NATCON25

May 5-7 • *Philadelphia*

NATIONAL COUNCIL
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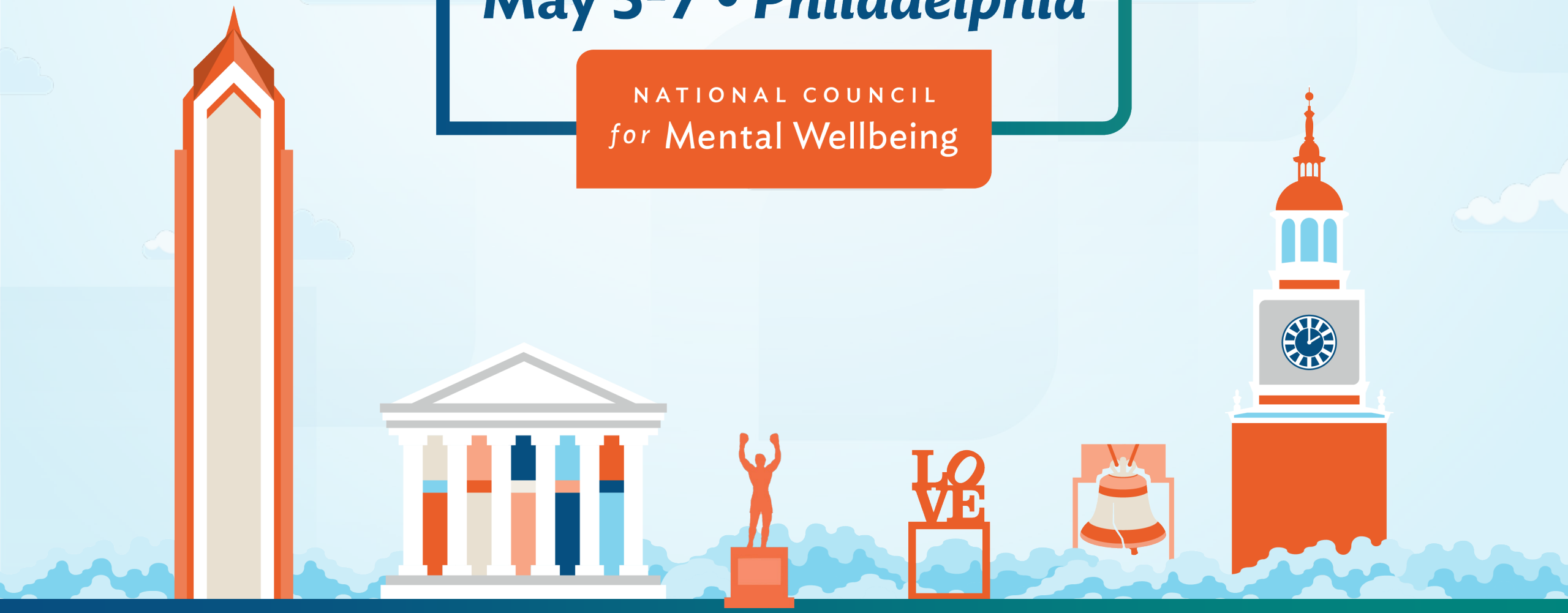


NATCON25 Philadelphia
NATIONAL COUNCIL for Mental Wellbeing

Value Based Payment Strategies In Publicly Funded Behavioral Health

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services (OMHSAS)

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mercer

Value Based Payment Strategies In Publicly Funded Behavioral Health

Peter D. Liggett, PhD
Principal & Licensed Psychologist
Mercer Government

- Licensed Clinical Psychologist.
- Consultant to several state Medicaid and human services agencies.
- Focusing on behavioral health, benefits design & modernization, integrated care models (e.g., CCBHC), alternative payment models, and workforce issues.

Jocelyn M. Maddox
Director, Bureau of Quality Management & Data Review, Pennsylvania — Office of Mental Health & Substance Abuse Services

- OMHSAS is within the PA Department of Human Services which administers the Medicaid program.
- Jocelyn manages a team of over 40 professionals.
- The bureau administers OMHSAS' value-based payment and quality management strategies and handles complaints, grievances, clinical reviews, and systems management for Medicaid recipients.

Charlotte Carito, LMHC, BC-DMT
Sr. Principal, Federal Health Practice Leader
Mercer Government

- Licensed Mental Health Counselor with over 20 years of experience.
- Consultant to several state Medicaid agencies and federal programs.
- Background includes leadership roles with state government, managed care, hospital systems, and direct clinical experience.
- Expertise in health policy, system redesign/innovation, payment reform, value-based payment strategies, and managed care design and implementation.

