DDAWNY

DEVELOPMENTAL DISABILITIES ALLIANCE OF WNY

June 25, 2020

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Commissioner of Health
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Via E-Mail ONLY peoplefirstwaiver@opwdd.ny.gov

Dear Commissioner Zucker and Commissioner Kastner:

On behalf of DDAWNY, the Developmental Disabilities Alliance of Western New York, these comments are being submitted in response to the draft 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 (SIP-PL) dated February 12, 2020 (hereinafter "I/DD System Requirements and Standards draft"). DDAWNY previously commented on draft MMCO I/DD System Transformation Requirements and Standards to serve the I/DD population in SIP-PL on October 16, 2018. DDAWNY incorporates by reference our previous comments of October 16, 2018 as part of these comments.

DDAWNY is a collaborative group of member voluntary agencies providing supports and services to people with developmental disabilities. While honoring individual agency missions, it is the intent of the Alliance to assist agencies to develop relationships, promote unified strategies, and share risks for the mutual aim with and for the benefit of people with disabilities.

DDAWNY member agencies employ over 22,400 individuals in the seventeen Western and Finger Lakes counties of New York State providing supports and services to over 33,000 individuals with developmental disabilities and their families and/or circle of supports. DDAWNY has also formed a Family Committee to give voice to the people served in the disability arena, but whose voices are often unheard.

General Comments

DDAWNY has reviewed and is pleased to provide comment on the State's draft Requirements and Standards to Serve Individuals with I/DD in SIPs-PL. DDAWNY is supportive of New York State's goal to improve health outcomes, control Medicaid costs in a sustainable way, and provide Care Management for all Medicaid enrollees by aligning incentives for the provision of high quality, integrated, and coordinated services. DDAWNY supports the State in its effort to transform the healthcare delivery system for the I/DD population from a fee-for-service model to a value-based Alternative Payment Model (APM).

DDAWNY believes the State's effort to transition its health care system for the I/DD population away from FFS and toward shared risk and population-based payment is necessary, though not sufficient, to achieve a value-based health care system. DDAWNY acknowledges that financial incentives to increase the volume of services are inherent in FFS payments, and certain types of services are systematically undervalued. FFS is not conducive to the delivery of person-centered care because it does not reward high-quality, individualized, and efficient care.

However, reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support. In the absence of adequate pay for direct support professionals, any transformation of our service delivery system will fail. Value-based incentives must reach the direct support professionals in order to minimize staff turnover and improve the quality of services and supports in the community. Value-based incentives must be intense enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage.

The APM Framework began as a payment model classification system originally presented by the Centers for Medicare and Medicaid Services (CMS) and later modified and refined by the Health Care Learning and Action Network (LAN) work group. The APM Framework advances the goal of moving payment away from fee-for-service (FFS) and into APMs that reduce the total cost of care while improving quality. The framework tracks progress toward payment reform and provides a pathway for the delivery of person-centered care. The framework identifies four categories of payments and defines eight subcategories of payment reform. These payment categories include:

1. Category 1. **Fee-For-Service**. No link to Quality & Value

2. Category 2. **Fee-For-Service**. Link to Quality & Value

    A. Foundational Payments for Infrastructure & Operations. (*e.g. care coordination fees and payments for health information technology (HIT) investments*)

B. Pay for Reporting. (*e.g. bonuses for reporting data or penalties for not reporting data*)
C. Pay-for-Performance. (*e.g. bonuses for quality performance*)

3. Category 3. **APMs Built on Fee-For-Service Architecture.** Providers are held financially accountable for performance on available measures of "appropriate care"[1]. Measures of appropriate care are essential for Categories 3 and 4 APMs to ensure providers are incentivized to reduce/eliminate only care that is wasteful and potentially harmful for consumers.

    A. APMs with Shared Savings (*e.g. shared savings with upside risk only – based on savings from cost or utilization* targets)
    B. APMs with Shared Savings and Downside Risk (*e.g. episode-based payments for services and supports delivered and comprehensive payments with upside and downside risk based upon savings/losses from cost or utilization targets*)

4. Category 4. **Population-Based Payment.** Prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care.

    A. Condition-Specific Population-Based Payment. Bundled payments for the comprehensive treatment of specific conditions (*e.g. per member per month payments, payments for specialty services, such as behavioral health services or forensic population services*)
    B. Comprehensive Population-Based Payment. Payments are prospective and population-based, and cover all of an individual's health care needs (*e.g. global budgets or full/percent of premium payments - payers and providers are organizationally distinct*)
    C. Integrated Finance & Delivery Systems – These systems bring together insurance plans and delivery systems within the same organization. (*e.g. global budgets or full/percent of premium payments in integrated systems – These systems may include joint ventures between insurance companies and provider groups, insurance companies that own provider groups, or provider groups that offer insurance products.*)

[1] Appropriate care adheres to evidence-based guidelines and comparative effectiveness research; it avoids unnecessarily costly, harmful, and unnecessary procedures; its intensity is commensurate with the consumers' goals, prognoses, and needs; and it reflects the outcome among individuals, their circle of support, and providers.

