DISABILITY RIGHTS NEW YORK

www.drny.org mail@drny.org 518-432-7861

DRNY Comments on Draft of New York State 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 (SIPs-PL)

October 3, 2018

Disability Rights New York ("DRNY") submits the following comments on the Department of Health ("DOH") and the Office for People with Developmental Disabilities ("OPWDD") proposal: New York State 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 (SIPs-PL) ("Plan"). As the statewide Protection and Advocacy system for people with disabilities, DRNY has an interest in ensuring that people with disabilities receive the support they need to live independently in their communities. We appreciate DOH and OPWDD's commitment to these goals. However, the current plan for a successful transition to managed care is grossly deficient.

I. Plan Development

The Plan is Inaccessible to Most OPWDD Service Recipients and Violates the ADA

As noted in DRNY's previous comments, under Title II of the Americans with Disabilities Act, OPWDD and DOH are required to take steps to ensure their communications with people with disabilities are as effective as communications with people who do not have disabilities.[1] However, the 92-page highly technical Plan is neither clear nor an effective means of communication for people with intellectual and/or developmental disabilities. The length, coupled with the format, makes the Plan inaccessible.

The Plan, as well as the entire transition to managed care, is so unwieldy and unclear that most people with intellectual and/or developmental disabilities and their families are unaware of the magnitude of changes to come. They are therefore unable to meaningfully understand the transition to managed care.

[1] 28 C.F.R. §35.160 (2005).

Lack of Stakeholder Participation

The Centers for Medicare and Medicaid Services ("CMS") requires States to solicit and engage with stakeholders in the development of an 1115 Waiver, including the Plan.[2] These outreach efforts must also include a summary of the Plan, which neither DOH nor OPWDD has provided to the public.[3] Further, the State is required to convene at least two public hearings on the Plan. While OPWDD held public hearings on the transition to Care Coordination, to date it has not convened public hearings solely on the transition to managed care. Accordingly, DOH and OPWDD have failed to meet their obligations as required by CMS, and therefore this Plan must be retracted until they do so.

In addition, OPWDD and DOH claim that the plan to discontinue the Home and Community Based Services ("HCBS") Waiver and transition to managed care is an outgrowth of specific recommendations made by OPWDD's Transformation Panel. However, of the 18 members of the Transformation Panel, only two are parents of individuals with developmental disabilities and only one is a self-advocate and direct stakeholder. Representation by recipients of services through OPWDD is shockingly inadequate. Similarly, representatives of self-advocacy and disability rights organizations, as well as any other organizations or agencies that represent the rights and interests of people with disabilities must be involved in this process. Excluding these voices compromises effective transition and the possible implementation of managed care.

The Plan is Incomplete

As noted in DRNY's prior comments, the Plan offers grossly inadequate specificity regarding implementation of managed care. The Plan itself states that the final transition to managed care "will be described in amendments to the Comprehensive HCBS Waiver and the MRT 1115 Waiver."[4] DOH and OPWDD's piecemeal approach compromises an effective assessment and response. Instead, a comprehensive managed care proposal should be released, rather than the current fragmented approach.

No Translated Versions of the Plan

As noted in DRNY's prior comments, the lack of readily available translated versions of this important document prevents a significant percentage of service recipients and their families from commenting.

[2] 42 CFR § 431.408
[3] Id.
[4] Plan, 5.

There is no translation of the Plan in Spanish or other languages spoken by service recipients and their families. According to the 2015 census, 15.2% of New Yorkers speak Spanish. By failing to provide a translated plan, DOH and OPWDD are excluding a large population of service recipients and their families. Further, it is unclear whether a request for a translated document is even possible or how such a request can be made. Even if such a request can be made for translated documents (as DOH has stated previously in this process) that stance erroneously assumes someone with Limited English Proficiency ("LEP") will not face barriers in navigating such a request process. With such a tight timeline set for review and comment LEP persons are not likely to be able to request the translation, receive it, read it, comprehend it, and be able to provide comments before the deadline.

Lastly, there is also a lack of linguistic competence as this Plan is not provided in any language other than English. According to the 2015 NYS census information, 30.9% of New Yorkers are categorized as "Other" language speakers in the home. DOH and OPWDD should have translated versions of the plans for public comment readily available in the most common five languages spoken in New York State to ensure LEP participation.