Nothing to Disclose

Agenda

1. The Pennsylvania Story
2. Current State of OMHSAS Value Based Purchasing (VBP) Program and How We Got Here
3. Key Components of Behavioral Health (BH) VBP Success
4. The Next Frontier of BH VBP

The Pennsylvania Story

1

Steady Persistence

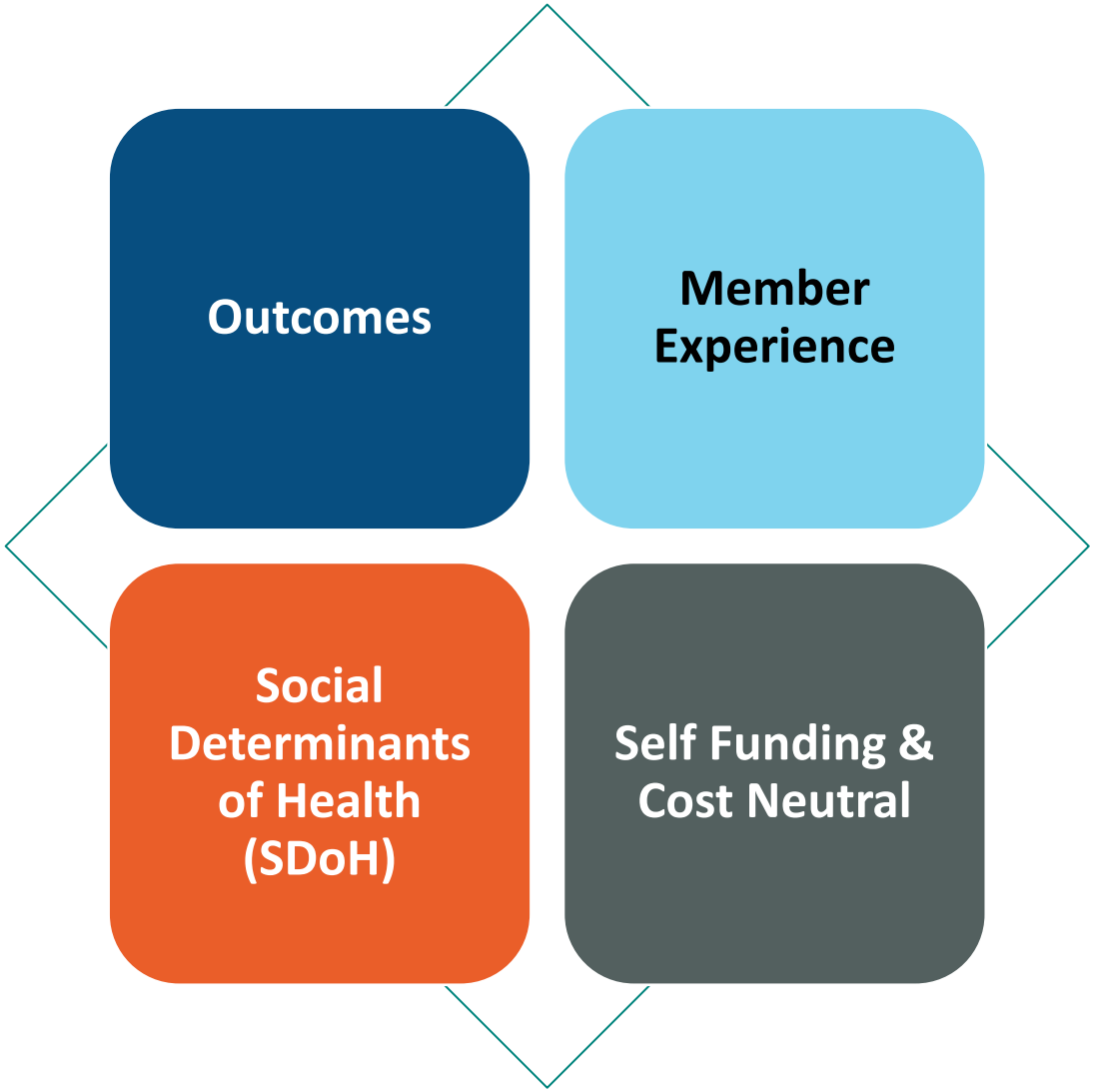
A course of action, a purpose, a state, etc., especially despite difficulties, obstacles or discouragement.

The Commonwealth's Quality Commitment

- CMS, per regulation 42 CFR § 438.340(a) and 42 CFR § 457.1240(e), requires states to have a managed care quality strategy (MCQS) for their managed care programs.
- DHS embeds quality improvement activities throughout its cross-cutting programs, operations, and strategic initiatives.
- State initiatives that support MCQS goals and objectives include:
  - Value-based Purchasing
  - Integrated Community Wellness Centers (ICWCs/CCBHC)
  - Initiatives that address SDOH including Community-Based Care Management (CBCM) and those embedded in the ICWC and VBP models
  - Integrated Care Plan (ICP) Program
  - Community-based organization (CBO) partnering
  - CMS-approved Directed Payments that support the advancement of the Commonwealth's goals and objectives (including ICWC payments)

Best in Class Program Evolution

- OMHSAS is a Best-in-Class example of how to start, maintain, and grow VBP in the behavioral health continuum of care.
- The Steering Committee developed four domains to drive focus and intent in the VBP program.
- These are still relevant today.



The Commonwealth's VBP Timeline

2017

Environmental scan to begin engaging BH system in VBP

Establishment of Behavioral Health – Managed Care Organization (BH-MCO) contract requirements for VBP

Specific VBP arrangement levels are established.

