VIA EMAIL to peoplefirstwaiver@opwdd.ny.gov

June 25, 2020

Donna Frescatore
Medicaid Director
New York State Department of Health
One Commerce Plaza
Albany, New York 12210

Dr. Theodore Kastner
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Executive Office
44 Holland Avenue
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Re: Questions/Comments on Revised Draft SIP-PL Qualifications Document

Dear Ms. Frescatore and Commissioner Kastner:

On behalf of four organizations that intend to apply to become Specialized I/DD Plans - Provider Led (SIPs-PL) and their associated Care Coordination Organizations (CCOs), we support the State's plan to transition the I/DD population to a provider-led managed care model as evidenced by the White Paper that we sent to the Governor last week (also attached to this letter).

Moreover, we are pleased to share the below comments on the Revised Draft New York State Medicaid Managed Care Organization I/DD System Transformation Requirements and Standards to Serve Individuals with Intellectual and/or Developmental Disabilities in Specialized I/DD Plans - Provider Led (SIPs-PL) that was issued on February 20, 2020.

Implementation Timeframes

1. We are concerned that the revised draft SIP-PL Qualification Document does not reference a timeframe for implementation of the transition to managed care as referenced in Table 1 of the original draft Qualification Document released in August 2018.
    a. We strongly urge the State to consider reinstating a timeline to ensure the effective implementation and transition to managed care so service providers, individuals, families, and other stakeholders can appropriately prepare for the work ahead.
    b. We propose Statewide voluntary enrollment into SIPs-PL beginning in 2021 with mandatory enrollment beginning in 2022.

Application Review Process

2. The revised qualifications document mentions that "it is written for organizations that have first applied to obtain Article 44 licensure as an MMCO" (page 4).
    - For entities that intend to become a SIP-PL, are qualified per the revised qualifications document, and have already applied to obtain Article 44 licensure as an MMCO but have not yet been approved, can the Article 44 application and SIP-PL application review processes, including the readiness reviews, be done concurrently rather than sequentially to speed up the overall approval process towards launch?

Enrollment

3. The revised qualifications document mentions that "MMC eligible non-I/DD family members of SIP-PL enrollees may enroll in a comprehensive MMC program also operated by the SIP-PL" (page 8).
    - Does the above sentence mean that an entity operating a SIP-PL must also operate a Mainstream Medicaid plan in all of the counties where it operates a SIP-PL?
    - While it may be a benefit for family members of individuals with I/DD to be enrolled in a plan operated by the same organization that operates a SIP-PL, operating a comprehensive MMC program, in addition to a SIP-PL, would cause both a financial and administrative burden.

4. The revised qualifications document mentions that "SIP-PL enrollment will be rolled out Statewide and begin with the voluntary enrollment of individuals with Medicaid only. Thereafter, enrollment will be expanded to include individuals with both Medicaid and Medicare coverage and individuals with Medicaid and comprehensive Third-Party Health Insurance (TPHI)" (page 8).
    - We strongly urge the transition into managed care to be inclusive of all eligible individuals, regardless of coverage type, at the outset to ensure full integration (Medicaid, TPHI and Dual populations) and allowing all eligible individuals the benefits of receiving holistic person-centered care.
    - The document doesn't go into detail on coordination with Medicare benefits, but there would need to be policies for coordination, and presumably a separate rate developed for duals.
    - While the document mentions coordination with Medicare Advantage plans, the SIP-PL plans would also need to be able to coordinate care for individuals who remain in Medicare fee-for-service.
    - It may be beneficial to mandate dual eligible individuals to enroll in the Medicare Advantage product operated under the parent organization of the SIP-PL plans. This idea of creating an integrated approach or even product for duals with I/DD aligns with the MRT II initiative concerning enrolling duals into an integrated product.

5. The revised qualifications document mentions that "the shift to mandatory enrollment will be subject to CMS approval and may only begin if there are sufficient Plans available to ensure choice, per CMS requirements." (page 10).
    - How many plans must be available to ensure choice? Is it different if it is an urban county vs. a rural county? We propose minimally two plans per county to meet the criteria of ensuring choice, per industry standards.
    - If there are sufficient plans available in some geographies and not others, will the transition to mandatory enrollment happen in those counties and stay voluntary enrollment in other counties pending the availability of sufficient plans?