At its core, the SIP-PL framework outlined in the I/DD System Requirements and Standards draft seeks to move from a Fee-For-Service model to a Category 4C APM. However, the I/DD System Requirements and Standards draft fails to articulate a path to get from Category 1 to Category 4C. In particular, there is no discussion of the need for further investment of state funds to support Subcategories 2A, 2B and 2C activities necessary in order to move the I/DD service delivery system from Fee-For-Service with no link to quality & value to a service delivery system with some links to quality and value.

DDAWNY appreciates that since the 2018 creation of the seven Care Coordination Organizations who are delivering I/DD federally recognized Health Home services, including the delivery of a comprehensive array of core services,[2] the State has begun to invest in some of the foundational payments for infrastructure and operations necessary to move toward a fee-for-service payment structure linked to quality & value. However, even after eight years of planning, New York State has not yet identified where the funds will be found to pay for the new managed care infrastructure, upgraded HIT systems providers will need, the development of real-time data collection tools[3], the development of meaningful I/DD Quality measures, the development of value based metrics, and funding to support the finalization of the Coordinated Assessment System (CAS) tool to replace the flawed DDP-2 assessment tool.

The new State assessment structure, the Coordinated Assessment System (CAS) has still not been finalized and OPWDD continues to rely on the outdated deficit based DDP-2 Assessment tool to inform rate setting and utilization. DDAWNY continues to object to the use of DDP-2 scores to measure acuity. The DDP-2 instrument is flawed and should not be used in the I/DD Medicaid Managed Care System transformation. DDAWNY believes OPWDD and the State need to finalize the CAS acuity scoring and applicable due process appeals processes for any disputed acuity scoring prior to the transition to mandatory managed care.

In early January, the roll out of the Coordinated Assessment System, Resource Balancing Model Project (CAS-RBM) was publicly announced. At the time, OPWDD indicated the agency would include a review of the CAS-RBM project timeline, purpose, process, and output of the final model variables and validation, tier descriptions, and stakeholder themes. Thereafter, the presentation was abruptly cancelled and has not been rescheduled. This is a critical component of any alternative payment model (APM) including managed care.

Category 3 payments are based upon cost and utilization performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. In order to move from a Category 2 payment structure to a Category 3

[2] These core services include comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family support; referrals to community and social support services; and the use of Health information technology (HIT) to link services

[3] CMS recognizes the need for the creation, exchange, and re-use of key domains and associated data elements of HCBS person-centered planning, assessment, and services so it is piloting an eLTSS system, which may be rolled out across all states.

payment structure in an APM, accurate utilization targets and accurate cost data is required. DDAWNY cannot support the further transition to any alternative payment structure without a fully functioning CAS to replace the DDP-2 assessment tool.

There are no scientifically valid, nationally recognized I/DD specific value-based payment (VBP) metrics developed at this time. In December of 2016, the I/DD Clinical Advisory Group identified seventeen quality measures that could be used for VBP quality measures. The I/DD VBP Advisory Group did not meet again until May of 2019 when it was presented with a roadmap to VBP for I/DD services and has not met since that time.

DDAWNY believes that any movement to a risk-based APM structure, as contemplated in the I/DD System Requirements and Standards draft, must be delayed until a validity study of as yet undefined value-based payments, which specifically identify and validate the quality outcomes for the I/DD population, is completed and piloted. While there are a number of nationally recognized metrics to measure quality health outcomes (e.g., HEDIS and CAHPS) at the current time, DDAWNY is unaware of any nationally recognized outcome measures to grade the value, or quality of services for people with I/DD. Until these I/DD-specific quality measures are identified, measured, quantified, and validated, it would be premature to move to a risk-based payment structure for the I/DD population.

As the State moves towards more community-based models of care, there is the need for standardized performance measures for community support services and new technology-enabled models for those support services. In addition, evaluating value and developing consensus performance standards will require stakeholder agreement on the measures of performance in serving individuals with I/DD. Currently, there is limited consensus on the “right service package” for a particular individual with I/DD. This is a critical conversation which must occur, involving governmental policy makers, funders, payers, self-advocates, individuals with I/DD, their families and circle of supports, and providers. DDAWNY believes it is essential additional stakeholder involvement, including robust participation by providers in the development of valued outcomes that reflect the whole person, not just the medical needs of the individual, is necessary in order to insure a successful systems transformation.

DDAWNY does not believe a risk based APM for persons with I/DD will generate short-term savings. Indeed, DDAWNY believes the State will need to increase upfront financial supports for both the new specialized managed care organization and providers. For the new SIP-PL model to work, the state and federal government will need to embrace some version of premium stabilization model involving temporary risk corridors and reinsurance along with a permanent risk adjustment program. It is unclear at this time, given the current national political climate, whether CMS policy makers will authorize New York to enter into any type of premium stabilization program.

DDAWNY members and the SIP-PLs will need to invest significant resources to ensure the type of robust information and data necessary for managed care to succeed. Encounter data is essential to assess access and quality and to set actuarially sound rates. The information technology system is complex for data related to Long-Term Supports and Services (LTSS). LTSS claims and the specific data elements necessary to support these claims vary substantially from pure medical claims. LTSS service claims and data elements will need to be standardized and consistency in data collection will be required in order to allow for necessary outcomes analysis and reporting. DDAWNY believes the State should be informed by the CMS eLTSS pilot and the standard datasets derived from the eLTSS Initiative before moving to the next stages of an APM. The current reliance on historical rates, which have been artificially limited by a ten-year freeze of any trend factors does not accurately reflect the actual cost of care. In addition, significant additional resources will need to be invested in our workforce.