2018

OMHSAS begins training and technical assistance with stakeholders

Establish a statewide VBP Steering Committee

Submission of first VBP plans to OMHSAS. Established as an annual submission for new or changed VBP models

2019

BH VBP models launch across the state, $493M in VBP spend; 78% of this was performance-based contracting

VBP Steering Committee Consensus Document Issued: *Commonwealth of Pennsylvania Steering Committee for Standardization of Behavioral Health (BH) Value-Based Payment*

Standardized performance measures across four domains (outcomes, member experience, social determinants of health, cost)

Statewide *BH Value Based Purchasing: Supporting Whole Person Care* Conference

The Commonwealth's VBP Timeline

2020

- Steering Committee begins to identify standardized measurement approach coined "Transitions to Community"
- All Primary Contractors have at least one VBP arrangement targeting inpatient psychiatric care
- Draft *Transitions to Community VBP Approach* released to Steering Committee
  - Created a structure for standardized performance measures to better support care transitions from inpatient psychiatric hospital discharge to community-based services across the entire healthcare system.
  - Designed to begin understanding how natural pathways of care could possibly structure standardization of attribution for VBP arrangements.
    - Phase I - Standardized performance measures tied to payment for IP providers and data collection and reporting for outpatient (OP), Behavioral Health Home Programs (BHHP), and Case Management providers

The Commonwealth's VBP Timeline

2021

Phase I of Transitions to Community rolls out across 4 program types using FUH for Mental Illness measure and REA within 30 days of IP Psychiatric Discharge

CBO requirement added to BH-MCO contracts

OMHSAS issued statewide VBP Readiness Assessment Survey to providers

2022

VBP Web based Monitoring Tool is developed and deployed to make submitting proposals and communicating between OMHSAS and BH-MCOs easier.

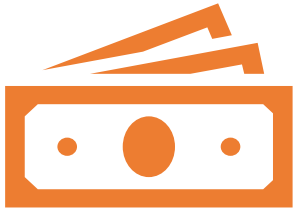
Dashboards are created to monitor statewide program.

The Commonwealth's VBP Timeline

2023

OMHSAS recognizes the synergy between the Community Based Care Management(CBCM) program and its VBP efforts.

Continued post-pandemic growth in the program



2024

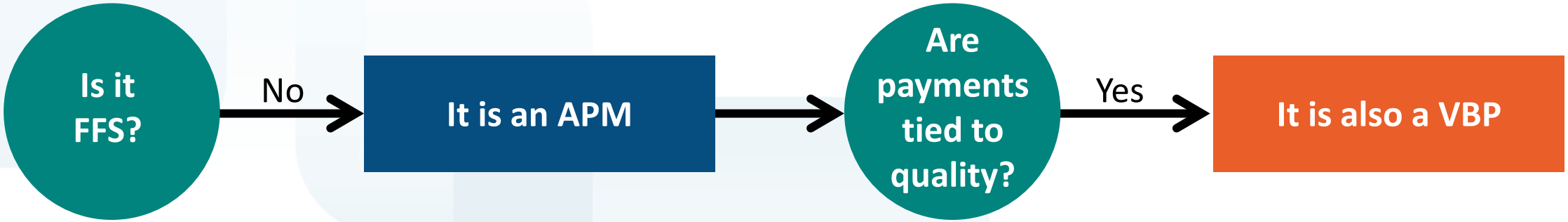
BHMCOs are required to have 30% of BH medical spend tied to VBP arrangements with 15% of total spend tied to shared savings or higher risk models

$1.6B in total VBP spend through 155 VBP models

What is an Alternative Payment Method (APM)?

An alternative payment model or APM is any payment model/program that does not use the traditional fee-for-service (FFS) to pay providers. These models may or may not include the payment being tied to quality.

How can you tell if a payment is *Alternative* and/or *Value-Based*?



- Alternatives to traditional FFS provider payment model
- APMs are not necessarily tied to quality/value
- Most purchasers use the Health Care Payment Learning and Action Network (HCPLAN) continuum as a guide for their APMs

- Payment must be tied to appropriate outcome measures
- Risk sharing between payers and providers is often involved but many providers are NOT equipped to take on risk
- VBP is more likely to result in quality improvement and improved patient satisfaction than cost savings

Changing the way payment is made does not automatically change the way services are delivered

HCPLAN APM Categories

	Category 1 Fee-for-Service with No Link to Quality and Value	Category 2 Fee-for-Service Link to Quality and Value	Category 3 APMs Built on Fee-for-Service Architecture	Category 4 Population-Based Payment
Definition	Utilizes traditional fee-for-service payments that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics.	Utilizes traditional fee-for-service payment but these payments are then adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics.	Payments are based on cost performance against a target, irrespective of how benchmarks are established, updated, or adjusted. Payments are also structured to encourage providers to deliver effective and efficient care.	Payments are structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care.
Payment Type(s)	• **Fee-for-Service**	• **2A –** Foundation Payments for Infrastructure and Operations (example: care coordination fees) • **2B –** Pay-for-Reporting (example: incentives for reporting data or penalties for not reporting • **2C –** Pay-for-Performance (P4P) (example: incentive payments for quality performance)	• **3A** – APMs with Shared Savings (example: shared savings with upside risk only) • **3B** – APMs with Shared Savings and Downside Risk (example: episode-based payments for procedures and comprehensive payments with upside and downside risk) • **3N** – Risk Based Payments NOT Linked to Quality*	• **4A** – Condition-Specific Population-Based Payment (example: per member per month payments) • **4B** – Comprehensive Population-Based Payment (example: global budgets or full/percent of premium payments) • **4C** – Integrated Finance and Delivery System (example: global budgets or full/percent of premium payments in integrated systems) • **4N** – Capitated Payments NOT Linked to Quality*

OMHSAS VBP Level	HCPLAN Category
L1	2B and 2C
M2	3A
M3	3B
M4	4A
H5	4B

3N and 4N are not allowable models in the OMHSAS program.

