through Federal Financial Participation (FFP) of Designated State Health Programs (DSHP) in accordance with the attached list of programs.

Accompanying this letter are documents related to this request including a program overview, budget neutrality projections, proposed Designated State Health Program (DSHP) match list, and public notice documents. If you have any questions, please contact Kalin Scott of my staff at 518-474-3018. We look forward to working with you on this important initiative. Thank you for your consideration of this request.

Sincerely,



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Attachments

cc: Michael Melendez, CMS
John Guhl, CMS
Angela Garner, CMCS
Deb Steinbach, CMCS

**New York State
Ending the Epidemic
MRT Plan Waiver Amendment**

Introduction

New York State is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its 1115 Medicaid Redesign Team (MRT) Waiver to advance the initiative to end AIDS as an epidemic in New York State. This effort will involve expansion of programs associated with the plan to end the epidemic, including access to Pre-Exposure Prophylaxis (PrEP) services for persons at high risk to keep them HIV negative; linkage to and retention in care initiatives for persons with HIV who are not in care and not virally suppressed; and programs that address social determinants of health to facilitate access to and retention in care. Approval of the waiver will improve the health of New York Medicaid members living with HIV and prevent transmission of HIV, bringing New York State toward its goal of reducing new HIV infections to the point where, by the end of 2020, the number of persons living with HIV in New York State will be reduced for the first time. New York requests that CMS approve a \$45 million investment into these programs, funded through Federal Financial Participation (FFP) of Designated State Health Programs (DSHP) in accordance with the attached list of programs.

Background

The dialog about the AIDS epidemic has changed dramatically and is now about ending the epidemic. There is agreement that the U.S. and the world can begin to end the epidemic due to access to drugs that can treat and prevent HIV. Scientifically proven biomedical interventions use medical, clinical, and public health approaches to prevent HIV infection, reduce susceptibility to HIV, and decrease HIV infectiousness. Research demonstrates the effectiveness of antiretroviral treatment (ART) for HIV-infected patients in both improving health outcomes and reducing risk of HIV transmission. National HIV prevention goals call for significant increases in the number of people living with HIV who are in care and receiving ART to maintain viral suppression. Focused, coordinated, effective prevention efforts include finding people who are infected with HIV, linking them to and retaining them in care, and achieving viral suppression by prescribing and ensuring adherence to ART.

The effect of ART in preventing progression to AIDS, improving health and saving lives has long been known. Science has shown that treatment is also effective in preventing transmission to others. A 2011 study showed that effective treatment of a person living with HIV reduced the risk of transmission to partners by 96 percent, on par with a vaccine. In addition, Pre-Exposure Prophylaxis (PrEP) is a relatively new HIV prevention method in which people who do not have HIV take a daily pill to reduce their risk of becoming infected. Based on studies showing significant reduction in HIV acquisition among HIV-negative persons who use PrEP consistently and receive a package of services, the U.S. Food and Drug Administration approved combination ART for use as PrEP among sexually active adults at risk for HIV infection.

The momentum to bring the epidemic to a close in New York State exists. The New York State Department of Health has effectively used evidence-based strategies to reduce the number of new infections and improve the health of persons living with HIV/AIDS (PLWHA). For example, New York State's comprehensive approach to HIV prevention and care has led to many successes, including a 40% reduction in newly diagnosed cases,¹ a reduction in the proportion of new cases among injection drug users from 54% to just 3%,⁵ the recent elimination of mother-to-child transmission for an 18-month period from 2014 to 2016,³ and a state viral load suppression rate that exceeds the national average.⁶ These successes – in particular the dramatic decline in new cases among injection drug users and the elimination of mother-to-child transmission – fueled deliberations about the possibility of ending the epidemic in all populations, especially given the emergence of biomedical advances in preventing HIV.

Major inroads into the epidemic have been made as a result of the program and policy infrastructure that has been developed in the last 30 years in New York State. The “Cascade of HIV Care” refers to the graphic representation of how many people get tested, get linked to care, stay in care, get on antiretroviral treatment, and ultimately get to a suppressed viral load. Please see http://health.ny.gov/diseases/aids/general/statistics/docs/cascade_of_care_2014.pdf. It provides a picture of how close we are, or are not, to achieving the end of the AIDS epidemic. New York exceeds the nation in terms of the percentage of PLWHA who are in care, retained in care, and virally suppressed. However, significant challenges remain. Improvement is needed in the elements of the Cascade. For example, more than 8% of the estimated HIV-infected individuals in the State have not been identified. These 10,000 New Yorkers most likely have high viral loads and may be responsible for up to one-half of all new infections. Thirty-seven percent of HIV-infected persons, or about 46,000 people, have not been linked to continuous care, are not virally suppressed and are sources of ongoing infections. Viral suppression is key to preventing progression to AIDS and preventing transmission of HIV. A focused effort – and the resources needed to support such an effort – will lead to improved viral suppression to the extent that HIV-infected persons no longer progress to AIDS, and additional infections are minimized due to reduced transmission. The effort is consistent with the goals of the National HIV/AIDS Strategy (NHAS), which include ensuring that new HIV infections are rare and, when they do occur, ensuring that every person has access to high quality, life-extending care.

On June 29, 2014, Governor Cuomo announced a three-point plan to end AIDS as an epidemic in New York State. The goal of the initiative is to decrease new HIV infections to the point where, by the end of 2020, New York State will achieve a reduction in HIV prevalence for the first time. The plan includes three priorities:

1. Identify persons with HIV who remain undiagnosed and link them to health care.
2. Link and retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission.
3. Facilitate access to Pre-Exposure Prophylaxis (PrEP) for persons who engage in high risk behaviors to keep them HIV negative.

In October 2014, Governor Cuomo announced appointments to a 63-member expert Ending the Epidemic (ETE) Task Force charged with advising the Department of Health on recommendations to achieve the goals of the Governor's plan. The four committees of the Task

Force reviewed nearly 300 recommendations submitted online and received during regional listening forums held across New York State. The Task Force developed *The 2015 Blueprint to End AIDS* – a plan comprised of 30 Blueprint recommendations related to the Governor’s plan as well as additional recommendations related to minimizing new infections, inhibiting disease progression, and addressing social determinants of health. The matching funds will support the strategies and recommendations in the Blueprint. Following is a link to the Blueprint. http://health.ny.gov/diseases/aids/ending_the_epidemic/docs/blueprint.pdf

Program Design

The goal of this program is to advance the Ending the Epidemic effort. Additional investment is required to drive HIV below epidemic levels in NYS. The programs and services are consistent with the recommendations in the Blueprint.

A critical component of the Governor’s plan to end the AIDS epidemic in New York State calls for increasing the frequency of HIV-related medical care among persons living with diagnosed HIV infection and increasing the percentage of people who are virally suppressed. Improvements were realized in this area between 2013 and 2014. Data show the percentage who had evidence of continuous HIV care increased from 67% to 68% and the percentage who were virally suppressed increased from 63% to 68%. The number of persons estimated to be virally suppressed increased by 6,000 – from 71,000 in 2013 to 77,000 in 2014.

