



SKIP OF NY COMMENTARY ON PLANNED NYS CCO MODEL

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We're appreciative of the opportunity to provide feedback to the planned CCO model from the New York State OPWDD. Our objection to this model is strong, factually-based and urgent. Following is our candid commentary.

General Reaction:

The entire initiative lacks a demonstrated *proof of concept* that would and should serve to test the impact of this model. The cost and real-life impact on families of ripping apart models of excellence that already exist in the state and which *do* have proven track records of success do not appear to be considered or woven into this fabric. There are currently agencies in place that have achieved the exact outcomes sought by this model based on efforts created over a 30+ year time frame.

Further, OPWDD has performed program audit after program audit and been impressed with the depth and person centered approach they witnessed and yet there has been no attempt to incorporate the structure they encountered in any model throughout the years of operation; rather, this new model appears to just wrap new vocabulary and nomenclature around new initiatives that will not lead to positive solutions or goal outcomes without a proven foundation. A life plan by name or a care plan by name does not improve outcomes or level of satisfaction. Indeed, it highlights the very elemental essence behind the effort to come together in partnership with members that has eluded OPWDD for so long.

Frankly, this planned "solution" – which essentially is institutionalized care management -- is frighteningly reminiscent of OPWDD's misguided efforts years ago which resulted in the horror of Willowbrook. Haven't we learned that lesson?

We cannot and do not understand why OPWDD insists that the solution to an overabundance of community providers must be shrink-wrapped into two silos per region. If OPWDD does not have the appetite to cull out lesser performing providers that are not serving current members well, how will the agency evaluate this "one size fits all" model? We are aware of no metrics that will tell the tale that the silos will be forthright about the outcomes. The area expertise of community-based providers that do have exemplary relationships and outcomes cannot transform large groups or be effectively transformed into two very costly regional systems when further analysis of areas of excellence have been tossed to the side along with the not so well observed ingredient of having developed relationships with members and their families.

A simple solution: If one already has incorporated the elements versus the language into their branded service delivery model, why not replicate that model? The big box model is crashing all around us in the general marketplace, so what is to preclude that from being

the case here? The big box approach has even less of a chance of success in a sector which relies so heavily on people-focused services to achieve desired outcomes.

In our view, none of the planned elements are proven or even demonstrated by a written plan, but rather are nested in the hope that this model has the (untested) *potential* to be viable.

Cost and Risks to Families:

The cost to members and negative impact upon them is immeasurable. So many families and members have been in partnership with providers since the members were infants. While we understand that in this planned model the members will presumably retain the same coordinators, this too is not certain. A trusting relationship does not appear out of a vacuum and takes time and energy to build. This model is not *person-centric* by any means. Rather, it is a model presumably constructed to solve a conflict free and managed care requirement that must be attended to, yes, but which *has already been satisfied without* the dismantling and chaos associated with this proposal within NYS.

Currently, there are models in New York State and throughout the country that have allowed members to retain the partnership and select community-based care managers that represent models they relate to, feel safe with and want to continue partnering with. Indeed, the Department of Health has created an adult and pediatric model that has retained these principles. In an impressive effort to curtail expenses the state has actually merged different populations, albeit retaining the vision of need and different services. In contrast, the real cost of OPWDD's model when all the spotlights are on New York State with a huge push back from the federal government defy logic. The apparent fiscal advantage of this model is for federal monies to flow into to the state during the construct. But there are basic, logical inalienable truths that persist and are of great concern, not the least of which is sustainability.

The very real unintended risks are:

- A loss of history and understanding for the member and his/her family in instances past or future will not be shared until strong relationships are built. There are so many life examples that destabilize families who are very proficient in directing and informing providers about the needs of the members.
- This information exchange that enables transitions from one system to another, valid responses to the loss of a dear family member which can shake the construct of care to the core, health scares, a divorce, a move, a loss of employment and so many more subtle or obvious events that require relationships and partnerships are absolutely voided in the model.
- In a time of being mindful of excessive spending there are overt omissions that jump right off the reports from the advisory committee. There is absolutely no proof of concept or market testing demonstrated, as compared to standing models already developed in the state. No development in the State of New York should be enabled without testing the market and publicly presenting that data. Our view is that the deficit model will hurt members should this model collapse. Rather, the more *appropriate approach would be to merge with the current Health Home Structure, which is a model that is constructed to serve 100 times the membership of this model without loss of targeted services or community based identity.*
- The HH model created by DOH incorporates a blend of need. Everyone appreciates the fine points of the IDD population, but those should be woven into the bigger

frame of HH, constructed to blend costs and not be forced by overspending to restrict services.