For examples, see Section 5.

Current State of OMHSAS VBP Program and How We Got Here

2

VBP Contract Requirements — High-level Overview

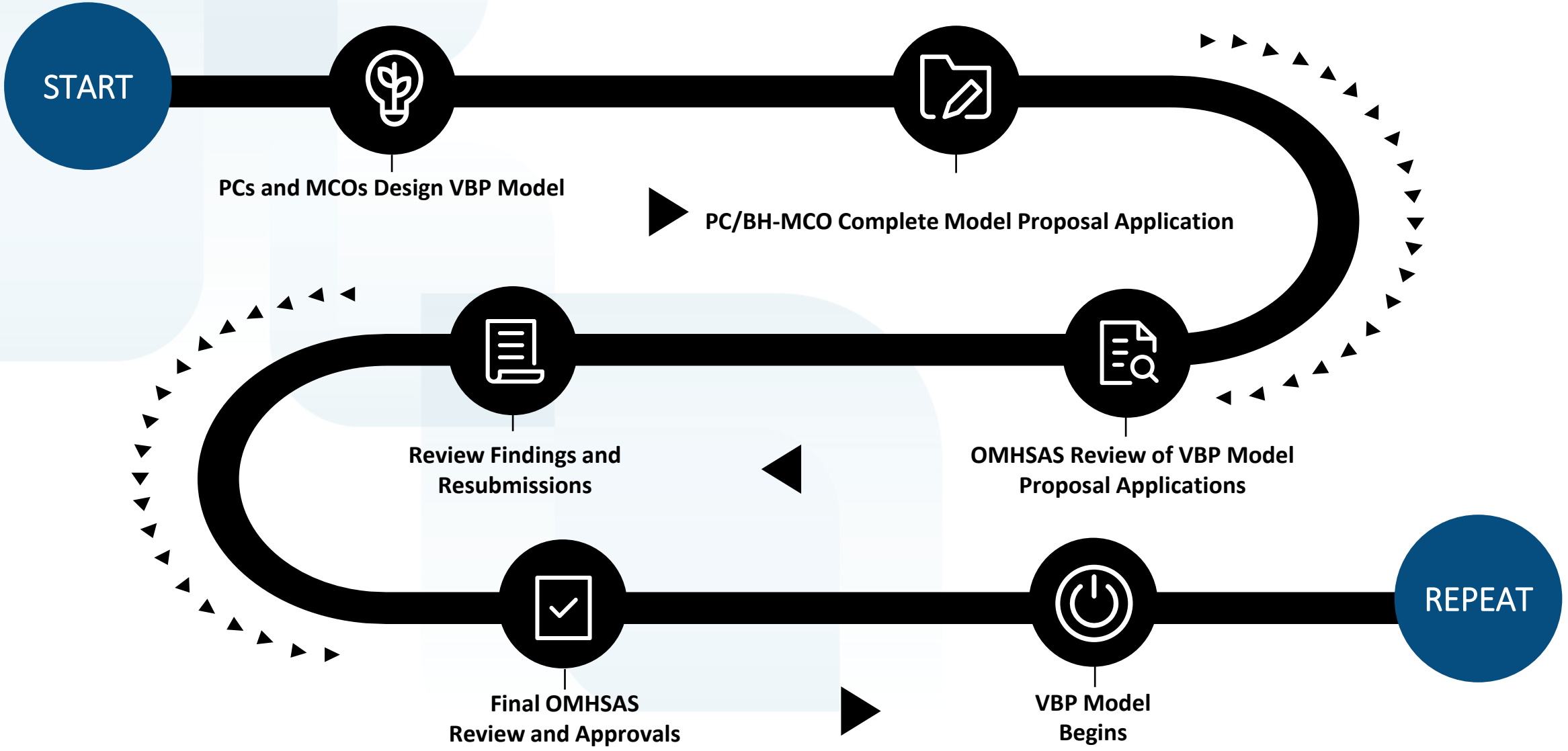
Program Standards and Requirements — Appendix U of Annual BH-MCO Contract

- The Primary Contractor (PC) and its Behavioral Health-Managed Care Organization (BH-MCO) must enter into VBP Payment Arrangements with Providers that incorporate approved VBP Strategies (L1, M2, M3, M4, H5).
  - OMHSAS will review all models and provide approval.
  - Transition To Community is the only required model.
- Calendar Year 2024 Requirements:
  - **30%** of the *total medical expenses* must be expended through *VBP strategies.*
    - Only approved models will count towards the VBP medical spend requirement.
  - At least **50%** of the **30%** of *total medical expenses* (15%) must be from a *combination of medium or high financial risk payment strategies.*
  - **85%** of VBP medical spend for strategies that are *medium and high risk* must incorporate one or more Community-Based Organizations (CBOs) that together address **two or more** SDoH domains.

