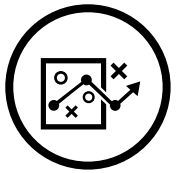
Value-Based Purchasing

A Resource Guide

January 2025
Developed by the PA Culture of Communications VBP Subcommittee

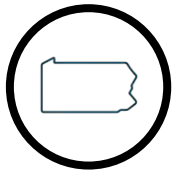
Goals of this presentation

- Understand what Value-Based Purchasing (VBP) is and why it's useful



- Understand tools that will make providers successful in improving quality (and therefore successful in VBP programs)

- Understand how and why Managed Care Organizations (MCOs) develop VBP programs



- Understand the role played by Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) in VBP

- Understand how providers can prepare to engage with MCO VBP programs

What is Value-Based Payment?

What is Value-Based Purchasing?

Value-Based Purchasing (VBP) is a healthcare strategy that rewards high-performing providers by **linking provider payments to improved healthcare quality outcomes** for the members served.

- ✓ Allows providers to focus on clinical outcomes instead of number of visits
- ✓ Data shows payers the “big picture” so that interventions can affect change without increasing cost/resources

Who are the key stakeholders in Pennsylvania?

1. **Commonwealth of PA / OMHSAS**: The Commonwealth of Pennsylvania oversees the HealthChoices program. OMHSAS (Office of Mental Health and Substance Abuse Services) is the specific office within the state government responsible for managing and implementing mental health and substance abuse services under Medicaid.

2. **Payer**: Refers to the entity responsible for financing health care services. In the context of HealthChoices, the payer is typically the Primary Contractor, operators of the state Medicaid program that provides the funding for services, often in partnership with managed care organizations (MCOs).

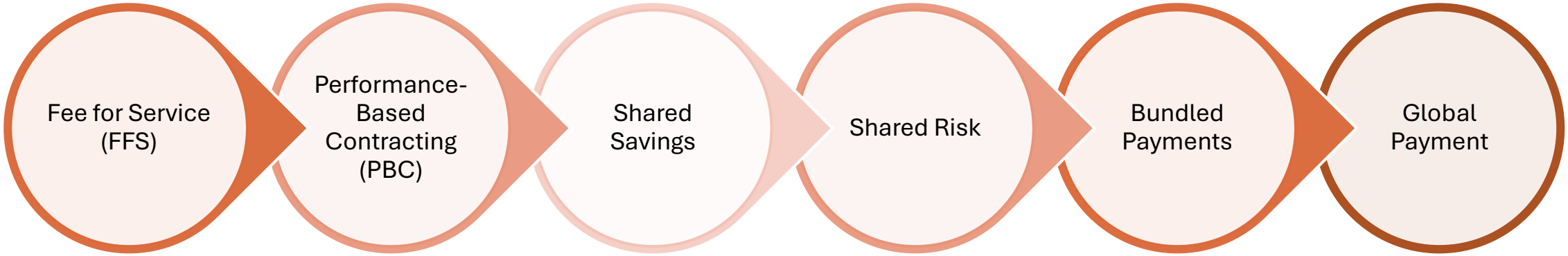
3. **Managed Care Organization (MCO)**: A health care organization that provides services to Medicaid beneficiaries through a network of providers. In HealthChoices, MCOs are contracted by the Primary Contractors to deliver mental health and substance abuse services, ensuring that members receive the necessary care while managing costs and quality of service.

4. **Provider**: A provider is any individual or organization, such as doctors, clinics, hospitals, or therapists, that delivers health care services to members enrolled in the Medicaid program. Providers work within or in collaboration with MCOs to offer mental health and substance abuse care to beneficiaries.

5. **Members**: Members are individuals enrolled in the HealthChoices Medicaid program who receive mental health and substance abuse services. They are the beneficiaries of the program, accessing care through the network of providers organized by the MCOs.

6. **Primary Contractors / Counties**: These are typically the entities or local government units, such as counties, that hold primary contracts with the state to administer parts of the HealthChoices program. They play a crucial role in driving priorities and funding considerations, as they manage the distribution and oversight of services within their regions, ensuring that the needs of their communities are met in alignment with state-wide objectives. They may also contract with MCOs to facilitate service delivery.

