

January 27, 2016

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Re: Comments on VBP Subcommittee Recommendations

The NYS Council for Community Behavioral Healthcare appreciates the opportunity to submit comments on behalf of our members on the 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.

The NYS Council’s members recognize the potential of 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 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. We offer these comments as a means of enhancing and improving the structures that support our clients and the agencies that serve them.

*In terms of the Regulatory Impact Subcommittee recommendations, below are our suggestions.*

**Comprehensive Medication Management**

We support the proposal to establish a voluntary program for collaboration between a qualified pharmacist and a practicing physician. We recommend clarification and specific protocols be established in regard to sensitive medications such as anti-psychotics, long-acting injectables, opioid replacement therapies, etc.

*In terms of the Social Determinants of Health and Community Based Organizations Subcommittee recommendations, below are our suggestions.*

To begin, we appreciate the revisions that have been made that change certain elements from a “'recommendation” to a “standard” that includes:

* financial incentives for ameliorating an SDH
* 2-3 contracting entity must contracts and engage with a minimum of Tier 1 CBO

**Recommendation #1**

In this recommendation, and referenced in several others, is the concept of approaching social determinants of health from an overall population health and community needs perspective. While we agree that this begins with the individual perspective (e.g., the air conditioner for the asthma patient) and the plans may focus on this, we recommend a stronger commitment from the State to lead on this issue, and provide some direction to the Plans, with input from CBOs, communities, and other stakeholders. We believe this will help to make it a statewide response to a public policy issue versus an individual by individual response.

**Recommendation #2**

We support the investment in effective interventions that have a meaningful impact on SDH but think this will be problematic to make it a standard for Level 2 or 3 providers. There is currently no reimbursement mechanism and it will be difficult to hold providers accountable for something that cannot be paid for.

**Recommendation #3**

We believe that for this recommendation to be meaningful there will need to be funding in place for the resources referenced, especially if they involve CBOs, and other grassroots entities. This might be better maintained centrally right from the start. We do not believe that every provider/ provider network should have to invest in building and maintaining the database but instead recommend that the state build the database without an expensive and inefficient delay.

**Recommendation #4**

While we agree that providers should employ a culturally competent and diverse workforce at all levels to reflect the communities they serve, we are also faced with serious workforce issues across the State. There continues to be a shortage of psychiatrists as well as difficulty hiring other levels of staff. In addition, the challenge of finding staff who reflect the population being served is not limited to any profession, but is a universal challenge for staff at all levels from line staff to executive leadership. This may soon be compounded by the proposal to increase minimum wage, and how this will affect the behavioral health provider’s bottom line.

**Recommendation #5**

We support the idea of a data system and dashboard that displays providers/provider networks' and MCOs' success but also recommend that this should be an “integrated” data system and there needs to be timely data and analytics if this is to inform real time activity.

**Recommendation #7**

Implementing yet another screening tool for providers will become burdensome as providers are already dealing with multiple screening tools. Developing a uniform tool in the long-term is a good suggestion that should include plenty of providers and other stakeholder input. In terms of “the healthcare organization must ensure providers/care teams have access to SDH information for their members” we ask that there be further clarification as to how “healthcare organization” is defined.

**Recommendation #15**

We agree that the State should assess economic development investments. We also recommend that the State expand the scope of this recommendation to include other initiatives for their impact on SDH and budgeting – possibly including transportation policy to farm policy to consumer affairs.

**Recommendations #16-18**

In terms of the overall topic of decreasing the knowledge deficit, we agree that this is important as a useful readiness activity. Our question here is how quickly will these recommendations be implemented? We believe that it is essential that this be done as quickly as possible or else it might not be useful given the speed of the transformation activities already underway.

**Recommendation #20**

We completely agree that State funding should be made available to CBOs to facilitate their participation in specific VBP arrangements and strongly encourage this recommendation be adopted.

**Recommendation #21**

We support this recommendation that the State encourage integration of community-based care teams into the clinical care setting. However, we also recommend that the State encourage the integration of clinical care teams into CBOs. One suggestion to implement this would be to use the small clinic license which has been under consideration for the last several years.

**Recommendation #22**

We are concerned here that the focus on CBOs was agencies with no Medicaid billing capacity. We understand they must be included but it should be noted that a great of the SD work is done by CBOs with diverse lines of business. We recommend that this be taken into account when finalizing this recommendation language.

In addition, we recommend that a retrospective review include a calculation of the real savings associated with the work of the CBOs. This calculation would be important related to the efficacy of the process, and would be more complex than CBOs would be able to conduct on their own.

*In terms of the Technical Design II Subcommittee recommendations, below are our suggestions.*

**Financially Challenged Provider Status**

The definition of a financially challenged provider seems to only refer to hospitals. This excludes many behavioral health and other community providers who should be included. We recommend that this definition be broadened and behavioral health and other community providers be offered the opportunity for technical assistance and corrective action before being excluded.

**Workforce Measures**

We recommend that in addition to the unions and regulators working to devise workforce measures, that management and other stakeholders also are included in the discussions. We agree these measures are key and believe they should be determined with a wide variety of input.

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

Sincerely,

Lauri Cole

Lauri Cole

Executive Director