



Coalition Of Provider Associations

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TESTIMONY SUBMITTED TO THE

**ASSEMBLY STANDING COMMITTEE ON MENTAL
HEALTH AND DEVELOPMENTAL DISABILITIES**

on

**Access to Mental Health and Developmental Disability
Services and Supports**

Presented by

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For the Coalition of Provider Associations

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Representing More Than 250 Provider Agencies in New York State

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Good morning Committee Chair Gunther and members of the Assembly Standing Committee on Mental Health and Developmental Disabilities. Thank you for your ongoing support of people with intellectual and developmental disabilities (I/DD) and for the opportunity to speak with you today regarding access to developmental disabilities services and supports.

We are Wini Schiff of the InterAgency Council of Developmental Disabilities Agencies (IAC) and JR Drexelius of the Developmental Disabilities Alliance of Western New York (DDAWNY). Barbara Crosier of the Cerebral Palsy Associations of NYS is with us in spirit and regrets not being able to join us in person today. We are here on behalf of the Coalition of Provider Associations, or COPA.

COPA consists of five associations – The Alliance of Long Island Agencies, Inc. (ALIA), Cerebral Palsy Associations of New York State (CP of NYS), the Developmental Disabilities Alliance of Western New York (DDAWNY), the InterAgency Council of Developmental Disabilities Agencies, Inc. (IAC), and the New York Association of Emerging and Multicultural Providers (NYAEMP) – because people with disabilities, their families, and the organizations that support them felt the need to unify in their quest to ensure that adequate services are available for those who require them. COPA represents over 250 not-for-profit agencies across New York State that provide supports and services to hundreds of thousands of New Yorkers with intellectual and developmental disabilities (I/DD) and employ more than 75,000 dedicated direct support professionals with combined annual operating budgets of nearly \$5.2 billion.

Our comments address a number of key areas where we feel the Legislature can play an important role in ensuring that New Yorkers with I/DD receive the high quality supports and services they and their families need to live the kind of life the rest of us take for granted.

1. COLA

Prior to 2011, Medicaid funded OPWDD services received yearly increases to cover the rising costs of providing services, called “Medicaid Trends.” In 2010, a Medicaid Trend of 2.08% was given to both state operated and voluntary operated programs. Since that time, with the exception of 0.2% given in 2017, voluntary OPWDD providers have been denied any Medicaid Trend to support agency operations. Again this year, the Enacted Budget did not provide a Medicaid Trend for not-for-profits which provide over 80% of all services, yet since 2015, State operated OPWDD services (constituting less than 20%) have received a yearly Medicaid Trend based on the Medical Care Service Index (MCSI) component of the Bureau of Labor Statistics Consumer Price Index for all Urban Consumers. Increases in rates for OPWDD not-for-profit service providers have been limited to Direct Support Professionals and other lower wage staff salaries in the amount of two 2% increases in 2015 and two 3.25% increases in 2017. The second increase in 2017 included clinical positions as well.

Federal and State law require that all payments to providers be based upon the reasonable cost of services. Reasonable costs take into account both direct and indirect costs, including personnel costs, administrative costs, costs of employee pension plans and normal standby costs (costs related to unoccupied beds). Prior to 2014, a provider's shortfall in funding could be appealed, either based upon the reimbursement rate for a particular category, or effective July 1, 2011, based upon a vacancy methodology appeal. Since recent rate transformation (aka "rate rationalization") has been implemented, periodic rebasing is intended to allow OPWDD to make better budget projections, provide greater provider accountability and create a more efficient and equitable system. Federal guidance, however, suggests that base year funding be trended forward, in order to ensure compliance with Social Security Act §1902(a)(30)(A), which requires that "payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers", to prevent underpayment, help ensure quality of care and retain an adequate pool of providers. COPA believes the failure of the State to include a Medicaid Trend factor in its Medicaid rates for voluntary providers may be a violation of this federal law. We request, therefore, that the FY 2019/20 budget include the statutory COLA/Medicaid Trend based on the CPI-U which is calculated this year at 2.9%, in order to cover rising costs, particularly indirect and administrative costs, which have been ignored over the past 8 years. We request this COLA/Trend in addition to the #bFair2DirectCare Living Wage increases described in the next section. The absence of a COLA/Trend over many years caused the inability to provide reasonable salary increases which has led to the staffing crisis we are experiencing today, and the need for remedial payments. The restoration of a yearly COLA/Trend, beginning now, will prevent this crisis from developing again in the future.