What are the different types of VBP Payment Strategies?



Limited financial accountability → ***Moderate financial accountability*** → ***Full financial accountability***

These type of strategies are referred to as "upside only" meaning providers do not have any risk of owing penalty payments or returning funds based on VBP outcomes. Often, providers continue to receive payments for services provided and can receive bonus incentive payments for certain clinical outcomes.

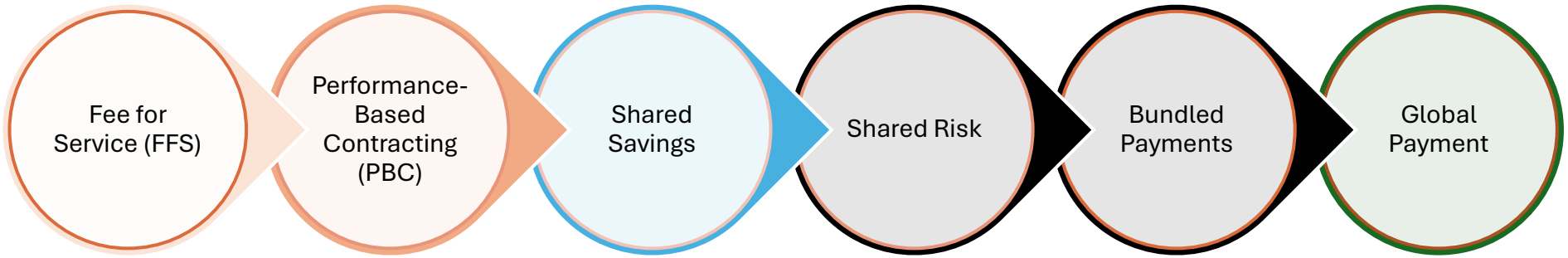
Providers in these programs may continue to receive payments for services provided. By providing more effective care, providers can generate cost savings that can be shared in the form of incentive payments.

Payers may introduce more risk with these programs, meaning that if cost of care increases, providers may be responsible to return funds to payers.

The details of the program are clearly identified during the VBP contracting process to ensure all stakeholders understand the potential risks and benefits.

Providers receive payments that cover all services rendered for a population of members served. These payments can either be made in bulk, delivered over regular predetermined intervals, or based on fee-for-service payments with retrospective reconciliation to a global budget. Providers are at full risk for outcomes and for financial targets.

Payment Model Definitions



Fee for Service: Revenue generated only from fee-for-service billing. No additional performance-based contracting.
Performance Based Contracts: Incentives are paid to providers who are able to meet quality or outcomes targets. Incentives are in addition to revenue generated through the delivery of services (fee for service).
Shared Savings: Supplemental payments to Network Providers if they can reduce health care spending relative to an annual cost benchmark, either for a defined Member sub-population or the total Member population served by a Network Provider.
Shared Risk: Supplemental payments to Providers if they are able to reduce health care spending relative to a cost benchmark, either for a defined Member sub-population or the total Member population served by a Network Provider and also include shared losses with Network Providers if costs are higher relative to a benchmark.
Bundled & Episodic Payments (also called "Case Rate"): Payments for services for an identified condition during a specific time period. The payments may either be made in bulk or be paid over regular predetermined intervals.
Global Payment: Population-based payments that cover all services rendered by a Network Provider, hospital or health system by the participating MCO.

What do providers need to know about Value-Based Purchasing?

What do providers need to know about VBP?

- ***The goal of VBP is to improve health care quality outcomes for members***

- **OMHSAS reviews almost all VBP arrangements to ensure compliance with Commonwealth expectations**
  - This includes parameters around how payouts are calculated and how performance is measured
  - There is an emphasis on partnering with providers to increase financial accountability (see slides 8-9)

- **There are several aspects of VBP that result in improved outcomes:**
  - Accessing and understanding your agency's data (utilization trends, cost of services, etc.)
  - Understanding how your agency measures positive outcomes
  - Having a strategic plan to achieve quality targets

- **Providers are a key partner in VBP development**
  - Providers have access to meaningful data about trends in members' care
  - Providers understand what it takes financially to provide high quality care to members. Providers can conduct their own analysis on their billing patterns to identify trends.
  - Providers should include both clinical leadership and administrative leadership (such as CEO and CFO) in partnerships. CFOs may have meaningful insight on the bullet above.