The State has repeatedly promised any net savings achieved due to more efficient service utilization will be invested back into the OPWDD system. Numerous studies have indicated risk-based managed care for persons with disabilities is not likely to generate short-term savings[4]. Advocates have pointed out to Commissioner Kastner that as the State moves forward with managed care, resources to fund the administrative costs associated with managed care must not come out of the current OPWDD service delivery system.

According to the New York Alliance for Inclusion & Innovation, based on the experience of implementing managed care in other sectors and for other populations, the Alliance believes the plan start-up and operating costs associated with implementing managed care to be 7-10 percent of the overall service system. Assuming these estimates are accurate, this would mean $500 million to $800 million in transition readiness resources for the OPWDD service sector.

At one time OPWDD and DOH indicated these costs would be funded with DOH Global Cap resources. On June 14, 2017, OPWDD and DOH jointly issued Policy Guidance for the Implementation of Managed Care for the I/DD Population. The guidance noted that the FY 2017-2018 budget contained language providing that the net additional upfront costs associated with the transition to managed care for the I/DD population would be financed as part of the DOH global cap resources.

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[4] See *SERVICE DISRUPTED: Managed Long-Term Services and Supports Falling Short for Adults with Intellectual and Developmental Disabilities*, Community Catalyst, Center For Consumer Engagement in Health Innovation, November 2019, accessed at: https://www.communitycatalyst.org/resources/publications/Service-Disrupted_MLTSS-for-Adults-with-IDD.pdf ;
UTHealth Final Report to the Texas Health and Human Services Commission, December 2018 accessed at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/idd-srac/feb-2019-idd-srac-agenda-item-3.pdf
ANCOR and Health Management Associates, Current Landscape: Managed Long-Term Services, Supports for People with Intellectual and Developmental Disabilities June 11, 2018 accessed at:https://ancor.org/sites/default/files/ancor_mltss_report_-_final.pdf,
People with Disabilities and Medicaid Managed Care: Key Issues to Consider, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2012.

DDAWNY believes that given current state fiscal conditions, the State may wish to pause its transition to a managed care or other alternative payment model for the I/DD population and may even wish to reconsider its approach as outlined in its I/DD System Requirements and Standards draft in light of more recent developments in the health care industry in general and the recent experiences of other states which have sought to implement an APM for the I/DD population.

Even before COVID-19 hit New York, the State's fiscal situation had significantly deteriorated. Since COVID-19 attacked New York, the State's fiscal situation has become dire. Senior Executive Chamber officials have indicated the State's dire fiscal situation will force OPWDD to impose an additional two percent across the board rate cut on all OPWDD voluntary providers effective July 1, 2020[5]. This rate cut will eviscerate the positive impacts of the two-year DSP BFair2Directcare rate enhancement included in the enacted FY21 budget adopted in April of this year.

The challenge to implementing managed care among the I/DD population is not managed care, *per se*, rather the question is how to develop systems that offer appropriate alternatives to residential care. This cuts to the core of what the "right service package" is and the need to develop a consensus from advocates. families, individuals with I/DD, payers, and providers on what community-based services should be provided, by whom and to whom.

Managed care for the I/DD population is not new. Long-term supports and services, including I/DD, have been incorporated in Medicaid managed care since the advent of Medicaid in Arizona in 1988. However, managed care models do not necessarily offer cost savings from reduced use of institutions because there is relatively low utilization of facility-based interventions and there is an increase in the number of individuals with I/DD seeking services, including housing opportunities in the community.

We can all agree that while large institutions have closed, more needs to be done to move individuals with I/DD into the community. New York State continues to have one of the highest percentages of the population housed in intermediate care facilities (ICF/IDs) with seven to 15 beds. In its 2013 Transformation Plan, New York committed to CMS that it would shift nearly all ICF/IDs to smaller community-based facilities with six beds or less. In addition to reducing ICF/ID capacity, managed care will necessarily seek to develop alternative and less costly alternatives of residential care.

Even without managed care, New York State is successfully rightsizing its residential population. New York increased the population of individuals with I/DD receiving housing supports by 5% between 2015 and 2017. At the same time, there has been a 30% reduction in the number of individuals living in large institutions or large congregate care community settings. Individuals living in either a large state institution

[5] DOH and OPWDD have recently posted notice of a State Plan Amendment and 1915(c) waiver amendment that replaces this 2% across the board cut with targeted cuts to residential providers and new assessment tools and review processes intended to limit utilization of community habilitation services, saving the state over $100 million in FY2021 and reducing provider and health home reimbursements by $328 million annually.

or any size ICF/ID have decreased by nearly 20% in this same period. Individuals living in any community congregate care setting have also decreased. Meanwhile, during this period the State has increased the number of individuals living in some type of supportive living arrangement by 18%.