People whose test results show undetectable viral loads are healthier and much less likely to transmit HIV to their sexual partners. Recent dialog suggests that undetectable equals not transmittable. In fact, experts at the national level have indicated that with full virologic suppression, one is not able to or capable of transmitting HIV to a sexual partner. This is the principle of treatment as prevention. When people with HIV receive treatment, it improves not just their own health but the health of their communities.

As noted in the Blueprint, new HIV infections do not happen in isolation but rather come tied to numerous contextual factors, such as poor health care, lack of access to medications, lack of access to condoms, delay from testing to linkage to care, lack of health and sexual health education, poverty, housing and food insecurity, mental health problems, and substance abuse. In many cases, these factors overlap. However, certain populations are more affected by contextual factors and experience the highest rates of associated health disparities. These include MSM, especially Black and Hispanic/Latino MSM, within age clusters with specific characteristics and needs, such as young MSM; all transgender people; women of color; injection drug users; and sero-discordant couples. The stated demographics do not, in and of themselves, place individuals at risk of HIV infection. Rather, contextual factors in which HIV occurs, such as poor health care, poverty, inequality, mental health problems, and geographic disadvantage amplify HIV risk. The program design includes initiatives aimed at addressing social determinants of health to facilitate access to and retention in care.

Following are examples of the initiatives that will be supported.

- HIV testing in emergency departments; provision of home test kits; mobilization of medical teams in health care settings to scale up routine HIV testing; hepatitis C screening programs
- Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) services in a variety of settings; PrEP and PEP starter kits
- Linkage and retention in care, including grants for linkage and retention projects, expanded partner services, and transgender health services
- High-impact prevention, including services in STD clinics, services for men who have sex with men (MSM), including young MSM, and condom access, as well as investigation of sentinel events, defined as AIDS mortality and infections related to injection drug use
- Workforce development: Fellowship Program and peer workforce development

Testing: Point one of the three-point plan to end the epidemic in NYS is to identify persons with HIV who remain undiagnosed and link them to health care. Though New York State’s HIV Testing Law requires health care professionals to offer a voluntary HIV test to all patients (with limited exceptions) between the ages of 13 to 64, compliance is low in Hospital Emergency Departments (EDs) and Urgent Care Centers where there are economic disincentives to expand HIV testing. A NYS IPRO review of 191 hospitals with emergency departments demonstrated low HIV testing rates. Hospital EDs receive a bundled reimbursement rate whether or not an HIV test is conducted and therefore there is a lack of fiscal incentive to expand HIV testing. Some urgent care centers, especially those serving large Medicaid Managed Care populations, may also have a lack of incentive to increase HIV screening because this service has historically not been prioritized when reimbursement rates are negotiated.

In a 2013-14 a National Health Interview Survey on “Reasons for Emergency Room Use Among U.S. Adults Aged 18–64” reported that 20% of U.S. adults seek health care at the emergency rooms each year, a percentage that has remained largely unchanged in the last decade. Age of those surveyed was categorized into three groups (18–29, 30–44, and 45–64), and previous research has shown that young adults receive a greater proportion of their care at an ED compared with other age groups. The 18–29 age group is one noted for transitions between youth and adulthood, and a time when patterns of health care access and health behaviors are developing as well as increased potential for HIV and STDs due to risk behavior.¹ Expanding HIV testing in EDs would further reach those young adults who are potentially HIV infected yet unaware of their status as well as those using EDs that may be related to unknown HIV illness and health conditions related to risk behavior for HIV such as Injection Drug Use.

A potential solution to expand HIV testing in Hospital Emergency Departments is to develop a “pay for performance” model. This strategy provides financial rewards in target sites for improvements in HIV testing rates for broader testing of at-risk individuals who use Emergency Departments and urgent care as a point of access for medical care, not for the evaluation and initial treatment of medical conditions caused by trauma or sudden illness, which is the mission of most hospital emergency departments.

The NYSDOH AI, in collaboration with the NYCDOHMH and OraSure, the manufacturer of OraQuick® in-home HIV test, provides free Home HIV Tests to gay men and men who have sex

with men (MSM) who otherwise would not have access to screening or who are unwilling to be screened by conventional HIV tests in regions of NYS contiguous with NYC (i.e., Long Island and Westchester and Rockland Counties). The NYSDOH advertises the HIV Home Test Giveaway (HHTG) on several social media platforms that cater to MSM in targeted regions. Funding will be used to expand the HHTG to other regions in NYS and populations at risk of HIV infection 2017.

In addition, a campaign will be launched to mobilize health care teams in medical settings to scale up and sustain routine HIV testing.

These proposals are consistent with *Blueprint* recommendations 1 and 2.

In addition, hepatitis C virus (HCV) is a major public health problem causing substantial morbidity and mortality, including cirrhosis and liver cancer. Nationally, HCV mortality rates have been rising for the last decade, and in 2013, the number of HCV-related deaths exceeded that of the combined total of 60 other nationally notifiable infectious diseases, including HIV, tuberculosis and pneumococcal disease. Since 2001, more than 250,000 cases of chronic HCV have been reported in New York State. Approximately one-third of persons living with HIV is co-infected with HCV. Co-infected persons suffer more liver-related morbidity and mortality than those infected with HCV only. Data reported from the AIDS Clinical Trial Group (ACTG) A5001 cohort demonstrate that HIV/HCV co-infected patients visit the emergency department more frequently, are hospitalized more often, and have longer hospital stays than HIV mono-infected patients. Other studies have established HCV-related end-stage liver disease as a leading cause of in-hospital mortality among HIV-infected patients. The reduction and treatment of HCV transmission is a key priority for ensuring one devastating epidemic is not ended while another, which impacts many of the same populations, continues. HCV detection and treatment directly relates to individual health outcomes and overall quality of care. With the arrival of new direct acting antivirals, more than 90 percent of people treated can be cured of their hepatitis C disease, including persons co-infected with HIV and HCV. The new drugs have minimal side effects, and the vast majority of infections can be cured in as short as 12 weeks. Treatment can prevent cirrhosis, liver failure, and liver cancer, and improves quality of life. Curing hepatitis C improves the clinical outcomes of people living with HIV. However, most people with HCV are unaware they are infected. Funding will support expanded HCV screening throughout NYS in order to identify persons with HCV and link them to care and treatment so they can be cured. Targeted efforts may potentially eliminate HCV-related morbidity and mortality among co-infected persons by providing HCV testing to all persons living with HIV.

This proposal is consistent with *Blueprint* recommendation 26.

PrEP and PEP: PrEP is a targeted biomedical intervention to facilitate “health care as prevention,” a six-pronged intervention for people who are HIV-negative and at high risk for infection. The intervention includes a once daily pill; periodic HIV testing; periodic STD screening; counseling about the use of condoms to prevent STDs; education about harm reduction options; and, counseling to promote adherence to the once-a-day PrEP medication. Funds will support expansion of PrEP services statewide, including grants for PrEP

services/pilots in a variety of settings and PrEP starter kits. This proposal is consistent with *Blueprint* recommendations 11 through 14.

Post-exposure prophylaxis (PEP) is provided to prevent acquisition of HIV infection following a non-occupational exposure to HIV. Current availability of PEP is geographically limited and inconsistent. Funds will support PEP services, education and awareness, and starter kits. This proposal is consistent with *Blueprint* recommendations 3, 4, 10, and 11 through 14.

