End the Authorization for Managed Care for IDD Services

Testimony for Mental Hygiene Joint Legislative Hearing, February 16, 2023

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Thank you for your time and attention.

Below you will find my brief oral testimony on this subject. Following that, I attach a series of three letters on "Myths of Managed Care", sent to the Governor by a coalition of all the independent Family Groups in New York State. Last, you will find a three page writeup which provides the evidence of the ineffectiveness of Managed Care for IDD services.

Oral Testimony

This year, the Legislature can put an end to a fruitless decade of 'exploring' the transition to Managed Care for the Long Term Supports and Services which are provided to New Yorkers through the Office for People with Developmental Disabilities, OPWDD. The Executive Budget calls for extending that exploration by yet-another five years. Please, don't extend it—End it!

The OPWDD service delivery system needs to be improved and reformed. We need to make practical changes which will have a positive influence on the lives of this collection of people who, through no fault of their own, have a greater need.

Instead of doing that practical block and tackle work of real change, we have spent the last ten years focused on moving to Managed Care. The advertisement said that Managed Care would solve all our problems, so why bother doing anything else?

Sadly, that advertisement was not true. The evidence is now in—Managed Care does not improve quality, neither does it have a positive impact on access. To be more precise, that is the average. Sometimes Managed Care makes things a little better, and sometimes it makes things a little bit worse. The results are very inconsistent, and never very dramatic. However, there is one thing which Managed Care always does—it costs more, due to the need for paper-pushers whose job is to deny services. Here in New York State, we asked Deloitte a few years ago to perform a financial projection of what would happen if we moved Long Term Supports and Services to Managed Care. Their conclusion: The transition would cost a Billion dollars—that is billion with a b—and after the transition the cost would go up by $200 million a year, forever, due to the need to pay a small army of administrative staff at the Managed Care Organizations.

That analysis was not released to the public. Instead, we are paying for yet-another report from yet-another consultant. And the executive is asking for yet another five years of distraction and delay.

There is much to be done to improve OPWDD. The Legislature cannot and should not micro-manage that effort. What the Legislature can and should do is to remove the distraction of Managed Care, and thereby free up OPWDD to do the detailed reform work needed. Please, don't extend it—End it!

Thank you.

DEBUNKING THE MYTHS OF MANAGED CARE September 2022

Dear Governor Hochul,

We are independent consumer and family advocates across NYS, and we want you to know: ***We remain opposed to Managed Care Support Services for People with Intellectual and Developmental Disabilities (I/DD)***. Managed Care for I/DD services will not save money, will not provide better care and will not address issues of equity and access to services.

The OPWDD service system faces many challenges. Growing demand, problems with supply and quality, and an on-going work-force shortage have amplified those challenges. Following more than a decade of system transformation and exploration, we are hearing a repeated message from some, that Managed Care for I/DD is the solution. This narrative creates the impression that a transition to Managed Care for I/DD services is inevitable.

Managed Care promises to improve access by leveraging its provider networks. It promises to improve quality by instituting value-based payments and risk sharing. It promises to bring more innovation, and many, many more promises. These promises sound too good to be true for a very simple reason – they are too good to be true.

We reject the unproven aspirations of managed care for I/DD support services. Instead, we want to focus on making improvements that have a direct and positive impact on people's lives, starting now. As the exploration of Managed Care for I/DD services continues, we will continue to challenge it. Managed Care for I/DD services is not here, is not inevitable, and is not a good idea. This is the first of a series, 'Debunking the Myths of Managed Care'. Please reach out to any one of us to discuss this issue.

Thank you,

Respectfully submitted on behalf of;

Families and Self-Advocates Representing People with Intellectual and Developmental Disabilities across New York State

CC: Dr. Mary Bassett, Department of Health
Kerri Neifeld, Office for People With Developmental Disabilities
Jihoon Kim, Deputy Secretary for Human Services and Mental Hygiene
Kim Hill, Chief Disability Officer
Robert Mujica, Division of Budget
Senate and Assembly Disability Committee Chairs
Senate Majority Leader
Assembly Speaker
Senate and Assembly Legislators

DEBUNKING THE MYTHS OF MANAGED CARE November, 2022

Dear Governor Hochul,

First, congratulations on your election to a full term. We remain appreciative of the commitment your administration has shown to people with Intellectual and Developmental Disabilities (I/DD) and look forward to working with you, the agencies and the legislature to improve the essential services and supports that our loved ones need.