According to data from The State of the States in Intellectual and Developmental Disabilities, 12th Edition 2020[6], as of FFY 2017, New York provided housing supports to 75,847 individuals, 3,761 more than the housing supports it provided in FFY2015. 3,087 individuals with I/DD resided in settings of sixteen or more (1,353 less than in FFY 2015). This includes nursing facilities, state Institutions, private ICF/ID, and other residential settings. At the same time, 18,520 individuals resided in settings of seven to 15 persons (496 more than in 2015 – however the ICF/ID population of those residing in ICF/ID institutions has been reduced to 3,414 (a reduction of 735 individuals over two years. The decrease in ICF/ID beds of seven to 15 persons is offset by a growth in large congregate care community residences, which grew to a population of 15,106 (1,231 more than in 2015). New York supports 54,240 individuals in community settings of six or fewer individuals. This includes 36,594 in supportive living (an increase of 5,493 since 2015) and 17,222 in other small congregate care community settings (a decrease of 800 since 2015).

As the demand for ICF/IDs and larger community residences necessarily declines, new opportunities to support individuals with I/DD in the community and in their homes will at the same time increase. This shift presents its own workforce challenges. Our direct support professionals are not minimum wage workers, yet they are paid close to minimum wage. This results in high turnover and less than optimal outcomes. We must develop a sustainable solution for raising salaries and retaining workforce. Using our workforce more efficiently requires the development of new and improved service delivery models and the expanded use of mobile technology.

Any move to managed care will require the development of better systems to estimate the value of the long-term supports and services by tracking outcomes. In particular, specific performance data that clearly shows the better outcomes a provider of community-based services achieves must be developed. The system will also need standardized performance measures for community support services and new technology-enabled models for those support services. Again, stakeholder buy-in, especially from natural supports, family members, and the individuals served for these community support services, is required if the system truly is to be transformed.

A recent blog posting by the Arlington Heritage Group looked at how states and the federal government are paying, managing, and promoting service delivery through managed care models[7]. The article points out that much of the country has moved to managed care for primary health care and behavioral health. While noting that important

[6] Tanis, E.S., Lulinski, A. & Wu, J., Braddock, D. & Hemp, R. (2020). The State of the States in Intellectual and Developmental Disabilities, Department of Psychiatry, University of Colorado. www.stateofthestates.org

[7] https://www.arlingtonheritagegroup.com/blog/how-can-managed-care-work-for-the-i-dd-population/

features of managed care programs, particularly care coordination and quality care have shown long-term Medicaid savings, individuals with I/DD are among the last groups to transition into managed care settings due to the complexity of their conditions. The author notes that managed care models for vulnerable populations require adequate investment and thoughtful implementation.

There are a number of managed care models across the United States. Over 20 states have planned or implemented managed care programs for long-term services for the I/DD population. Models range from mandatory enrollment of all populations with large, private, multi-state commercial health plan contracts to I/DD specific focused programs and provider-led initiatives.

A summary of the various state approaches to managed care for the I/DD population include:

- **Arizona** (Longest running program state agency management) - In Arizona, the management of care is delegated to the state I/DD agency, the Arizona Division of Developmental Disabilities (DDD). Service delivery is provided through state agencies and providers are interfacing with the DDD instead of large MCOs

- **Iowa & Kansas** (Mandatory comprehensive statewide contracts with large multi-state commercial health plans) In Kansas, KanCare was established in 2014, the program goals focused on improved health care access, decreased waiting lists, improved employment outcomes, and cost savings. Kansas' MCOs use risk corridors and high-risk pools, which lessen the financial risk for MCOs. In 2018, independent auditors of the program found data on KanCare was unreliable, there was a lack of oversight of MCOs, and cost containment did not occur as a result of KanCare. Providers reported outcomes had not improved, Kan Care has increased the administrative burden on I/DD providers, and the model does not address the needs of individuals with I/DD. In Iowa, the state implemented IA Health Link (using an InterRAI tool) in 2016 placing the care of all I/DD individuals, among others, in the care of three multi-state MCOs. MCOs, providers and consumers all reported a rough transition to managed care. One MCO left the system in 2017. UnitedHealthcare and Amerigroup referred to the experience as "catastrophic" and "dramatically underfunded". In 2018, Iowa also changed its actuarial firm, the entity charged with developing the cost estimates for the Medicaid Managed Care system and ensuring these estimates were in line with actual costs. The Iowa MCOs indicated the cost estimates were as much as 40% below actual costs. In FY2020, Iowa officials agreed to increase payments to I/DD providers as a state supplement to the Medicaid program.

- **Tennessee** (Incremental approach – contracts with large multi-state commercial health plans for parts of the system) CHOICES – MCOs are at risk for providing supports coordination (case management) for the I/DD Medicaid population. In 2016 CHOICES was expanded to include Employment and Community First (ECF). The program is focused around care coordination, person-centered

planning, and increased service provision for individuals and families. The program marks a paradigm shift in service structure in I/DD – reducing the focus on residential care and prioritizing family supports, community integration, and employment. The state priority is promoting and supporting integrated, competitive employment and independent community living as the first and preferred option for people with I/DD.

- **North Carolina** (Implementation of specially managed care plans following a federal health home model and run by commercial and provider-led MCOs.) Currently the state delivers Medicaid I/DD services under a managed care delivery system administered by seven regional Local Management Entities (LMEs) established as Prepaid Inpatient Health Plans (PIHPs). In May of 2019 the state released a strategy for developing and implementing BH I/DD tailored plans to serve individuals with serious mental illness, I/DD, and traumatic brain injuries. Intensive and integrated provider-based care management would be at the heart of the NC plan design and will act under a federal health home model. The plan design is also heavily focused around integrated, whole-person care and included person and family-centered planning, community-based care management, and community inclusion. Implementation was suspended indefinitely in November of 2019 when the Legislature and the Governor could not agree on the funding necessary to support the planned move to Managed Care.

