COALITION FOR WHOLE PERSON SUPPORTS, ADVISORY GROUP
RESPONSES TO THE SIP-PL MODEL WEBINAR PRESENTATION
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Question 1: **How does the model meet the goals of whole person supports?**	The SIP-PL aligns with all of the goals of the whole person supports. The Model was developed as an integrated care model to create person centered and individualized supports The SIP-PL model meets the goals of whole-person supports by offering an integrated, person-centered approach that addresses all aspects of an individual's health and support needs. Assuming it has the necessary flexibility, this creates a unified system capable of adapting to the evolving needs of individuals with IDD. The concept of integrating all Medicaid funding & benefits into a single managed care system – particularly one that is provider led and involves interdisciplinary care coordinating teams – provides a basis for delivering truly individualized care and support to the whole person. PHP dual eligible seems to be working with 9 years' experience - why isn't expanded? There seems to be different examples of activities that are limited in location, population, time frame that are looking at the whole person. The barrier seems to be making it available to everyone, everywhere that is eligible.
Question 2: **What are the positive attributes of the model?**	This is a model that includes medical, behavioral and IDD services that allows for providing the necessary supports for the individuals when they need it and more importantly breaks down the silos that prevent folks today for getting what they need when they need it The SIP-PL model offers several positive attributes, including comprehensive, person-centered care that integrates medical, behavioral, and long-term support services. It improves coordination, flexibility, and care management, ensuring that services adapt to the evolving needs of individuals with IDD. The model emphasizes long-term support and accountability through provider-led care, potentially leading to cost savings and better health outcomes. Similar to PACE models, an integrated, capitated payment – if implemented/regulated properly – can incentivize a focus on improving outcomes for individuals while also lowering costs overall due to having those improved outcomes. It also provides a construct to allow value-based payments to be used to further promote better outcomes. It has the potential of reducing or eliminating program and care silos, if done correctly, which would be great. A non-provide provider led model vs a traditional managed care plan model better ensures the plan comes with experience in delivering supports and services for the

	population. Also, it avoids the potential risk that comes from allowing very large, for-profit plans to enter the market where their primary focus is on shareholders and profits. Focus on the whole person support Pros: **1. Financial Savings and Flexibility:** Lower Costs: SIP-PL often reduces insurance premiums, enabling organizations to redirect savings into programs and services for individuals with ID. Customizable Coverage: These programs can be tailored to meet the specific needs of individuals with ID, focusing on areas like healthcare, behavioral supports, or emergency care. **2. Improved Quality of Services:** Enhanced Oversight: Organizations have more control over claims and risk management, leading to proactive measures to improve care quality. Faster Response: Claims and reimbursements may be processed more quickly compared to traditional insurance, reducing delays in service delivery. **3. Encourages Preventative Care:** SIP-PL models often incentivize providers to focus on risk mitigation and prevention (e.g., training staff in crisis management, reducing workplace injuries), which directly benefits people with ID by fostering safer environments. **4. Stability for Long-Term Care:** For organizations serving people with ID, SIP-PL ensures consistent funding and coverage, even during market fluctuations or policy changes in traditional insurance.
<u>Question 3:</u> What are the drawbacks of the model?	The drawback is having government move this model forward. While the SIP-PL model aims to improve coordination, individuals with cross-system needs (e.g., those requiring both IDD services and behavioral health care) may still face challenges. These individuals may fall between the cracks if the coordination between the managed care plans and HCBS is not seamless. Transitioning to a partial capitation model could be complex, requiring significant changes to existing service delivery systems. Integrating multiple care types under one managed care plan may lead to confusion or difficulty in execution, especially for individuals with complex needs. If the model requires providers to handle new, more complex roles (like integrating physical and behavioral health services), some providers may lack the capacity or experience to effectively manage such a broad range of services, potentially leading to inconsistent quality or gaps in care. While provider-led is a better model than traditional and/or for-profit plans, conflict of interest challenges may still exist in which providers' self-interests may influence various decision-making/actions by the plan and its leadership. While the model works great in theory, it can be difficult to implement in a way that truly produces the outcomes that were intended. The Guidehouse report looked at the NCI-IDD

	outcomes of the FIDA-IDD plans, and they really were not impressive at all. Also, my understanding is that plans that focus on serving people with high/complex needs tend to struggle financially, which would indicate they are not being adequately financed or structured optimally or else not provided enough regulatory flexibility (which can be scary and produce other challenges) to optimally design care & supports to be most cost-effective. For any managed care model to work optimally, I believe the state needs to ensure regulatory flexibility for the plan and providers to fully coordinate care and get creative, which the state is often loathed to do – especially with HSBC waiver services. So, I'm not sure how I see HSBC waiver services such as IRAs, day programs, employment, self-direction, etc. being able to fit into this model as it's currently designed. It seems this model may be more suited for integrated clinical medical and mental health services. Also, managed care models tend to need large member volume and widespread risk to be financially stable with capitated rates. I think the state would need to be open to allowing those without complex needs be part of the plan along with highly complex needs – or else the would need to be willing to provide very high capitated payments to make it work financially for a plan that serves only the highly complex population. As a family member, I see it as complex and system is "spinning it's wheels" with a new project here and there and not being able to move on to do system wide system change. Some of the ideas are great but unless put into widespread practice, they are nothing more than ideas that give hope and then dash hope of the individuals and the families meant to be served. To prevent SIP-PLs from creating additional barriers, policymakers and providers should focus on: **1. Ensuring Comprehensive Provider Networks:** Expand provider participation requirements to include a diverse range of specialists and culturally competent practitioners. Incentivize participation in rural and underserved areas to reduce geographic disparities. **2. Preserving Continuity of Care:** Allow individuals with I/DD to continue accessing preferred providers, even outside the network, through out-of-network coverage or grandfathering provisions. **3. Improving Accessibility and Navigation:** Simplify administrative processes for individuals and families to reduce delays and confusion. Provide clear guidance and resources, such as trained care navigators, to assist families in accessing services. **4. Advancing Equity Initiatives:** Require SIP-PLs to monitor and report on disparities in access and outcomes, with a focus on addressing inequities. Increase funding for training care coordinators in cultural competency and inclusion principles.

