

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management  
for Individuals with I/DD, and the Development of Specialized Managed Care  
1/5/18**



We thank you for the opportunity to offer comments on the Draft Transition plan which implements significant changes in how people with disabilities will be authorized for and obtain access to needed services and supports. As an organization founded over 70 years ago by families who sought supports to maintain their family members in the community, CP of NYS offers the following insights and questions to ensure that this transition moves New York State forward rather than backward. A key concern in our advocacy over the years has been the responsiveness of a system established for a large population to meet the need of those with the most significant physical and behavioral needs. Whereas in the past, CP of NYS providers and others have made the decision to ensure services and supports would be in place for people with the highest needs, this new system holds the potential for the median and means language and policy-setting principles of managed care companies to severely compromise access and services needed by those who fall outside the bell curve and truly require more needs. In general, the State's embracement of a system that forces a regression to the mean is problematic for those whose disabilities define them as high need or high cost members of the disability community. While there are comments and assurances that needs will be met in this plan, we believe clearer processes and stronger safeguards are needed to ensure that all people with disabilities' needs will be met.

With that broad concern underlying our comments, we offer the following:

Section C, page 7:

"Throughout the transition period, the State will deliver educational materials through a variety of ways including, but not limited to . . ."

While the broad forms of communication are essential, it's important to note that particularly for many families, their physician and clinic site where medical services are rendered is the most common place for them to receive initial information for services. Once they have a contact with an organization – either intake or service coordinator – those people are the best resource for conveying information. The State must make the effort to provide education/information as outlined in the plan, but ensuring the access points and people who families depend on are informed and able to direct them to resources is critical. Further, we strongly suggest that from March of 2018 through January of 2019, OPWDD establish a working hours hotline to respond to and direct families seeking

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management for Individuals with I/DD, and the Development of Specialized Managed Care  
1/5/18**

information on the transition, accessing CCO's, changing care coordinators and/or CCO's, etc. Similarly, when the optional enrollment and mandated enrollment to managed care begins, a hotline should be available for people regarding their rights, the process, and options.

Moreover, to ensure families have the best information possible and the plan includes the ending of MSC services on 6/30/18, we encourage the State to use the CCO Care Coordinators to be part of the communication/notification process. Merely issuing guidance will not "ensure smooth transition". As the MSC service comes to an end, the field is already seeing gaps in family support/information sharing that a commitment to work with the CCO's immediately on the transition of communication/notification will address.

"CCOs/HHs will assume responsibility for trainings for MSC staff and providers, with support provided as needed by OPWDD."

The OPWDD support of CCO's and providers in this area that will be needed is significant. Allowing for any discrepancy across CCO's on information the former MSC's, now Care Coordinators, have on the process and the plan will only create confusion. One storyline/set of information must be used across CCO's for training staff. Again, as suggested above, OPWDD must offer a hotline as a backup to resolve any questions/concerns arising from information that CCO staff provide.

Section 4.a, pp 10 – 11

"Individuals and families will be informed of their options and rights throughout the transition." . . . "The Medicaid eligibility application processes will also remain the same as it does today by going through the LDSS." . . . "OPWDD DDROs will continue to assist individuals/families in obtaining Medicaid eligibility via their LDSS and HCBS eligibility through the DDRO."

It is critical in the transition that current practice in terms of working with families is accurately understood and discussed in the plans for CCO's to begin their work. The statements in this plan do not reflect the reality of how significant the role voluntary providers have played to date in assisting families in the eligibility process. With most agencies depending on their service coordinators to provide these support services, e.g., explaining the application process to families, assisting in compiling documentation and completing forms, following up with sources to obtain needed documentation, working with the social services office to ensure timely completion of approvals, etc., to what degree are the CCO's going to assume what has largely been non-billable services? If the CCO's are not being reimbursed for those supports, to what degree are the local DDRO's

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management for Individuals with I/DD, and the Development of Specialized Managed Care**  
**1/5/18**

and Social Services agencies positioned to pick up the family support and eligibility and enrollment services supports that Service Coordinators and voluntary agencies have been providing for years?

