MERCER
MAKE TOMORROW, TODAY

VALUE-BASED PURCHASING PLAN

November 17, 2017

Primary Contractor		**Submission Date**	
BH-MCO		**Effective Date**	
OMHSAS Reviewer		**Review Date**	

BACKGROUND AND INSTRUCTIONS

This document serves as the Primary Contractor(s) (PC) and Behavioral Health Managed Care Organization (BH-MCO) Value-Based Purchasing (VBP) proposal and the Office of Mental Health and Substance Abuse Services (OMHSAS) evaluation tool. The PC and BH-MCO will utilize their experience each year to update the VBP plan. The following schedule will apply and is based on the Primary Contractor (PC)'s Contract Year (CY) cycle:

DELIVERABLE	CY = CALENDAR YEAR CYCLE (JAN 1–DEC 31)	CY = FISCAL YEAR CYCLE (JUL 1–JUN 30)
Initial submission of VBP Plan.	January 1, 2018	April 1, 2018
Submission of updated VBP Plan describing plans for upcoming CY.	October 1, 2018 and annually thereafter	April 1, 2019 and annually thereafter
Annual submission of actual VBP arrangements to support evaluation of previous year's outcomes.	June 30, 2019 and annually thereafter	December 31, 2019 and annually thereafter

MARSH & McLENNAN COMPANIES

The annual summary for evaluation against contractual requirements is based on at least three months of run-out claims and includes the following:

- A review of the accomplishments and outcomes from the prior contract year;
- A report on the percentage of medical expenses expended through VBP strategies and the associated levels of financial risk; and
- A VBP detail report by provider that identifies the following:
  - Level of financial risk (i.e., no, small, moderate, large) and dollar amount spent for medical services expended;
  - VBP payment model(s) used (i.e., performance-based contracting, bundled and episodic, shared savings, shared risk, capitation, capitation plus performance-based contracting);
  - Program type(s) included, such as Federally Qualified Health Center, Certified Community BH Clinic, Assertive Community Treatment (ACT) and BH Homes, if applicable; and
  - Evidence-based Practices and Programs involved.

This document is organized into two sections:

Section A

Section A questions are about your general strategy and plan. The purpose of Section A is to provide a high level of summary of your plan with a longitudinal view across the three year timeframe.

Section B

Section B questions are initiative specific; each target area (e.g., population(s)/service(s)) should have its own interventions, performance measures (PMs) and reimbursement strategies. The purpose of Section B is to gather more detail about why each target area was selected and to better assess plans for ensuring successful implementation, monitoring and impact. Unless otherwise noted, Section B responses can be focused on the initiatives for the upcoming year.

SECTION A — VBP STRATEGY AND PLAN

1. The attached Excel workbook contains four tabs:
   A. **Instructions:** This tab includes detailed instructions for completing the remaining three tabs. Please read this section carefully.
   B. **Baseline VBP:** The Baseline VBP tab summarizes VBP arrangements implemented in CY2017. For Contractors on a Calendar Year contract cycle, this tab summarizes January 1–December 31, 2017 activities. For Contractors on a Fiscal Year contract cycle, this tab summarizes July 1, 2017–June 30, 2018. Please complete this tab for the initial submission of the VBP Plan.
   C. **Planned VBP:** The Planned VBP tab summarizes planned initiatives by provider/agency to be implemented in CY2018 (i.e., January 1–December 31, 2018 or July 1, 2018–June 30, 2019, depending on the Contractor's contract cycle). Please complete this tab for the initial submission of the VBP Plan.
   D. **Actual VBP:** The Actual VBP tab reports results on actual VBP arrangements implemented in CY2018. Contractors will complete this tab as part of the Annual Submission of Actual VBP Arrangements (i.e., June 30, 2019 or December 31, 2019).

EVALUATION CRITERIA A.1
1. The Baseline VBP tab in the Excel tool is completed correctly.
2. The Planned VBP tab is completed correctly and the VBP Plan clearly outlines the following:
A. Providers/agencies anticipated to participate in VBP arrangements in CY2018.
B. Targeted populations and/or services included in VBP arrangements each year.
C. The amount of medical spend that each VBP arrangement contributes to the overall VBP plan for each year.
D. Total Expected Primary Contractor Medical Spend for each year.
E. Confirmation/attestation that the same dollars are not counted twice in any given year.
3. A feasible phased-in approach of target population(s)/service(s) and VBP models that reflect progressive movement toward more advanced VBP models over time.
4. The projected percent medical spend for each VBP model and in total across the all VBP models aligns with target percent in framework (See Attachment 1).

OMHSAS DETERMINATION		
Met	**Not Met**	**Required Action(s):**
☐	☐	

2. Provide an implementation plan that addresses each of the elements in the evaluation criteria using a format similar to Table A.2 below.

TABLE A.2: IMPLEMENTATION PLAN

MILESTONES AND SUBTASKS	LEAD	START DATE	END DATE	% COMPLETE	COMMENTS
Year 1					
Milestone 1					
Subtask 1					
Year 2					
Etc.					

