

# Pennsylvania Value Based Purchasing Innovation Showcase

Informational Webinar

March 31, 2026

National  
MLTSS

National Health Plan Association

# About the MLTSS Association

The [National MLTSS Health Plan Association](#) is a national trade association of the leading managed care organizations that deliver high-value, quality managed long-term services and supports (MLTSS) for state Medicaid programs and beneficiaries. Our members also provide Integrated Plans for Dually Eligible Individuals.



# MLTSS Association Partnership Program

The MLTSS Association Partnership Program is comprised of select companies who serve individuals relying on long-term care services and supports.

Members of the MLTSS Association Partnership Program participate in workgroups alongside our health plan members to develop policy and programmatic recommendations.



# About the CHC MCO Coalition

The Community HealthChoices (CHC) Managed Care Organization (MCO) Coalition is an affiliated chapter of the National MLTSS Health Plan Association

It represents the three CHC-MCOs:

- AmeriHealth Caritas Pennsylvania CHC/ Keystone First CHC
- PA Health & Wellness
- UPMC



**UPMC Community HealthChoices**

# Agenda

I. Welcome

II. Overview of VBP Requirements in  
Community HealthChoices

III. Overview of the MLTSS  
Association's VBC Framework

IV. Showcase Application Process &  
CHC MCO Pain Points

V. Q&A



# **Pennsylvania Value-Based Purchasing Innovation Showcase**

**Presenter: Juliet Marsala, Deputy Secretary  
Office of Long-Term Living  
March 31, 2026**



# Agenda

- Value-Based Purchasing (VBP) Overview
- VBP Definitions
- Payment Strategies Overview and Allowability
- Calendar Year 2026 VBP Requirements



# Value-Based Purchasing (VBP) Overview

- VBP is the Department's initiative to transition Providers to being paid for the value of the services provided, rather than simply the volume of services.
- VBP Payment Strategies and VBP Models are critical for:
  - Improving Quality of Care
  - Efficiency of Services
  - Reducing Cost
  - Addressing Social Determinants of Health



# Value-Based Purchasing (VBP) Definitions

- **VBP Purchasing Payment Strategies** — Refers to the mechanism that Managed Care Organizations (MCOs) use to pay Providers
  - Performance-based contracting
  - Shared Savings
  - Shared Risk
  - Bundled Payments
  - Global Payments
- **VBP Models** — VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay Providers.

## Value-Based Purchasing (VBP) Payment Strategies (Low Risk)



### Performance-based contracting may include:

- Incentives for meeting quality benchmarks or incremental improvement, or
- Penalties for not meeting quality benchmarks or incremental improvement, or
- Both.
- Performance-based contracting models **alone** are **NOT** being solicited for this initiative; however, this strategy may be used in combination with a medium or high-risk strategy

# Value-Based Purchasing (VBP) Payment Strategies



## Shared Savings and Shared Risk (Medium Risk)

- Supplemental payments given if the Provider(s) can reduce healthcare spending relative to an annual cost benchmark.
- May be for a defined Participant sub-population or total population served.
- The supplemental payment is a percentage of the net savings generated by the Provider.
- In **Shared Risk** arrangements, there are also shared losses with Providers if costs are higher relative to a benchmark.
- These arrangements **ARE** eligible for this initiative.

# Value-Based Purchasing (VBP) Payment Strategies (Medium and High Risk)



## Bundled Payments (Medium Risk)

- Payments for services rendered to treat a Participant for an identified condition during a specific time period.
  - Example Maternity bundled payment in HealthChoices.
- These arrangements **ARE** eligible for this initiative.



## Global Payments (High Risk)

- Population-based payments that cover all services rendered by a Network Provider, hospital, or health system by the participating Community HealthChoices Managed Care Organization(CHC-MCO).
- These arrangements **ARE** eligible for this initiative.

