

# *Medicaid* **Medicaid Matters New York** *Matters*

## Comments on New York State's 1115 Waiver Amendment Application November 2019

Medicaid Matters New York is the statewide coalition representing the interests of New Yorkers who are served by the Medicaid program. On behalf of the over 100 individuals and organizations that make up our coalition membership, thank you for the opportunity to submit the following comments regarding New York's 1115 Waiver amendment submission:

### **Extension of the Delivery System Reform Incentive Payment (DSRIP) program**

The concept paper describing the State's submission of an application to extend the DSRIP program provides extensive information about DSRIP successes and outcomes towards the overall goals of the program. While a major focus of the DSRIP program was the inclusion of community-based organizations (CBOs) in the administration of DSRIP projects, the experience of CBOs has been a mixed bag. Some report having had strong working relationships with the Performing Provider Systems (PPS), that funds flowed to them appropriately, and that they were included in governance and decision making. Many more, however, report the opposite. From the perspective of Medicaid Matters and many of our members, DSRIP has been a frustrating endeavor with much time and many resources spent on trying to figure out how to be involved in a meaningful way with little return. There is broad understanding DSRIP was never intended to be a grant program for CBOs or some new opportunity for balancing CBOs' books. However, CBOs have much to contribute to reaching DSRIP goals, and many were left out because they were not asked to lend their expertise to the projects, take part in leadership roles, or adequately supported for what they could or did provide. From the community perspective, New York's DSRIP program has been hospital-centric, representing a lost opportunity to tap community resources for their expertise, cultural competency and more.

Medicaid Matters provides the following recommendations for an extension of the DSRIP program:

- Engagement of consumers and community representatives must be required in the DSRIP program extension. Consumer and community perspective should be incorporated into DSRIP by including people and representatives impacted by DSRIP in governance and oversight structures, by completing community needs assessments – done by agencies with proven experience working within communities in culturally competent ways – to ensure goals are appropriately identified, and by fostering consumer and community involvement through public forums and culturally-competent communications.
- The concept paper is silent on independent oversight. It is critically important there be an independent body that receives periodic updates, reviews the activities of the Value-Driving Entities (VDE), examines funds flow, and more. This oversight function may be fulfilled by the existing Project Approval and Oversight Panel or some other independent body, and must include consumers and community representatives. Meetings of such a body should take place in public with opportunities for public comment.

- There must be a concerted effort to address health disparities. People of color, people residing in underserved communities, and people with disabilities have poorer health outcomes than others. The DSRIP program must focus on reaching better outcomes and achieving wellness for people who have historically experienced poor health due to their race, ethnicity, disability status, neighborhood, and other circumstances. While the current DSRIP program has made some strides in addressing health issues common in communities of color (such as asthma and diabetes, for instance), there has not been a dedicated focus on reaching health equity. Existing PPS should be asked to report how they addressed the disparities identified in the community needs assessments they were required to do at the beginning of the DSRIP program, and only those PPS that can demonstrate they were successful in addressing the needs of their communities should be eligible to apply to be a VDE for the purposes of a DSRIP extension.
- The concept paper envisions managed care organizations (MCO) will have a formal role in a DSRIP extension. It is expected they will be part of VDE networks alongside health care providers and CBOs. To contribute to the overall DSRIP goals, there must be an expectation of transparency when it comes to MCO participation. MCOs must be expected to share data across all entities involved in a VDE network to help facilitate meaningful engagement and coordination.
- For people with multiple needs or who use services across multiple systems, there is still much confusion about care coordination and who to go to within which system to get their needs met. One person may have multiple care managers or care coordinators that serve different functions, and they often operate in silos. The next DSRIP program should address this by streamlining care coordination across silos to eliminate confusion and minimize the need to go to different people across different systems.
- The newly-created Social Determinants of Health Networks should be led by CBOs. CBOs of all types bring deep knowledge and rich histories of success in meeting people where they are to address social needs.
- Attention must be paid to ensuring meaningful, efficient participation of all entities within a VDE network. This is necessarily to support data collection and reporting, as well as cross-system referrals for a variety of services. IT and data systems will need to accommodate all VDE entities, and technical assistance and support must be provided to CBOs in particular to allow them to operate in the same way as health care providers and MCOs. The regional CBO consortia have shown some success in this area, and funding should be provided to them to ensure the continuity of effective consortia-related activities.
- Long term care reform is listed in the concept paper as a new high-need priority area, which is overdue and applauded. However, people with intellectual and developmental disabilities (I/DD) and the services on which they rely are still not mentioned as a focus for reform. Work has been done to incorporate people with I/DD and their service system into the State's work toward Value Based Payment (VBP) by engaging a clinical advisory group to develop appropriate metrics for this population, and by formally adding this area of interest to the State's VBP Roadmap, which is reviewed by the federal Centers for Medicare and Medicaid Services (CMS) annually. In addition, the state Office for People with Developmental Disabilities (OPWDD), in conjunction with the state Department of Health (DOH), is working on a plan to transition this population to Medicaid Managed Care. The DSRIP extension should attempt to address the needs of people with I/DD in the health care delivery system by building on work that is already underway in the area of VBP and managed care. This should result in better health, reduced cost, and reduced hospitalizations.

