pennsylvania
DEPARTMENT OF HUMAN SERVICES

Physical and Behavioral Health HealthChoices: Incorporating Community-Based Organizations into Value-Based Purchasing FAQ #2

Abbreviations:
BH: Behavioral Health
CBO: Community-Based Organization
DHS: Department of Human Services
FAQ: Frequently Asked Questions
FRR: Financial Reporting Requirements
HC: HealthChoices
MCO: Managed Care Organization
OMAP: Office of Medical Assistance Programs
OMHSAS: Office of Mental Health and Substance Abuse Services
PH: Physical Health
SDOH: Social Determinants of Health
VAS: Value-Added Service
VBP: Value-Based Purchasing

New requirements were added to the PH and BH HealthChoices programs for 2021. BH Primary Contractors and MCOs must incorporate CBOs into medium and high-risk value-based purchasing arrangements, as an effort to address the social determinants of health. These questions and answers refer to those requirements. The first FAQ was published online on December 21, 2020, and is available here: https://www.dhs.pa.gov/HealthInnovation/Documents/12.14.20%20CBO%20FAQ.pdf. These FAQs answer additional questions that the Department has received.

The requirements in the HealthChoices agreement are:
By March 1, 2021, 25% of medium and high-risk VBP payment strategies must incorporate at least one CBO that addresses at least one SDOH domain. By June 1st, 2021, 50% of medium and high-risk VBP payment strategies must incorporate at least 1 CBO that addresses 1 SDOH domain. By September 1st, 2021, 75% of medium and high-risk VBP payment strategies must incorporate at least one CBO that addresses one SDOH domain, and 25% of medium and high-risk VBP arrangements must incorporate one or more CBOs that together address two or more SDOH domains. The SDOH domains are the same that are mandatory for assessment in the RISE PA tool (except for the SDOH domain "medical access"): childcare access and affordability, clothing, employment, financial strain, food insecurity, housing instability/ homelessness, transportation, and utilities.

Question #1: What is the role of providers in this process?

A CBO can be incorporated into a VBP arrangement through a contract with a provider. For example, the provider may enter into a VBP arrangement with an MCO and the provider may in turn, contract with a CBO to provide food or housing services to support the VBP arrangement. This counts for the purposes of the VBP requirements to incorporate CBOs.

Question # 2: What portions of Medicaid funds can be used to pay for commodities like food? How are they reported?

DHS understands there has been confusion about which funding streams can be used to pay for commodities (ex. rent subsidies, food, etc.). To clarify, payments from a MCO to purchase commodities, such as through a CBO, are considered value-added services (VAS). VAS must be paid for out of excess revenue, unused capitation revenue or other non-capitation sources (see Question #5 for details) and cannot be included in future capitation rate development. Similarly, funds allocated for the CBCM program can only be used for care management. For questions on how to report VAS in the FRR, please follow up with individual program offices.

Payments from an MCO to a provider under a VBP arrangement should be reported consistent with other MCO service expense reporting. A provider in a VBP arrangement may choose to contract with a CBO to address SDOH needs as part of a value strategy to improve outcomes and reduce other expenses.

Question # 3: Do MCOs' CBO agreements need to be approved by DHS?

No, CBO agreements are not approved by DHS at this time. However, DHS is looking to move towards more aligned oversight of VBP arrangements across OMHSAS and OMAP.

Question # 4: Could there be consideration to allow for more time between the different milestones for incorporating CBOs into VBP?

DHS is not planning on extending the time between the first and second milestone. The intent is to rapidly scale involvement of CBOs, so rapid-cycle evaluation may be needed.

Question # 5: Can you describe any funding sources which the MCO can use to implement the program and to offset additional overhead which will be part of developing these programs.

Payments to CBOs can occur from excess revenue or affiliated foundations. Both PH-MCOs and BH primary contractors may also use revenue obtained through the MCO pay-for-performance programs to implement contracts with CBOs. Both PH-MCOs and BH primary contractors may spend unused capitation revenue for payments to CBOs. PH-MCOs and BH primary contractors may also use the shared savings from a reduction in the total cost of care, as part of a medium or high-risk VBP arrangement, to allow the CBO to share in such savings. Lastly, BH primary contractors may also use reinvestment funds to enter into a vendor contract with a CBO.

Question # 6: Can you provide some guidance on ensuring adequate funding for CBOs through VBP while still remaining cost neutral in the HealthChoices program?

VBP arrangements are treated as cost-neutral in rate development, but because medium or high-risk VBP arrangements take into consideration the overall total cost of care, addressing unmet social needs may decrease the total cost of care and the cost of providing the services to CBOs may be an offset. DHS does not expect that PH-MCOs or BH Primary Contractors will be able to know ahead of time the return on investment overall for incorporating CBOs into a VBP arrangement; however, payment strategies that reward delivery system innovation and high quality care may help to offset investments to address unmet social needs.

Funding available through capitation rates must continue to follow federal regulations. Capitation rates must be actuarially sound, which means the rates are projected to provide for all reasonable, appropriate and attainable costs for the covered Medicaid population in a specific time period.

Question # 7: Can DHS please clarify the agreement language surrounding the percentage of medium and high risk VBP that must incorporate a CBO?

In general, the HealthChoices Agreement (for both PH and BH) dictates a minimum required level of service cost expenditures that must be made through VBP contracts. For example, in HC-PH, 50% of an MCO's medical expenditures must be attributable to VBP arrangements. If the MCO has medical expenditures of $1.2B, $600M must have been paid out through VBP arrangements. In HC-PH, 50% of the VBP expenditures must be in medium or high-risk arrangements (such as shared savings, shared risk, bundled payments, or global payments), so in our example, $300M must be in medium or high-risk arrangements. For the subset of payments made through medium and high-risk VBP arrangements, a minimum percentage (increasing over the course of 2021 as described above) must involve a CBO in that arrangement. As of March 1, the requirement is 25%. Continuing the same example, 25% of $300M, or $75M of the VBP payments, must be made to providers that involve a CBO addressing a SDOH domain. In this example, the MCO will have paid $600M to providers outside VBP arrangements, $525M to providers through VBP arrangements that do not involve a CBO, and $75M to providers through VBP arrangements that do involve a CBO, for a total of $1.2B in provider payments.

Question # 8: Please explain reporting requirements for VBP arrangements.

Please refer to existing FRR documentation. For specific questions, contact OMAP or OMHSAS financial reporting staff.

Question # 9: How does the 25%, 50% and 75% contract language come into play if the MCO contracts directly with CBOs?

The VBP milestones for incorporating CBOs refers to the percentage of medium and high risk VBP arrangements with providers that must incorporate a CBO. If the CBOs are contracted either with the PH-MCO, BH primary contractor, or provider, and are providing social services that meet unmet SDOH needs to patients who are seen by the provider in the VBP arrangement, this counts as being incorporated into the VBP arrangement. See Question #7 for an example.