Page 11, 2<sup>nd</sup> paragraph indicates that “in recognition of the transition activities underway in the Spring of 2018, OPWDD and DOH propose a temporary extension for the annual LOC redeterminations that are due in May through July 2018 to be completed no later than September 30, 2018”. We not only support this concept but ask that it be expanded to include at least the months of March and April 2018 which is when MSC staff take on more responsibilities related to the transition to care management for themselves as well as the individuals and families they support. Similarly in Section 5.a, page 13, the plan States: “The DDRO will continue to perform the following responsibilities [during the transition]: . . .OPWDD HCBS Eligibility determination and discussion of the available OPWDD HCBS providers within the individual’s/family’s region to choose from for the delivery of HCBS.” Again, we question whether OPWDD staffing levels are adequate to perform this role as stated. The current practice differs significantly from what the “continue to perform” in the plan suggests. We do not contend that the role of DDRO should be different from what is stated, but we are not aware that OPWDD has added funding to their agency to pick up these functions which were largely provided as non-billable services from the voluntary provider community. We are concerned that a key part of family support will be lost or place undue stress on the newly formed CCO’s who won’t be reimbursed for these services. We are also very concerned that the communication and understanding of these changes between the State and LDSS will not go smoothly resulting in individuals “temporarily” losing their eligibility and services (care management as well as HCBS).

Section 5.b, page 14, “The State will also develop changes to claims and billing systems to authorize FFS reimbursement, ensure defined allowable scope of benefits and to monitor expenditures.” How this happens is central to the success of the transition; CCO’s and providers will need detailed information beyond what is in this plan on how this will occur and what the transition to managed care will mean for their billing and claiming systems.

Page 19, last paragraph notes that MSC service coordinators will be beginning to reach out to individuals/families on the benefits of enrolling in a CCO/HH once the MSC agency has affiliated with a CCO/HH. Most MSC agencies have already affiliated with an emerging CCO yet it states that “this process is expected to begin April 1, 2018”. We believe the process will take a significant amount of time given the nearly 100,000

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management for Individuals with I/DD, and the Development of Specialized Managed Care**

**1/5/18**

individuals enrolled in MSC and should be able to be commenced at least in early March. We also would like to know when will the State have its educational information available to share with the MSC agencies and the CCO/HH's and what role the State expects CCO/HHs to play in this process.

Page 19, last paragraph notes that MSC service coordinators will be beginning to reach out to individuals/families on the benefits of enrolling in a CCO/HH once the MSC agency has affiliated with a CCO/HH. This is problematic for a number of reasons. Most significantly, the timeframe for completing new "All About Me" assessments and life plans does not seem practical. We do not believe it is reasonable to expect care managers to accomplish this monumental task in 6 months without severely limiting their ability to perform their basic CM functions, i.e., supporting people. MSCs will just be transitioning into their new expanded CM roles and will be learning to use a new software system. If there is any problem with getting signatures on a letter or other necessary documentation, then the CCO's will not be able to bill for care management services. For these reasons, and we are sure there many others, potential (billable) productivity will be restricted, thereby adding to our already significant concerns about cash flow for emerging CCO's. One recommendation that we offer is that given the short timeline and the necessity to prevent any interruption in services, individuals should be automatically enrolled into the CCO that their disability service provider has affiliated with. Then the Care Managers will work to inform them of their options to opt out, change CCO's, or remain with their current CCO.

We have significant concerns about the impact of the proposed enrollment process on families and continuity of services. Even with a letter that must be signed, there will be difficulty for CCO's to oversee/ensure the quality and message of MSC agencies seeking to ensure the signing of a letter agreeing to be part of the new CCO by July 1. Communication with families is critical, and expecting current MSC agencies to transition families in a timely way to outside organizations may not be realistic. The CCO's need to be able to ensure that the outreach is being done, letters signed, and any communication with families in line with the message the CCO/OPWDD has developed regarding choice/options/ability to continue to work with the Service Coordinator of their choice so that the new service can begin on July 1. Much of that work will take time and families need to understand the options; not all that communication can be expected to be done by non-CCO organizations prior to July 1 – it will take months for the CCO's to accomplish this for all 100,000 program participants, and billing should not be held up for the CCO's who will be performing care management beginning July 1 because administrative forms are not in order.

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management for Individuals with I/DD, and the Development of Specialized Managed Care**  
**1/5/18**

Page 20, last paragraph, "In accordance with CCO/HH requirements and State standards, CCO/HHs will be required to provide Health Home core services training for all current MSC Service Coordinators.....", we recommend that OPWDD be responsible for providing and recording the initial training on the 6 health home core services and the Care Manger Checklist. This will ensure a consistent message is provided across the State to all transitioning MSCs.

Page 20, section 4.a. "To ensure there is no disruption of services during the transition process . . . ." and "Once enrolled in a CCO/HH applicants must establish a process for requesting a change in Care Manager . . . option to enroll with a CCO/HH of their choice."