- Medicaid Matters also applauds the focus on children’s population health as a high-priority area. Much work has been done over the past few years to draw attention to the needs and opportunities specific to children’s health. This includes extensive discussion by the Children’s Subcommittee of the Medicaid Redesign Team, implementation of the children’s behavioral health transition to managed care, and implementation of the First 1000 Days on Medicaid initiatives (which includes the identification of metrics by the Preventive Pediatric Care clinical advisory group of the VBP Workgroup). The DSRIP extension should build on this work and careful attention should be paid to avoid duplication of efforts.

## Expansion of Medicaid Managed Care

One of the major initiatives that came from the deliberations of the Medicaid Redesign Team in 2011 was a significant expansion of Medicaid Managed Care. Referred to as “Care Management for All,” this initiative sought to move people and services previously exempt or excluded from managed care into some model of care management. Medicaid Matters has engaged in extensive advocacy related to these changes and continues to urge the State to take great care to ensure Medicaid consumers are protected in the context of managed care, during transition, through to a managed care model and beyond.

Medicaid Matters provides the following comments related to Medicaid Managed Care:

- DOH and the State Office for Mental Health (OMH) have been implementing a transition to managed care for children’s behavioral health services. This includes a distinct set of home- and community-based services for children with significant needs and their families. Advocates recently learned the readiness reviews conducted with the managed care plans over the summer of 2019 demonstrated that none of the plans were adequately prepared for this transition. The State agencies report that remediation efforts have or will address the issues found by the readiness review, but this is still very concerning. The adult behavioral health transition has not gone smoothly; data shows people are not accessing the home- and community-based services that were the promise of enrollment in Health and Recovery Plans (HARP). Advocates fear the adult transition is a bellwether for what we may see as the children’s transition takes shape. Special attention must be paid to making sure children and their families are able to access the services they need.
- The next big transition associated with “Care Management for All” is the move to managed care for people with intellectual and developmental disabilities. OPWDD has indicated the 1115 Waiver will not be the mechanism for implementing this transition. However, the 1115 Waiver may present opportunities to address some of the needs of individuals and their families as this transition takes shape. To that end, Medicaid Matters offers the following considerations:
  - o The seven regional Care Coordination Organizations (CCO) established in 2018 are the precursor to managed care for the I/DD population. They have replaced what used to be the services provided through the Medicaid Service Coordination (MSC) program. They are currently responsible for assessments, development and maintenance of a person’s Life Plan, and coordination of any and all needed services. It is unclear whether the current CCO activities will continue to be the responsibility of the CCO, the MCO, or some combination of both. The implementation of managed care for people with I/DD must include clear

- delineation of roles so individuals and their advocates have precise information about who is responsible for what functions.
- Assessment for services must be evidence-based and person-centered. Individuals and their advocates report this is not always the case, resulting in service authorization that does not adequately or accurately reflect a person's needs.
  - Due process protections must be in place for this population. Individuals and their advocates must understand enrollees have rights in the context of managed care and how to exercise them.
  - Independent ombuds services must be available to this population.
  - Communications and notices from state agencies and MCOs must be clear, accessible, and understandable. Notices, letters, website posts, etc. should be run by a number of people with I/DD.
  - Stakeholder engagement is critical to ensure person-centeredness. Individuals and their families must be part of the implementation process by being offered opportunities to provide feedback and input. People with I/DD and their families and advocates should be asked to serve on state agency and MCO advisory bodies, and their participation must be supported and fostered.