Linkage to Care: It is estimated that 77,000 of the approximately 123,000 persons estimated to be living with HIV are virally suppressed, leaving as many as 46,000 people with HIV possibly receiving no or sub-optimal treatment. A key approach to preventing more infections is to identify people living with HIV as soon as possible and link these individuals to care. Early initiation of antiretroviral therapy (ART) medication is recommended and has shown to improve the health of people with HIV, as well as slow disease progression from HIV to AIDS. Ensuring access to continuous care and achieving viral load suppression are critical for reducing morbidity and mortality, thereby reducing the number of new infections in New York State. Funds will support expansion of linkage and retention programs, including grants for linkage to and retention in care for persons living with HIV; contracts with counties for expanded partner services; and transgender health services. In addition, funds will support linkage and retention programs targeted to Medicaid managed care plan enrollees. Viral load suppression rates of Medicaid managed care plans exceed the statewide rate. The 2015 viral load suppression Beta QARR measure showed a viral suppression rate of 79% in HIV Special Needs Plans (SNPs) and 76% in mainstream managed care plans. ETE linkage and retention in care efforts have been targeted to Medicaid members to increase these rates. Specifically, Medicaid and surveillance data have identified 6,400 people in Medicaid managed care plans who are not virally suppressed. Funding has been directed to the Medicaid managed care plans with the largest percentages of persons not virally suppressed to launch initiatives that will link these people to care. Funding is needed for the remaining Medicaid managed care plans. This project is part of the HIV Health Improvement Affinity Group, a joint CMS-HRSA-CDC project built upon the CMS Affinity Group platform with the goal of improving the HIV care continuum, also known as the Cascade of HIV Care. These proposals are consistent with *Blueprint* recommendations 5 through 8, 19, and 26.

In addition, as noted above, approximately one-third of persons living with HIV is co-infected with HCV. Co-infected persons suffer more liver-related morbidity and mortality than those infected with HCV only. Data reported from the AIDS Clinical Trial Group (ACTG) A5001 cohort demonstrate that HIV/HCV co-infected patients visit the emergency department more frequently, are hospitalized more often, and have longer hospital stays than HIV mono-infected patients. Other studies have established HCV-related end-stage liver disease as a leading cause of in-hospital mortality among HIV-infected patients. The reduction and treatment of HCV transmission is a key priority for ensuring one devastating epidemic is not ended while another, which impacts many of the same populations, continues. HCV detection and treatment directly relates to individual health outcomes and overall quality of care. With the arrival of new direct acting antivirals, more than 90 percent of people treated can be cured of their hepatitis C disease, including persons co-infected with HIV and HCV. The new drugs have minimal side effects, and the vast majority of infections can be cured in as short as 12 weeks. Treatment can prevent

cirrhosis, liver failure, and liver cancer, and improves quality of life. Curing hepatitis C improves the clinical outcomes of people living with HIV. Funds will support linkage to care and treatment programs for persons with HCV. This proposal is consistent with *Blueprint* recommendation 26.

High-Impact Prevention: STDs are a major public health challenge and continue to have a significant impact on the health, safety and welfare of citizens of NYS. STD rates are higher among gay, bisexual, and other MSM, and people with an STD are at increased risk of HIV infection. Funds will support grants to strengthen the public health STD infrastructure to serve as HIV hubs of care and prevention; grants for peer-delivered partner services; provider education to improve HIV/STD screening, diagnosis and treatment; and locally tailored social marketing and media campaigns to promote STD and HIV prevention in key populations. This proposal is consistent with *Blueprint* recommendation 4. Funds will also support prevention and support services for MSM, particularly young MSM, which is consistent with *Blueprint* recommendations 2, 3, 12, 22, 25, and 28. Funds will also support the condom access program, which is consistent with *Blueprint* recommendations related to key populations and specific recommendations 3 and 23. Further, funds will support the investigation of “sentinel events,” similar to the work that has led to elimination of mother-to-child transmission of HIV. For example, each IDU transmission should be viewed as a “never event,” just as each mother-to-child transmission is viewed as a “never event.” Due to the availability of harm reduction services for substance users, the proportion of new cases among injection drug users has been reduced from 54% to just 3%. A “sentinel event” project will investigate all IDU transmissions and identify barriers to accessing the harm reduction services that would have prevented such transmissions. Similarly, AIDS mortality will be considered a “sentinel event” and will be investigated to identify the health-related and contextual factors associated with mortality. “Sentinel event” investigations may include chart review. The information obtained will be invaluable in the work toward elimination of transmission among IDUs and improving the health of persons living with HIV/AIDS. These proposals are consistent with the second set of Task Force recommendations in the *Blueprint*, as well as specific *Blueprint* recommendations 15, 29, and GTZ3.

Health Care Workforce Development: NYS ranks first in the country for number of persons living with HIV/AIDS and had 126,275 STD diagnoses reported in 2014. Fortunately, access to health insurance and preventive services is improving for New Yorkers as a result of Federal and State health care reforms including the Affordable Care Act, expanded Medicaid coverage, preventive care incentives, the Delivery System Reform Incentive Payment (DSRIP) Program and the State Health Improvement Plan (SHIP); however, this increased access coupled with a projected rising demand for health care will lead to additional strain on the health care system.

To meet these increasing demands, more than 400,000 physicians, nurse practitioners, physician assistants, and nurse midwives throughout the U.S. will be needed to fill new and existing positions between 2014 and 2024. Research shows that these clinicians will receive insufficient training related to HIV during their medical education. HIV is not taught in many health profession schools because schools are not required to do so by accrediting agencies, and with more patients being seen in outpatient settings, fewer students are exposed to people living with HIV/AIDS during residency, which is skewed toward inpatient care. Understanding the

complex medical and psychosocial needs of HIV, which requires lifelong care, remains challenging for providers in training. The medical needs require a keen understanding of the effects of antiretroviral therapy and the impact of HIV on the generation of inflammation and chronic diseases.

Funds will support the AIDS Institute Fellowship Program, which aims to address this clinical knowledge gap in NYS through training that reflects the priorities set by the State to move toward ending the epidemic, including culturally competent promotion of LGBT health, overall sexual health, as well as up-to-date care for HIV and STDs. Training clinicians in these syndemics, or infections which occur in similar groups of people, will lead to a more comprehensive public health response, as the same behaviors and community characteristics associated with HIV also place individuals and communities at risk for STDs and viral hepatitis. In this way, the Fellowship will lead to achieving the goals of integration of public health and primary care, an important strategic objective of the National Academy of Medicine (IOM). Funds will support a contract or contracts with an academic medical center that will implement clinical fellowships for physicians, nurse practitioners, and/or physician assistants. This proposal is consistent with the *Blueprint* recommendations in categories 2 (Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission) and 3 (Provide access to PrEP for high-risk persons to keep them HIV-negative).

Funds will also support the expansion of a certified peer workforce that can provide linkage, reengagement, treatment adherence, and retention in care services. As noted in the *Blueprint*, peers reflect the diversity of the people they are serving, and they are uniquely qualified by their shared experiences to assist HIV-positive consumers to navigate various health care environments across the service continuum. Peers help to ensure that a consumer-centered approach is taken in service delivery and that access to culturally- and linguistically-appropriate interventions and health care services are more available. Integration of a peer-delivered model in the health care system requires the development of a standardized training program that leads to a certification or designation accepted by service provider agencies and payers, and pays a living wage. Funds will support contracts with 10 programs throughout the State to recruit, support training, and hire a full-time peer or peers with responsibilities related to the ETE goals. Community-based organizations and health care facilities will select peer workers, support them through the certification process, and hire them at a livable wage. This proposal is consistent with *Blueprint* recommendation 21.

