NYS Council for Community Behavioral Healthcare

April 8, 2016

NYS Council Comments on Value Based Payment Roadmap Annual Update

The NYS Council for Community Behavioral Healthcare appreciates the opportunity to submit comments on behalf of our members on the Value Based Payment (VBP) Roadmap Annual Update.

Our organization is a statewide non-profit membership association representing the interests of 100 behavioral health (mental health and substance use) prevention, treatment and recovery organizations across New York. Our members include free standing community-based agencies, general hospitals, and counties that operate direct services.

The NYS Council and its members support New York's transition to VBP to improve access to, and coordination of, care for people with serious mental illness (SMI) and chronic substance use disorders (SUD). We have offered comments throughout the VBP process and are encouraged by the State's willingness to consider our suggestions. This version of the Roadmap adds important new concepts that we fully support and detail at the end of our comments. We begin by offering our comments on areas where we feel the language in the Roadmap raises some implementation concerns and/or where we strongly believe issues need to be added or expanded further.

METRICS

Our first concern is regarding the issue of performance metrics; we believe they are critical to the success of VBP for community-based behavioral health (BH) providers. If managed care organizations (MCOs) are held accountable for metrics that are reflective of the work done by BH providers, MCOs and VBP contractors will be incented to prioritize the work of the BH field in VBP arrangements, and the value added by BH providers will be recognized and rewarded. *It is essential that all Medicaid managed care products are held accountable for these performance metrics, not just HARP products*.

The structure indicated by the June 2016 update takes this into account, but does not offer sufficient detail to assuage any concern about the inclusion of these metrics, and in fact the document explicitly recognizes this shortcoming. "Measures focusing on rehabilitation and individual recovery including housing stability and vocational opportunities…are as yet underrepresented." The Clinical Advisory Group (CAG) on Behavioral Health has been working to identify metrics, both clinical and HCBS-related, but their work has not been integrated into the Update, and it is not clear if these essential metrics will

be included in the revised model contract, the most definitive way to ensure MCOs are accountable for these metrics.

The Update does indicate that the state foresees including these metrics in the model contract, but there is no assurance that they will be, nor that they will be satisfactory to the community BH sector when they are. Unfortunately, the state does not indicate that there will be an opportunity to comment on the model contract before it is finalized, and, in fact, indicates just the opposite, that the model contract will not be posted until it is approved by CMS.

In an earlier version of the recommendations from the Regulatory Subcommittee (SC), it stated that "after consideration of the comments from the SC, DOH will share the updated Model Contract with the public and solicit comments before finalization. DOH will post all of the received comments on the DOH website prior to the adoption the Model Contract." *We believe there should be a public comment period on the model contract so that we will have an opportunity to ensure the inclusion of metrics representative of the work our members do—in the contracts for all managed Medicaid products—before the model contract is finalized.*

SOCIAL DETERMINANTS OF HEALTH (SDH)

Much progress has been made with respect to SDH in the Update. We support the Roadmap's plan that Level 2 and 3 VBP contractors should be required to implement at least one intervention designed to address a social determinant of health and that managed care organizations (MCOs) share in the costs and responsibilities of the investment. (p. 41)

The selection of the type of social determinant intervention to be implemented "should be based on information including (but not limited to): SDH screening of individual members, member health goals, the impact of SDH on their health outcomes, as well as an assessment of community needs and resources." (p. 42). We support this design - it is critical to be guided by individual members' own health goals and desires and community needs and resources.

VBP "contractors should also create a report explaining a measureable reason why the SDH was selected, and identify metrics that will be used to track its success. We support this requirement and recommend that it follow a similar process/procedure to that used by the current Vital Access Provider (VAP) program, where the provider selects what they want to focus on, develops metrics, and reports back to the State." (p. 42)

"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO." (p. 42)

"The Advocacy and Engagement and Social Determinants of Health Subcommittees also recommended the development of several workgroups, in order to dig deeper into a number of critical issues. Areas for follow up may include: a taskforce focused on children and adolescents in the context of VBP…" (p. 59)

We are concerned, however, that the SDH metrics included in the Update are process measures, not outcome measures, and while it's a positive movement, it leaves quite a long way yet to go; SDH interventions should be incented by outcomes, not tacked on as process measures.

