Good afternoon,

The New York State Council is a statewide membership association representing 120 mental health and substance use disorder/addiction organizations serving New Yorkers residing in local communities across New York.  We are strong supporters of the CCBHC demonstration (CCBHC-D) model.  At the present time, our association represents 9 of the 12 demonstration agencies here in New York.  As such, we appreciate the opportunity to provide comments as SAMHSA works to update the CCBHC criteria.

**Prospective Payment Rate Methodology**

The current methodology for calculating the CCBHC rate in the demonstration requires the use of total cost divided by total visits, resulting in a rate equal to the average cost per visit.  To maintain a fiscally viable program model, this methodology would assume that every consumer receiving CCBHC services would have a payment made for such services at this average amount.  However, individuals with no insurance coverage, and no ability to pay for such services, even under the provider’s adopted Sliding Fee Scale, leaves a percentage of services un-reimbursed.  Not all CCBHC services (most frequently/ notably Psychiatric Rehabilitation, Targeted Case Management, and Peer Services) are covered by insurance other than Medicaid, including Medicare.  This results in a revenue gap for providers.  Failure to address this gap results in an unfunded mandate on the provider.  This issue is jeopardizing the fiscal viability of CCBHC programs.  Offering care to those with an inability to pay is essential, however covering the costs of the services that insurance companies will not reimburse is a burden to the CCBHC and reduces access to care for the highest need people.  In addition, Medicaid should pay up to the Medicaid rate for people with Medicaid as a secondary payer.  Currently, CCBHC-Ds are only reimbursed the patient responsibility (copayment or deductible) amount.

**Recommendation:**The Prospective Payment System (PPS) Rate Methodology must be amended to either (1) recognize Bad Debt as an allowable expense or (2) allow rates to be modified with an adjustment for indigent care/safety net visits/costs.

**Staffing Requirements**

CCBHC-D agencies in New York State are facing extreme challenges with hiring due to a variety of factors.  Workforce shortages across the state limit provider ability to attract clinicians that, post-COVID, prefer remote positions that offer higher salaries and more flexible work conditions. The majority of CCBHC-D agencies here in New York have significant workforce shortages at the present time, demanding maximum flexibility in order to recruit and retain valued clinicians and other staff.  Rapid access sorted by acuity is a requirement of the CCBHC however it has been problematic due to staffing shortages to continually manage the higher-than-normal volume of clients.

**Recommendations:**

CCBHC-D agencies would benefit from funding enhancements that permit hiring of additional support staff for PSR and Peer Services.

**Crisis Services**

Having to complete a full assessment and treatment plan often increases the risk of disengagement, as the person is seeking urgent care for an issue that will likely be resolved within a short duration of time. Completing the large assessment does not meet their needs, resulting in them ceasing linkage.

**Recommendation:**

Allow for Crisis Visits to be a brief episode of care that do not require a full assessment and admission into treatment.  Allow for brief episode of care under a crisis model that does not need to translate into longer term care.  For example, an individual experiencing an acute need that will not extend beyond 3 to 4 visits.

**Quality & Reporting**

The effort to gather the CCBHC data measures is burdensome. The need to collect so much information **at initial contact** impacts the ability to engage and complete a clinical assessment. Some measures, while they may be important to collect over the episode of care, are burdensome to collect at intake  (i.e., BMI).

**Recommendations:**
·      Require data measures that are not imperative for admission or initial treatment plan, to be gathered over time, or by a certain milestone in care.   A significant portion of the assessment is just data gathering, not addressing the acute clinical needs the person is presenting with.
·      Offer feedback to CCBHC-D agencies about why HEDIS measures are still the most relevant measures to focus on, to help further improve care.
·      Balance data requirements with the ability to engage people in services as a primary goal, then collect information throughout the course of care.
·      Move towards quarterly reporting requirements.

**Dep-Rem 12:**

Currently, a client can only be successful on this measure if their follow-up PHQ-9 is under 5. This means that a client can come into treatment with the highest possible score (27), reduce their depression all the way down to a 5, and still not be counted as a success.

**Recommendation:**

Adjust the benchmark for success to match the clinically significant measure of success, which is reduction by half of baseline.

**CDF-BH, SRA-A and SRA-BH-C:**

This metric was designed with primary care practices in mind – PCPs see their patients once per year at a minimum. It is very cumbersome and unnecessary to complete weekly.

**Recommendation:**

Revise the frequency of the PHQ and suicide risk assessments at every visit to be once per quarter.

**ASC:**

Currently only a full, standardized screening tool is allowable, but a full screening is often unnecessary for clients with no history of use, and makes the assessment process unnecessarily time-consuming and cumbersome for clients.

**Recommendation:**

Expand allowable ways to assess for unhealthy alcohol use to include a single-question screening, to mimic what is currently allowable in SRA-A and SRA-BH-C.

**Scope**

We strongly recommend keeping TCM, peer and psych rehab services as part of the criteria for eligibility as these services help to eliminate barriers to access to care, create a holistic treatment team, build supports around people to mitigate risks, and improve Social Determinants of Health outcomes for individuals served.   In order to manage the high volume of consumers seeking CCBHC services, we absolutely need the entire array of Targeted Case Management, Peer and Family Peer Advocate services available through this model.

**Care Coordination**

**Recommendation:**

Incorporate more tele health models within treatment and services.  This will increase accessibility for many clients, and especially those who are unable to travel to receive care or those who may be reluctant to visit a traditional service setting.

**Criteria 4.d.3**

I-EVAL measures the length of time from when someone calls or walks into the program to request services to the start of “treatment” as defined by completing 9 points. If providers does not collect all 9 points, SAMHSA does not see that treatment has begun thus increasing the length of time.  However, treatment does in fact start at the first visit. Most individuals are anxious or upset and clinical interventions need to be utilized to de-escalate.  The initial visit should only be about why the individual is seeking assistance.  The practitioner should assess for safety.  Additional points (5) (8) (4) and (9) can wait.