In addition, as noted above, approximately one-third of persons living with HIV is co-infected with HCV. Co-infected persons suffer more liver-related morbidity and mortality than those infected with HCV only. Data reported from the AIDS Clinical Trial Group (ACTG) A5001 cohort demonstrate that HIV/HCV co-infected patients visit the emergency department more frequently, are hospitalized more often, and have longer hospital stays than HIV mono-infected patients. Other studies have established HCV-related end-stage liver disease as a leading cause of in-hospital mortality among HIV-infected patients. The reduction and treatment of HCV transmission is a key priority for ensuring one devastating epidemic is not ended while another, which impacts many of the same populations, continues. HCV detection and treatment directly relates to individual health outcomes and overall quality of care. With the arrival of new direct

acting antivirals, more than 90 percent of people treated can be cured of their hepatitis C disease, including persons co-infected with HIV and HCV. The new drugs have minimal side effects, and the vast majority of infections can be cured in as short as 12 weeks. Treatment can prevent cirrhosis, liver failure, and liver cancer, and improves quality of life. Curing hepatitis C improves the clinical outcomes of people living with HIV. It is essential to expand the availability of care and treatment for HCV. Funds will support education and training of clinicians and other health care workers in order to expand HCV treatment. This proposal is consistent with *Blueprint* recommendation 26.

Eligibility

Eligibility will vary among initiatives but will primarily be programs serving persons with HIV infection or at high risk of HIV infection. Some initiatives will target specific populations, such as young MSM, young MSM of color, and transgender populations. Eligibility is established through the procurement process for each initiative.

Expansion Program Benefits

New York State has already implemented numerous initiatives toward ETE. Additional investment is needed to make the goal a reality. An ETE simulation modeling project conducted by the State University of New York's Rockefeller Institute of Government found that despite projected declines in new infections, the ETE goals cannot be met without additional interventions similar to those described in the Blueprint.

The programmatic enhancements that will employ scientific advances and biomedical interventions will pay for themselves as each infection averted saves the system almost \$400,000 in lifetime medical costs. Current NYS efforts are already saving about \$1 billion per year. The further reduction in new infections brought about by the plan to end the epidemic in NYS will increase the savings.

Impact on Medicaid Members

Approximately 60,000 persons with HIV in NYS are Medicaid recipients. The majority of persons served through the ETE initiatives are Medicaid recipients. Program and services aimed at prevention of acquisition and transmission of HIV and improving linkage to care and treatment for persons who are out of care in order to improve health and achieve viral suppression will benefit the Medicaid members living with and at risk for HIV.

Sources of Non-Federal Share of Funding

The funding supporting ETE efforts include Medicaid, as well as State funds appropriated in the State budget annually. Federal grants also support ETE initiatives, including federal Ryan White funds awarded to the State by the U.S. Health Resources and Services Administration and federal prevention funds awarded by the Centers for Disease Control and Prevention.

Budget Neutrality

A return on investment (ROI) perspective provides the opportunity to examine costs and benefits in a structured way. The state's expenditures on efforts to end AIDS as an epidemic should be viewed as investments rather than costs, and HIV infections and their associated lifetime treatment costs averted as the benefits to be realized. Using a recently published estimate of \$357,498 as the lifetime HIV-related medical care costs (expressed in 2013 US dollars), achieving the goal of reducing new HIV infections from 3,000 to 750 per year by the end of 2020 would result in saving medical costs of \$804.4 million from averting 2,250 HIV infections. An ROI approach has been used to assess the return on the public health investment of a large-scale HIV testing program. The Centers for Disease Control and Prevention's Expanded HIV Testing Initiative demonstrated a return of \$1.95 for every dollar invested. (An ROI above \$1 suggests a positive return on investment, where the dollar value of the benefits realized exceeds the dollar value of the resources invested to achieve those benefits.) The state's efforts to eliminate mother-to-child transmission (MTCT) of HIV also demonstrated a positive ROI, as these efforts averted 749 MTCTs of HIV between 1998 and 2010 and returned almost \$4 for every \$1 invested. An ROI perspective takes a financial approach to demonstrate whether an intervention or program is at least cost-neutral, if not cost-saving. Briefly stated, a cost-effectiveness approach takes an economic perspective by considering such economic measures as opportunity costs and productivity losses when computing the costs of an intervention, which are then compared to outcomes that are measured using a common scale, such as HIV infections averted or quality-adjusted life-years. An intervention may be considered to be cost-effective when compared to some other intervention or some accepted benchmark, though it may not necessarily be cost-saving. Many HIV-related interventions have been shown to be cost-effective, such as:

- Interventions aimed at increasing the proportion of HIV-infected persons linked to care within three months of diagnosis;
- Syringe exchange in terms of HIV infections averted, as well as costs saved from not having to treat those infections;
- Condom distribution, which is also cost-saving with relatively small increases in condom use; and
- PrEP for high-risk MSM in high-incidence areas.

Ending the Epidemic investments save lives, avert costs, and advance wellness across diverse communities in NYS. ETE efforts are cost effective and benefit the State's Medicaid program.