As previously stated in our September 23, 2022 letter; we are independent Self and Family Advocates from across New York State and we remain opposed to moving supports and services for people with I/DD into Managed Care. We continue to share our concerns surrounding the promises made about the efficacy of managed care. One such promise is belied by an article published in the New York Times on October 8, 2022.

As you may have already seen, this article is about opportunism and greed in the Medicare Managed Care system. The article details the perversion of a system that was created to encourage the provision of services to those whose needs are complex and costly. It may be true that different forms of fraud and abuse are more often found in Medicare Managed Care than in Medicaid Managed Care, but the fact remains that after 30 years of Medicaid Managed Care, there is little evidence that it has improved service delivery in any way. There are those who continue to promote Managed Care for I/DD with assurances that under a system of provider-led Managed Care organizations, we will avoid the types of problems described in this article. That position may be optimistic and well intentioned but sadly mistaken.

Thank you,

Respectfully submitted on behalf of Families and Self-Advocates Representing People with Intellectual and Developmental Disabilities across New York State

Encl. New York Times; How Insurers Exploited Medicare Advantage for Billions, 10/8/22

https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html

CC: Dr. Mary Bassett, Department of Health
Kerri Neifeld, Commissioner, Office for People With Developmental Disabilities
Jihoon Kim, Deputy Secretary for Human Services and Mental Hygiene
Kim Hill, Chief Disability Officer
Kathryn Garcia, Director of State Operations
Robert Mujica, Division of Budget
Senate and Assembly Disability Committee Chairs
Senate Majority Leader
Assembly Speaker
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DEBUNKING THE MYTHS OF MANAGED CARE January 2023

Dear Governor Hochul,

Happy New Year! We welcome in the New Year with renewed hope for people with Intellectual and Developmental Disabilities (I/DD) and their families. Our independent family and self-advocacy organizations continue to oppose Managed Care support services for people with I/DD, and are against extending NYS legislative authorization to continue further exploration when it expires this year. The effort to pursue Managed Care for I/DD support services has already been extended for more than a decade. We believe that too much time and money has already been wasted. Extending the authorization will only result in delaying any effort to implement other needed changes to the service system.

In November of 2022, OPWDD awarded a $1.44 million consulting contract "to study and evaluate how the implementation of managed care would assist in improving Long Term Services and Supports (LTSS) for people with I/DD." Previous studies to determine the effects of Managed Care for I/DD services show no evidence of cost benefit, improved access to services or quality of care in states that have attempted to transition.

- A 2019 study funded by the Texas Legislature concluded: "While there are savings achieved on Long Term Services and Support claims, the amount of increased administrative expenditures outweighs savings from claims" (www.tinyurl.com/TX-IDD-Deloitte-Report)
- The Medicaid and Chip Payment and Access Commission, a non-partisan group of experts concluded in 2021: "While much research has been conducted on whether Managed Care delivery systems result in better outcomes than fee for service (FFS), there is no definitive conclusion as to whether managed care improves or worsens access to or quality of care for beneficiaries www.macpac.gov/subtopic/managed-cares-effect-on-outcomes)

Even more disconcerting is a NYS funded study by Deloitte that estimates the cost for initial implementation of Managed Care for I/DD services would be $200 million and would result in a similar increase in annual administrative costs.

The money spent on studying managed care over the last decade might have been put to better use serving the needs of people with I/DD and the workforce supporting them. Given the urgency of stabilizing and improving the workforce, increasing residential options, improving access and diversity as laid out in OPWDD's Strategic Plan, this continued distraction over managed care comes with the even greater cost of failing to take needed action to implement these goals. Please let the authorization to explore Managed Care expire so that stakeholders can immediately get to work accelerating changes that have a meaningful and positive impact on people's lives.

Thank you,

Respectfully submitted on behalf of Families and Self-Advocates Representing People with Intellectual and Developmental Disabilities across New York State

CC: Dr. James V. McDonald, Acting Commissioner Department of Health
Kerri Neifeld, Office for People With Developmental Disabilities
Jihoon Kim, Deputy Secretary for Human Services and Mental Hygiene
Kim Hill, Chief Disability Officer
Kathryn Garcia, Director of State Operations
Sandra L. Beattie, Division of Budget
Senate and Assembly Disability Committee Chairs
Senate Majority Leader
Assembly Speaker
Senate and Assembly Legislators

Services for Individuals with IDD Evidence that Managed Care is Ineffective

Jim Karpe & Brad Pivar January 06, 2023

Summary: In Practice, Managed Care Does Not Work for LTSS

Managed Care is a beautiful theory. The hypothesis is that better and cheaper care will result from putting in place the appropriate financial incentives. The theory was developed for medical care, where "an ounce of prevention is worth a pound of cure". In the last three decades it has been applied to long-term supports and services (LTSS) paid for through Medicaid funding.