Where do VBP programs come from?

These are specific performance goals set for healthcare providers within a particular geographic area. The targets are usually based on the health needs of the population in that region and aim to improve the quality of care provided. They are often aligned with broader state or national healthcare objectives (such as HEDIS®) and serve as benchmarks for assessing provider performance within a VBP program.

This involves the systematic examination of data collected from healthcare providers to evaluate performance, identify trends, and drive decision-making. In VBP programs, data analysis is essential for monitoring provider compliance with quality targets, assessing patient outcomes, identifying areas for improvement, and informing policy or program adjustments.

These refer to evidence-based medical practices and treatment guidelines that are recognized as the most effective and efficient methods to achieve optimal patient outcomes. In the context of VBP programs, clinical best practices guide healthcare providers in delivering high-quality care while maximizing resource use, thus contributing to improved patient outcomes and cost savings.

These are collaborations between providers, Primary Contractors, MCOs, and other stakeholders, aimed at achieving common goals within a VBP program. Effective provider partnerships facilitate coordinated care, shared resources, and collective efforts to meet quality targets, improve patient outcomes, and reduce costs.

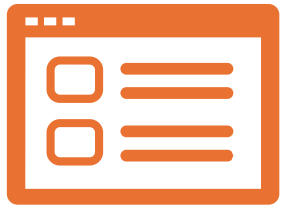
Where can data come from?

Claims

Authorizations

Surveys

Assessments



Provider Self-Report

(billing reports, service utilization reports, etc.)

Thriving in a VBP environment

Understand VBP foundations

- VBP arrangements work to improve quality of services by focusing provider attention on interventions that are demonstrated to improve outcomes
- As a result of this quality improvement, VBP arrangements aim to reduce cost of care
- Evidence-Based Practices are often the foundation of VBP arrangements because they are studied & proven to effect change

Be an empowered Provider

- Be attentive to EBP used within your agency → ***Can they be used to create VBPs with payers?***
- Pay attention to the data shared by payers or data you can access within your agency

The results

- Culture of communication between payers and providers → ***share feedback!***
- Improved outcomes for members
- Infrastructure of treatment that is focused on outcomes while still financially supporting providers

What does the Commonwealth/OMHSAS look for in MCO VBP Programs?

Complex Approval Process for VBP Arrangements

- **Primary Contractors and BH MCOs must navigate a complex process to obtain approval from the Commonwealth for each VBP arrangement. Key considerations for approval include:**

- Reporting, monitoring, and cost requirements
  - Sophisticated data and outcomes reporting mechanisms are required for each individual provider VBP. Arrangements must demonstrate cost savings or cost neutrality to be viable (must be able to project a concrete number using historical data).

- Variability in service delivery goals
  - Primary Contractors have different service delivery goals based on their assessed local needs. This means that an arrangement that gets approved in one region may not be 100% transferrable to another region.

- Primary Contractors are required to engage a certain percentage of funding in VBP arrangements, requiring focus on larger providers and provider systems

- Primary Contractors are required to operate a certain percentage of medium and high risk arrangements, limiting the ability to enter into low risk or Performance Based Contracting arrangements

- Most models are required to incorporate a tie to improving Health Related Social Needs (previously known as Social Determinants of Health), particularly through the use of HRSN providers called Community Based Organizations (CBOs)

How can providers engage now?

Connect with Stakeholders

- Attend webinars hosted by OMHSAS / the Commonwealth to learn about VBP and how providers can be supported in building VBP strategies
- Connect with associations such as RCPA to hear from other providers who have successfully launched VBP strategies with MCOs and share feedback/lessons learned from your own experience building VBP strategies
- Identify a contact at the Behavioral Health Managed Care Organization that can answer questions about VBP or provide more information about launching a VBP strategy