II. Comments on the Substance of the Plan

Existing Shortage of Services and Workers is Not Addressed

Despite prior comments, the Plan continues to be entirely silent as to how the proposed transition to managed care will address the current scarcity of direct support professionals ("DSPs") to deliver services to individuals with intellectual and/or developmental disabilities. DRNY has received numerous complaints from individuals who are eligible for HCBS Waiver services, but cannot obtain services due to a dearth of DSPs.

Consequently, individuals with complex needs are forced to receive services in institutional settings including hospital emergency rooms, nursing homes, intermediate care facilities, and psychiatric centers. Some individuals without complex needs are forced to go without any community services despite being approved for them. For example, DRNY has received complaints that numerous persons approved for HCBS Waiver services such as respite, community habilitation, supported employment, and day program will oftentimes be eligible for these services for years, but not actually receive them because of systemic issues within the OPWDD service delivery system. Many times the only solution is for individuals and their families to self-direct them. However, many individuals and their families are unable to find workers and coordinate these services on their own, and thus go without any services.

The Plan is silent as to how managed care will specifically be able to address this issue. Since managed care organizations ("MCO") will eventually receive a capitated rate, in time this problem will likely be exacerbated, as this model will incentivize MCOs to deliver fewer services to individuals with intellectual and/or developmental disabilities. In fact, it is DRNY's understanding that an MCO has no incentive to keep individuals with complex medical needs out of nursing homes or other institutional settings; once the placement occurs the individuals will be removed from an MCO's plan after 90 days. Before any move to managed care is implemented, OPWDD and DOH must formally and thoroughly assess the existing gaps in the service delivery system under Medicaid fee-for-service ("FFS"), and ensure that a managed care model does not continue or exacerbate this issue and the institutionalization that results.

Financial Concerns of MCOs

The Plan raises concerns regarding the long-term financial viability of the capitated-rate managed care model as well as the incentive for MCOs to profit by providing fewer services to members. As we have seen in the similarly-organized managed long term care ("MLTC") system, multiple MLTC plans have closed or are in danger of closing due to financial issues, leading to disruption in member care.

The Plan states that at first OPWDD HCBS Waiver services and OPWDD residential services will be paid via an FFS rate pass-through, while the remainder of the benefit package is paid via a capitated rate. Then, 24 months after the implementation of mandated managed care, OPWDD HCBS Waiver services and OPWDD residential services will be placed into the capitated rate. This means that individuals with intellectual and/or developmental disabilities who have complex and intense medical or behavioral needs will be given the same funding levels as other individuals who have significantly fewer needs.

The Plan lacks any details regarding how capitated rates will be set for the SIPs-PL other than to say that they will be "actuarially sound." It is disturbing that the Plan lacks any details regarding the rates and how they will be set. If the FFS rates are to be used as a basis for capitated rates, it will only further exacerbate the availability of DSPs and workers.

Even under the current system, individuals with the most complex needs are denied services they are approved to receive. For example, dozens of individuals at the remaining Developmental Centers are eligible for discharge with enhanced funding, but remain institutionalized. Similarly, over 200 adult graduates at residential schools are lingering in institutional settings despite enhanced funding. Consequently, if OPWDD and DOH eliminate enhanced funding for these and other individuals with complex needs, there is no doubt the number of people unable to

access community based services will only grow, as will the number requiring institutionalization.

Accordingly, the Plan must directly require DOH and OPWDD to set the capitated rate sufficiently high or continue to provide enhanced funding for these individuals above and beyond the capitated rate so the new development and services can be implemented for individuals with the most complex needs.

DOH and OPWDD should also consider providing start-up funding for the development of SIPs-PL, but any such funding should be fully publicized and transparent.

Medical Necessity and Utilization Management Concerns

As in the broader New York managed care system, SIPs-PL are required to use New York's "medical necessity" standard for utilization management ("UM").[5] DRNY is concerned about the use of a medical model to assess the need for non-medical services like HCBS. While we appreciate that, per the Plan, "the State supports a person-centered approach to care in which the individual's needs, preferences, and strengths are considered in the development of the Life Plan,"[6] the Plan needs to include concrete detail on how this will be defined, carried out, and enforced.

For example, the Plan needs to detail the protocol for the SIPs-PL to "review and approv[e] of Life Plans inclusive of HCBS Waiver services."[7] If a CCO/Health Home or other care manager develops an appropriate Life Plan, by what standards and processes can the SIP-PL overrule the drafter? Again, a capitated-rate model does not encourage MCOs to approve full and comprehensive services. A denial by the SIP-PL of a Life Plan service should trigger notice and due process rights.