6. The revised qualifications document mentions that "Prior to the time when SIP-PL enrollment becomes mandatory for OPWDD services, individuals who are enrolled in an MMCP will have the option of retaining their MMCP and receiving OPWDD services via Medicaid fee-for-service or opting to enroll in a SIP-PL. At the time when SIP-PL enrollment becomes mandatory, OPWDD benefits may only be accessed through a SIP-PL" (page 8).
    - In order to increase the population that is eligible to enroll in a SIP-PL during the voluntary period and support viability of SIPs-PL if the transition to mandatory enrollment gets delayed, we recommend that:
        - Starting one year after voluntary enrollment starts, OPWDD benefits may only be accessed via Medicaid fee-for-service if the individual is not enrolled in a MMCP or via the SIP-PL if the individual opts to enroll in a SIP-PL; and
        - Once SIP-PL enrollment becomes mandatory, OPWDD benefits may only be accessed through a SIP-PL (this is included in the current guidance).
    - This change would increase the pool of potential SIP-PL enrollees in the event that the transition to mandatory enrollment is delayed beyond one year after voluntary enrollment starts. Moreover, it would increase the potential for individuals with I/DD to have their care managed by an insurance plan that has population-competent care managers rather than generic care managers from a Mainstream plan.
    - We also encourage the State to address the mechanism by which individuals who do not select a plan during the mandatory phase would be assigned to a SIP-PL.

Enrollment/Rates

7. The revised qualifications document mentions that "SIP-PL enrollment will be rolled out Statewide and begin with the voluntary enrollment of individuals with Medicaid only. Thereafter, enrollment will be expanded to include individuals with both Medicaid and Medicare coverage and individuals with Medicaid and comprehensive Third-Party Health Insurance (TPHI)" (page 8).

- Will the capitation rates for individuals with Medicaid only be different from the rates for individuals with both Medicaid and Medicare coverage and the rates for individuals with Medicaid and comprehensive Third-Party Health Insurance?
- If so, will the rates be actuarially sound for each of the groups individually?
- In addition, will the State release data books showing the costs and utilizations of each of these three groups for planning purposes?

8. Will plan rates and rate assumptions be issued well in advance of launch? It's critical as plans build out staffing and service delivery to ensure it aligns with State assumptions and reimbursement.
9. Will the State be implementing risk adjustment for plan payments?
10. What is the State's target retention ratio for the SIPs-PL?
11. Is there any anticipated relaxation of Equity/Capital Surplus requirements for SIPs-PL?

Marketing

12. The revised qualifications document restricts the ability of plans to market: "Managed Care Plans may not conduct outreach/marketing activities directly to individuals to encourage enrollments" (page 10). Only "passive marketing" (for example, creating a brochure) would be allowed.
    - While this type of restriction could be imposed at the time that enrollment becomes mandatory, we are concerned that including this restriction in the initial years, while enrollment is voluntary, will limit the growth of the plans.
    - The State should consider engaging plans as their partner to build awareness and acceptance for this new approach to caring for beneficiaries with I/DD needs.
    - We would recommend instituting similar guidelines as CMS has for Medicare plans including allowing for face-to-face marketing.

Residential Services

13. The revised qualifications document mentions that "the OPWDD residential benefit is expected to be carved into the SIP-PL benefit package no less than two years after voluntary enrollment begins" (page 10).
    - While the plans would not be at financial risk for these services in the first 2 years after mandatory enrollment, it will be important for plans to have a stake in the VBP arrangements that are described. The plans must be able to partner with providers and share in the savings that result from good quality outcomes.
    - We are concerned with this fragmented approach and strongly believe that the State to carve-in all health, long-term care and OPWDD services from the onset of the transition into managed care to ensure full integration, allowing all eligible individuals the benefits of receiving holistic person-centered care.