Required Yearly Submissions:

- VBP Proposed Models
  - (New Models or Updates to Models, including Discontinuance)
- Actual Spend Submission
  - VBP Provider Spends, Total Medical Spend, Total VBP Spend
- Outcomes and Accomplishments
- Exception Request (If Applicable)

Lifecycle of a VBP Model Submission



Model Distribution

Models

Spends

CBO & SDoH

2021	2022	2023	2024*
Total # of Proposals 134	Total # of Proposals 128	Total # of Proposals 144	Total # of Proposals 155
Total # of Approved 89	Total # of Approved 122	Total # of Approved 133	Total # of Approved 80
Total # of Not Approved 45	Total # of Not Approved 4	Total # of Not Approved 1	Total # of Not Approved 2
	Total # of Discontinued 4	Total # of Discontinued 10	Total # of Discontinued 26

Approved Models by Strategy Level

	L1	M2	M3	M4	H5
2021	42	23	13	10	1
2022	49	45	12	16	0
2023	60	44	12	17	0
2024*	50	21	2	7	0

BH VBP Spend since 2021

Models

Spends

CBO & SDoH

	2021	2022	2023	2024*
Projected	Total VBP Spend $966.9M Average Spend per Model $7.2M Average Spend per Arrangement $613.9K	Total VBP Spend $1.61B Average Spend per Model $13.9M Average Spend per Arrangement $486.9K	Total VBP Spend $1.55B Average Spend per Model $10.38M Average Spend per Arrangement $477.1K	Total VBP Spend $1.6B Average Spend per Model $10.2M Average Spend per Arrangement $598.7K
Actual	Total VBP Spend $1.1B Average Spend per Model $11.8M Average Spend per Arrangement $670.8K	Total VBP Spend $1.6B Average Spend per Model $12.5M Average Spend per Arrangement $554K		

CBO Involvement with VBP

VBP Performance Measures

- Any quality measure can be used in the OMHSAS VBP program to evaluate the model. OMHSAS has performance measure categories that are flagged in the VBP model proposals. The categories include:
  - Follow-Up After Hospitalization
  - Inpatient Readmission Rates
  - Admissions to Higher Levels of Care
  - Service Intensity, Duration, or Engagement
  - Standardized Assessment Tool
  - Cost Savings or Benchmarks
  - Consumer or Family Satisfaction
  - Fidelity Assessment
  - Support Engagement (Family/Natural)
  - Staff Training or Retention
  - Physical health or Primary Care Provider Utilization
  - Other

**Calculation based on industry standard codes used in HEDIS®*

Challenges in Measuring VBP Outcomes

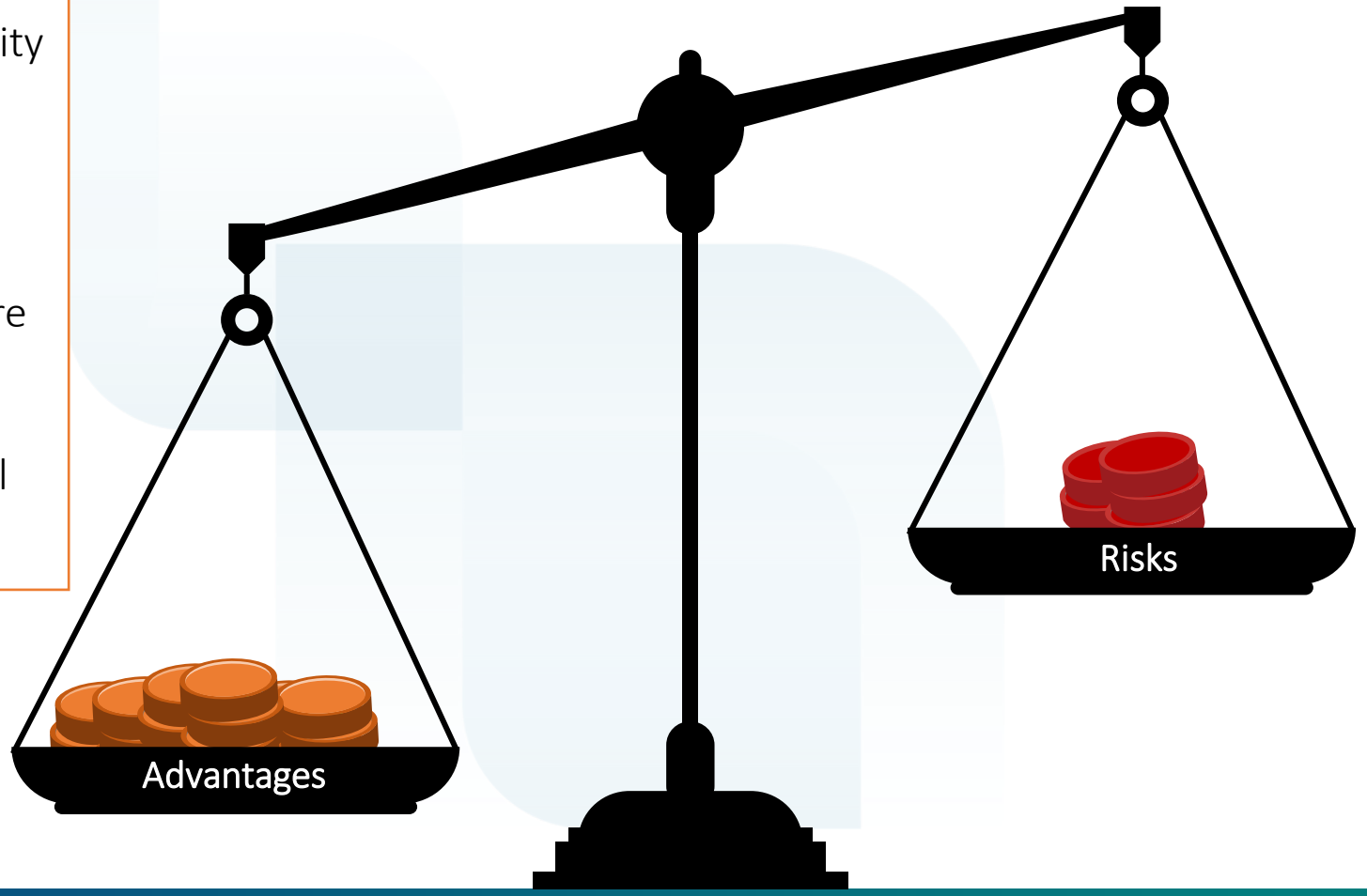
- Often rely on generic, already collected health care quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS®) measures.
  - HEDIS® may not be relevant to the population being served or the target issues that need to be resolved for better health and therefore a poor indicator of performance.
  - Measure sets like HEDIS® do not often include functional outcome measures (i.e., measures do not capture how the person is functioning in their daily life. The measures focus on clinical indicators and their results may or may not indicate an improvement of function or quality of life.
- Many factors impact outcomes.
  - It can be difficult to tease out the effect of any individual VBP program.
- Usually, no comparison population when an VBP program is implemented. This makes it difficult to determine statistical significance of results.
- Size of payment incentives or VBP population is often small.
  - It may not change behavior and therefore impact may be minimal.
- There is a substantial lag for the data required to assess impact, such as data on avoiding admissions and readmissions.