- **New York and Arkansas** are the only states seeking to create statewide I/DD provider-led managed care organizations. Arkansas is currently implementing a new Medicaid managed care program called the Provider-Led Arkansas Shared Savings Entities (PASSE) model. It is designed to coordinate health services for BH and I/DD beneficiaries through the development of a PASSE entity requiring at least 51% ownership by local health care providers. The program is being implemented in two phases. Phase one is care coordination with the PASSEs receiving Medicaid funds for administrative services and physicians continuing to be reimbursed FFS. Savings are based on expenditure caps on therapeutic services and the use of a new assessment tool placing people in tiered categories that control access by more closely aligning needs with authorized options. In phase two, the PASSE receives a capped member monthly global payment to pay for all Medicaid-covered services a beneficiary receives. PASSEs must meet quality metrics and may receive monetary incentives or penalties based on meeting these quality metrics. Legislative changes are expected to prohibit indirect MCO ownership and/or multiple PASSE involvement, potentially affecting MCO-owned subsidiaries.

- **OPWDD Transition to Managed Care**. Guidance regarding the requirements and standards to serve individuals with intellectual and/or developmental disabilities (I/DD) in Specialized I/DD Plans - Provider Led (SIP-PL) were released for public comment in February. According to the State, responses to the qualifications document will be used to better inform the agency on the

system's readiness for managed care and the fiscal impacts. The State will assess the potential effectiveness and sustainability of the proposed delivery system to ensure individuals continue receiving appropriate services in the most cost-effective manner

Various lessons learned can be gleaned from the above experiments:

KanCare providers recommend States need:

- Meaningful input from I/DD providers
- Baseline data for the I/DD population
- Protection of existing resources
- An adequate oversight structure
- Funding, funding, funding

The Arlington Heritage Group article suggests:

- Limited Managed Care Experience - States should conduct a real pilot first and learn from the experience of states/stakeholders who have been through the process
- Need for meaningful Quality Measures – Testing quality measures (CQL) is a must.
- Direct Staff Turnover - Initiatives that support enhanced wages and benefits of direct support staff in community service programs to improve the quality of services they provide and minimize staff turnover are key.
- Role of I/DD Case Management & Support Coordination – The consumer comes first, and the implementation of person-centered and integrated care planning must become best practices statewide with the move to managed care.

The University of Texas Health Science Center at Houston School of Public Health in its Final Report to the Texas Health and Human Services Commission identified four key lessons to be learned from a national review implementing comprehensive Medicaid managed long-term services and supports (MLTSS) for individuals with I/DD. UTHealth identified these lessons as follows:

- The transition of individuals with I/DD should move slowly, with clearly defined stages of initiation.
- It is worthwhile to pilot the approach to transitioning individuals with I/DD to MLTSS. It is important to build stakeholder buy-in and prove value and have ongoing, comprehensive stakeholder engagement as MTLSS programs are refined or new populations are included in existing programs.
- The State and contracting MCOs should be well prepared in advance of the transition. This means that the State needs to be clear on its expectations regarding cost, quality measures, and outcome measures. The MCOs should be

required to validate their degree of readiness to provide MLTSS services and the State should consider requiring that the contracted MCOs be required to be NCQA accredited and attain MLTSS distinction.

- The transition to MLTSS for individuals with I/DD requires that MCOs comply with CMS LTSS network adequacy standards which may reduce the number of providers. Some licensed and/or certified professionals may opt out of participating through an MCO. Since network adequacy standards limit the time and distance that beneficiaries must travel to providers and providers travel to beneficiaries, geographic access, particularly in rural areas, can make it hard to meet these standards. Network adequacy standards maty need to be flexible to the extent that the program allows for client choice.

UTHealth concludes:

> "In states that have transitioned, providing an adequate timeframe for planning, communicating, and implementing an MLTSS program for [individuals] with I/DD is vital. MLTSS programs must address needs that change with lifecycle phases. There is the potential through effective integration of MLTSS for I/D into managed care to improve social determinants, such as housing, employment, and community integration as well as health outcomes. These outcomes can lead to increased budget predictability for states and health plans."[8]

New York is already moving forward with developing a robust new I/DD case management & service coordination initiative. Less than two years ago and using enhanced Federal funding, OPWDD and DOH were able to successfully transition to an enhanced care coordination model through the development of regional Care Coordination Organizations (CCOs), a necessary first step in transforming the service delivery system. DDAWNY believes this new model deserves time to grow and mature. These entities can and should gain experience working with current MCOs, particularly those which provide acute managed care to the I/DD population. This will help inform best practices and identify inefficiencies and inconsistencies in the management of the I/DD population in the acute care world. This time will allow traditional health care providers and traditional health care payers to better understand the complexity of the conditions of the I/DD community and inform best treatment and utilization decisions for this population.

Some have asserted that the FIDA-DD pilot project provides us with the lessons we need to learn as we transition to managed care. Unfortunately, the finding of this experiment has not as of yet been shared broadly with the field. DDAWNY strongly believes the transition to managed care for the general I/DD population should be informed by the results of the FIDA I/DD Demonstration, which is currently ongoing.