Data

14. The revised qualifications document states that "SIP-PL Applicants will be given information about the providers that most frequently serve the I/DD population and will be encouraged to contract with them" (pages 5-6).

- We encourage the State to make this information available as early in the process as possible to help facilitate the development of strong provider networks.

15. The 2017 FFS Data included in Attachment J: Pro-forma Template shows a range of Medical PMPM of between $230.07 and $1,431.48 for the various cohorts. Included in this are unit costs and PMPM for individual medical services.
    - What does the unit cost for each of the various services represent? For example, what is considered a unit for "Inpatient General" and why does the unit cost range between $23 and $35?
    - Will the State conduct a webinar/training to go over the data included in the attachment and answer specific questions on the data?
    - In addition to 2017 FFS data, does the State plan to release any additional data books and rate books for this implementation? If so, what is the timing for sharing the information?
    - We would recommend that the State provide 2-3 years of additional historical data on the utilization and cost for the I/DD population so that prospective SIPs-PL can better understand trends and develop more informed projections going forward.

Personnel

16. Overall, the document is very prescriptive about key staff roles and the qualifications for people who would fill these positions. There is a very heavy emphasis on experience with I/DD populations and behavioral health services across the board, and very little emphasis on developing leadership in the plans that have experience in a managed care setting. In Attachment C, for example, the document states that the I/DD care management director must be a Nurse Practitioner.
    - We are concerned that the detailed qualifications outlined in the document could hinder the plans' ability to recruit qualified people for these positions.
    - We ask the State to review this approach.

Continuity of Care

17. The document describes very strong transitional care requirements for members who enroll in the SIP-PL (pages 30-31). For example, if a member is receiving care from a provider, he/she can continue to see that provider for 24 months on an out-of-network basis. In addition, members receiving care management from a CCO can continue with their pre-existing CCO.
    - These types of requirements could limit the ability of the plan to effectively work with providers to manage the members' care.
    - The requirements could also inadvertently create a disincentive for providers to contract with the plans.
    - We recommend that the State follow standard Medicaid and Medicare regulations on this matter which typically mandate a continuity of care period of "90 days or until the active course of treatment is completed."

Utilization Management

18. The revised qualifications document mentions that "in general, denials, grievances, and appeals of health and behavioral health services must be peer-to-peer. A peer is defined in Public Health Law Section 4900(2)(a) (i-iii). Further, the following standards shall apply to SIP-PL staff conducting utilization management reviews for the SIP-PL…" (pages 35-36).
    - Are the physician review requirements separate depending on the service being reviewed or do all decisions need to be rendered by an MD with experience in the I/DD population and one of the other specialties (eg: if a child with I/DD then it needs to be a child psychiatrist with I/DD experience)?
19. The SIP-PL is required to accept the CCO's life plan at the time of enrollment (page 34).
    - Although this is a member protection that ensures continuity of care, it could make it more difficult for plans to ultimately manage service utilization when combined with the transitional care requirements described on pages 30-31.

Value-Based Payments

20. There is a passing reference to VBP, and the need for SIP-PL plans to support the State's strategy to foster VBP contracts.
    - We strongly agree with the value of VBP arrangements in order to shift from quantity to quality of services.
    - It will be important to understand the actual goals and requirements that the State intends to include in the final SIP-PL design.

Reporting Requirements

21. In the list of reporting requirements (attachment b), there are numerous data elements that the SIP-PL plans will need to develop from record review and other ancillary databases.
    - We anticipate that there will be a wealth of electronic data available in the plans' management information systems and we should avoid burdensome reporting requirements.
    - It should be noted that this was another flaw in the FIDA demonstration that we should not repeat.

We appreciate having the opportunity to share feedback and look forward to working with OPWDD and DOH to make this transition a success.