APM Performance Measurement

Benefits vs. Risks

Benefits:

- Incentivize high-quality care
- Achievement of positive health outcomes
- Improved patient care experiences
- Improved management of total cost of care



Risks:

- Measures may be tied to economic incentives that lead to underutilization of care or harm from over-treatment
- Measures may not be relevant to the health condition or alternative payment model
- Data may be poor, leading to incorrect assessments of performance

Transitions to Community Outcomes and Accomplishments

Measures

- OMHSAS has two sets of indicators that are used to assess follow-up and readmissions
  - NCQA's HEDIS® Follow-up Indicators
    - Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge*
    - Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge*
  - Pennsylvania (PA)-specific Follow-up Indicators
    - Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge
    - Follow-Up After Hospitalization for Mental Illness Within 30 Days after Discharge
    - 30-day Readmissions Following Acute Inpatient Psychiatric Stay

Outcomes & Accomplishments

- 138 active models with 63 P4P (L1) models, 46 Shared Savings (M2) models, 12 Shared Risk (M3) models, and 17 Bundled Payment (M4) models.
- Over 160,000[1] members were attributed to VBP models.
- A total of $1.55 billion was spent on VBP models (projected spend of $1.39 billion).
- Of the 87 models where savings was reported, an estimated $47,877,711.04 was saved.
- 1,197 unique providers participated in the program amongst 2,188 arrangements.

OMHSAS and SDoH

For patients to not only access care but be successfully treated they need more than just insurance and doctors. OMHSAS targets eight SDoH domains. VBPs within the OMHSAS program are expected to tackle at least two or more SDoH within each model.

OMHSAS VBP SDoH Domains

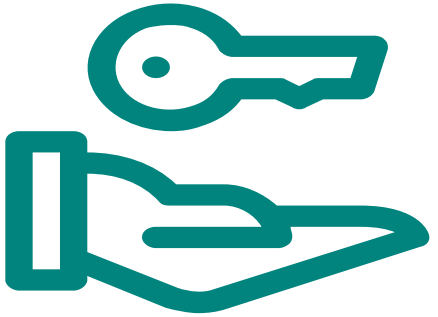
CBOs and SDoH

- CBOs can help provide the resources that health care providers are not able to.
- VBP arrangements can leverage the foundation that a CBO has built by providing CBOs additional funding to support the goals of the arrangement.
- OMHSAS requires CBO participation in specific VBP arrangements.
- Partnering with CBOs provides a more cohesive network to meet patients needs and improve the value of care while simultaneously reducing cost.

Leveraging Multiple Initiatives for Better Outcomes

- Community-Based Care Management (CBCM) program began in Behavioral HealthChoices in 2021 with requirements for BH-MCOs and counties to develop programs to engage high-risk members with the goals of improving care coordination and increasing use of preventive care to improve behavioral health outcomes and reduce disparities.
- The CBCM program focuses on integrating physical health care with behavioral health services, ensuring that individuals receive holistic support.
- CBCM emphasizes the use of quality indicators to monitor and improve care delivery, which is part of a broader initiative to advance primary care innovation within the Medicaid-managed care framework.
- OMHSAS intentionally focuses on the synergy between CBCM and VBP.