Further, the Plan states that "When an individual no longer meets [medical necessity criteria] for a specific service, the SIP-PL should work with the individual's provider to ensure that an appropriate new service is identified (if needed), necessary referrals are made, and the enrollee successfully transitions without disruption in care."[8] We support this proactive approach. However, the State should develop a specific protocol so that parties can understand the responsibilities of the SIP-PL in this situation and hold the SIP-PL accountable if it fails to meet

[5] Plan, 36.
[6] Id.
[7] Plan, 37.
[8] Id. at 36.

its responsibilities. Clarity is also needed regarding how this approach coordinates with the formal appeals process to ensure non-interference with due process rights.

Finally, in addition to the UM protocols being approved by the State, they should also be standardized and public.

Lack of Due Process Protections

The Plan lacks sufficient detail on due process protections, particularly because SIPs-PL are new to the responsibilities of an MCO in New York State. The Plan fails to discuss the process for appealing an adverse decision, initiating an objection, or requesting a Medicaid fair hearing.

The Plan states that SIPs-PL "must meet[] all requirements in the MMC Model Contract unless otherwise stated."[9] We understand that to include the Model Contract's provisions and requirements pertaining to the grievance, appeal, and fair hearing process. However, due to the critical importance of due process rights, particularly in this transition period, we urge DOH and OPWDD to detail the due process rights in the final plan, rather than incorporating them by reference to the Model Contract.

Further detail is especially important because the due process provisions of the MMC Model Contract/managed care system are different from those in the OPWDD system. Presently, 14 NYCRR § 633.12 provides individuals in the OPWDD system with due process protections and allows individuals to initiate an objection "related to facilities or HCBS waiver services . . . regarding: (i) any plan of services . . . . (ii) plans of placement . . . . (iii) proposal initiated by the agency/facility to discharge . . . . (iv) a proposal to reduce, suspend or discontinue HCBS waiver service(s). This objection process does not require the individual to exhaust administrative remedies. Given the nature of the services at stake – including living arrangements and critical community supports – the protections in § 633.12 must be incorporated in this Plan.

The Plan should also be clear that due process protections apply to dis-enrollments. Again, it does seem that the MMC Model Contract rules on disenrollment in Section 8 and Appendices H and Q will apply. Nevertheless, we believe that as these disability-focused SIPs-PL are developed, it should be emphasized that, per the Model Contract, they may not dis-enroll a member "because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs."[10]

[9] Id. at 19.
[10] 42 C.F.R. § 438.56.

Likewise, DOH, OPWDD, Local Departments of Social Services ("LDSS"), and the SIP-PLs should be prepared to coordinate and solve issues of Medicaid eligibility to ensure that members do not lose access to services. This should include, where appropriate, communicating with members, assisting with recertification, and providing a grace period of managed care coverage. This has been a recurring issue across the managed care system and we hope that the OPWDD transition can learn from past mistakes.

Failure to Discuss Ombudsman

The Plan does not mention the managed care participant ombudsman. DOH and OPWDD must provide specificity regarding the ombudsman and require that the new MCOs cooperate with the ombudsman. The Plan must include language similar to the MLTC Model Contract on this topic ("The Contractor will cooperate with, and may not inhibit, the Participant Ombudsman in the exercise of its duties . . ."). [11] In addition, we recommend that each SIP-PL be required to name a designated contact person to respond to concerns and questions from the ombudsman.

Care Coordination for Individuals who are Dually Eligible

The Plan requires a clear definition of "coordinat[ing] the benefit package with Medicare" [12] and the responsibilities of the SIPs-PL and care managers for arranging for Medicare-covered services for their dual-eligible members, such as durable medical equipment ("DME").

We have seen in the MLTC system that MLTC care managers do not fully understand or implement coordination of Medicare services, particularly in regards to DME, leading to long wait periods and missed opportunities for needed equipment and supplies.

The Draft Plan Lacks Meaningful Information about the Coordinated Assessment System

The Plan includes very little information on the Coordinated Assessment System ("CAS"). In the definitions section, it describes the CAS as "an assessment tool specifically tailored to capture the unique health and support needs of individuals with I/DD in New York State . . . [that] is being implemented in phases." [13] The only other mention of the CAS is in Attachment D, outlining the training topics to be completed 30 days before the new system goes live.

