

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

Abbreviations:

BH: Behavioral Health
CBO: Community-based organization
CPT: Current Procedural Terminology
DHS: Department of Human Services
HCPCS: Healthcare Common Procedural Coding System
MA: Medical Assistance
MCO: Managed Care Organization
MLR: Medical Loss Ratio
OMAP: Office of Medical Assistance Programs
OMHSAS: Office of Mental Health and Substance Abuse Services
PH: Physical Health
SDOH: Social Determinants of Health
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 moderate 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.

1. How does the Department define a CBO?

The definition of a CBO is in the definitions section of the BH Primary Contractor and MCO agreements. The agreement states that CBOs are “nonprofit organizations that work at a local level to improve life for residents and normally focus on building equality across society in many areas, including but not limited to access to social services. These organizations must also be registered as a 501(c)(3) nonprofit corporation in Pennsylvania. A health care provider is not considered a CBO.”

2. How do dollars flow to CBOs, thereby “incorporating” the CBO into a VBP arrangement?

Dollars can flow to CBOs to be incorporated into a VBP arrangement in a couple of ways. First, through a VBP arrangement money can flow to a Medicaid provider who, in turn, can contract with a CBO to address the social determinants of health for a patient population. Second, BH Primary Contractors and/or MCOs can enter into a vendor contract with a CBO, and the CBO can help mitigate social barriers for a patient population that is attributed to a provider engaged in a VBP arrangement. Third, the CBO can be incorporated into a shared savings arrangement with both the network provider and the BH Primary Contractor/MCO, such that the CBOs receives some of the shared savings if the total cost of care is reduced relative to a benchmark.

3. Is the CBO required to have a Promise ID for payment of services?

No, the CBO is not required to have a Promise ID for payment of services.

4. How will DHS monitor the incorporation of CBOs in VBP arrangements?

With regards to VBP, OMHSAS has added a new CBO component to its VBP reporting template so that BH-MCOs and BH Primary Contractors can report which CBOs are incorporated into which VBP arrangements with providers. OMAP is also looking to add similar reporting mechanisms. Additionally, DHS is examining whether a non-financial reporting mechanism makes sense as well to better judge the success of the program.

5. Does the payment to a CBO go through the payer's claims system? If so, what CPT/HCPCS codes is acceptable to DHS?

In some cases, payment will be made to a CBO through whatever vendor management/payment process the BH Primary Contractor or MCO has in place. In other cases, the CBO would be funded through a provider that is part of a VBP arrangement with the BH Primary Contractor or MCO, and so payment would not be going through a claims system. Neither of these cases will require CPT/HCPCS codes, so the Department will not be collecting them.

6. Where does the funding come from that can be used for vendor contracts with CBOs?

Dollars may come from the MCOs directly or through the network providers in the VBP arrangement with the BH Primary Contractor or MCO. BH Primary Contractors or MCOs can use their medical, administrative, or excess revenue dollars to contract directly with a CBO through a vendor contract. BH Primary Contractors and BH-MCOs may also use reinvestment funds, subject to the approval of OMHSAS.

7. Can funding for activities that address the social determinants of health be included in the numerator of the Medical Loss Ratio (MLR)?

Pursuant to 42 CFR § 438.8 (e), the numerator of the MLR includes incurred claims, activities that improve health care quality, and fraud prevention activities. As stated in 42 CFR § 438.8 (e)(3), if the payment for an activity that addresses a social determinant of health meets the requirements of 45 CFR § 158.150(b) and is not excluded under 45 CFR § 158.150(c), then it would be reported in the numerator of the MLR as an activity that improves health care quality.

8. Can funding for activities that address the SDOH be included in future managed care capitation rates?

Prospective managed care capitation rates are based on Medicaid-eligible state plan services and CMS approved in lieu of services. Value-add (or "in addition to") services are not allowed or included in prospective managed care capitation rates. Care management activities that improve health care quality, such as coordinating meals for members, may be reported by MCOs or BH

Primary Contractors as administrative costs, and thus included in prospective managed care capitation rates

9. Can the funds to CBOs be paid through the Community-Based Care Management Program?

Dollars may be paid to CBOs to perform the Community-Based Care Management services as specified in the PH and BH MCO agreements for 2021. However, if there is payment for a commodity that is not a Medicaid-eligible state plan service, such as room and board for housing, that commodity cannot be funded with community-based care management dollars.

10. Most of the CBOs that I currently work with are payer agnostic. Do they need to start tracking the payer to participate in this program?

Medicaid funding of VBP models can only be used for Medicaid eligible individuals. MCOs and BH Primary Contractors will need to work with CBOs to track services they are providing to MA eligible individuals as part of an agreement with the MCO or through a VBP arrangement with a Medicaid provider. DHS is aware that some CBOs have limited ability to track this data in which case the BH Primary Contractor or MCOs can consider arrangements that allow another partner to be responsible for tracking services provided to the MA eligible population by CBOs. For example, a hospital contracts with a CBO to provide food service upon discharge and the hospital tracks referrals and shares information with the CBO to better coordinate care and to support the contractual/financial arrangement with the CBO.

11. Do BH Primary Contractors or MCOs need to take the CBOs through a credentialing process? Does DHS currently credential CBOs?

For PH MCOs, the quality management and utilization management program must have standards for credentialing and recredentialing providers to determine whether physicians and other health care providers, who are licensed by the Commonwealth and under contract to the PH-MCO, are qualified to perform their services. Because CBOs do not provide medical services as a health care provider, credentialing is not required.

The 2020 BH Agreement requires that “the BH Primary Contractor or its BH-MCO must establish written credentialing and recredentialing policies and procedures. The BH Primary Contractor or its BH-MCOs must adhere to credentialing requirements under the Pennsylvania Department of Health regulations, 28 Pa. Code §§ 9.761 and 9.762 for all State Plan Services Provider types as well as for Providers of in-lieu-of and in-addition-to services in the BH-MCO Provider network. Provider types interested in participating as a Provider within the network must obtain credentialing from the BH Primary Contractor or its BH-MCO (who will ensure the service is within the Provider’s scope of practice) and approval from a county who wishes to offer the service.” So, under the BH agreement, if the CBOs are providing state plan services, in lieu of, or in addition to services, they would need to be credentialed, but otherwise do not need to be credentialed.

12. Once billed, how do the BH Primary Contractors or MCOs pay the claims to CBOs in order to meet the requirements for encounters to be submitted to DHS?

DHS views these as vendor contracts, so DHS is not expecting a claim or encounter to be submitted. The BH Primary Contractors or MCOs should use their own internal mechanisms for tracking members served and service provided.

13. Can the MCO issue funds to a CBO without having a contract with the CBO?

If the MCO is issuing funds to a CBO, then a contract is required. If the network provider is instead issuing funds to a CBO, the network provider will determine how to engage with, and fund, CBO activities.

14. Will there be any changes to the Medicaid state plan or the chart of covered services?

There are no current plans to change the Medicaid state plan or covered services.