Key Components of BH VBP Success



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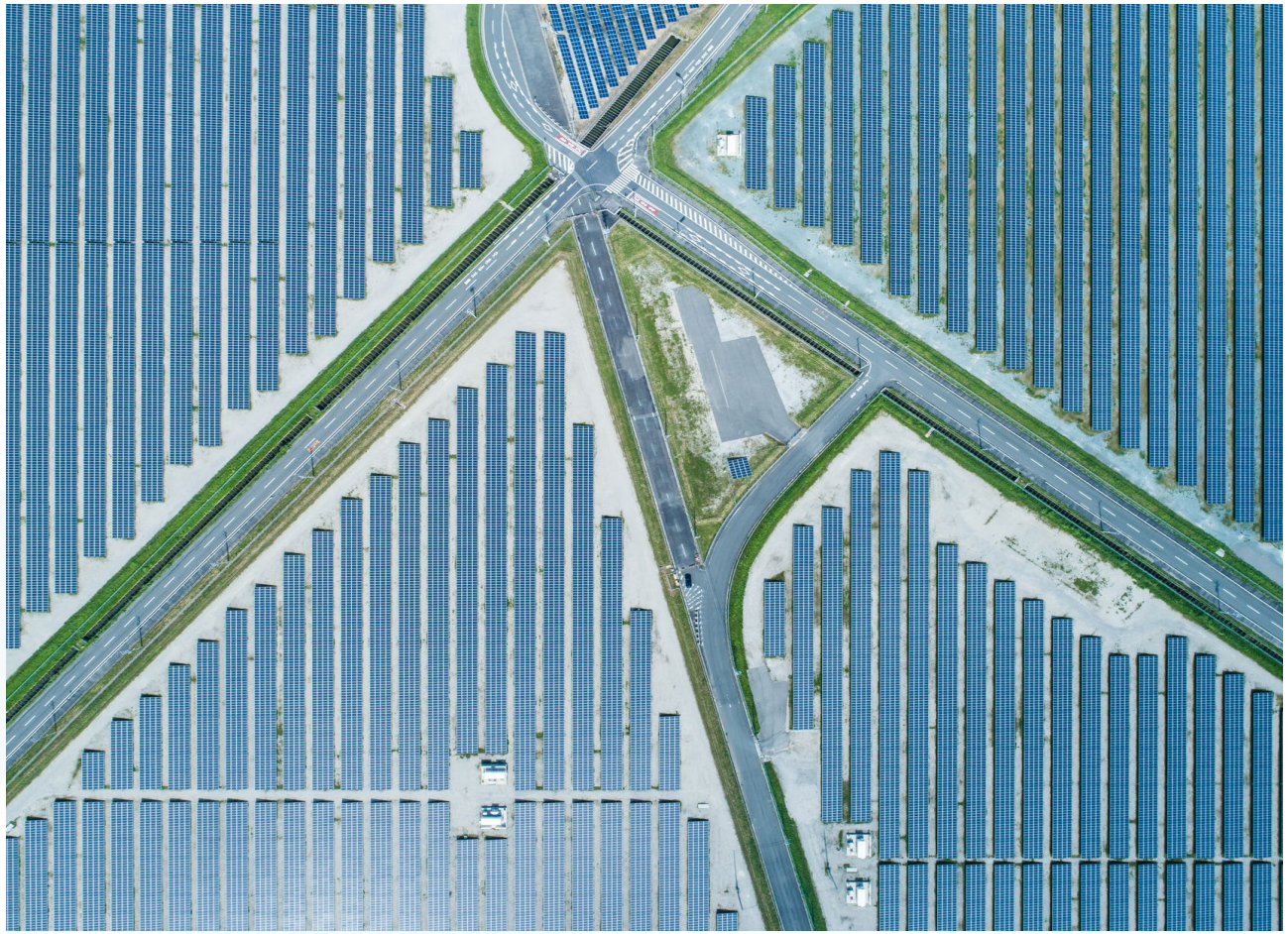
Working Together

- Form a Steering Committee with Cross Stakeholder Engagement
- Coordinate with the provider trade association
- Create a transparent Proposal Review Process (including high level of what is collected)
- Over communicate
- Anticipate points of failure
- Establish feedback touch points on proposal findings, implementation challenges and success. The devil is in the details.
- Respond to Providers identifying impasses with MCOs so the state can support the movement toward value

Managing Expectations

The Next Frontier of BH VBP



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BH VBP — The Next Frontier Systems

Working Across Publicly and Commercially Funded Populations

When in doubt continue to:

- Integrate BH at all levels of care
- Push the development of metrics to measure what people value — wellbeing, quality of life, engagement, reduction in chronic-acute episodes
- View BH as equally important as physical health
- Share engagement strategies that can also work with PH conditions

BH VBP Provider and Payer Network Strategies

Cross-Payor Opportunities Across Populations

Explore capacity building arrangements with other payors, including Medicare, Commercial, TRICARE, and Veterans Community Care

Begin to think about how to offer specialty BH services that other populations will benefit from too.