[8] UTHealth Final Report to the Texas Health and Human Services Commission, December 2018, pg.46-47 accessed at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/idd-srac/feb-2019-idd-srac-agenda-item-3.pdf

The Demonstration program began in April of 2016 and is scheduled to conclude on December 31, 2020. CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of the FIDA-I/DD Demonstration on participant experience of care, quality, utilization, and cost. The evaluator has designed a New York-specific evaluation plan that is looking at the FIDA-I/DD Demonstration and will conduct a meta-analysis that will look at the State Demonstration overall.

The key issues targeted by the evaluation will include: participant health status and outcomes; quality of care provided across care settings; participant access and utilization of care across care settings; participant satisfaction and experience; administrative and systems changes and efficiencies; participant is supported in the most integrated setting possible; long-term care rebalancing effectiveness; and, overall costs or savings for both Medicare and Medicaid.

As part of the Demonstration, CMS is requiring quarterly reports to provide rapid cycle monitoring of enrollment, implementation, utilization of services, and costs. The evaluator is also submitting New York State-specific annual reports that incorporate qualitative and quantitative findings to date and will be required to submit a final report at the end of the Demonstration. In addition, the State is required to engage and incorporate feedback from the public during the implementation and operational phases of the Demonstration.

DDAWNY is unaware of any public sharing of these evaluations and public feedback at the current time. The information does not seem to be available on any DOH or OPWDD publicly accessible website. DDAWNY believes these reports, meta-analysis, and public feedback ought to be made freely available in a transparent and timely manner, and the information learned should be used in order to inform the transition of the general I/DD population to managed care. The FIDA I/DD Demonstration can and should provide valuable feedback in developing the structure of Managed Care for the entire I/DD population.

More broadly, DDAWNY is increasingly concerned the concept of small provider-led specialized I/DD Plans (SIP-PLs) may no longer be a viable strategy in light of the macroeconomic reality of mergers, acquisitions, and other forms of consolidation in the health care industry.

The health insurance industry has experienced significant M&A activity over the past several years, including CVS Health's (2020 revenue of $262 billion) purchase of Aetna, Cigna's (2020 revenues of $154 billion) acquisition of Express Scripts, and Centene's (2020 revenue of $82 billion) acquisition of WellCare. UnitedHealth Group, the nation's largest health insurer (2020 revenues of $246 billion), recently acquired payment platform Equian and is integrating the firm into its Optum medical care provider business.

Last week, Blue Cross and Blue Shield plan Highmark Health (2019 revenues of $18 billion) with more than 5.6 million health plan enrollees in Pennsylvania, Delaware, and West Virginia, announced an affiliation agreement with HealthNow New York (2019 revenues of $2.8 billion) in a major consolidation of health insurance plans in the northeastern United States. HealthNow New York currently serves nearly 1 million enrollees in the 8-county Western New York and 13-county Northeastern New York service area. Other deals are said to be in the works among Blue Cross and Blue Shield plans, which see the need to consolidate to compete with CVS, Cigna, UnitedHealth Group, and Humana.

Industry experts expect the healthcare landscape to continue to evolve. Significant change is a given, driven by the shift toward value-based care, a move toward decreased care in institutional settings, technological advances, continued consolidations, and other forces.

Experts expect more healthcare entities will continue to merge together. Increased consolidation will result in a narrowing of the field of contracting options, resulting in greater dominance by fewer entities in the market. Industry insiders believe consolidation is the way to survive in the new ACA healthcare landscape.

One of the reasons for continued consolidation is the need for capital, especially to invest in technology. The impact of digital technology and artificial intelligence/machine learning driven change will continue to scale up. Technology giants are locked in a trillion-dollar battle to win share in the public cloud and to retain consumer mindshare and engagement. They are investing billions of R&D dollars into their platforms to create services easily usable across a range of customers and for a range of applications (for example, predictive analytics) that accelerate innovation. The effective use of technology is essential for healthcare organizations that want to compete with other providers utilizing value-based payments.

The move from the fee-for-service financial model to a value-based care model is another reason for these recent consolidations. According to many healthcare insiders, making the transition from the fee-for-service model to a model based on value has proven more complex than expected. As value-based payment models become more common, organizations that invest in consumer-engagement technologies, virtual health, and care coordination will likely be well-positioned. Even if value-based care only trudges along, those same organizations could wind up in a stronger competitive position with consumers. According to one Health Law expert, “the belief is that value-based care models require single unified entities as opposed to more contractual-based ventures to succeed”.

Last year, just five national health insuring organizations -- Centene, WellCare (now merged with Centene), Anthem (2020 revenues of $109 billion), UnitedHealthcare and Molina Healthcare (2020 revenue of $17 billion) -- served approximately 26.6 million individuals, representing over half of the population served in Medicaid managed care.

As insurers continue to consolidate, the divide in the insurance space between the haves and the have-nots will escalate. Aside from providers, who face worse rates in negotiations with big insurers, startups like Oscar Health, Clover Health, and the proposed I/DD SIP-PLs face a difficult future. These startups have less scale with which to negotiate and far too little capital to compete in this rapidly evolving healthcare environment. DDAWNY continues to question the economic viability of what essentially are insurance entities where the covered lives these entities will serve constitute just one and two-thirds percent of the state's total Medicaid population. If there are just four SIP-PLs created statewide, each would only have approximately 25,000 covered lives. DDAWNY does not believe such an insurance product will meet the healthcare needs of this special population, nor will the Department of Financial Services find such an entity financially viable.