EVALUATION CRITERIA A.2

1. The implementation plan clearly outlines detailed milestones and associated tasks for CY2018 as well as those necessary to achieve the three year goals.
2. Timelines and responsible parties are identified for CY2018.
3. Provider outreach and engagement allows for provider input to VBP design, including target population(s)/service(s), metric selection and calculation, interventions, etc.
4. Provider selection, education and technical assistance to support VBP readiness are evident.
5. Performance metrics including selection, specifications, calculation of baseline performance, setting target threshold performance and re-calculation of performance against target are addressed.
6. Financial management, including defining the method and associated timing for calculating incentives, penalties, shared savings, etc. under each VBP model, overall cost neutrality/savings, etc. and administering payment are included.
7. Annual performance review of current year VBP initiatives with corresponding updates to the VBP Plan for the remaining years is addressed.
8. High level milestones for VBP expansion in each subsequent year, including submission of updated VBP plan based on prior year VBP evaluation is included.

OMHSAS DETERMINATION

Met	Not Met	Required Action(s):
☐	☐	

3. Describe the planned collaboration with other PCs who have overlapping BH-MCOs or provider networks to achieve the targets specified in OMHSAS' VBP Framework, addressing each of the elements identified in the evaluation criteria.

RESPONSE

EVALUATION CRITERIA A.3
1. The description includes efforts at the PC and BH-MCO level to ensure that provider burden is reduced and that target population(s)/service(s) are coordinated to meet the specific Commonwealth of Pennsylvania VBP goals.
2. At a minimum, standard PMs are utilized across PCs and BH-MCOs for a single target area whenever appropriate and relevant to the VBP strategy, target population(s)/service(s) and goals.
3. PCs subcontracted with the same BH-MCO and shared providers are collaborating on specific initiatives, as appropriate to their geography.

OMHSAS DETERMINATION		
Met	**Not Met**	**Required Action(s):**
☐	☐	

SECTION B — VBP TARGET AREAS

4. Identify and describe the process for selecting target population(s) and/or service(s) (e.g., ACT, Integrated Care for Individuals with Serious Mental Illness) listed in the Excel tool. Please review the evaluation criteria for additional information about what to include. **Repeat the table below to provide a separate response for each target area**.

TABLE B.1: TARGET AREA DESCRIPTION	
TARGET AREA 1: (INSERT VBP TARGET AREA [e.g., ACT])	
ELEMENT	**DESCRIPTION**
Population/service area characteristics	
Data source and approach to identify population/ service	
Number of enrollees impacted	
Target area goals	
Planned interventions	
PMs	*[List and number PMs — e.g., 1. Seven day readmission rate using performance based contracting specifications,* *2. Substance Use Disorder initiation and engagement rate using HEDIS specifications.]*

EVALUATION CRITERIA B.1
1. The target area has the potential for moderate to high impact (e.g., patterns of over- or under-utilization that present a threat to health or functional status; the potential to impact health, functional status or satisfaction for a significant portion of enrollees; high-volume or high-risk conditions of the population served).[1]
2. There is a clinically sound and data driven process for selecting VBP target population(s)/service(s), interventions and performance indicators. The following were considered and addressed, as relevant:
A. Credible data sources have been identified.[2]
B. Affected enrollees can be clearly identified within the target population(s)/service(s) for measurement and attribution.
C. Data can be collected and analyzed through an automated data system to support inclusion of the entire population/service area or if the data must be collected manually, a credible sampling methodology is defined (i.e., HEDIS® sampling methodology for HEDIS® measures; probability/random sampling or non-probability sampling for non-HEDIS® measures, as appropriate).[3]
D. Attribution of improvement/gains/savings for members served by multiple providers.
3. The goals are clear, simple and stated in a way that supports the ability to determine whether the intervention has a measureable impact for a clearly defined population/service.
4. The interventions planned are clearly related to the goals of the PC.
5. Each VBP target area has one or more measures to track performance and improvement over a specific period of time.
A. The number and complexity of measures is reasonable to administer.
B. The measures look beyond simple process measures to address financial and/or clinical outcomes.
C. The measures are objective, clearly defined and can be expected to be reliable and valid indicators of the desired financial and/or clinical outcomes based on current clinical knowledge or health services research.

[1] High-risk conditions may occur for infrequent conditions or services or populations, including individuals with special health care needs, such as children in foster care, adults with disabilities and the homeless.

[2] Credible data sources include:
- Enrollment data on enrollee characteristics relevant to health risks such as age, sex, race/ethnicity, language, geography, disability or functional status;
- Claims data on utilization, cost, diagnosis or outcome information such as avoidable admissions, readmissions;
- Other data to the extent available or applicable such as survey data, grievance and appeals, adverse incidents, disenrollment, requests to change providers, outcomes assessment data using validated tools, public health reports, health registry data

[3] Probability sampling means leaving the selection of population units totally to chance and removing biased selection of study subjects. Probability sampling includes Simple Random Sampling, Systematic Random Sampling, Stratified Random Sampling and Cluster Sampling. Non-probability sampling uses specific characteristics of the study subject. An example would be a study of the performance of a group practice by sampling all the patients that were seen in that office on a specific day. Types of non-probability sampling include Judgment Sampling, Convenience Sampling and Quota Sampling.