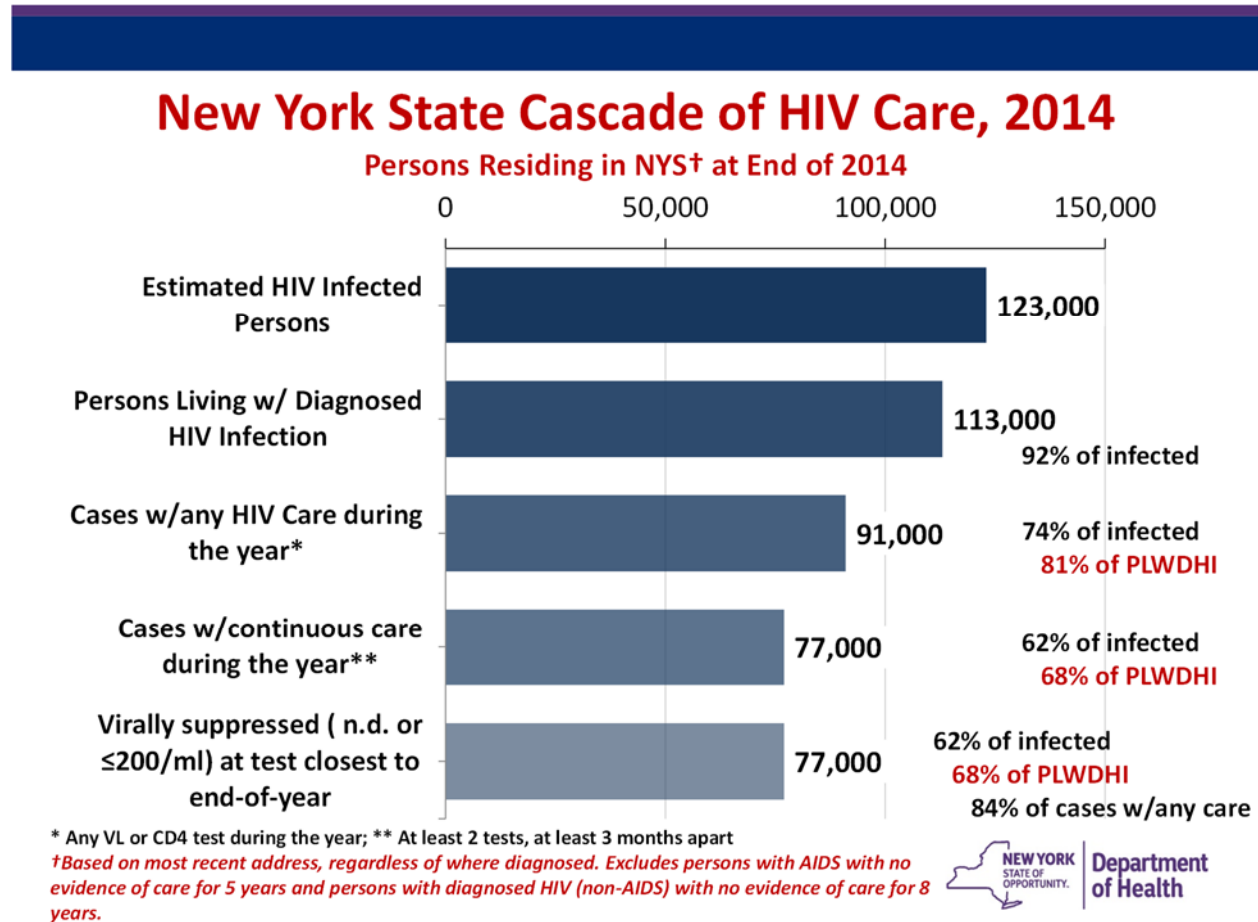
Reporting, Program Monitoring and Quality Management

Metrics used to evaluate the amendment will focus on the measures associated with the Cascade of HIV Care:

- Estimated HIV-infected persons;
- Persons living with diagnosed HIV infection (i.e., persons aware of their status);
- Persons with any HIV care during the year;
- Persons in continuous care during the year;

- Persons virally suppressed.

Following is the State’s Cascade of HIV Care for 2014:



The ETE effort aims to push the bottom four bars of the cascade by increasing persons diagnosed, persons in care, and persons virally suppressed.

Additional metrics are being developed to assess progress toward meeting ETE goals and to evaluate the amendment, including:

- **Incidence:** By the end of 2020, reduce new HIV infections to 750
- **Linkage to Care:** By the end of 2020, increase the percentage of newly diagnosed persons linked to HIV medical care within 30 days of diagnosis to at least 85%
- **Time to AIDS (progression):** By the end of 2020, reduce the rate at which persons diagnosed with HIV progress to AIDS by 50%
- **Any Care:** By the end of 2020, increase the percentage of persons living with diagnosed HIV infection who are in care to 90%
- **Continuous Care:** By the end of 2020, increase the percentage of individuals living with HIV infection with continuous care to 90%

- **Viral Suppression:** By the end of 2020, increase the percentage of individuals living with diagnosed HIV infection with suppressed viral load to 80%

Public Comments Received and Response

¹Gindi RM, Black LI, Cohen RA. Reasons for emergency room use among U.S. adults aged 18–64: National Health Interview Survey, 2013 and 2014. National health statistics reports; no 90. Hyattsville, MD: National Center for Health Statistics. 2016.



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

September 30, 2016

Mr. Eliot Fishman
Director
Center for Medicaid and CHIP Services (CMCS)
Center for Medicare and Medicaid Services
7500 Security Blvd, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Mr. Fishman:

Pursuant to the terms of New York State's Medicaid Section 1115 Demonstration Partnership Plan (11-W-00114/2), the State is required to seek Federal approval of any amendments. In accordance with this requirement New York State Department of Health (NYSDOH) is submitting this request to the federal Centers for Medicare & Medicaid Services (CMS) to amend the 1115 Waiver, seeking the following changes:

NYSDOH is requesting an authorization of federal Medicaid matching funds for limited and targeted Medicaid services to be provided in the 30-day period immediately prior to release to incarcerated individuals who are eligible for and enrolled in Medicaid, and are eligible for New York's Health Home program (i.e., they have two or more chronic physical/behavioral conditions, serious mental illness (SMI) or HIV/AIDS). The goals are to establish linkages to health care prior to release to help ensure individuals can remain healthy and stable in the community. The Amendment will also facilitate the goals of Delivery System Reform Incentive Payment (DSRIP) program to reduce avoidable hospitalizations and health care costs, as well as improve health outcomes.

The covered Medicaid services to be made available during the 30-days prior to release from the correctional facility are:

- Health Home care management, including outreach, enrollment and development of a care plan;
- Limited clinical consultation services provided by community based medical and behavioral health practitioners to facilitate continuity of care at post release; and
- Certain medications including long acting or depot preparations for chronic conditions (e.g. schizophrenia, substance use disorders) or suppressive or curative medications (e.g. HIV, hepatitis C) that would support longer term clinical stability post release.

Individuals released from incarceration often experience significant barriers to successful community re-entry. Research supports that a disproportionate number of persons are incarcerated with behavioral health conditions (i.e., substance use disorders and mental health diagnoses) as well as HIV/AIDS and other chronic diseases. The ability to provide Medicaid services during the 30-day period prior to release will help to bridge the gap in connectivity to health care services for incarcerated individuals as they re-enter the community. Specifically, the Amendment will provide incarcerated individuals the ability to:

- Effectively engage with a Health Home care manager to begin to develop an integrated care plan that identifies medical, behavioral health and social needs to support a stable and successful community life;
- Establish relationships with critical community based medical and behavioral health professionals prior to discharge; and
- Receive appropriate stabilizing medications prior to release to facilitate maintaining medical and psychiatric stability while facing the challenges of transitioning back to the community.

If CMS wishes to discuss this request further, please contact Lana Earle of my staff at 518-473-0919. Thank you for your consideration of this request.

Sincerely,



Jason A. Helgeson
Medicaid Director
Office of Health Insurance Programs

Attachments

cc: Michael Melendez, CMS
John Guhl, CMS
Angela Garner, CMS
Deb Steinbach, CMS
Gregory Allen, NYS DOH
Lana Earle, NYS DOH
Jonathan Lang, NYS DOH
Peggy Elmer, NYS DOH
Priscilla Smith, NYS DOH
Paul Francis, NYS Executive Chamber

New York State
Criminal Justice
Partnership Plan Waiver Amendment

Introduction:

New York State is requesting approval from the Centers for Medicare and Medicaid Services (CMS) for an amendment to its Partnership Plan Waiver to authorize federal Medicaid matching funds for limited and targeted Medicaid services to be provided in the 30-day period immediately prior to release of incarcerated individuals who are eligible for and enrolled in Medicaid, and are eligible for New York's Health Home program (i.e., they have two or more chronic physical/behavioral health conditions, serious mental illness (SMI) or HIV/AIDS.) Coverage for these services is requested for persons incarcerated and sentenced in county and state facilities.