The experience of Health Republic and Northwell's CareConnect in New York and AmeriHealth Caritas, an insurer who focused on serving the I/DD population in Iowa, are cautionary tales on how difficult it is for provider-owned or smaller provider-friendly/consumer-friendly insurance companies, which seek to align performance and outcomes with financial incentives thru a value-based care structure, to survive while in competition with large, for-profit, payer led commercial insurers.

DDAWNY is unsure if a SIP-PL will be successful in developing an adequate medical provider network for the future needs of the individuals our provider agencies serve. Medicaid Managed Care Plans (MMCP) across the state have existing provider networks for primary care, specialists, hospitals, and many ancillary providers. DDAWNY is very concerned the SIP-PL entities will not be able to compete with MMCP on network adequacy for medical, dental, and other ancillary providers, especially many years after implementation. Building provider networks to include large and small hospital systems in both urban and rural areas, and primary care and specialty care providers in these settings, will be a very expensive and complex undertaking.

Specific Comments

While OPWDD is "confident" a small SIP-PL Managed Care entity will improve provider availability, including access to specialists[9] in a new Alternative Payment Model, DDAWNY has no reason to believe this statement is verifiable. Indeed, DDAWNY strongly doubts provider availability will be enhanced under this new model. DDAWNY is very concerned the movement of 100,000 to 120,000 individuals with I/DD into a SIP-PL entity may have considerable and potentially unintended consequences to the individuals our provider agencies serve, especially if the SIP-PL does not have the same network advocacy as an existing MMCP, or even FFS Medicaid.

[9] NYS MMCO SIP-PL Qualifications Document, February 12, 2020, 1.0 Vision, pg. 5

DDAWNY remains concerned, given the medical complexity of many of those with I/DD, a change to a medical provider, or lack of access to a particular hospital system due to lack of "in-network" providers will have a devastating impact of their continuity of care and overall treatment plan. DDAWNY would note the definition of a Single Case Agreement permitting payment to an out of network provider only applies to a Specialized I/DD Plan-Mainstream (SIP-M) and does not apply to the proposed SIP-PLs[10]. DDAWNY remains unconvinced this new payment model will improve the provider network for individuals with I/DD

The I/DD System Requirements and Standards draft indicates that current oversight, incident reporting requirements and the current regulatory framework will continue to apply during the transition[11]. DDAWNY continues to believe successful implementation of any Alternative Payment Model requires significant effort by the State to lessen the crushing and unnecessary over-regulation of the field. Without real and significant regulatory reform, compliance costs -- already significantly in excess of what other human service agencies face in other New York State regulated areas -- are growing exponentially. As compliance costs increase, new administrative and Information Technology (IT) costs related to newer value-based payment models are incurred and with revenues related to service delivery dramatically reduced, DDAWNY is concerned about both the fiscal viability of many of our provider agencies and also the ability of remaining provider agencies to continue to provide quality supports and services to all who are eligible for these supports and services. The State needs to move to a facilitating role, encouraging entrepreneurial efforts and away from its current controlling, regulatory role.

The I/DD System Requirements and Standards draft alters the enrollment and choice options originally proposed in 2018. The 2018 draft contemplated a two-stage approach to SIP-PL voluntary enrollment beginning 9 months after the NYS MMCO SIP-PL Qualification Document was finalized. In addition to a detailed timeline for implementation, the 2018 draft proposed a downstate rollout of voluntary enrollment followed by upstate rollout 5 to 12 months later. Mandatory enrollment would have been rolled out over the next two years. In addition to SPA benefits and OPWDD HCBS Waiver Services, State Plan Community First Choice Option (CFCO) Services would be included in the benefit package[12].

[10] NYS MMCO SIP-PL Qualifications Document, February 12, 2020, 2.0 Definition, pg. 16

[11] NYS MMCO SIP-PL Qualifications Document, February 12, 2020, 1.1, pg. 6

[12] NYS MMCO SIP-PL Qualifications Document, August 2018, pg. 4-12

DDAWNY appreciates the State addressing some of the concerns expressed by DDAWNY in our October 16, 2018 comments related to the wisdom of the abbreviated timeline for implementation. The State now recognizes that SIP-PL enrollment must be based on the timing of SIP-PL readiness and qualifications. DDAWNY is supportive of this more flexible approach to enrollment. DDAWNY continues to believe it is important to pilot any new alternative payment model and believes the previous two-stage approach, with downstate beginning voluntary enrollment first followed by the rest of state enrollment, is a superior design to the current proposal to roll out voluntary enrollment statewide at the same time[13]. DDAWNY continues to object to mandatory enrollment in SIP/PLs as soon as one year after voluntary enrollment begins. DDAWNY believes it will take more than one year (and one budget cycle) to determine if the proposed SIP-PL concept is operating consistent with the goals of system transformation. DDAWNY understands the CFCO implementation has been paused pursuant to MRT II as a result of the state's precarious financial situation; however, we believe these approved SPA benefits will in the long term be an important tool for individuals with I/DD who are seeking to live more integrated lives in the community.

DDAWNY has a number of concerns related to the Definitions section of the I/DD System Requirements and Standards draft.