[11] MLTC Model Contract Article V(E)(6) on Enrollee Protections.
[12] Plan, 9-10.
[13] Id. at 12.

Other than these meager references, the Plan contains no information on the CAS or what role it will play within the SIPs-PL. For example, it does not state whether the CAS will be used as an eligibility screening tool as is now the case with standardized assessment tools for some other HCBS programs or whether and how it will impact the amount or type of services that an individual is able to access. The Plan does not explain how and when individuals will be informed of their CAS score and what procedural protections are available to individuals who wish to contest their results. Nor is there any explanation of the timeline for implementation of the CAS statewide or where or when the aforementioned phases will be occurring.

This lack of information prevents stakeholders from providing informed feedback on the role of the CAS in the SIPs-PL structure. Previous feedback from individuals, families, and other stakeholders demonstrates that the CAS is not well understood, particularly how it works and how it impacts the services that a recipient is able to receive. OPWDD and DOH should provide additional information about the CAS and fully detail how CAS results will be used by the SIPs-PL. This information should be released as early as possible to afford stakeholders sufficient opportunity to comprehend this component of the new system and offer feedback to shape future iterations of the plan.

HCBS Services in Rural Communities

The Plan states each MCO will contract with at least two HCBS provider agencies to deliver HCBS services in each county. However, in many rural counties there is only one service provider who offers in-home supports and services like respite and community habilitation. Moreover, according to OPWDD's provider directory there is presently not a single voluntary agency that offers these in-home services in Hamilton County.

The Plan states that in counties like these where there is insufficient network capacity an MCO must contract with a provider in a neighboring county. If network capacity is still insufficient then the MCO should contract with a provider in another Developmental Disabilities Regional Office ("DDRO"). The Plan gives the example that if someone lives in Rensselaer County and cannot obtain an HCBS service from a provider within its DDRO region, the MCO should just contract with a provider in Sunmount or Hudson Valley to provide the HCBS service. This proposal is wholly impractical. It is unreasonable to assume that a DSP would be willing and able to drive two or three hours each way, unpaid, to deliver in-home respite to someone in a neighboring county or region. Before the transition to managed care occurs, OPWDD and DOH must increase service delivery capacity and ensure that each county has at least two providers that can deliver HCBS services.

The Plan states that individuals will be allowed to continue with their medical providers for 24 months following enrollment for episodes of care that were ongoing during the transition. After this period they will be required to obtain medical and behavioral care from in-network providers of their MCO. In rural communities this change could cause significant disruption in the ability of individuals with intellectual and/or developmental disabilities to obtain needed medical and behavioral services.

Rural communities already have significant health service gaps including severe shortages of physicians and specialists that require residents to utilize tertiary medical providers.[14] These difficulties will make it challenging for an MCO to construct a provider network in rural areas, as MCOs "can threaten rural health delivery systems with selective contracting that omits local providers."[15] Accordingly, when Vermont constructed a managed care system it required MCOs to contract with any willing medical provider who could meet the plan's contract terms, thus ensuring access to medical services in rural communities.[16] The Plan does not include this needed provision for rural communities and should be amended accordingly.

Out-of-State Call Centers

The Plan states that call centers can be placed out-of-state so long as customer service representatives are "adequately trained on all New York State requirements."[17] However, the Plan makes no mention of what "adequately trained" means and how DOH or OPWDD will implement and ensure such a threshold is met.

It is very concerning that call centers, especially crisis call centers, will be based out-of-state. Call centers have immediate and critical interactions with service recipients and families, yet DOH and OPWDD appear willing to abdicate needed oversight and training requirements. Call centers must remain under the watchful eye of DOH, OPWDD, and other stakeholders. If DOH and OPWDD mistakenly move forward with out-of-state call centers and employees, it should be made clear to service recipients and stakeholders how these individuals will be trained to ensure they have the appropriate knowledge of New York State's complicated service system, particularly when an individual is in crisis.

[14] Eileen Griffin and Andrew Coburn, Integrated Care Management in Rural Communities, 12, (May, 2014), accessible at: https://muskie.usm.maine.edu/Publications/rural/Integrated-Care-Rural-WorkingPaper.pdf.
[15] Id.
[16] 8 V.S.A. § 4089b (2015).
[17] Plan, 28.