The evidence is now in: When Managed Care is applied to long-term supports, the result is neither cheaper nor better. This is not particularly surprising, since the largest costs in long-term supports are housing and day-services, and "prevention" does not apply. There is no humane way to prevent the need for housing and for something to do during the day. There are innovative ways to approach those needs, but the track record is clear: Managed Care does not create innovation. In some cases, MC maintained pre-existing innovations, as in Kansas where those innovations allow services to be provided at lower cost. In other cases, MC destroyed innovative systems of care that were producing extraordinary results, as in Wisconsin's Dane County.[1]

Even when applied to health services there is little evidence of the efficacy of Managed Care, outside the narrow domain of preventable emergency department visits. It is useful to view MC as if it were a new breakthrough drug which showed considerable promise in early trials—but when applied broadly, the benefits do not fulfill that early promise and negative side effects emerge. Such a drug would soon be pulled from the marketplace. Why does Managed Care continue? Most likely because of the large profits it creates. In a self-sustaining cycle, those profits are used to influence public policy so that the profit-taking can continue.

That self-sustaining cycle is playing out in New York State today—the Care Coordination Organizations were setup with rates that far exceed the costs of Care Management, and they are using that money to influence public opinion and lobby for Managed Care for people with IDD. The website of TriaDD, a partnership that three CCOs have funded to the tune of millions of dollars, tries to create the impression that Managed Care has already been achieved:

> "the TriaDD partners have created a best-in-class IDD Provider-Led managed care model that builds on national experiences and successes."[2]

The following pages lay out the evidence backing up the statements in this summary.

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[1] Dane Valedictory 1.0, John O'Brien, 2018. www.tinyurl.com/Dane-County

[2] https://triaddny.com/about-us/ (retrieved July 10, 2022)

The (limited) effectiveness of Managed Care

Managed Care can work when restricted to a narrow domain. The MC approach of investing in prevention has been effective in reducing preventable emergency department visits. This is a relatively simple problem to solve, and relevant data on ED visits is routinely collected[3]—thus making it difficult to 'game the system'. We could draw a bright line around ED visits and provide the hospitals with a fixed fee for that service, per member per month. The hospitals could then fund tele-health options. They might even invest in access to clinical services outside the ED, including dental clinics.

Or, even in this area of ED visits where Managed Care has produced good outcomes, we could produce those same outcomes without the overhead of the Managed Care Organization. Instead, OPWDD could directly fund tele-health initiatives and dental clinics.

Where does MC fail?

Unfortunately, when applied outside the narrow goal of preventable ED visits, MC creates more problems than it solves. Recent NY Times articles showed that MCOs serving senior citizens:

- decrease costs by denying needed care
  'Every year, tens of thousands of people enrolled in private Medicare Advantage plans are denied necessary care that should be covered under the program, federal investigators concluded....audits of the private insurers show evidence of "widespread and persistent problems related to inappropriate denials of services and payment"… '[4]
- increase revenue by exaggerating diagnosis
  These 'strategies — which were described by the Justice Department in lawsuits against the companies — led to diagnoses of serious diseases that might have never existed. But the diagnoses had a lucrative side effect: They let the insurers collect more money from the federal government…'[5]

This pair of investigative articles document the encounter between reality and the beautiful theory of Managed Care. In theory, financial incentives produce better healthcare. MCOs will seek innovative ways to invest now and thus prevent *future* costs. In practice, as detailed in the articles, MCOs corrupt the process in two ways. They prevent costs today by improperly denying care, and they increase revenues by exaggerating the diagnoses. The MCOs were very innovative when it came to finding ways to "add additional illnesses".

> "As a result, a program devised to help lower health care spending has instead become substantially more costly than the traditional government program it was meant to improve."[6]

What about Medicaid Managed Care?