A glaring omission from the definition section is any definition of "Habilitation services". The I/DD System Requirements and Standards draft indicates "Section 4403 Subdivision 8 and Section 4403-g of the New York Public Health Law (PHL) authorize the Commissioners of NYSDOH and OPWDD to jointly designate and oversee contracts to manage the I/DD, medical, behavioral health, and long-term services and supports (LTSS) need of individuals with I/DD enrolled in Medicaid"[14].

Section 4403-g, Section 1, subdivision (c) specifically defines "Habilitation services" and DDAWNY believes this statutory definition must be included in the final NYS MMCO SIP-PL Document. DDAWNY would propose the following definition be added to 2.0 Definitions:

> **Habilitation services**: Services available through the state's home and community-based services waiver for persons with developmental disabilities, state plan for medical assistance, and any other authorized federal funding for such services designed to assist persons in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings.

[13] NYS MMCO SIP-PL Qualifications Document, February 12, 2020, 1.2, pg. 8-10

[14] NYS MMCO SIP-PL Qualifications Document, February 12, 2020, Introduction, SIP-PL Legal Authority, pg. 5

In addition, Section 4403-g, Section 1, subdivision (d) specifically defines “Health and long-term care services”. The definition of Long-Term Supports and Services as defined in the I/DD System Requirements and Standards draft fails to capture the full extent of the statutory definition. DDAWNY would propose the definition of Long-Term Supports and Services (LTSS) contained in the I/DD System Requirements and Standards draft be amended as follows to comport with the statutory definition:

> **Long Term Supports and Services (LTSS):** Comprehensive health services and other services as determined by the commissioner of health and the commissioner of the office for people with developmental disabilities, whether provided by state-operated programs or not-for-profit entities, including, but not limited to, habilitation services, home and community-based and institutional-based long term care services, and ancillary services, that include medical supplies and nutritional supplements that are necessary to meet the needs of persons whom the MMCO is authorized to enroll. Each person enrolled in the MMCO shall receive health and long-term care services designed to achieve person-centered outcomes, to enable the person to live in the most integrated setting appropriate to that person’s needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace, and other community settings, provided that all such services are consistent with such person’s wishes to the extent that such wishes are known and in accordance with such person’s needs.

DDAWNY believes the definition of Concurrent Review should include the following language: “Concurrent reviews are performed on inpatient, outpatient, *habilitation and other health and long-term care services*.”

DDAWNY believes the definition of Retrospective Review should include the following language: “Retrospective reviews are performed on inpatient, outpatient, *habilitation and other health and long-term care services*.”

The 2018 draft NYS MMCO SIP-PL Qualification Document included a definition of Value Based Payment (VBP). The I/DD System Requirements and Standards draft of February 12, 2020 no longer includes a definition of Value Based Payment. DDAWNY believes Value Based Payments should be defined in the document. DDAWNY would be comfortable with a modification of the 2018 draft definition of Value Based Payment as follows:

> **Value Based Payment (VBP):** A strategy that is used by purchasers to promote quality and value of health and long-term care services. The goal of a VBP program is to shift from pure volume-based payment, as exemplified by Fee-For-Service payments not linked to quality and value to payments that are more closely related to both quality and cost outcomes, linking provider payments to improved performance and creating a continuum of clinical and financial risk for holding provider organizations accountable for both the cost and quality of the care they provide.

DDAWNY also believes the definition of Medical Necessity as defined in the I/DD System Requirements and Standards draft. fails to address the needs of individuals with I/DD. I/DD is not a disease with a cure. I/DD is a chronic lifetime condition. The definition of Medical Necessity as defined in New York Social Service Law Section 365-a fails to capture the health and long-term care needs of the I/DD community. DDAWNY would propose a modification of the definition of Medical Necessity as follows:

> **Medical Necessity**: For purposes of serving the needs of individuals with I/DD, medically necessary medical, dental, remedial, habilitative, rehabilitative, health, and long-term care services and supplies in the Medicaid program are those necessary to prevent, diagnose, correct, cure, maintain, or improve conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity. These include eliminating barriers that prevent an individual from living in the most integrated setting appropriate to a person's needs, and to enable the person to interact with non-disabled persons to the fullest extent possible in social, workplace, and other community settings; promote independence and community engagement, derived from a person-centered planning process, based upon the evaluation of an individual's goals and valued outcomes and consistent with such person's wishes to the extent that such person's wishes are known; and in accordance with such person's needs, or threaten some significant handicap and which are furnished to an eligible person in accordance with state law.

The I/DD System Requirements and Standards draft indicates "Care Management must also comport with the I/DD HH service model and with the person-centered planning regulations found at 14 NYCRR § 636, subpart 636-1. The requirements of the Care Management provided to individuals with I/DD will be described in a forthcoming policy document[15]. DDAWNY believes the NYS MMCO SIP-PL Qualification document should not be finalized until this Care Management policy document has been issued and public comment received on its contents.

[15] NYS MMCO SIP-PL Qualifications Document, February 12, 2020, 3.1 Organizational Capacity, Subdivision 11, pg. 20

DDAWNY appreciates the opportunity to comment on the draft 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 (SIP-PL) and continues to work as a partner with OPWDD and other State and Federal authorities to improve the lives of individuals with Developmental Disabilities, their families and their circle of supports.

Respectfully Submitted

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