# Calendar Year 2026 Value-Based Purchasing (VBP) Requirements

- The CommunityHealth Choices (CHC) Managed Care Organizations (MCOs) have specific requirements around VBP in their agreements
  - 15% of the medical portion of the capitation expended through VBP. The 15% medical spend may be from any combination of strategies.
  - 25% of Long-Term Services and Supports (LTSS) payments expended through VBP arrangements. 10% of the LTSS spend must be through medium or high risk VBP models.
- Administrative functions of the CHC-MCO will **NOT** be considered an approvable VBP model.
  - Examples include Nursing Home Transition (NHT) and Service Coordination, even if the CHC-MCO contracts with a Service Coordination Entity or NHT Entity.
- The Department encourages all interested Providers to review the pending CHC-MCO agreement for 2026 for all requirements for VBP arrangements. It can be found at:  
<https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-providers/documents/2026-03-12-2026-chc-agreement-pending-approval.pdf>

Thank You!



# Advancing Value-Based Contracting in MLTSS: Strategies for Better Outcomes and Care Quality

## KEY DOMAINS: VALUE-BASED CONTRACTING IN MLTSS



### Collaboratively Defining Value for a Unique Population

- Collectively defining value and quality in LTSS
- Member and provider education on quality and value
- Alignment with HCP LAN framework



### Data Infrastructure and Analytics

- Standardize data collection & reporting
- Invest in technology, infrastructure and capacity building
- Provider and vendor readiness & education



### Plan and Provider Collaboration

- Goal setting and discovery process
- Stepwise approach to the planning, execution and evaluation of a plan-provider relationship



### The Importance of Flexibility to Promote Innovation

- Balancing standardization and flexibility
- Aligning quality metrics with outcomes
- Stakeholder collaboration

# VBC Domains

## Defining Value for a Unique Population

- Explores how "value" is defined and measured for populations receiving LTSS
- Importance of addressing the unique needs of these populations, whose value metrics may differ significantly from those in traditional healthcare settings
- Balancing cost considerations with outcomes like quality of life, patient-centered care, and recognizing qualitative differences between institutional and home-based settings

## Plan and Provider Collaboration

- Step-wise approach to the development of a relationship between a managed care organization (MCO) and provider engaging in a VBC arrangement
- Alignment in goals, roles, and responsibilities to successfully implement VBC models
- Overcoming challenges related to differing capacities and resources among providers and ensuring sustained partnerships that drive effective VBC initiatives