Sincerely,

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The NYS I/DD System Transformation Through Provider Led Managed Care: The Time is Now 6/18/2020

Overview: The Current Landscape of NYS' I/DD Services

This position paper is submitted in light of current factors within the New York State (NYS) system of disability services presenting substantial risk to individuals with intellectual and/or developmental disabilities (I/DD). The system of I/DD services and supports, in the aggregate, costs government more than $11 billion, in Medicaid, Medicare and 100% state funds, to support approximately 120,000 New Yorkers with I/DD, in addition to significant governmental overhead. Despite this significant investment, the most spent by any state, the system is failing and at a critical juncture. The need for transformation, along with re-imagining the role of State government, must begin now to prevent the collapse of disability programs - a probable outcome considering current financial, regulatory, and policy impediments. NYS must manage the significant investment of more than $11 billion investment in a different, more efficient and effective way.

Why is the I/DD service system heading toward collapse? Overall, it is a system that supported the "status quo" with little incentive to support innovation and creativity. We all participated in developing a system that failed those we were trusted to support; now we must work collectively to course-correct the resulting unsustainable system.

What are the main causes of the problem?

The underlying financial model is broken. The current system of fee-for-service payments, which impact most of the spending for I/DD services, promotes greater spending rather than efficiencies. This financial model continues to result in rate inequities, causing fiscal and programmatic failures for I/DD service providers. The fee-for-service structure limits the flexibility needed for innovation and transition to a service system driven by value rather than volume. As a result, quality is eroding, even as regulations have grown and become onerous, and despite the significant financial investment, the front-line workforce for I/DD programs continue to face dire shortages, with no plan for resolution in sight.

The current I/DD service system has become one of "haves and have nots." This applies to the distribution of resources on an individual, provider and regional level. This inequity is perpetuated year after year, causing an even greater chasm within the industry. Services at the individual level vary significantly, with acuity playing only a limited role. Provider funding varies tremendously, as it is tied to individual provider historical spending and initiation date of services. Regional variances are substantial when considering the distribution of funding across counties as compared to the population distribution; they do not align. Much of this void was created with the closure of the Office for People with Developmental Disabilities (OPWDD) institutions, many of which were in less populated areas of the State, and residential congregate settings were created nearby to support the de-institutionalization.

There is an imbalance in the investment of the financial resources. Currently, almost 66% of the OPWDD budget is spent on certified residential congregate settings and another 22% on

mostly congregate day services. This totals 88% of the budget. What remains is 12% of the OPWDD budget for all other community-based services. This imbalance first started with the closure of OPWDD institutions and has been expanded over many years as resources became available. Such an investment has also resulted in a heavy capital debt load on providers, State and nonprofit.

The I/DD services sector has been slow to integrate into other care delivery systems. For decades, the I/DD system failed to gain a sufficient foothold to integrate critical services related to medical, behavioral health, dental and long-term care services. Unfortunately, these silos continue. The integration issue is rooted in the lack of coordination between the I/DD service system and the general medical, behavioral health and dental communities. This led to access challenges which results in either utilization of higher cost services (such as emergency room and hospitalization) or potential duplication/overlap of services such as personal care and community-habilitation being delivered simultaneously. While the creation of Care Coordination Organizations (CCOs) was the first step toward improving integration of services for the I/DD population, this alone cannot address the fiscal and programmatic management required for true system reform. The confines of the current siloed OPWDD fee-for-service system make it difficult for providers to innovate in the delivery of services and, in fact, rewards providers financially for increased utilization and higher costs.

Service growth at the current rate is unsustainable. Each year, there are several thousand individuals in NYS with I/DD who are either in need of initial services or have changing needs for services. For years, this has been examined through a single lens – that overall system cost must grow to cover the entirety of service growth, generally more than $100M. This is not sustainable, and, in fact, the State's approach is to devise and hoist "efficiencies" onto the service providers.

The role of State government must be re-examined. State government, primarily OPWDD, plays a significant and costly role in the I/DD system since inception of the Office over 40 years ago. The State's role is dual and conflicting as both a regulator and provider of I/DD services. The State's costly role as a provider of service, which remains the largest in the country, was historically considered the provider of last resort. Today, this is no longer true. From a regulatory standpoint, in the wake of the horrors of Willowbrook and other abuses, the system became over-regulated and inflexible, while driving up cost of both the service providers and OPWDD administration.