EVALUATION CRITERIA B.1
D. By year two, the target area incorporates recovery measures and indicators that assess total cost of care for more advanced VBP models.
OMHSAS DETERMINATION
Met ☐ **Not Met** ☐ **Required Action(s):**

5. Describe the financial arrangement(s) for the target population(s) and/or service(s) for VBP models (i.e., models 1 through 6) being implemented in the coming year. Please address each of the elements in the evaluation criteria. **Repeat the chart below for each VBP model utilized in each target area**.

TABLE B.2: VBP MODEL DESCRIPTION	
MODEL: (INSERT VBP MODEL NUMBER AND NAME [E.G., 2: BUNDLED & EPISODIC])	
ELEMENT	DESCRIPTION
Payment amounts	
Funding source	
Payment methodology	
Data needs and availability	
Operational Plan	

EVALUATION CRITERIA B.2
1. The VBP provider payment amount is contingent on achieving results.
2. The VBP payment models are proposed to be self-funded (i.e., paid for through expected savings in medical spend across providers based on the level of associated historical medical spend).
3. The payment methodology is adequately described and contains required elements, as applicable, including the minimum threshold for payout and the frequency of measurement/settlement.
4. Data needs to support the VBP reimbursement model design and updates are adequately described, including timelines and data sources.
5. Data for designing and updating the VBP reimbursement model is already available in sufficient quality or the proposal has established a realistic approach to producing data within the timeline to implement and evaluate the model.
6. There is an operational plan with realistic mechanisms to track financial and clinical outcomes for each VBP model within each target population(s)/service(s). The plan includes timely assessment and distribution of rewards.
OMHSAS DETERMINATION
Met ☐ **Not Met** ☐ **Required Action(s):**

6. Describe the process for selecting, engaging and assisting providers to move to more advanced VBP models. Please address:

- Your assessment of provider capabilities or readiness to participate in the target areas and VBP model for the coming year.
- The extent to which your current provider network has the capacity to move along the risk/reward continuum in the VBP framework to achieve quality outcomes and/or cost efficiency in this three year timeframe and any associated barriers or limitations.
- Planned education and technical assistance with selected providers on implementation of VBP strategies.

RESPONSE

EVALUATION CRITERIA B.3
1. There is an efficient approach to assessing clinical and financial readiness of providers that is not overly burdensome to providers, PCs, BH-MCOs and other involved parties.
2. Readiness assesses provider capabilities critical to the current year VBP model, including, as applicable:
A. Having electronic health records (EHRs).
B. Demonstrated clinical expertise to deliver evidence-based or best practice.
C. For providers targeted for more advanced VBP models, a track record of successfully monitoring and reporting on performance utilizing electronic means or a clear path to get them there.
D. For providers targeted for VBP models involving financial risk or withholds, the financial stability, resources and capacity to sustain the risk and/or challenges related to withholding a portion of their payment.
3. Readiness assesses barriers to expanding VBP that apply broadly across the network or to specific provider types or specialties.
4. The contractor describes specific training and technical assistance beyond contracting and written information to address gaps in readiness and/or barriers to expansion, including:
A. Resources needed to participate in VBP strategies (e.g., EHR and billing and monitoring system).
B. Informational and educational meetings.
C. Regular data sharing with providers with support in using the data to improve performance.
5. There are criteria for expanding the target population(s)/service(s) beyond a small group of large providers in a manner that will be cost-effective with good outcomes to scale.
A. There is recognition that smaller providers may be unable to move along a continuum of risk over time toward more advanced VBP models and allowance for remaining at lower levels of VBP models.
B. The PC has included criteria for the size of the provider volume that will support the VBP model selected and how that is sufficient to sustain any risk allocation to providers including:
i. Minimum case volume for a BH episode or bundled payment.
ii. Total client volume for a more advance risk sharing VBP strategy.

OMHSAS DETERMINATION		
Met	**Not Met**	**Required Action(s):**
☐	☐	

ATTACHMENT 1: HEALTHCHOICES BH VBP FRAMEWORK

CONTRACT YEAR	YEAR 1 (CY2018)	YEAR 2 (CY2019)	YEAR 3 (CY2020)
VBP Requirement	**5%**	**10%**	**20%**
VBP Models			
1. Performance-Based Contracting	Any combination of models 1–6.		
2. Bundled and Episodic		At least 50% of the 10% must be from a combination of models 2–6.	At least 50% of the 20% must be from a combination of models 2–6.
3. Shared Savings			
4. Shared Risk			
5. Capitation			
6. Capitation + Performance-Based Contracting			