The covered Medicaid services to be made available in the 30 days prior to release from the correctional facility are:

- Health Home care management, including outreach, enrollment and development of a care plan.
- Limited clinical consultation services provided by community based medical and behavioral health practitioners to facilitate continuity of care at post release.
- Certain medications including long acting or depot preparations for chronic conditions (e.g., schizophrenia, substance use disorders) or suppressive or curative medications (HIV, hepatitis C) that would support longer term clinical stability post release.

The ability to provide Medicaid services during the 30-day period prior to release will help complement other initiatives that the State has implemented to engage the criminal justice population in health care as they re-enter the community. These initiatives include: (1) the Health Home Criminal Justice Workgroup which is a NYS Department of Health (DOH) sponsored statewide group convened around the opportunities for the Medicaid Health Homes to engage the criminal justice population and (2) the Justice and Mental Health Collaboration Program (JMHCP) administered by the NYS Division of Criminal Justice Services (DCJS) in partnership with the NYS Office of Mental Health (OMH) to improve outcomes for individuals with mental illness by enhancing criminal justice and behavioral health collaboration at the local government level. At the local municipality and county level, there are also various health care, community provider and criminal justice collaborations working with criminal justice involved individuals (CJII). The goal of all of these initiatives is to improve the quality of care for this population, reduce their health care costs, and reduce the incidence of and financial cost of recidivism. The State and the stakeholders involved in these initiatives have recommend that the State pursue this waiver to complement and improve the success of these efforts.

Background:

There is ample documentation from across the country that the criminal justice involved population contains a disproportionate number of persons with behavioral health conditions (i.e., substance use disorders and mental health disorders) as well as HIV/AIDS and other chronic diseases. In New York this is evidenced by information from the New York State County Re-entry Task Forces: in the 19 participating counties, of the 4,079 persons eligible for the Task Force Program, 26% required mental health treatment and 79% required substance use disorder treatment while 82% required social

services.¹ A review of the 400 individuals who were jailed in New York City over 18 times in the last five years found a total of 10,000 jail admissions, equivalent to 5 jail admissions per year per person, on average.² Sixty-seven percent of these individuals had mental health problems; 21% had a severe mental illness; and 99% struggled with a substance abuse problem.³

State and local correctional facilities (i.e., prisons and jails, respectively) provide medical services including medications for medical and mental health conditions. Individuals also re-enter the community with a limited supply of medications. However, medication management for substance use disorders is generally not provided. The provision of medication for specific conditions occurs within the controlled setting provided by the facility. This stability disappears when a person is released into the community. Even when individuals are released with medications or a prescription, compliance with or access to medication is not assured. For individuals who have a history of serious mental illness or SUD, particularly opioid abuse, there is a greater risk of non-compliance and/or relapse upon reentry into the community. The inability to adhere to a medication regime increases the risk of recidivism. For previous opioid users, the lack of medication for substance abuse disorders presents a significant danger to previous users who may not appreciate their reduced tolerance and inadvertently overdose and die. Death by overdose is the most frequent cause of death in the first two weeks post release⁴. The use of depot/long acting medications for treatment of schizophrenia and opioid addiction can support a smoother transition into the community, facilitate the successful linkage to other services to further maintain stability⁵. The ability to begin the use of depot/long acting medications prior to release will ensure these medications are clinically appropriate and tolerated and remain in use when the member re-enters the community.

New York is seeking to build and strengthen the relationship between the care provided inside of its jails and prisons and the care provided by Medicaid providers upon release. One of the barriers to establishing this transitional connectivity to health care has been the State's suspension and reinstatement process for Medicaid. The process for re-instating has resulted in delays in having Medicaid coverage restored upon release and creates a problematic gap in which members cannot access services and the continuity of care is disrupted. In the absence of Medicaid coverage, providers are reluctant to make appointments prior to release and in the immediate period after release. In 2014, the NYS Council on Community Re-Entry and Reintegration was formed to address obstacles faced by individuals transitioning from incarceration to the community, including this gap in the reinstatement of health coverage. To facilitate the arrangement of critical services prior to release the Council recommended that NYS reinstate Medicaid benefits 30 days prior to release, but not allow services to be billed, and issue a Medicaid benefit card prior to release. The DOH Office of Health Insurance Programs is currently working to implement this "reinstatement without ability to bill" function.

To complement this effort and more effectively address the gap and increase the likelihood that post-release programs succeed with respect to the most medically and socially complex inmates, New York State enacted legislation as part of the Fiscal Year 2016/17 Budget permitting the State to:

¹ County Re-entry Task Force Program Activity Report: July 2013 – June 2014

² Mayor's Task Force on Behavioral Health and the Criminal Justice System: Action Plan (Dec. 2014)

³ Ibid.

⁴ Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors, I.A.Binswanger, et al., *Addiction Science and Clinical Practice* 2012 7:3

⁵ The role of long-acting injectable antipsychotics in schizophrenia: a critical appraisal, S. Brissos et al., *Ther.Adv.Psychopharmacol* 2014 Oct. 4(5): 198-219

“Seek federal authority to provide medical assistance for transitional services including but not limited to medical, prescription, and care coordination services for high needs inmates in state and local correctional facilities thirty days prior to release.”⁶

By receiving transitional services and linkages to community-based resources, justice-involved individuals with significant health conditions will be more likely to remain stable in the community, avoid relapse and overdose, reduce emergency department (ED) use and hospital admissions, and avoid re-incarceration.

Program Design:

The goal of this program is ensure a seamless transition to community based services for incarcerated individuals reentering the community who are eligible for the Health Home program. Thirty days prior to release, this amendment will provide incarcerated individuals the ability to:

- Effectively engage with a Health Home care manager to begin to develop an integrated care plan that identifies medical, behavioral health and social needs to support a stable and successful community life, and addresses eligibility/enrollment in a managed care and/or Health and Recovery Plan, if appropriate, in collaboration with the discharge planning services of the facility,
- Meet and establish relationships with critical community based medical and behavioral health personnel prior to discharge, and
- Receive appropriate stabilizing medications prior to release to facilitate maintaining medical and psychiatric stability while facing the challenges of transitioning back to the community.

The three components above, specifically Health Home care management, consultation with medical and/or behavioral health providers, and medications including long acting depot medications are currently Medicaid benefits. When a community provider cannot meet directly with the individual and discharge planner due to distance from a specific state prison, the majority of state prisons have videoconferencing that should allow services consistent with New York State Medicaid telehealth requirements. This amendment will provide the opportunity to address current restrictions on providing and billing for this tailored scope of Medicaid benefits that are critical to ensuring smooth transition to the community. New York State is ideally situated to implement a pilot, testing the efficacy of adding these services to covered Medicaid services in this limited environment. See chart below.

Table 1: Key Components of the Criminal Justice Reentry Program

Key Components of Criminal Justice Reentry Program		
Component:	Status:	Implementation Date:
Implementation of Suspension Status for incarcerated Medicaid members	In Place	2008

⁶ Chapter 59 of the New York State Laws of 2016, Part B, § 21-a.