Further, Attachment C of this plan states the following positions in the Plan are *not* required to be based in New York State: ID/DD Dental Coordinator, ID/DD Utilization Management Director, Member Services Director, Quality Management Director, Information Systems Director, Utilization Management, Clinical Peer Reviewers (multiple persons), Quality Management Specialists (multiple positions), and Provider Relations (multiple positions, and states "some staff must be in New York State"). Thus, out of 19 positions listed nine are not required to be in state. Three of these positions, (Clinical Peer Reviewers; Quality Management Specialists; Provider Relations) will also include multiple employees in each of these categories. Out of 10 Managerial Positons, four may be located out-of-state. Out of four categories of Operational Staff, four may wholly or partially be out-of-state. There is no clear reasoning stated in the Plan why these positions are permitted to be located remotely and how DOH will ensure these persons are trained and will adequately understand the complicated Medicaid system now implemented in New York State, let alone local resources and challenges. Finally, DOH and OPWDD should make clear what checks and balances are being put in place to oversee quality control when utilizing an out-of-state call center and employees.

Self-Direction

The Plan states that under managed care the "[u]tilization management protocols for self-direction will follow State guidelines and budgeting standards."[18] DRNY has received several complaints that current budgeting levels for self-direction are inadequate for individuals to live in the community. Presently, individuals with complex behavioral, medical, or mobility needs are often unable to participate in self-directed services because of OPWDD's cap on reimbursement. Accordingly, individuals who would like to move out of a more restrictive setting are unable to do so. OPWDD and DOH should remove or reassess budget caps so long as someone's budget is cost neutral.

Lack of Clarity Regarding the Role of the DDRO and DDSOs under Managed Care

Despite repeated inquiries, the Plan remains entirely unclear what the future role of OPWDD's DDRO and the Developmental Disabilities Services Offices ("DDSO") will be when managed care is mandated. While the Plan states that the DRRO and DDSO will continue to operate under managed care, it is silent as to what this will actually look like. For example, the DDRO hosts the Residential Opportunities Committee which facilitates the placement of individuals who are in crisis, homeless, or being abused and neglected. Finally, the Plan is silent as to what the role of the DDRO's Front Door will be when managed care is implemented.

[18] Plan, 36.

The Plan is also silent as to the role of the DDSO under managed care. It is unlikely that an MCO would want to contract with the DDSO for these services as they are often more expensive because DDSO employees are paid a much higher rate than those operated by voluntary agencies.

This is concerning, not only because it would effectively mean the privatization of thousands of State employees who are DSPs, but also because historically the DDSO was always the provider agency of last resort for people with complex needs. When individuals with complex behavioral needs, medical needs, forensic backgrounds, and those individuals who display inappropriate sexual behaviors are unable to receive services from non-profit agencies, the DDSO often provides care and treatment. If the DDSO were to cease to exist, it could potentially be impossible for these individuals to obtain services from an MCO.

Transitional Care Planning for Residential School Students

As noted in DRNY's prior comments, the Plan states that MCOs will provide discharge planning for residential school students. However, it is entirely unclear from the Plan how MCOs will be positioned to conduct discharge planning for residential school students.

Currently, OPWDD provides transitional funding for these individuals until a discharge plan can be developed. From the Plan it is unclear if OPWDD and DOH would now delegate this responsibility to an MCO. In addition, OPWDD provides enhanced funding for these individuals to provide a much-needed incentive to service providers to provide community services. However, according to the Plan this enhanced funding would be discontinued in 2024. Consequently, the Plan fails to specify how transitional and enhanced funding will operate under managed care. Finally, OPWDD's DDROs employ individuals whose job it is to coordinate the discharge of young adults in residential school. The Plan is silent as to whether these DDRO representatives will continue and, if so, how they will interface with an MCO. If OPWDD intends to privatize these DDRO positions it should explicitly state so.

Lack of Clarity Regarding the Future of State-Funded Services

The Plan states that "when an individual is institutionalized or in an unauthorized setting the individual will not receive HCBS."[19] However, as noted in DRNY's prior comments, OPWDD currently provides State-funded services for individuals who do not live in eligible HCBS settings, such as children in residential schools. State-funded services allow such children to receive respite and community habilitation when they are in the community with their families

[19] Plan, 43.

during school breaks and holidays to ensure necessary care. In addition, individuals in rehabilitation settings, hospitals, or skilled nursing facilities often require environmental modifications ("EMODs") made to the community setting as a condition of safe discharge. Currently, it is necessary for these individuals to obtain these EMODs through State funding. The Plan is silent as to whether State-paid services will continue under managed care. OPWDD and DOH should clarify if State-paid services will continue and, if so, how they will be obtained and funded.