The above examples come from years of investigations into Medicare. What about Medicaid, regulated by the same federal agency, CMS? The same story:

> "Several studies even find that access and care quality worsened in managed care vs fee-for-service models in some states.....Plans may exaggerate enrollee risk to inflate state payments and reduce utilization at the expense of quality."[7]

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[3] https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html
[4] Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds. New York Times, Apr 28, 2022.
[5] 'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions. New York Times, Oct 8, 2022.
[6] Ibid.
[7] Medicaid Managed Care: Further Reform Needed to Deliver on Promise. The American Journal of Managed Care, Feb 2021, Vol 27, Issue 2. Pg 53-56. www.ajmc.com/view/medicaid-managed-care-further-reform-needed-to-deliver-on-promise

General Ineffectiveness of Medicaid Managed Care applied to LTSS

In theory, Medicaid Managed Care achieves a triple aim of lower costs, better outcomes and a better experience of care. It does this by rewarding providers for taking the long-term view of the health and welfare of the populations entrusted to them.

When applied to Long Term Supports and Services (LTSS) the result has been higher costs, and no improvement in outcomes.

Evidence of lack of cost savings

Regarding savings, two reports funded by the Texas legislature analyzed the experiences of all fifteen states which had attempted to apply Managed Care to LTSS. The financial story:

> "While there are savings achieved on LTSS claims, the amount of increased administrative expenditures outweighs savings from claims."[8]
>
> "most states did not realize a cost savings…"[9]

Right here in New York State, a Deloitte report funded by New York State projected that MMC for LTSS would be more costly:

> "actuarial predictions made by DeLoitte … suggested that I/DD provider led managed care would cost $200M more than current total annual I/DD spending"[10]

This annual increase in cost has been verified by the table of projections from that report released by New York State in response to a FOIL request. Those projections show an annual cost increase of $197 million after steady-state is achieved in State Fiscal Year 2027—and a cumulative one-billion dollar cost of transition during three years prior to that.[11]

(Lack of) Evidence of improvement in outcomes

The achievement of the triple aim would be easy to prove, if it were really there. It is not:

> "While much research has been conducted on whether Managed Care delivery systems result in better outcomes than fee for service (FFS), there is no definitive conclusion as to whether managed care improves or worsens access to or quality of care for beneficiaries."[12]

When it comes after "much research has been conducted", absence of evidence is evidence of absence. The accumulation of data about the actual results of MC has led some proponents to abandon the triple aim. They now routinely say that they are not trying to achieve cost savings. Instead, they claim Managed Care creates a system that is more flexible. No evidence has been presented to backup this claim.

We do need changes in the system of care. Managed Care for Long Term Supports and Services does not achieve the Triple Aim originally claimed, nor does it achieve the more recently claimed flexibility. Some other states deliver LTSS with greater flexibility than NYS, but that has nothing to do with Managed Care. Instead it is due to negotiation of the HCBS waiver, an interaction between state agencies and CMS.

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[8] pg 12. IDD LTSS Carve-In Cost-Effectiveness Evaluation Report. Deloitte. Jan 11, 2019 www.tinyurl.com/TX-IDD-Deloitte-Report

[9] pg. 35. Intellectual and Developmental Disability Care Evaluation. UT Health. Dec 31, 2018 www.tinyurl.com/TX-IDD-UTHealth-Report

[10] pg. 7. Irregularities in the Procurement and Financing of Care Coordination Organizations. Sept 12, 2020. Provided by NYS in response to FOIL request. Kastner 2020

[11] IDD Population Transition to MC (SIP-PL) Fiscal Plan. Undated. Provided by NYS in response to FOIL request. Deloitte projections

[12] Retrieved Nov 14, 2022 www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/

Appendices

Appendix 1: Managed Care Theory and its Application

A Brief Dive into The Triple Aim framework

The Triple Aim framework sits at the heart of Managed Care for Healthcare. This framework[13] calls for the simultaneous pursuit of:

1. improved patient experience,
2. improved population health,
3. reduced costs.

For healthcare, this might make sense. As the ancient adage puts it, an ounce of prevention is worth a pound of cure. We should aim for the prevention of preventable diseases. In theory, MC for Healthcare can result in a better experience of care for the patient, with better outcomes, at lower cost.

Taking diabetes as an example, patient experience is about the quality of care for an individual diabetic patient. It's about improving what happens when a person needs treatment, such as a reduction in the wait time at the dialysis center for a person who has kidney failure. Population outcome is partly driven by better individual treatment and is also about reducing the need for individual treatment by focusing on interventions that reduce the rate of diabetes. These interventions can be broad policies such as higher taxes on sugary foods, or can be individualized interactions with patients such as assistance with nutrition and exercise. Sustained activity will eventually produce the outcome of improved population health due to a lower rate of diabetes. We achieve the triple aim: better individual experience, better health, and reduced costs. In theory.