Medicare must be maximized to the full benefit of the State. Approximately 50% of the I/DD population is enrolled in Medicare due to the continuing efforts of OPWDD, service providers and the CCOs. This saved State costs by shifting previous Medicaid-funded health care services to Medicare. However, we have not fully maximized the potential financial benefit to the State

except for the limited Fully Integrated Duals Advantage demonstration through Partner's Health Plan.

To avoid the collapse of the I/DD system, we must move forward with an integrated managed care model that encompasses all services – healthcare, long-term care, behavioral health, habilitative services - and that drives quality over quantity. The I/DD services sector movement into managed care will create savings and efficiencies, equally sharing those savings with the State while reinvesting back into the I/DD service system. This can truly be the mechanism to protect the viability of disability services and, by extension, the health and wellbeing of New York's most vulnerable citizens. The entire system of I/DD supports and services is at a crossroads. This Administration, under Governor Cuomo's steadfast leadership, can dramatically and enduringly change the system of I/DD service delivery, now and forever.

Proposal: The Path to I/DD Managed Care

I/DD services are the only major Medicaid-funded programs outside of managed care in NYS. In 2011, Governor Cuomo's Medicaid Redesign Team recommended a transition from fee-for-service funding arrangements to specialty, provider-led Medicaid managed care for individuals with I/DD. Following these recommendations, OPWDD and the Department of Health (DOH) developed and began to implement a detailed plan and timetable for managed care, under structure of Specialized Intellectual and Developmental Disabilities Plan – Provider Led (SIP-PL) plans. OPWDD's plan was specifically designed to meet the needs and expectations of the I/DD community. Continued delays in implementation of managed care could impact future State costs and quality of care for individuals. I/DD service providers have or are prepared to invest in preparation for this transition and are ready to move forward.

The State and federal governments made a substantial investment in transforming New York's service system to a managed care model, beginning with the creation of seven CCOs, with responsibility for care planning and management. As stated in the 2018 OPWDD budget language, "the OPWDD system will transition to managed care in phases, beginning with an enhanced care coordination model through the development of regional Care Coordination Organizations (CCOs) before a transition to a fully capitated rate structure." Continuing to operate the CCOs in a fee-for-service environment does not align with the State's original vision and will not result in a more integrated, flexible, cost-effective system, meeting the needs of individuals and families. During the current COVID-19 crisis, the CCOs demonstrated the ability to respond quickly and efficiently to the needs of individuals with I/DD and their families. All CCOs converted almost overnight to remote service support, kept in regular contact with enrolled members, and adjusted service plans as needed.

The four emerging SIP-PLs have been preparing for the last few years to move forward with the next phase of this initiative per the clear direction by the State. All of them are either current managed care entities or closely affiliated with a managed care entity. These four entities collectively represent the seven CCOs that serve about 110,000 individuals with I/DD in the state of New York. Significant

resources have been invested toward creating an infrastructure that showcases structural integrity, IT readiness, fiscal solvency and readiness of these organizations to move into a managed care environment. These provider-led organizations are most optimally situated to lead this change at this time due to their experience and insight into the challenges and needs of this population. Their experience with launching and effectively implementing the CCO transition serves as a springboard to effectively operate a managed care plan designed to serve this population. They are geographically located to collectively serve the entire population in the state of New York and all have the appropriate funding and necessary alliances. Therefore, they would not require preoperational funding at this time due to the significant investments and reserves already accounted for under the State's direction.

Call to Action:

Our call-to-action for this Administration requires the following:

- Expedited implementation on or about April 1, 2021 of the SIP-PL program. NYS DOH and OPWDD must finalize the application and expedite the submission, review, and approval of applications from the emerging SIP-PL applicants which evolved from the CCO program.
- Immediate passive enrollment of people with I/DD into the fully integrated provider-led SIP-PL managed care plans. Mandatory enrollment and enrollment of dual Medicare/Medicaid insured individuals should be accomplished through an expedited and phased approach. However, all services (I/DD, including residential, healthcare, behavioral health, etc.) must be included in the benefit package from initiation, to ensure the fully integrated care model this initiative looks to achieve.
- Recognition of analysis performed by NYS I/DD system financial experts, which estimate that, when fully implemented, managed care for the NYS I/DD population in its entirety (approximately 110,000 individuals for whom the State and federal governments spend more than $11 billion in Medicaid funds), will only need to provide for modest, yet planned, spending growth due to system-wide efficiencies. These efficiencies will yield savings that, in part, can be shared with the State, with the remaining reinvested into the workforce and service expansion efforts. Such efficiencies will be generated through comprehensive case management, transformation of the I/DD residential and day service systems, focus on quality outcomes through cost effective value based payment arrangements, reshaping the role of the State, use of telehealth, needs-based home care, use of other underutilized and potentially new/innovative services for the I/DD population to delay or prevent placement to higher levels of care, and consolidation of CCO administrative costs with the SIPs-PL.
- Undertaking a comprehensive review of all regulations and policy directives governing services for individuals with I/DD. This review must streamline all requirements to be consistent with an integrated managed care environment that supports innovation.
- Support for integrated, whole-person care, which is critically needed to manage, support, and fund the services required of a comprehensive I/DD care delivery system. This can only be

accomplished through managed care, which integrates disability services, healthcare, behavioral health, and other social care supports into one conduit. Managed care is the vehicle that will provide a cohesive, 360-degree platform for the care and supports required by the oftentimes complex I/DD population.

- The start-up capital should be lower on a percentage basis than in other fields and can be supported by private capital and other existing resources to the extent possible. NYS should also strongly consider modifying or phasing in insurance reserve requirements for this comprehensive benefit package that NYS currently holds risk for in the current fee-for-service model.
- Similarly, SIP-PL administrative costs should be kept to a minimum and funding should not be financed by the global cap, reducing needed services or service provider rate reductions. This would fulfill the exact scenario that service providers, service recipients in the I/DD system and their families fear: diverting the money used for their care in order to fund administrative costs. Instead, as much as possible, administrative costs should be financed on a whole-system basis. It is time for a bold move to redesign the role and focus of government and shift the administrative responsibility from OPWDD, DOH, local government units (LGU), etc. to the SIPs-PL. The reduction/modification in regulations will allow the State to identify administrative savings that should be reinvested to fill this need.

This call-to-action for the implementation of statewide managed care for individuals with I/DD supports Governor Cuomo's directive to accelerate the strategies of MRT I while creating course corrections to help restore financial sustainability to the Medicaid Program. Managed care for the I/DD population will provide the flexibility necessary to adapt to projected large future NYS budget deficits. Additionally, this plan cohesively aligns with the recent recommendations of the MRT II Team, particularly as it relates to the auto-enrollment of individuals upon dual eligibility (representing approximately fifty percent of the I/DD population in NYS).

Addressing the concerns of the individuals

Lastly, the voices of individuals with I/DD and the people who support them will continue to be at the center of all planning, implementation, and monitoring of the I/DD managed care system. Through the lens of the COVID-19 pandemic, individuals and families are witnessing firsthand the results of an inflexible, cumbersome fee-for-service-system. Self-advocates and families express concerns about the financial and programmatic futures of service providers who deliver critical services and supports. The flexibility, innovation, and creativity that individuals and families desire from the I/DD community can only be accomplished through a truly integrated, whole-person approach to the delivery of services.

With the spotlight that COVID-19 shines on the instability of the system that supports people with I/DD, now is the time for systemic change. The innovation and transformation that was brought to other high-

needs populations in the State (HIV, behavioral health and other chronic conditions) through the vehicle of properly funded managed care must now be extended to the I/DD community.

Conclusion

The past decade has seen numerous policy papers, comment periods, advocacy forums, financial analysis, and legislative hearings related to the I/DD system's transition to managed care. As the COVID-19 crisis has shown us, the time for further pontification and debate is over. The Cuomo administration, with the Governor's call to re-imagine NYS, is now presented with an opportunity to impact the citizens of NYS living with I/DD in an unprecedented way; one that will not only sustain but dramatically transform the foundation of supports that serves people with I/DD and their families.

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