2. #bFair2DirectCare

Direct Support Professionals (DSPs) are the approximately 100,000 people (full time and part time) who deliver the supports and services that individuals with developmental disabilities and their families depend on, 24 hours each day, seven days a week. These highly trained staff members perform mentally, emotionally and physically demanding work, requiring sophisticated judgment and decision making. In many cases, the health and wellbeing of the people they serve rests entirely on their shoulders. These are not minimum wage jobs. Yet years of grossly inadequate funding have led to wages that have lagged behind where they should be, considering the importance of the work.



The FY 2018/19 enacted Office for People With Developmental Disabilities (OPWDD) Aid to Localities budget included \$44 million to continue to provide funding to implement the new minimum wage, but more importantly, \$145.8 million to continue the phase in of a living wage for our lowest paid staff. We are grateful to the Governor and Legislature for recognizing the need to address this issue and we look forward to New York State's continuing support as we seek to reach our living wage goal. A previous survey of providers across the State shows that

for 2017, vacancy rates had increased to 14.4% (an increase of 30% from 2016) and the turnover rate had increased to 26.7% (up 7.5% from 2016) causing providers to pay over 10 million hours of overtime last year, and approximately \$29 million in expenses to replace lost staff (when even possible). Our new survey results are still being analyzed, but it appears that vacancy and turnover rates have not increased. Overtime paid, however, has increased significantly. Full results will be available soon which we will share with the Legislature, Governor's office and the Division of Budget.

Unlike hospitals and other healthcare providers, those who support individuals with I/DD are almost exclusively funded through Medicaid with no alternative source of funding to increase wages. We cannot raise our prices or otherwise substantially increase our revenue. If we can't attract and retain qualified workers we are forced to accept less qualified applicants and/or reduce the amount of support we provide for each person and/or cut services. Labor is by far the largest component of our budgets, with more than 70% of funding going directly to compensation for front-line staff who provide direct supports. Unlike other sectors where automation and use of technology may offer alternatives, the supports we provide require talented human beings.

The ability for COPA members to continue to provide supports and services depends on increased wages for low paid workers – especially those providing direct supports to individuals with I/DD. We have joined every association in the State representing individuals with I/DD and their families including DSPANYS (the Direct Support Professional Alliance of NYS), SANYS (the Self Advocates Association of NYS), and the parent group SWAN (the StateWide Advocacy Network), to form the #bFair2DirectCare Coalition. As previously stated, we commend both the Governor and Legislature for supporting the initial steps in this endeavor and look forward to continuing to work together to realize the goal of a new living wage for our dedicated professionals in the near future. Without an adequate supply of qualified staff, incidents which endanger the welfare of the people in our care will increase, those staff who stay will experience "burn-out" due to the burden of increasing overtime hours worked and staff, families and, most importantly, the people with I/DD who depend on us, will suffer. There is no safety net beyond the not-for-profit providers. Of the more than 138,000 New Yorkers with I/DD supported by OPWDD, most are supported by the nearly 100,000 direct support professionals and other staff in our nonprofit, community-based organizations.

In short, the staffing crisis continues to threaten the availability of supports and services, and we urge you to continue your support for #bFair2DirectCare by including funding for years three and four of a six year commitment to a living wage. We request full funding for the third year of the #bFair2DirectCare stabilization funding on 4-1-19 and implementation of the fourth year of funding on January 1, 2020 to move our low wage workers closer to a living wage. As previously noted, we request this stabilization funding in addition to the statutory 2.9% COLA/Trend since these payments will correct the years of underfunding and the COLA will prevent this situation in the future.

3. Funding Services and Supports for People with High Needs

At one time, not-for-profits could provide supports and services for people with a variety of support needs and intensities without additional funding since, on balance, there was adequate funding to cover individuals varying needs for support. The result of COLA/Trend deferrals, rate rationalization, the elimination of rate appeals and severe staff shortages, however, is that providers now are no longer able to support high needs individuals without additional funding. As deinstitutionalization continues, requiring placement of individuals with the greatest challenges in more integrated community settings and students with significant behavioral and physical challenges age-out of residential schools, providers are receiving more and more referrals of high needs individuals. They require enhanced staffing to maintain their own safety, the safety of their fellow program participants, housemates and staff. Many providers can no longer accept these high cost, high need individuals given their under-resourced financial situations. While these high need individuals are being accepted by those providers still financially stable enough to manage the extra cost, even they are being destabilized in the process. OPWDD is in the midst of developing a high needs funding methodology, but this initiative focuses on those currently receiving services whose needs have changed due to a "precipitating event" which changes a person's support needs abruptly. While this new high needs funding methodology is being designed and final approvals from the State and federal governments are being sought, providers are still serving those high needs individuals without additional funding. In addition, as many in the disability community age and develop more complex needs, the current system lacks the responsiveness to meet them in a timely way. Further, the increased prevalence of mental health diagnoses highlights the lack of coordination across state agency programs within our system of supports and services. It is quite complicated for a medically frail person with a mental health diagnosis to access supports in a coordinated fashion across programs overseen by different State agencies. In order to accept new individuals with high needs into programs, providers must complete an arduous and uncertain process for evaluating and obtaining state approval for additional funding. If this situation is not addressed, those most in need of services will not obtain the supports and services they need.