Applying the Triple Aim Framework to Healthcare

The triple aim framework was created to address the specific challenges of providing healthcare to group of people. Managed Care tries to achieve the triple aim through influence on the behavior of healthcare organizations, giving them targeted incentives to find and implement the ounces of prevention. When Managed Care is rolled out without sufficient safeguards and oversights, the healthcare organizations are not actually held accountable. Instead, they seek to reduce costs by rationing. They restrict access to needed treatments rather than doing the difficult work of finding those ounces of prevention which keep people healthier so that they do not need treatment.

In theory, an implementation of Managed Care for Healthcare can have sufficient transparency and accountability baked in from the start. In practice, as documented in the body of this report, this has not been achieved despite decades of effort.

Applying the Triple Aim Framework to LTSS spending

Healthcare makes up only a small fraction of the Medicaid spending for IDD. The overwhelming majority of spending is for long-term services and supports (LTSS), the full array of services which help support people with IDD in the community.

In this area, Managed Care theory simply does not apply: One cannot prevent the need for long-term supports such as housing. Long Term Supports and Services are not like diabetes. Instead, they are like your grocery bill. You can reduce food waste, but there is no system of clever management that will prevent the need for food. It would be absurd to create a system of "Managed Food"— turn our monthly grocery money over to a corporation and let them decide what type and quantity of food to provide. The most likely outcome would be rationing for us, and high profits for them.

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[13] The Triple Aim framework was originated by the Institute for Healthcare Improvement. Their introductory video is three minutes long: www.ihi.org/Engage/Initiatives/TripleAim

The theory does not apply, and so it is not surprising that it fails in practice. Moving LTSS to Managed Care does not result in lower costs, as seen in the excellent reports executed by Deloitte and by The School of Public Health at the University of Houston. It bears repeating.

> UT Health executed a national survey of the experience of the 15 states that had moved some portion of the LTSS for IDD to Managed Care and found
>
> > "most states did not realize a cost saving"[14]
>
> A set of financial projections created by Deloitte for the State of Texas provides insight into the lack of savings. They sum up their ninety-page report with these words
>
> > "While there are savings achieved on LTSS claims, the amount of increased administrative expenditures outweighs savings from claims."[15]

Appendix 2: New York State Experience

Evidence of ineffectiveness in New York's FIDA-IDD pilot

New York has run a long-term pilot program for Managed Care of Long Term Supports and Services. This program, delivered by Partner's Health Plan (PHP), has not performed well.

> "OPWDD's Department of Quality Improvement.... report was finalized in the summer of 2019. It demonstrated that PHP operates at a significant overall loss. ... The report also determined that there were no significant improvements in health or satisfaction for individuals enrolled in the I/DD FIDA. The report was submitted to Paul Francis for discussion and approval for dissemination. However, Mr. Francis has not released the report for publication."[16]

The FOIL request for the DQI report mentioned in the excerpt above, was "fulfilled" by sending a document in which most of the pages are completely blacked out.[17] A 2019 power-point presented to the Joint Advisory Council showed that 21% of all people who had tried FIDA-IDD had decided to leave.[18] This high dis-enrollment indicates high levels of dissatisfaction.

There have been no public reports of disenrollment numbers since then. Out of every ten eligible people, only one remains enrolled.

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[14] pg. 35. Intellectual and Developmental Disability Care Evaluation. UT Health. Dec 31, 2018 www.tinyurl.com/TX-IDD-UTHealth-Report

[15] pg 12. IDD LTSS Carve-In Cost-Effectiveness Evaluation Report. Deloitte. Jan 11, 2019 www.tinyurl.com/TX-IDD-Deloitte-Report

[16] pg. 7. Irregularities in the Procurement and Financing of Care Coordination Organizations. Sept 12, 2020 Kastner 2020

[17] FIDA-IDD Evaluation. Dec 2019. www.tinyurl.com/FIDA-IDD-2019

[18] Shown on slides 30 & 31 there were 1,365 people enrolled and 449 dis-enrolled. Of those, 13% became excluded, leaving approximately 390 who left voluntarily.
www.opwddmanagedcare.files.wordpress.com/2019/10/final_jac-8-14-19.pptx