	5. Stakeholder Engagement: Involve individuals with I/DD and their families in decision-making processes to ensure policies and practices align with their needs and priorities. Cons: **1. Risk of Financial Loss:** High Claims Impact: If there is a high volume of claims or a single catastrophic event (e.g., a significant medical or liability case), SIP-PL funds can be depleted, potentially affecting the organization's ability to support individuals with ID. Underfunding Risks: Poor financial planning or underestimating risk exposure can lead to insolvency. **2. Administrative Complexity:** Increased Responsibility: Organizations must manage claims, administer the fund, and comply with legal and regulatory requirements. This can divert focus and resources from direct services for individuals with ID. Expertise Required: Administrators need a strong understanding of risk management and insurance law, which might not align with the organization's core mission of supporting people with ID. **3. Potential Service Disruptions:** If SIP-PL funds are strained, service providers may face budget cuts, which could lead to reduced access to quality care or programs for individuals with ID. **4. Unequal Distribution of Risk:** In pooled programs, high-need populations (like individuals with significant intellectual disabilities) may draw more resources, leading to tensions among participating organizations. **5. Regulatory Challenges:** Legal frameworks for SIP-PL vary by jurisdiction, and compliance can be particularly complex for organizations serving vulnerable populations like those with ID
Question 4: **How would you modify this specific model?**	I wouldn't The model may face challenges in gaining buy-in from different governmental agencies, particularly as services like healthcare, social services, and education often have different oversight and funding structures. Modification: Establish a dedicated task force or working group that brings together key stakeholders from various government sectors (e.g., Medicaid, OPWDD, and local health departments). This group should be tasked with ensuring alignment of goals and processes across agencies, as well as overseeing the implementation of integrated care. I'm struggling how to modify it other than suggesting that the state find a way to allow more regulatory and programmatic flexibility and creativity and risk-taking to allow even more coordination and creativity with individualize clinical and community-based supports to occur.

	The CCO's came up and I understand why it was necessary for the change but the CCO's are not doing the job that needs to be done, which dumps the work back on families and individuals that includes cleaning up the "mess" that is sometimes created by a care manager. There is a need to get the "O agencies" to work together to provide supports in a unified manner to people who need those supports. While SIP-PLs aim to enhance care coordination and service quality for individuals with I/DD, the potential for limited specialist access and preferred care restrictions highlights significant risks to equity and inclusion. Addressing these challenges proactively through stakeholder engagement, inclusive policies, and targeted reforms can help mitigate these barriers and ensure that the system serves all individuals fairly.
Question 5: **Do you have any other general recommendations?**	I hope members of the advisory questions OPWDD's lack of follow through on this model of service delivery and assists in pushing OPWDD to going back to the draft application and restart the implementation of the model. The concept of managed care where all the diverse Medicaid program costs are integrated and able to be used flexibly in order to optimally care/support people with disabilities is an ideal model. But its success depends on how it's implemented and regulated by the state. My own professional experience with NYS moving programs to managed care is that they often just took the existing programs and their existing regulatory structures and "plopped" them into managed care. I did not see this leading to much changing for the consumer on the ground (although I do recall some consumers reporting that accessing durable medical equipment was quicker/easier, but not much else). Could the state instead start experimenting with a pool of state funds where interdisciplinary teams of providers were able to design innovative holistic and integrated community-based and clinical supports – outside of many of the existing regulatory programming and federal financing structures – as a way to identify innovative managed care models that work best? "Anything" can be done on a real small scale, but the reality is that OPWDD is struggling to provide needed services on a large, small system. It is waiting for people to "exit" OPWDD in some form to allow others to access to some of those services. If you take the person with the high support needs and can be successful then it should be easier to provide the supports to others who have less needs. Some of the models out there are not user / consumer driven and/or are created by "experts" who know what is needed from a theory point of view. Families and individuals are the experts who should be part of

	the design that is flexible enough to individualized to the person and not designed on the “label of the person”. I found it a bit confusing to imagine what this would look like for families/providers/etc. It did seem that the PHP and Keystone programs demonstrated some potential but not sure how that would translate to the single funding stream or in NY state. If we do a follow-up, I think it may make sense to do sort of a case study of how an individual currently receives services vs what it would look like under SIP-PL.