While elsewhere in the plan (p. 23) it states that people can change their care manager at any time, it is not clear in this plan how those who want to change their CCO will do that. Is there an enrollment period or a means that will be developed by each CCO to ensure that people know how/that they are entitled to change their CCO and what that might mean for their relationship with their care coordinator? There needs to be clear processes for changing CCO's for those enrolled in one as well as identifying how those without an MSC can enroll in a CCO.

Page 23, 2<sup>nd</sup> full paragraph addresses the State's requirement to "complete the Health Home Services checklist, Attachment A, which is designed to assist care managers in ensuring the necessary action items are completed to initiate a smooth transition into HH services for the individuals they serve". The checklist must be completed for each person enrolled in MSC/PCSS between April 1, 2018 and June 30, 2018. While the goal and time frame are laudable, we question the real world practicality of such a timeline. Given the extent of the questionnaire and the number of people to be enrolled, we doubt the transition period allows for enough time to complete this data gathering of data elements. It doesn't seem feasible that this checklist, including confirming and identifying the members of the interdisciplinary team all well as all providers responsible for providing care to the enrollee and the completion of HH core services, can be fully completed for everyone in a three-month transition span of time. We agree that this work should begin in April 2018 but should be completed by the time the first Life Plan is created but no later than December 31, 2018.

On page 27, section e, "Oversight" the plan states that CCO's will be subject to "ongoing performance monitoring and management." Further, the plan notes that "Underperforming HH, in accordance with severity of underperformance, will be subject to remediation measures."

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management for Individuals with I/DD, and the Development of Specialized Managed Care**  
**1/5/18**

Where are those standards identified? How can a health home establish itself without knowing the criteria upon which they will be judged? OPWDD and DOH will have “monthly discussions” but who is ultimately responsible for making “remediation measures” determinations? What will the appeal process be – is there one for providers? Earlier in the document, on pages 14-15 “quality oversight” activities reference specific regulations that will be implemented – are there specific NCQA, HEDIS or other standards that will be enforced before a CCO is deemed to be “underperforming”? Much more clarity regarding who the lead agency will be, what the standards will be, and the appeals process for enforcing the review of the CCO’s needs to be developed and/or divulged.

Pages 35-36, in the discussion of specialized managed care plans, the transition plan references people’s right to a fair hearing and the continuation of that process along with the statement that “The State will conduct a desk review, followed by on-site readiness reviews, to ensure that the required components of serving individuals with I/DD have been met by the applicant.”

Is “The State” the Insurance Department? Is it OPWDD? Is it DOH? Is it a combination of those agencies? Will OMH have input to assessing the competency of the MCO? We strongly urge that a combination of OPWDD and OMH system and clinical experts be part of the plan to assess the competency of MCO’s looking to evaluate the needs and make resource allocation determinations on people currently supported through OPWDD. Similarly, the desk reviews, on-site audits and “readiness reviews” must contain clinicians and program representatives from OPWDD with expertise to assess the plan’s comprehension and knowledge of the specialized needs, particularly the importance of maintaining services for high needs people.

Page 35, 1<sup>st</sup> full paragraph indicates that “during both the voluntary and mandatory enrollment period the current regulatory framework continues to apply to services under OPWDD” with OPWDDs DQI surveying programs and services as they do now. With the shift towards personal outcome measures as part of the care management/HH service expectations and eventual shift to VBP payment methodologies under managed care, we believe that OPWDD needs to retool the survey protocols they fully implemented last fall. The OPWDD Provider Associations and representatives from the CCO’s should work with OPWDD to review the programs’ regulatory requirements and to streamline the survey and on-site review process.

In regard to value based payments, CP of NYS through the Centers of Excellence project has advanced the exploration of valid measures for the disability field,

**CP of NYS Comments on Draft Transition Plan for HCBS, Health Home Care Management  
for Individuals with I/DD, and the Development of Specialized Managed Care  
1/5/18**

and we hope that the work from the Centers along with representatives from the Centers would be part of a larger OPWDD effort to identify and establish acceptable measures that then could be brought to the CCO's and ultimately the MCOs as valid metrics for the VBP activities.

Page 38, Quality Review – while NCI indicators are a start, the POMS are not sufficiently understood and evenly implemented across the provider community to be a reliable measure of quality. They might be part of the equation, but the reality is that POMS implementation across providers has not reached a level of uniformity to suggest that POMS would be a reliable measure of quality.

We appreciate the hard work that went into the development of this transition plan and the many attempts to collect provider and family feedback. With that said, we do encourage New York State to consider adding more explicit language and measures that will ensure that issues related to high needs (often high cost) people are more specifically allowed for and addressed in the move to CCO's and, perhaps more importantly, the move to specialized managed care.

Thank you for the opportunity to comment on the plan – we look forward to working with you on the transition process.