Case Management	Peer Services	Employment Services	Psychiatric Rehabilitation	Assertive Community Treatment Services	Medication-Assisted Treatment	Substance Abuse Rehabilitation	Crisis Services	First Episode Psychosis Programs

BH VBP Provider and Payer Network Strategies (Cont.)

TRICARE — Active Military and their Families, Retirees, Reservists (9.6 Million Beneficiaries)

- Military health has two delivery systems that beneficiaries can access care. The direct care or Military Treatment Facilities (MTFs) and the purchase care system. The TRICARE purchase care system (Humana and TriWest) is most people and BH providers are familiar with.
- TRICARE beneficiaries can access care in either delivery system.
- Medicaid serves as a critical safety net for military families. An estimated 850,000 people enrolled in Medicaid have TRICARE as their primary source of coverage.
- Approximately one in ten children (10 percent) of active-duty service members with TRICARE also have Medicaid coverage.
- Research suggests military families are more likely to have children with special health or mental health needs compared to the civilian sector.
- Medicaid's key pediatric benefit has its roots in ensuring the nation's military readiness. A 1964 White House study showed high rates of military draftees were disqualified from service due to preventable conditions during childhood, which led to the development of Medicaid's pediatric standard of care, known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
- TRICARE 5th Generation was launched January 1, 2025, modernizing payments to providers using VBP in demonstrations.
  - This includes all levels of risk arrangements.
  - Focus on chronic conditions and BH.
  - Focus on advanced primary care models.

https://ccf.georgetown.edu/2025/01/27/medicaids-role-for-military-families/

BH VBP Provider and Payer Network Strategies (Cont.)

Community Care Plan — Approx. 9 Million Veterans with 5.6 Million Accessing Care

- Veterans Health has two delivery systems to access care. The VA system and the community care system. The community care system is what we know as the provider, civilian or purchase care network. The community care system is the system most people and BH providers are familiar with.
- Veterans can access care in either delivery system.
- Mental health care accounts for about 5% of community care spend. This increase has been significant over the past four fiscal years.
- VA continues to focus efforts and promote clinical and business models that address PTSD, suicide, homelessness, employment, and other paths to recovery.

VA | Serving America's Veterans Trust Report
Red-Team-Executive-Roundtable-Report.pdf

BH VBP — The Next Frontier Systems

Working Across Publicly and Commercially Funded Populations

When in doubt continue to:

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2. Push the development of metrics to measure what people value — wellbeing, quality of life, engagement, reduction in chronic-acute episodes
3. View BH as equally important as physical health
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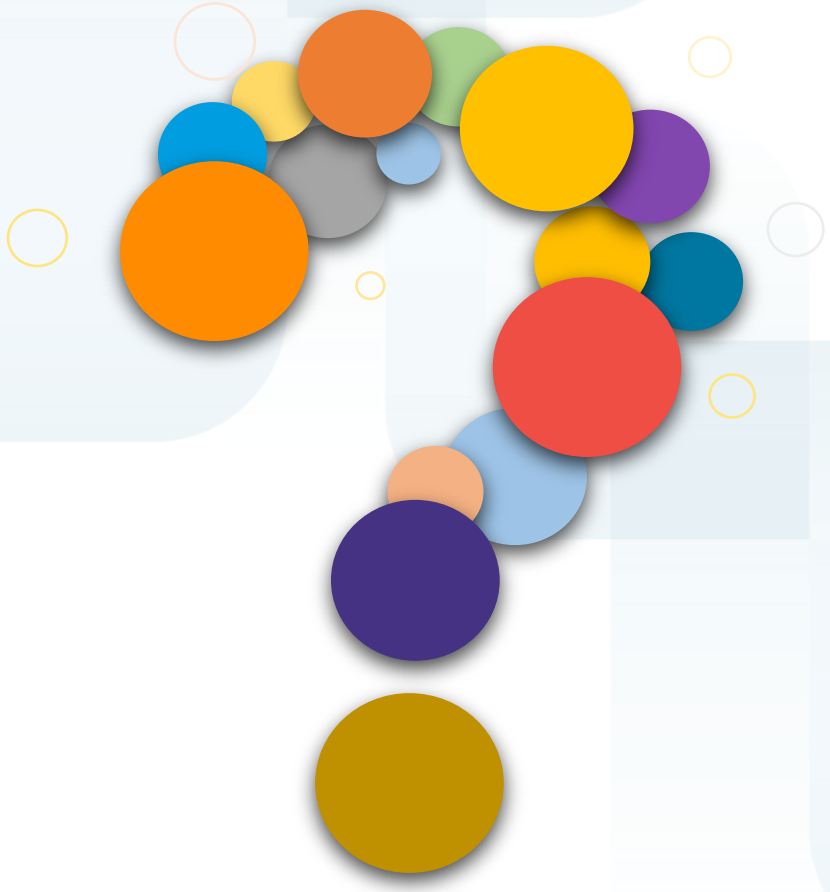
Questions and Closing



Thank you for attending today's workshop!

Should you have any questions regarding today's content, please reach out to Mercer. (charlotte.carito@mercer.com and peter.liggett@mercer.com)