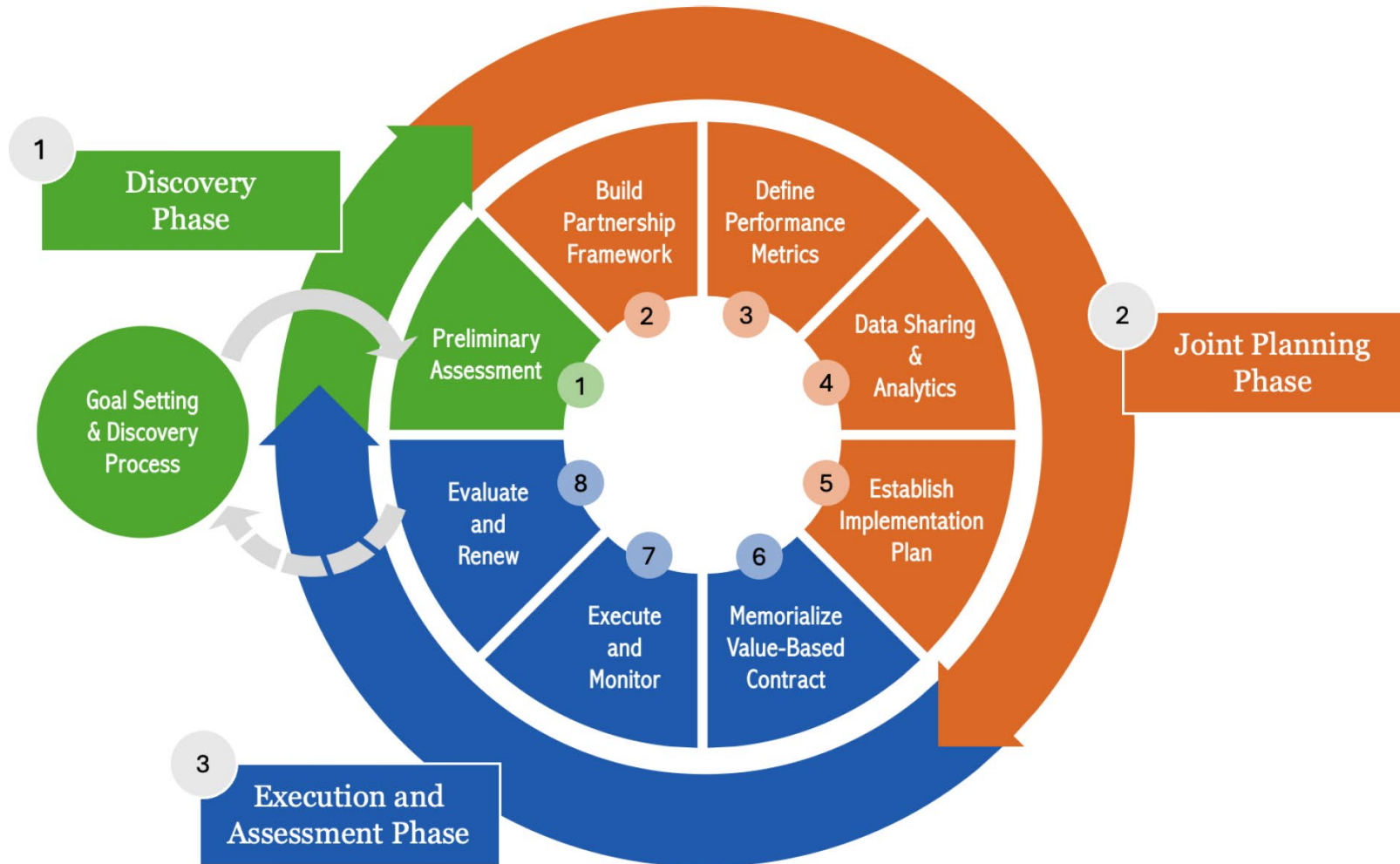
## Data Infrastructure and Analytics

- Development of robust data systems to support VBC in MLTSS by focusing on the relationship between plan, provider, and state
- Consideration of the collection, integration, and analysis of data from various sources to track performance, quality, and cost outcomes
- Challenges of standardizing data, ensuring accuracy, and enabling effective data sharing across different stakeholders to support informed decision-making

## Flexibility to Promote Innovation

- Striking a balance between standardization and flexibility in VBC frameworks to foster innovation
- States and MCOs can create adaptable VBC models that encourage experimentation and innovation while maintaining accountability
- Balancing regulatory requirements with the need to develop new approaches that better meet the needs of LTSS populations

# Plan and Provider Collaboration on Design and Implementation of VBC



## *Problem Statement*

- Fragmented nature of the LTSS delivery system poses challenges for plans and providers in tracking and reporting VBC metrics, managing financial risk, and aligning goals.
- States, MCOs and providers must work together to build capacity, share resources, and establish clear expectations for performance.
- ***MLTSS Association has developed this template for a stepwise approach in the planning, execution, and evaluation of a plan-provider VBC relationship.***

# VBP Innovation Showcase Timeline



# Complete the online Application Form by April 17th

Overview of VBP model including pertinent elements to demonstrate it is a medium to high risk model

Share any data you have to support the viability of this model

How does this model meet Participant needs and align with the goals of CHC?

Proposed implementation approach, including health plan resources needed

Background: Contact info, services & geographies, current contracting status in CHC

Anything else the review committee should consider?