The BH CAG has identified SDH-related outcome measures, including measures related to housing, criminal justice, employment and education. The problem is not that SDH-related outcome measures are inconceivable, but that they are not included in clinical or claims data. The Update indicates that "the State will evaluate the feasibility of incorporating SDH measures into Quality Assurance Reporting Requirements (QARR) performance measures." *This is a positive step, but we believe there should be a commitment to include SDH in QARR measures.*

RESOURCES FOR COMMUNITY BASED ORGANIZATIONS (CBOS)

There are a number of recommendations included in the Update for supporting CBOs in making the transition to VBP. They include "creating a self-assessment process for groups to assess their readiness for VBP participation; State funding and the creation of additional workgroups to address the capacity, monetary, and infrastructure deficits impacting numerous organizations; convening a team of experts with whom CBOs could consult on VBP participation; and evaluating the feasibility of creating a bi-directional system for provider/provider network and CBO communication."

While we support these recommendations, we also remain concerned about provider's current issues of continuing to provide quality services while participating in transformation initiatives, including payment reform. The community based health care providers have not had access to the same amounts of funding that other providers have had access to. CBOs will need funding for: infrastructure development, including IT systems; ability to do measurement and data collection to demonstrate their value; contracted services, such as fiscal and legal expertise; among other things. To that end, *we recommend a clear and transparent process for determining the extent of the resources being considered, especially financial resources, who is eligible for them, and how they are allocated*. *We also recommend that the state establish a loan fund to assist with cash flow issues that may arise if payment to CBOs in VBP arrangements is delayed.*

We are encouraged by the idea of realizing savings from the work that is occurring in the community based health care providers but believe this savings should be shared among all participating providers. The fact that a provider is unable to take risk shouldn't determine their ability to share in savings. *If their investment and participation in the VBP arrangement generated savings, then this savings should be returned to them for future investment.*

ATTRIBUTION

The question of to whom members with chronic behavioral health conditions should be attributed has not been adequately addressed in the Update. Attribution is in part about risk and it doesn't preclude VBP participation in any way. For the BH-related chronic conditions (bipolar disorder, depression and anxiety, and substance use disorders) attribution continues to be the Primary Care Physician (PCP), and HARP members continue to be attributed to the MCO assigned Health Home. We believe that in both instances, it makes more sense to default to a behavioral health provider.

There is movement in a positive direction, because "an MCO and VBP contractor may deviate from this guideline and agree on a different type of provider to drive the attribution on the condition that the State is adequately notified." Nonetheless, the default continues to be misaligned from the provider who is best positioned to impact the course of a person's illness. *For people with chronic BH disorders (or at the very least for HARP members), attribution should be to the housing provider, or to the multi-service BH provider from whom the client currently receives care.*

HOUSING

There are some good ideas about housing contained in the Update, including prioritizing NY/NY housing for people eligible for HARP, collecting standardized housing data, seeking CMS approval to use Medicaid more flexible for housing, leveraging MRT housing workgroup money to advance the VBP agenda, and coordinating with the Continuum of Care. They are, however, somewhat uncoordinated. *We believe a Service Advisory Group (SAG) for housing (analogous to the CAGs)—and perhaps a SAG for employment—would be beneficial to the VBP infrastructure.*

TIMING

Throughout the document there are challenges created for providers by the fact that key information is not yet available. These mis-aligned timelines are a serious impediment to providers planning appropriately and entering into relationships based on sufficient information to make informed decisions. Some of the most challenging instances of this are:

- The Clinical Advisory Groups have done significant work, but have not yet reached consensus on some important issues and therefore there are meaningful gaps throughout the Update. Statewide definitions and quality measures "will be made available."
- That "the State is currently developing risk adjustment methodologies for both HIV/AIDS and HARP."
- That "in the first half of 2016, the State will make the total risk-adjusted cost of care available per PPS and MCO for the total population, as well as per integrated care service delineated above (Maternity Bundle, Chronic Bundle, Integrated Primary Care, HIV/AIDS, HARP)."
- Baseline survey results will be "the starting point for NYS Medicaid VBP," but they are not available.

- "There remain a few outstanding considerations that DOH will further evaluate, including contractual safeguards that may need to be included around prompt payment in the VBP environment." Issues around prompt payment should really be resolved prior to anyone entering into VBP arrangements.

ENFORCEMENT AND CLARITY

There are a number of places where the state indicates what "ought" to be, or what PPS' or MCOs "should" do. It is unclear how these areas will be monitored and/or enforced. Some important instances of this are:

- Because of the importance of maintaining the population health-focused infrastructure, patient-centered integration and workforce changes that are being purchased with DSRIP funding, "the PPS or its hubs will have to submit a plan outlining how this infrastructure will be maintained." How this will be enforced, or even incented, is unclear.
- The guidelines for distribution of shared savings amongst providers are an excellent example of this.
  - "Savings should be allocated appropriately among providers; especially behavioral health, long term care, and other community based providers should not be disadvantaged." We couldn't agree more, but if/how that will be either monitored or enforced is not clear.
  - The guiding principles for the distribution of shared savings delineated on pp 20-21 speak to the importance of fairness, equity and protection of small providers, but offer no actual protection.
- MCOs will be penalized for failure to achieve VBP targets from 2018 on. At that point, they "may pass on such penalties to incentivize providers that can reasonably be expected to make this transition to work with the plans towards realizing these common goals." We believe there is a lack of clarity here that will impact providers. Who determines which providers can be "reasonably expected to make this transition?" On what basis?
- "Smaller, less prepared providers may need access to resources and support to develop the sophistication to succeed, and DSRIP funds are explicitly intended to facilitate this progress." If DOH expect PPS' to use their DSRIP funds to support small provider preparedness for VBP, a mechanism for enforcing that expectation would be useful.

INTEGRATION OF REPORTING AND POPULATION HEALTH

The Roadmap indicates that the PPSs/hubs that are not contracting entities should maintain infrastructure for population health, patient-centered integration, and workforce strategy (p. 16). Non-contracting PPS' will be well-positioned to contribute reports on the impact of VBP arrangements. However, reports on the impact of Medicaid VBP arrangements will be most valuable viewed in the context of other payer initiatives, including Medicare VBP and commercial arrangements. It will be important for the State to ensure that PPS reports and population health planning activities are

integrated into broader community assessment and planning efforts, such as those generated by successful Population Health Improvement Programs (PHIPs). We recommend that the State explicitly recognize PPS' population health assessments as taking place in collaboration with other state-funded entities conducting broader health planning activities that include Medicare and commercial VBP arrangements.

EDUCATION AND TRAINING

We recommend that the State and/or a third party develop educational materials on VBP that focus on both CBOs' part in the system and guidance on the value proposition CBOs should expect to provide when contracting with providers/provider networks and MCOs. Additionally, the State and/or a third party should provide technical assistance for the providers/provider networks and MCOs (non-CBO) contracting entities on how to work effectively with CBOs.

In order to ensure that information concerning VBP and how it varies from FFS is understood, we suggest that it be communicated effectively to Medicaid members. The State should also communicate general information about new structures and incentives under VBP. MCOs or ACOs should communicate more specific information about VBP and FFS programs their members are enrolled in.

We also recommend that the State create a "design and consultation team" of experts from relevant State agencies, advocacy and stakeholder groups, to provide focused consultation and support in a way that is affordable to CBOs who are either involved or considering involvement in VBP.

VBP AND CONSUMERS

The Roadmap indicates that the Managed Care Patient Bill of Rights will be updated to include information relevant in the VBP context. This is an essential task, but is insufficient to assure that consumers understand the implications of VBP and how it affects them. The Roadmap should reference some of the other important actions recommended by the Subcommittee that the State has committed to undertake, such as ensuring that plans and providers communicate information to consumers that explains the difference in incentives that payment mechanisms generate; the workgroup that will be created to develop a larger communication strategy.

Consumer education and patient activation are needed around what is meant by a "high value provider," as well as their right to question their providers, seek a second opinion, and obtain consumer assistance/ombudsmen services. The State's Independent Consumer Advocacy Network and any and all consumer assistance/ombudsmen programs should be equipped to provide assistance in the VBP context; ICAN and other staff will need to be appropriately trained and fluent in VBP concepts to assist people in the new VBP environment.

ADDITIONAL COMMENTS

The NYS Council supports the following new concepts included in the Roadmap Update:

The Roadmap articulates this "Payment Reform Guiding Principle," which we support: "Financially reward, rather than penalize, providers and plans who deliver high value care through emphasizing prevention, coordination, and optimal patient outcomes, including interventions that address underlying social determinants of health." (p. 8)

We support several components of the section on "Incentivizing the Member," including the focus on positively incentivizing desired behavior and stating clearly that "burdening disadvantaged members by introducing co-pays or co-insurance as disincentives for poor choices is not a policy option." (p. 38)

We support the State's plan to eliminate the $125 incentive cap for incentive programs (the roadmap describes the current cap as applying to preventive services. We believe the reference should be to an existing cap on incentive payments). (p. 40)

We support the State's interest in measuring and encouraging creativity in incentive programs, specifically its plan to "analyze any collected data and identify best practices on, at least, an annual basis, and will make this information publically available. The State will also convene a group of experts and consumers to create more detailed guidance for the development of incentive programs, with a particular focus on achieving cultural competency in program design." (p. 40)

Thank you for the opportunity to provide comments on the Value Based Payment Roadmap Annual Update. If you have any questions, please contact me at (518) 461-8200 or nyscouncil@albany.twcbc.com.

Sincerely,

Lauri Cole

Lauri Cole
Executive Director