- It makes little sense to have disparate HH models for a relatively small population when the federal government has established the mandatory criteria and this document merely re-names the overall mandates and intent.
- The monies would be better used to develop housing and meet those needs head-on, because none of the described CCO models will have an impact unless that problem is dealt with head on and not as a sidebar. Health improvement and maintenance is a target measurement and valued outcomes which are not attainable until the community-based alternative for housing is firmly in place.
- These issues and concerns are not just notions but are already proven by the collapse of the DISCO initiative. It was not the design of the service or care coordination that generated that loss of interest or momentum; but it was clear thinking that determined the missing elements for success.
- We have an opportunity to chart the lessons learned in the development of the Self-Directed Model, which was also rolled out in a frenzy of disparate messaging, recalling the endurance tests families had to sustain. This SDS model is still under construct with a dearth of providers willing to expand this conceptually stellar service delivery notion.
- We anticipate a very costly IT construct that will be developed by each applicant that will highlight what is already considered out of control spending by NYS when existing models already cannot communicate efficiently and have no external portals for member access. So the logic of 10 new constructs is at best illusive. All of this additional and substantial cost expected, for a population of well fewer than 90,000 eligible valued members who cannot by virtue of different financial eligibility criteria all be enrolled into the described model or who will perhaps seek out the new IDD FIDA model. The question remains: Will the prospect of extravagant spending cost the members services and, if so, how much more? This alone is demonstrative of one of the most poignant and disturbing oversights by the model advisory developers.
- Perhaps there is wisdom in a clearer merger with extant HH, but with a deep understanding that the IDD membership must have access to targeted services to enable full community integration, without a separatist approach, but with clear intent to retain and expand maintenance of effort and direct dwindling resources towards that more impactful endeavor.
- The optics that all the advisory participants have already begun to form the CCOs prior to the general public comment period raises more questions about the very nature of passing a conflict of interest sniff test. This speaks volumes. The amount of information exchange coming out of the membership is representative of curtailed and a questionable level of public transparency.
- The resources and information that will be tossed to the side are shameful. These include resource libraries, QA investment, automation, training manuals, resources for individual families and more.
- There needs to be some attention paid to the loss of revenue directed to the community-based agencies. The notion that the CCOs will or even can pay for the loss is wrong and not viable. Do they intend to pay the rent so agencies can continue to provide home and community based services? Will they pick up the deficit which will be huge for the agencies being divested of income?
- There are so many elements that are involved in knowing a member well. Has anyone done a review of the leasing requirements within the community-based agencies? Has anyone asked the current Medicaid Service Coordinators if they will remain in the field? Has anyone queried graduating masters level candidates if they

are willing to enter this model as the care manager requirements are elevated but in all the other models the requirements have much more emphasis on experience?

- The model is predicated on unlimited staffing resources but the cost of living in half of the state cannot keep pace with any salary structure under this fee structure. There is an absence of due diligence in the presentation of this model that is extremely troubling. Long standing community models have built their construct on these very factors but, in contrast, the architects of this new model and construct seem to be in a mode of abject disregard of these very real factors.
- One of the most salient omissions is provider capacity. The notion that the CCOs can use their own created MCO or attach themselves to existing ones begs an actuarial study, as the mere notion of a dearth of providers for health care services seems to elude the crescendo it is building toward. In the entire City of New York there are three providers who provide IBS services. There are waitlists amongst all of those providers, so leaving those critical elements for resolution somewhere down the line ignores members and their presenting needs as well as the urgency of the situation. *Network capacity should be the very first element demonstrated, and it is not.*
- An individual with documented IDD in need of active treatment can wait for a psychiatrist for six months in certain regions as we speak, even longer if they are under the age of 21. The relationship with providers and knowing a pathway to other services will not be enabled to serve the needs of the population.
- There has been no attempt to rectify the current disparate approaches to enrollment choice or uniformity in the localities. A problem so severe it is abundantly clear that members are not in receipt of equal access to service based on need. Standards vary from one DDRO to the next, from one person within the DDRO to the next, and although the complaints about this are not heard, or go unaddressed, this must be rectified to assure compliance with all state and federal guidelines. There is virtually no proper noticing to current or future members and, as such, rights are violated on a daily basis.
- The pretense that CHOICES has solved any of this is unfounded. One has to go on an email exploratory mission and have a targeted tracking system to know if the service request is approved.
- Building a more bi-furcated system on a three-legged stool with two legs missing when the current systems have deficits equates to a lack of understanding about the urgent need to first repair the infrastructure.
- The required appeal system and assurance that rights are not abrogated does not exist in this document as a fundamental requirement for any construct. It should.
- The inherent conflict of having linked parties approve services represents concerns and a lack of separation more intense than any conflict free requirement for case management. The overarching decision making about services type and quantity will be held by the very organization that has a vested interest in eliminating cost.
- In other models eligible members across diagnoses can receive their services under one model. With this sequestered model they cannot. Therefore, this is not a person centric or family centric model and it should be. How will the roll out of CCO branded MCOs provide all the sub-specialists required by the IDD population? So metrics cannot be tallied or measured in a void of access.
- The quote from page 8 of 43 indicates this: "Members who are determined, by the OPWDD Front Door process, to be eligible for Health Home and OPWDD HCBS services and decline OPWDD HCBS service but opt to receive Health Home may be served in Health Homes designated to serve adults or children." This is difficult to comprehend because the eligibility criteria in the DOH model today do not have the same IDD diagnoses in either the children's or adults' HH definitions.
- Reference is made to identifying assessment tools for use in the OPWDD HH model. It does not, though, indicate they will be uniform, so there is obvious exposure to

different outcomes. This makes service access and eligibility uneven, which is contrary to the goals and execution of such a model.

- Certain requirements, such as mandating attendance at follow-up visits, are out of reach based on the possibility that there is another payer other than MA involved and, if the information is not shared, it is impossible to assure. This is an example of the model not accounting for situations in which many payers can be involved, nor the real limitations of Care Managers without solid histories, relationships and communication. It also underscore that most of the requirements are directed to members who are not living with their families, which is a true failing of the model.
- The regrettable truth is that there is a major loss of free care as is currently provided by community-based agencies. This will have substantial negative impact on those we are intending to help.
- There is no mention of the requirement to meet EPSDT standards, which is something that should permeate as a standard of care, but does not.

Having just returned from a discussion held by DOH and CMS, it is clear to me that the major principles of any care delivery system are formed by three pillars: Clinical Integration of Care, Robust Care Management and Fiscal Alignment. If those principles do not exist in this model, and they are wanting in this description, then it is a fair assumption that the roof will collapse on this model.

Submitted by:
Margaret Mikol
Executive Director
SKIP of NY
(212) 268-5999 x 139
mmikol@skipofny.org