No Specifics Regarding Family Supports and Services

The Plan is silent as to whether individuals and their families will continue to be eligible for family supports and services. As noted in DRNY's previous comments, family supports and services provides necessary funding for a variety of services. OPWDD and DOH must clarify if family supports and services will continue and, if so, how families will obtain these funds.

Failure to Address Individuals in Children's Residential Projects

As stated in DRNY's previous comments, the Plan as written is silent as to whether Children's Residential Projects ("CRP"), as jointly funded programs between New York State Education Department and OPWDD, will be incorporated into managed care. DOH and OPWDD should provide clarity on this issue as CRPs serve a critical need for students with disabilities.

Failure to Address START Services

As discussed in DRNY's prior comments, the Plan states that MCOs will enter into contracts with regional Systemic, Therapeutic Assessment, Resources, and Treatment ("START") programs so individuals can obtain crisis services when needed. The Plan once again fails to address START's systemic problems and how it will reduce institutionalization by providing adequate crisis intervention services to individuals with intellectual and/or developmental disabilities.

Based on DRNY's experience with individuals involved with START services, the State lacks tangible services to adequately address individuals in crisis. For instance, almost all OPWDD regions lack a freestanding crisis respite program to treat and evaluate individuals with complex behavioral needs. Some regions do not have START; others have long waiting lists. The Plan must address improving the inadequate infrastructure critical to START's purpose and success.

Failure to Address Ability to Access LDSS Prevention Services through Managed Care

As discussed in DRNY's prior comments, it is not clear whether individuals will still be eligible for services from their LDSS once managed care is implemented. The loss of LDSS services, including preventive services, family abuse prevention, budgeting assistance, and child care assistance would be detrimental to many families and individuals. Without the ability to access these services, many children with disabilities could be unnecessarily placed in institutional settings through the foster care system. The Plan must clarify whether access to these integral services are still available under managed care.

Failure to Address Access to Skilled Nursing and CDPAP through Managed Care

As noted in DRNY's prior comments, the Plan is silent as to whether individuals will continue to be eligible for consumer directed personal assistance program ("CDPAP") and skilled home nursing services. Without these supports, individuals would require institutionalization in nursing homes and similar facilities. Because of the OPWDD cap on the self-direction budgets, supplementing with CDPAP and skilled nursing is critical to community-based living for individuals who require close to 24/7 support in their homes. The Plan must specifically allow continued access to supplemental services.

Social Transportation

The Plan states that managed care will add social transportation as a service. We fully support this. However, the Plan fails to specify how an individual will access this service as it is not currently offered as an HCBS service to individuals with intellectual and/or developmental disabilities. The Plan should provide more details regarding the mechanics of this new service.

III. Conclusion

When managed care was implemented in Kansas, the results were detrimental to people with intellectual and developmental disabilities. According to Disability Rights Kansas, when managed care was implemented there, "it became a constant battle [with managed care companies for individuals with disabilities] to get what you're entitled to."[20] Services were cut substantially at the sole discretion of managed care companies.[21] In addition, Wisconsin also experienced significant problems when managed care for people with intellectual and

[20] Kansas Health Institute, KanCare Not Working for People with Disabilities Advocates Say, (July 7, 2015), accessible at: http://www.khi.org/news/article/kancare-not-working-for-people-with-disabilities-advocates-say
[21] Id.

developmental disabilities was implemented there when three MCOs became bankrupt and three others were forced to consolidate due to financial issues.[22]

While the Plan is couched in language of improving access to services, it appears quite unlikely MCOs will actually be able to do this given the significant discretion entrusted to the agencies, conflicts of interest, and existing systemic barriers in the OPWDD service delivery system. In addition, under a capitated payment model, MCOs would have an incentive for people to underutilize services. Ultimately, this will result in lack of access to community based services and increased institutionalization of individuals with complex needs.

As written, DOH and OPWDD should not implement this Plan, as it will have profound negative effects on individuals with intellectual and developmental disabilities. OPWDD and DOH must conduct further outreach to stakeholders, and provide clarification, measurable outcomes, and further development of its proposal to ensure access to necessary services for people with intellectual and developmental disabilities. As we have stated before, as the federally mandated Protection and Advocacy system in New York State for persons with disabilities, DRNY would welcome the opportunity to participate in this process.

[22] Telephone Interview with Disability Rights Wisconsin (August 10, 2017).