Key Components of Criminal Justice Reentry Program		
Component:	Status:	Implementation Date:
Health Homes	In Place	2012
Health Home Criminal Justice Workgroup	In Place	2012
Reinstatement of Medicaid benefits for incarcerated persons 30 days prior to release (no billing allowed)	In Process	Anticipated to begin Fall 2016
Medicaid Coverage for Transitional Services for Medicaid members beginning 30 days prior to release	Requested	January 2016

While the State has implemented many actions to assist those transitioning from incarceration to the community, there remains a significant gap in the ability of the State to provide transitional services prior to discharge. Individuals leaving incarceration often have experienced significant social disruption that they need to resolve. They may be homeless, they may be abandoned by families or only have connections to the persons, places and influences that initially lead to their involvement with the criminal justice system. There are numerous stories of persons committing crimes only to facilitate return to the stability of a correctional facility where they are housed, fed and provided medical care – none of which they were able to access within the community. Even under the best of circumstances, when a person is discharged without prior contact with his/her future care manager or care provider or does not have long acting depot medications, there is a high risk he/she will establish other priorities and will not engage with critical service providers when they reenter the community. Engagement and contact with the individual needs to be happen prior to release to comfortably facilitate the continuity of care after discharge. This remains the critical piece to complete the activities that New York State has already implemented.

Table 2: Services Requested in the 30 Days Prior to Release from Incarceration

Services	Covered under Medicaid?	Requested for coverage in 30 days prior to discharge?
Health Home Care Management (Engagement and care plan development), including by telemedicine linkage	Yes	Requested
Initial consultation by physician, nurse practitioner, licensed/registered/certified substance use disorder or mental health specialist, including by telemedicine linkage	Yes	Requested

Services	Covered under Medicaid?	Requested for coverage in 30 days prior to discharge?
Medications used for management of substance use disorders (e.g., buprenorphine and other long acting depot medications)	Yes	Requested
Medications used for management of psychiatric disorders	Yes	Requested
Medications used for management of high risk chronic disorders including HIV/AIDS; Hepatitis C	Yes	Requested

Eligibility:

Individuals eligible for this program are those whose Medicaid benefits were limited to inpatient hospital only, are 30 days from their expected release date (ERD), and who meet New York State’s Health Home eligibility criteria. Specifically, individuals must have two or more qualifying chronic diseases, HIV/AIDS, or serious mental illness. Medicaid members who are eligible for HARPs are also eligible for Health Home services.

Currently, reinstating Medicaid 30 days prior to release is more easily accomplished in the state prison system where there is more certainty around release dates and there are systems in place to exchange such data between Department of Corrections and Community Supervision (DOCCS) and DOH. The State is now working to develop data exchange processes between county jails, state criminal justice agencies and DOH. During the development of those processes, the State will phase in the demonstration by beginning the program in the State prisons, and then expanding to county jails.

As shown in the table below, there are 25,019 annual discharges from prison, and 193,349 annual discharges from jail (64,699 in New York City, and 128, 650 in rest-of-State jails). The State preliminarily estimates that approximately 55% of this population would be eligible for Health Home (25% serious mental illness, 5% HIV, and 25% with chronic conditions, which include a SUD or Hepatitis C diagnosis).

Table 3: Incarcerated Population in New York State

Incarcerated Population in New York State			
Aggregate Sites	Average Daily Population	Total Annual Discharges (includes multiple discharges for same person)	Date of Statistic
New York City Department of Correction —County Jail	9,753	64,699	2015
Rest of State – County Jails	15,573	128,650	2015

New York State Department of Corrections and Community Supervision – State Prison	52,045	25,019	2015
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Enrollment:

DOH will work with counties and DOCCS to provide training around the provisions of the amendment, the Health Home program and Health Home eligibility requirements. Individuals who are eligible for Health Home will be identified by the health care providers within the DOCCS prisons and county jail systems. The State will also work with DOCCS and counties to match Health Home eligible lists to members who are approaching the 30 day pre-release timeframe. The Health Home care manager will be the focal point for discharge planning, including using the limited scope of Medicaid benefits authorized under this amendment within the 30 day period. The Health Home care manager will be the hub for conducting and maintaining continuity of care with the individual during pre and post discharge to the community. The Health Home care manager will also identify HARP eligible members and arrange care planning accordingly, including connectivity to Home and Community Based Services. Members not eligible for HARP will be assisted with enrollment in a managed care plan.

Expansion Program Benefits:

As referenced above, New York already has implemented many initiatives to improve care for the justice-involved population with chronic conditions, including those affected by the opioid epidemic, other substance use disorders, mental health conditions (e.g., NYS Office of Mental Health Medication Grants Program), and/or HIV/AIDS (“End the Epidemic”). The State has expanded Medicaid coverage to all low-income adults; elected to suspend rather than terminate Medicaid eligibility for inmates; designed a benefit package that covers the optimal continuum of substance use disorder and mental health services; established Health Homes initiatives focused on the criminal justice-involved population at release; and launched an ambitious delivery system reform effort- the Delivery System Reform Incentive Program (DSRIP). This amendment will complement and facilitate the success of those efforts by ensuring inmates with serious physical and behavioral health conditions can return to the community with the services they need already in place and be better poised to appropriately leverage needed State and Federal services in the community.

Impact on Medicaid Members:

The targeted scope of Medicaid benefits provided to inmates 30 days prior to release under this amendment will provide for effective discharge planning by linking individuals with serious physical and behavioral health conditions to a comprehensive system of care and transitional supports during pre **and** post discharge to promote stability in the community. The introduction and linkage to services pre-release ensures connectivity to care at release. Authorizing the targeted scope of benefits for this well-defined group of criminal justice involved individuals will improve health outcomes, and consistent with DSRIP goals, reduce avoidable hospitalizations, and Medicaid costs. Further, this Amendment will

provide CMS and New York the data to evaluate the improvements in health outcomes and the reduction in Medicaid costs of providing critical discharge planning services to inmates pre-release.

It is well documented that inmates with serious health conditions use relatively costly Medicaid services (inpatient hospital stays, psychiatric admissions, ED visits for overdoses) at a high rate in the weeks and months immediately after release:

- One in 70 individuals are hospitalized within a week of release from prison or jail (2.5 times higher than non-inmates) and 1 in 12 are hospitalized within 90 days (nearly 2 times higher than non-inmates),⁷ rates which are likely higher for high-cost, high-need inmates targeted by the demonstration waiver.
- According to a national study by Frank et al., nearly a quarter of ex-inmates had a first emergency department (ED) visit within one month of release and were more likely than the general population to visit the ED due to a mental health condition, substance use disorder, or ambulatory sensitive condition.⁸
- According to Althoff et al., immediately after prison release, HIV+ released prisoners are at high risk of discontinuous primary care and lapses in antiretroviral therapy (ART) adherence.⁹

There is also strong evidence that appropriate transitional services can reduce the poor outcomes and high costs among former inmates.

- Pre-release discharge planning has been associated with increased retention in HIV care among HIV+ individuals released from jail across 10 diverse U.S. sites.¹⁰
- In one three-year pilot program for newly released inmates, only 2 of 83 patients on long-acting injectables used illegal drugs or alcohol.¹¹ Similarly, in one observational study, patients who received long-acting antipsychotic medications were twice as likely to remain in treatment as those who received oral antipsychotic medications.¹²
- Long-acting antipsychotic medications also impact recidivism rates. Only 21% of former inmates receiving these medications were re-incarcerated within three years of their release, far below the national average of 70% of inmates returning to jail within three years.¹³

Network Adequacy and Provider Readiness Analysis:

⁷ A High Risk of Hospitalization Following Release from Correctional Facilities in Medicare Beneficiaries: A Retrospective Matched Cohort Study, 2002 to 2010 (Sept. 2013). Available from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4069256/pdf/nihms-586569.pdf>

⁸ Emergency Department Utilization among Recently Released Prisoners: A Retrospective Cohort Study (Nov. 2013). Available from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3818565/>

⁹ Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study (Oct. 2013). Available from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3714328/>

¹⁰ Ibid.