4. The Residential Shortage

As New York State seeks to transform the system supporting people with I/DD so that it will be sustainable for future generations, housing is a key and complex component which requires thoughtful planning and investment to ensure that our successful system will include community living options for people with all levels of I/DD.

The most current Residential Request List (RRL) that OPWDD has publicly released shows that 11,745 people are in need of residential services. 6,436 of those have an urgent need. \$120 million has been allocated in last year's budget, but this amount must cover all new

services, including residential, day and other programs. COPA strongly believes that this allocation is woefully insufficient, in addition bureaucratic delays routinely impede the use of these funds. The current budget provides for a pool of \$15 million in capital funds allocated for the development of OPWDD sponsored affordable housing for people with developmental disabilities. We wholeheartedly support this program and urge you to advocate for increasing it as part of the OPWDD multi-faceted housing solution.

Current practice often results in placements that are not ideal for the person in need or those with whom he or she might be placed. Considerations of choice and least restrictive setting become almost impossible to honor when an “emergency priority” approach is combined with an overall lack of opportunities. Regulatory issues and funding silos between agencies prevent creative housing opportunities from being developed and/or implemented. In order to support the rising number of aging New Yorkers with developmental disabilities who are living longer and need accommodations that all aging people need, new graduates from day and residential school programs who need a variety of supports and services and are increasing in number with the rising incidence of autism spectrum disorders, and with existing resources mostly allowing those in only the most urgent circumstances to obtain out of home housing supports, we need to work together to develop solutions.

We would like to raise three main issues in residential services for people with I/DD that can be addressed to begin to fix the housing dilemma:

- Staff Shortages
- Development, Modification and Transformation Funding Shortages
- Systemic Roadblocks

Each of these areas would take more time to fully develop than we have here today but we welcome the opportunity to have these conversations with you to develop sound recommendations to address these issues.

Staff Shortages

It appears that the first two phases in the investment in “Fair2DirectCare” direct support living wage funding has at least stopped the growth of our staff vacancy and turnover rates but we need this investment to continue in the upcoming budget. It cannot be overstated that health and safety is severely compromised by a lack of staffing, leading to inexperienced, unqualified caregivers, burnout and exhaustion and increased incidents which could result in extremely negative consequences. The cost of onboarding a new DSP can be estimated at \$4,000, and with vacancy and turnover rates of 14.4% and 26.7%, this cost is exorbitant. To further illustrate our growing crisis, we have conducted a new vacancy and turnover survey and results will be available shortly.

Development, Modification and Transformation Funding Shortages

While we are grateful for the investment in the last two budgets which will begin to create a living wage for our direct support professionals who are the backbone of all of our services, we must point out that we have not received a meaningful cost of living increase in eight years, nor have we received necessary funds to facilitate the transformation of our system of residential supports and services to comply with federal requirements or the changing needs of the people in our care.

Our residential schools have a backlog of graduates who are unable to move to adult residential settings due to the housing shortage. Despite identifiable numbers of students each year progressing through our residential schools, we do not have plans in place to ensure these graduates will transition in a timely way each year. This residential capacity problem impacts the schools as well – there are many children who are placed in out of state schools due to the lack of capacity in New York, with a much higher cost to the State, not to mention the strain on families who are not able to keep their children near home. OPWDD has recognized this problem and has been working with the Centers of Excellence in the Care and Treatment of Children with Autism Spectrum Disorders and Other Complex Disabilities, but further investment in the work being done through the Centers requires Legislative support to ensure the cost savings opportunities are realized while also ensuring a better flow of students in and out of this school system. Additionally, a new and innovative program in Western New York integrates OMH and OPWDD services supporting people with autism and dual diagnoses which we expect will further decrease the need for residential school placement. Participants in these programs will need residential opportunities as well.

