

Date: October 30, 2015

To: Jason Helgerson, Director, NYS Medicaid

Marc Berg, KPMG

From: Lauri Cole, NYS Council for Community Behavioral Healthcare

Re: Comments on Draft VBP Subcommittee Recommendations

The New York State Council for Community Behavioral Healthcare appreciates the opportunity to submit comments on behalf of our members on the Draft Value Based Payment (VBP) Subcommittee Recommendations.

The NYS Council 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.

In terms of overall comments, we believe it is important to emphasize that the NYS Council’s members recognize the potential of New York State’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 are acutely aware of the poor health outcomes in the United States for people with significant behavioral health challenges, and the disproportionate impact of social determinants of health on them, and we are hopeful that the systemic transformations underway in New York will facilitate better outcomes for the people we serve. It is in that spirit that we offer these comments, as a means of enhancing and improving the structures that support our clients and the agencies that serve them.

While there are many areas within the Draft VBP Subcommittee Recommendations on which we can comment, we are highlighting those we think are most critical to ensuring the wellbeing of people with serious behavioral health challenges in a VBP environment.

*Technical Design I Subcommittee Recommendations*

We are fully supportive of the Subcommittee’s proposed guideline that attribution is done prospectively. Prospective attribution is more likely to result in a circumstance in which the provider who is actually doing the work and producing the outcomes is rewarded for their efforts. Within that context, however, we are concerned about how attribution will be driven for people with SMI and SUD. We believe that people with SMI and SUD should be attributed to the provider with whom they have the most frequent contact. In some instances, that will be the primary care physician (PCP), but in some instances it will be a behavioral health service provider. The provider with whom they have the most frequent contact will be the one most likely to have an impact on their health outcomes, and as such, should be the attributed provider. This is true for people who enroll in HARP, as well as for people with SMI and SUD who choose not to enroll in HARP. In addition, attributing HARP members to Health Homes is problematic in that Health Home is an optional service for HARP enrollees, so some will have no Health Home involvement.

We are also concerned about the Subcommittee’s recommendation that poor performing VBP contractors receive downward adjustments beginning in 2018. While 2018 seems to be well into the future at this point, given the magnitude of the programmatic, administrative and infrastructural changes providers need to make to engage in VBP relationships, providers who are in the learning category will likely just be beginning to participate in VBP in 2018. If downward adjustments begin in 2018, it will provide a huge advantage to those providers currently in the leading category, who will have an opportunity to participate in VBP prior to the imposition of penalties. We therefore propose that downward adjustments to the target budget be delayed until 2020.

In addition, we very strongly support the Subcommittee’s recommendation that shared savings be distributed among providers by the VBP contractor according to the provider effort, performance and utilization patterns in realizing the overall efficiencies, outcomes and savings while taking into consideration investments and losses providers made in order to deliver these quality outcomes. This recommendation is, in some significant way, the most fundamental to the success of the VBP initiative. VBP will only work if savings (and losses) are distributed in a manner that actually reflects the true impact of a provider’s services on a client’s outcomes. As such, we propose that this recommendation be made a standard, rather than just a general guiding principle.

*Technical Design II Subcommittee Recommendations*

We are concerned that the Subcommittee chose not to recommend a process for State intervention and assistance when contract negotiations reach an impasse. While we agree with the Subcommittee’s assessment that the contracting environment will change, we nonetheless feel that it is essential that the State Department of Health have a process in place to expedite resolution of contractual deadlocks. The absence of this process will have the practical impact of benefiting larger, wealthier organizations, which will be better positioned to weather any lengthy delay. This would result in smaller providers being forced to enter into contracts with disadvantageous terms, and an eventual consolidation of money and power in fewer and fewer organizations, which will benefit neither Medicaid recipients nor the state’s oversight abilities. We therefore strongly urge the state to immediately develop a robust and authoritative process for expeditiously and fairly resolving contract stalemates.

We are strongly supportive of the standard proposed to pay for a defined set of preventative services on a fee-for-service (FFS) basis as a form of VBP. We would propose, however, that screening for common behavioral health disorders be explicitly named as a preventive service that will be paid FFS as a form of VBP. Despite the ease of implementation and cost-efficacy of screenings like the PHQ-9, CRAFFT, AUDIT and DAST 10, routine screening for behavioral health disorders has not been adopted as widely as it ought to be. By including these behavioral health screenings—with appropriate quality measurements—in the defined set of preventive services that remain on a FFS basis as a VBP will incent the PCPs and their practices to implement these population screening tools as broadly as is appropriate.

We do not feel that the Subcommittee’s recommendation regarding technical support for providers in VBP arrangements who are encountering substantial challenges accurately reflects the reality of the support which is currently available to providers, either through MCOs or PPSs. If NYS does not put into place a process for providing support to providers in VBP arrangements whose performance is not what it ought to be, the likely result will be that consumers served by those providers will receive suboptimal care until such time as the MCO or VBP contractor chooses to cut them out of the process. MCOs in New York State have a very limited track record of providing this type of technical assistance to providers in their networks, and PPSs, at least to this point, have no track record in this area of any kind. If New York State’s objective is to ensure that providers who are encountering challenges receive technical support, rather than punitive actions, the state will need to devise a paid mechanism to provide it.

*Regulatory Impact Subcommittee Recommendations*

While we support the Subcommittee’s recommendation that providers be permitted to enter into Level 2 VBP arrangements without a financial security deposit under Regulation 164, we believe that doing so requires more explicit safeguards than the SC has currently proposed. We propose that the state of New York establish regulations that will facilitate the offer of an insurance product for providers who are entering into VBP arrangements and lack the contingency reserves necessary to provide adequate safeguards.

While we understand the reasons the Subcommittee chose not to recommend that Prompt Pay rules apply to certain VBP contractual arrangements, we nonetheless urge that the state establish standards for timeliness of payments, both between MCOs and VBP contractors and between VBP contractors and providers in the VBP arrangement. Prompt payments will be essential for enabling providers of all sizes to enter into VBP arrangements, as smaller providers will lack the cash reserves needed to withstand lengthy payment delays. We do not believe that contractual negotiations between the relevant parties will be likely to lead to sufficient safeguards for providers, especially smaller providers lacking in cash reserves.

*Advocacy and Engagement Subcommittee Recommendations*

We are supportive of the recommendations of the Advocacy and Engagement Subcommittee. We do, however, recommend that the $125 incentive cap for preventative care be raised, rather than eliminated as proposed. While we agree that the $125 cap is overly limiting, we are concerned about the potential for abuse of the cap is eliminated entirely.

*Social Determinants of Health (SDH) and Community Based Organizations (CBOs) Subcommittee Recommendations*

We are strongly supportive of the recommendations of the SDH and CBO SC, especially those recommendations that relate to housing. We support the recommendation that all providers/provider networks should implement interventions on a minimum of one SDH, as a start. We recommend the State be more intentional about developing an evidence and cost base for this work beyond just letting the “market” figure it out. Over time, as providers and provider networks grow more comfortable addressing SDH and as the knowledge base about effective interventions for SDH grows, providers and provider networks should be incentivized to increase their level of intervention in SDH.

Thank you again for the opportunity to provide comments on the Draft VBP Subcommittee Recommendations. If you have any questions, please feel free to contact me at (518) 461-8200 or [nyscouncil@albany.twcbc.com](mailto:nyscouncil@albany.twcbc.com).