¹¹ Breaking Good: Vivitrol, A New Drug Given As A Monthly Shot, Is Helping Addicts Stay Clean (March 2015). Available from https://www.washingtonpost.com/lifestyle/magazine/his-last-shot-will-a-monthly-jab-of-a-new-drug-keep-this-addict-out-of-jail/2015/03/05/7f054354-7a4c-11e4-84d4-7c896b90abdc_story.html

¹² Time to Discontinuation of Depot and Oral First-Generation Antipsychotics in the Usual Care of Schizophrenia (March 2008). Available from <http://www.ncbi.nlm.nih.gov/pubmed/18308914>

¹³ Vivitrol Program Helps Inmates Stay Sober (April 2015). Available from <https://www.pgdf.org/vivitrol-program-helps-inmates-stay-sober/>

Every county in New York State has at least one active Health Home already interacting with substance use disorder, mental health and physical health providers, community based organizations, and county mental health services (Single Point of Access [SPOA]). A number of these Health Homes are already working with criminal justice involved individuals and engaged with prisons and jails. Additionally, all Health Homes are working with Health and Recovery Plans, a managed care option for individuals with significant behavioral health needs. The ability to identify and link HARP eligible members prior to release will help facilitate the enrollment of HARP members and, most importantly, link them to the array of Home and Community Based Services they are eligible for and which will help transition former inmates to the community.

DOH is now working to strengthen the health information exchange process between the criminal justice system, Health Homes and the State. While there is good communication between DOCCS and DOH for the purposes of managing the suspension process, the data exchange capabilities between counties and the State is still in an early stage of development; however, the State is exploring opportunities to create shared systems of communication for the purposes of outreach referral and linkage to Health Home care management.

Sources of Non-Federal Share of Funding:

The services that are being requested for coverage during the 30 days prior to release from state and county correctional services are currently already covered for Medicaid members who are not incarcerated and who are in fee for service or Medicaid Managed Care Plans. Services are covered with State and Federal matching funds in accordance with the individual's category of eligibility. The State expects savings from drug rebates and from unnecessary services (e.g. Emergency Room and inpatient) that are avoided as a result of providing a limited scope of Medicaid benefits. The State will manage the upfront costs to the Global Spending Cap (GSC).

Budget Neutrality:

New York State and CMS are continuing to discuss the methodology around determining budget neutrality and savings calculations which may result in changes to how members are identified and classified and the corresponding calculation of their costs and savings. Upon completion of those discussions the State will submit estimated costs for the program and demonstrate budget neutrality. Based upon discussions with CMS to date, the State is confident it will be able to demonstrate budget neutrality under this amendment.

Reporting, Program Monitoring and Quality Management:

Today, there are no nationally recognized metrics that address the health and wellness outcomes of reentry programs. This amendment will help provide that missing data and analysis. Metrics for analyzing the impact of the amendment will also naturally align with Managed Care Plan measures, DSRIP and value based payments. It is anticipated that DOH, DOCCS, and county/New York City jails in collaboration with the Health Home Criminal Justice Workgroup and other stakeholders, will monitor the implementation of the program and its anticipated outcomes. As discussed earlier, the State is

working to link Medicaid data and criminal justice information. Medicaid claims and encounter data will also be used to help evaluate changes to health outcomes of individuals covered under the amendment.

Metrics used to evaluate the amendment will include the following data and quality measures for each member (if applicable) that received any of the limited scope of Medicaid benefits authorized 30 days prior to release. Members will be tracked during the 30 day pre-release period and for at least 18 months, beginning with the month they re-enter the community.

- 1) The number and percentage share of members that had a primary care visit within 30 – 45 days of release.
- 2) The number and percentage share of members that had a behavioral health/clinic visit within 30-45 days of release.
- 3) The number and percentage share of members that remained continuously linked to Health Home (as measured by monthly billable care management services) or that were discharged from Health Home because they were determined to be stable and no longer need Health Home care management.
- 4) Number and percentage share of members that had improvements in clinical outcomes (e.g., HIV+, CD4 and VL, for DM, and HbA1c).
- 5) Number and percentage share of members that were not stably housed (as measured and tracked by the functional indicators of the Health Home “high, medium, low” payment methodology).
- 6) Number and percentage share of members that continuously adhered to medication regime (including substance abuse and mental health medications).
- 7) Number of emergency room visits per member, percentage of members that had one or two or more emergency room visits.
- 8) Number of inpatient stays per member, percentage of members that had one or two or more inpatient stays.
- 9) Number and percentage share of members that were arrested and number and percentage share that were arrested due to behavioral health incident (if known).

Public Comments Received and Response:

Please see Attachment 1 documenting public comments received in response to the State’s Public Notice regarding the submission of this amendment. The following provides a summary of the name/entity that submitted the comment, the date the comment was submitted, a brief summary of the comments and the State’s response.

- 1) Letter of Support from the Legal Action Center (in Attachment 1): Letter of support for the proposed waiver.
- 2) Comments from the New York State Conference of Local Mental Hygiene Directors, Inc. (in Attachment 1): The Conference expressed its support for this waiver and noted that the Local Governmental Units work closely with their local correctional facilities. They noted the following items for consideration:
 - a) have all inmates who meet Health Home criteria to be eligible for Health Home Plus, a higher intensity program. They provided their recommended criteria. DOH Response: The criteria are very broad and would appear to include essentially all Health Home eligible releasees. This is not consistent with current Health Home plans.

b) proposed a number of services including care management, mental health and SUD treatment, medication management, discharge planning, comprehensive assessment for mental health and SUD, psychotropic medications, peer services and group support. DOH Response: A number of the suggestions were already in the waiver. A number of the suggestions were already provided within the incarceration site or were in the class of Home and Community Based Services and not within the scope of this waiver request.

- 3) Comments from Ronald Harling, Superintendent, Monroe County Jail (in Attachment 1) : Mr. Harling submitted comments on the services that his team would like to be considered as part of the submitted waiver. Specifically he listed diagnoses including increasing population eligible for Health Home Plus and high risk circumstances that would identify high need inmates. Additionally, he suggested the following services: in reach care management, in reach chemical dependency and mental health intake, and groups by community providers. DOH Response: Comments on Health Home Plus will be shared with the Health Home team but are not consistent with current plans. The listed diagnoses are included in those for Health Home eligibility. High risk circumstances are further considerations already in Health Home eligibility. Three of the requested services are consistent with the current waiver request; group therapy sessions should be part of the services already provided with the facility and are not considered transitional services.
- 4) Email request from Elizabeth Hagan, Families USA, who was interested in writing an article about “New York’s great work”.
- 5) Email request from Chuck Hitchings, Treinen, requesting briefing documents. DOH Response: The gentleman was referred to the Public Affairs Group since his request was the broader state initiative.