We have a growing aging population in New York, both caregivers and those who need support, for whom the current system is not responsive. Many people are aging in residences developed many years ago that can no longer meet their needs without significant capital work. Funding is at best limited or no longer available for modifications or relocation. We should provide those who want to age in their homes with modifications and/or supports that meet their individual goals and preferences. ISS funding, which covers the rent for those able to live more independently in non-certified residential settings, is another option which could create additional vacancies in existing certified housing situations but the rent subsidy caps are too low to reflect market values in many areas of the state. In addition, it often takes three months to an entire year for OPWDD to reimburse providers who are forced to cover the rent for that period of time. While larger organizations have found ways to subsidize the program, this delay severely limits its success. The \$15 million in OPWDD affordable housing funding made available in the budget in the last few years has proven to be a successful addition to our housing development initiatives and increasing this allocation is highly advisable. The current allotment is spoken for even prior to the dollars becoming available.

Systemic Roadblocks

The Residential Request List (RRL) and Certified Residential Opportunity (CRO) lists are a good attempt at gathering information on need and planning for future residential needs, but unfortunately families and professionals are often unfamiliar with the process for getting on the lists – there is a crucial need for training and information dissemination. In 2017, 424 new certified opportunities were released, reportedly based on current need. We know there are many more individuals who currently have urgent needs for certified residential opportunities who would have been on the list if they had access to/knowledge of the CRO system. No additional certified residential development has been announced in 2018. Further, we ask that there be more transparency about the lists/numbers of people seeking residential supports, in general. We understand that “backfills” are a significant source of certified housing opportunities. When the opportunity available matches the needs of the individual seeking this option, then backfilling works! When it doesn’t, frustrating and possibly dangerous situations can result. Many in need of placement are medically frail or have significant behaviors which require enhanced staffing not available in the typical backfill opportunity. Federal mandates to honor choice dictate that requests for not sharing bedrooms, living with compatible roommates, etc., should be granted. When individuals and families choose not to accept a backfill opportunity, they are often placed on the end of the list, increasing their wait-time for needed residential services. Federal rules regarding Home and Community Based Settings Standards and size of the homes are additional complications. We need eligibility determinations to be streamlined and creative, cross-agency funding opportunities to be explored. Currently, more than 50% of people with intellectual and developmental disabilities supported by providers also have a mental health diagnosis, yet we often run into barriers that segregate what funds are available for capital development projects or ongoing supports.

New York State’s commitment to people with disabilities and their families, made after Willowbrook, has carried us this far. We are here today to seek your support for making the changes necessary to provide the appropriate residential opportunities needed when they are needed. This will require both investment and thoughtful changes in procedures

5. Transformation Issues

COPA continues to be troubled by the aggressive timeline the State is proposing to qualify new Specialized I/DD Plans-Provider Led (SIP-PL), enroll members and move to capitated rates for I/DD services. The State's movement to Managed Care includes a plan to allow the Care Coordination Organizations/Health Homes (CCO/HH) to transition to specialty managed care organizations and allows, if necessary, additional capacity through mainstream managed care organizations. This transition will take time which is not permitted under the current State Draft Anticipated Timeline for Requirements and Standards. It also requires an enormous investment in infrastructure, IT and administrative and overhead expenses that do not exist in the system

today. If New York is seriously committed to enabling community I/DD entities to develop into SIP-PL entities, it is important, at the onset, to acknowledge that MCO's and community I/DD providers are at two very different starting points. In terms of capital, reserves, IT, other infrastructure, etc., the MCO's already have it, whereas community I/DD providers do not. The draft timeline expects the CCO/HHs to apply to become SIP-PL's by February of 2019, three months after the final OPWDD Requirements and Standards Application is released. The timeline proposes to announce the qualified SIP-PL's by June of 2019 – a mere seven months after the Application is released, and less than a year after the CCO/HH's became operational.

The CCO/HH's have done a tremendous job of creating viable and robust case management organizations. They have hired staff, transitioned MSCs from I/DD provider agencies, developed training materials, policy manuals, sought to educate individuals with I/DD and their families on the new care management model, developed human resources operations, contracted with service providers and information technology companies (including the favored MediSked Person Centered Platform operation), are in the ongoing process of developing Life Plans© for their members (the state is requiring all Life Plans to be completed by June 30, 2019) and dealt with a myriad of glitches, miscommunications and false starts any new business enterprise can be expected to experience. While the CCO/HH's were only launched in July of 2018, there were years of development and planning for these provider-led organizations to become operational. Indeed the CCO/HH plan was initially presented to the provider community to be implemented in 2016 and was delayed due to the complexity of the transition.

Now the State wants these CCO/HH's to become SIP-PL's on extremely short notice. With the exception of Partners Health Plan, it is unclear how these new care management organizations, all less than six months old, can be expected to transform into fully functioning SIP-PL's. Nor do the draft Requirements and Standards provide the type of flexibility COPA believes is necessary to consider alternative models to provider led managed care in addition to SIP-PL's, to ensure that the CCO/HH's are sustainable long term. The aggressive timeline proposed is simply unworkable for any organization that does not already have an Article 44 license.

If the intent of the State is truly to permit new Provider Led Managed Care Plans to better meet the needs of individuals with I/DD and their families in the most comprehensive way possible, improve health outcomes, control Medicaid costs and provide Care Management for all Medicaid enrollees by aligning incentives for the provision of high quality, integrated, and coordinated services, it needs to provide more time.

There has, as yet, been no evaluation of the effectiveness of CCO/HH care management delivery model. Additional time will allow for changes in the current model in order to deliver truly person-centered outcomes for individuals with I/DD. The implementation of a SIP-PL, or an alternative provider led managed care model, is far more complicated and technical as compared to the development of the CCO/HHs in New York. Whatever the managed care model, it will involve not just I/DD services but also medical care. As such the new entities will need a

broader provider network. People with I/DD require both acute and long-term care from a broad array of specialists and specialized facilities. These new provider led managed care operations will need to enter into negotiations and ultimately contracts with additional providers in this new model. In New York, the creation of a new Article 44 typically takes the better part of one year, yet the draft Requirements and Standards would seemingly require this work to be done by February of 2019, when the SIP-PL applications are due.

COPA would also point out that the State's implementation of Managed Care for children and for those with significant behavioral health issues has not gone as planned, requiring significant changes in timelines and funding. These changes were often unanticipated and required additional time, effort and discussions from all stakeholders before actual implementation was begun. These plans are still undergoing growing pains and additional changes are likely as the State and the mainstream managed care organizations covering these sub-specialty populations continue to evolve. The behavioral health and children managed care rollout was led by experienced managed care companies with a history of working in New York State. The requirements for the SIP-PL are unique, requiring the creation of new Article 44 entities, with majority control by provider agencies, among other requirements. Additional time is necessary for these provider agencies and their partners to responsibly consider various models for partnership, alignment and the financial impact these relationships will have upon business operations.

COPA strongly urges the State to extend the Anticipated Timeline for Requirements and Standards by at least eight (8) months, preferably by one (1) year to encourage and support the thoughtful development of SIP-PL's, which truly are provider led and in the best interest of those served.

a. Life Plan, Staff Action Plans and Electronic Platforms

The person-centered planning process is intended to be a collaborative process between the individual and the service provider. COPA does not believe that it is the intent of OPWDD to mandate that all elements identified in the Life Plan, a new document meant to replace the current Individualized Service Plan, should constitute a binding mandate on the providers. Some of the early Life Plans contain upwards of 20-30 goals. Obviously, this is unmanageable, unrealistic and counterproductive to an individuals' success. As CCO/HH staff scramble to complete Life Plans within the mandated timeframes, providers have received plans that are incomplete, include inaccurate information, missing signature pages, have incorrectly assigned Goals/Valued Outcomes, and other errors that increase vulnerability of financial payback under audit. In addition, Staff Action Plans, which must be derived from the Life Plans, are required to be completed in an unrealistic timeframe.

As part of the transition to conflict free case management and ultimately a transition to managed care, a secure, web-based portal was to be created allowing providers access to the

Life Plan, as well as view and upload important documents. This portal is not readily available, which has impacted the effectiveness of communications between the Care Managers and providers. Care Managers are using inconsistent means to communicate important changes to individuals' services. Providers are now resorting to emails and paper documents to communicate when a Life Plan amendment is needed. Care Managers' acknowledgement of receipt of these requests is inconsistent, so providers are uncertain if the changes are being made. The result is confusion, disruption in the continuity of care, and increased audit vulnerability. Agencies will need training on the web-based portal. It is unclear who will be responsible for conducting this training. There are also technical issues that need to be addressed, such as the management of user access to the web-based portal. We are concerned that the CCOs will be asked to take on these tasks, further stretching their resources away from the focus on ensuring individuals receive care management services.

The web-based portal that all CCOs are using is called MediSked. Despite passing readiness reviews, MediSked appears to contain serious flaws. Case Managers have indicated that they very often cannot access any previous records. MediSked is not compatible with other systems, so any prior information must be uploaded into MediSked by hand, page-by-page. MediSked's file system is so challenging that even if a document is uploaded, it often cannot be found and later downloaded. It could be in any of several places within MediSked's memory stores, and MediSked currently lacks a search and sorting engine capable of finding files in its own memory stores. MediSked attested to both federal and state authorities that it was capable of storing and retrieving all previous and current records, connecting to any other database (such as CHOICES and RHIOs and all the former MSC agency databases), presenting relevant information to families and Case Managers in a participant portal, managing all accounting and billing and auditing functions, maintaining a comprehensive searchable database of all service options across the state for Case Managers to simply point-and-click at, and sending quality assurance reports to state and federal regulators. In the real world, MediSked can barely upload documents and little else. It crashes regularly. It is poorly designed and there are concerns from a number of IT professionals that the limitations of the MediSked are systematic. OPWDD established readiness review requirements for all Electronic Health Record vendors. Currently, these vendors are at different phases in meeting the requirements. Integration of the EHRs, particularly to MediSked, is critical to ensuring the consistency of health records. Specifically, this inability to fully integrate electronic systems is pushing providers to develop Staff Action Plans outside of their Electronic Health Records (EHR). This is a significant step backward. COPA is concerned that until the integration of data feeds between various EHR vendors are reconciled and integrated, the creation of a Life Plan and the integration of the Staff Action Plans used to deliver services and supports for individuals with developmental disabilities will be at risk.

b. Coordinated Assessment System (CAS) Inaccuracies

The CAS is a detailed evaluation tool which will act as a guide to a person's services, and in the near future, become the basis for capitated rates in managed care. An inaccurate CAS, at the

heart of a system of funding services and supports will be its downfall. When the CAS was originally introduced, providers were informed that only after years of validated data, would the CAS be used to inform resource allocation decisions. Today, we are faced with the prospect of having a validated instrument, yet data that is most certainly not at an acceptable level for families and providers to be comfortable with its being used in rate and resource allocation decisions. The State Plan suggests that as early as 2019, CAS data will be incorporated into the rate setting process for July 1, 2019 rates. This is entirely unacceptable – the provider community will soon be releasing an actuarially based report on the accuracy of the data. That report was commissioned after multiple families and providers across the State reported significant errors in the data in the CAS, e.g., non-ambulatory people were reported as able to walk, those who could tell a shirt from pants were described as able to dress themselves, among other gross misrepresentations. While ostensibly there is a process to contest the data, the field's experiences have not proven our inability to effect adequate change in the accuracy of the assessments.

c. VBP

COPA understands that for I/DD residential services and I/DD Targeted HCBS, the services will be reimbursed by these Specialized I/DD plans initially using a non-risk arrangement subject to the same Value Based Purchasing arrangements already approved in the current 1115 MRT Waiver.

The State proposes to require no later than 24 months after implementation of mandatory enrollment, the non-risk I/DD Targeted HCBS will be included in a risk payment arrangement between the State and the qualified SIPs-PL and any approved SIPs-M plans. COPA continues to believe this timeline is far too aggressive and would propose that the movement to a risk based payment structure to 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, COPA is unaware of any nationally recognized outcome measures to grade the value of, or quality of services for people with I/DD. OPWDD has had preliminary conversations with stakeholders on the possible ways to measure value, but no Value Based Payment (VBP) model has yet been identified. 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. COPA believes it is essential that 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.

COPA believes at a minimum the State should not require risk-based payments as related to either I/DD residential or I/DD Targeted HCBS for at least five (5) years after the implementation of mandatory enrollment.

In addition, COPA 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. The demonstration program was begun 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-IDD Demonstration on Participant experience of care, quality, utilization and cost. The State is required to engage and incorporate feedback from the public during the implementation and operational phases of the Demonstration. CMS requires quarterly reports to provide rapid cycle monitoring of enrollment, implementation, utilization of services and costs. In addition the evaluator is submitting New York specific annual reports that incorporate qualitative and quantitative findings to date, and will submit a final report at the end of the Demonstration.

COPA believes these reports, meta-analysis and public feedback ought to be made available in a transparent and timely manner, and in order to inform the transition of the general I/DD population to managed care. The FIDA I/DD demonstration should provide valuable feedback in developing the structure of Managed Care for the entire I/DD population.