# For Consideration: Common CHC-MCO Pain Points in VBP Partnership Discussions

1. KPI alignment with state-defined LTSS value
2. Attribution and shared accountability
3. Data integration, standardization, and timeliness
4. Scalability beyond pilot populations
5. Contract and regulatory fit
6. Sustainable financial risk design

# 1. KPIs should align with state-defined LTSS value

## Health plan pain points

- Vendors often propose process KPIs (engagement rates, contacts completed, alerts responded to) rather than outcome-anchored measures that matter to LTSS programs.
- KPIs may not align to:
  - State quality strategies (e.g., CHC priorities)
  - CAHPS / NCI / NCI-AD constructs
  - Outcomes the plan can reasonably put at risk
- Vendors may push proprietary or non-standard metrics, creating friction with reporting and state oversight.

## What plans worry about

“If this goes well, what improves that the state actually cares about?”

“Can I defend these KPIs in a contract amendment, audit, or readiness review?”

### Sample MCO KPIs of interest:

- Diabetes management
- CAHPS response rates and scores

Advice from an MCO: Don't forget to consider any impact on Participant experience in addition to financial and clinical outcomes!

## 2. Successful models require shared accountability

### Health plan pain points

- Vendors frequently influence outcomes indirectly (coaching, technology, care coordination), making attribution difficult.
- Plans struggle to determine:
  - What portion of an outcome is vendor-driven vs. provider-driven
  - Whether poor results are due to vendor performance, provider behavior, or member complexity
- Vendors may resist downside accountability while still seeking shared savings or incentive payments.

### What plans worry about

“Are the results directly attributable to the actions of this provider? What can we do to reduce “noise” from other entities in the results?”

“If we miss the target, who takes the hit?”

“Can I credibly put dollars at risk without full control?”

### 3. VBP requires standardized data with a clear understanding of the effort required to generate it

#### Health plan pain points

- Vendor solutions often depend on:
  - Near-real-time eligibility
  - Accurate member rosters
  - Claims, assessment, or care plan data that plans may not be able to share easily
- Common gaps:
  - Lagged data that undermines performance tracking
  - Inconsistent definitions (e.g., “engaged,” “success,” “avoidable utilization”)
  - Manual reconciliation between vendor and plan reports

#### What plans worry about

“Can I defend these numbers to the state?”

“Will my ops team spend more time fixing data than managing the program?”

Advice from an MCO: A partnership mindset is important. What will the feedback loops look like between the provider, MCO, and state?

# 4. The best programs are scalable across broader populations and geographies

## Health plan pain points

- Vendors frequently pitch:
  - High-touch, boutique pilots
  - Staff-intensive models that don't scale across regions or populations
- Challenges emerge when:
  - Scaling increases cost faster than outcomes improve
  - Vendor staffing models don't match LTSS volume variability
  - The program works for one subpopulation but not others (e.g., physical disability vs. duals)

## What plans worry about

“If the state asks us to expand this, can we?”

“Does success depend on heroics—or on a repeatable model?”

Advice from an MCO: Consider whether your model is positioned to work with all combinations of Medicaid/Medicare or better positioned for certain ones:

- Non-Dual participants only
- Dual participants only
  - Aligned (MCO has participant for both Medicare and Medicaid/CHC)
  - Unaligned (MCO has participant for Medicaid/CHC only but FFS/another MCO for Medicare)

## 5. Compliance is non-negotiable

### Health plan pain points

- Vendor proposals may not fully account for:
  - CHC contract requirements
  - State procurement rules
  - FWA, data-sharing, or delegation oversight expectations
- Some vendors push innovation that is conceptually strong but contractually misaligned

### What plans worry about

“Can I put this in a VBP contract without triggering a compliance issue?”

“How do I explain this to the state if results vary?”

## 6. Financial risk should be real and fair

### Health plan pain points

- Vendors may:
  - Seek upside without downside
  - Tie incentives to activities rather than outcomes
  - Propose payment models that don't align with HCP-LAN categories
- Plans struggle to structure:
  - Meaningful risk that drives behavior
  - Without exposing themselves to unmanageable financial volatility

### What plans worry about

“Is this true value-based contracting—or just pay-for-performance with a new label?”

“Does the risk align with the vendor’s actual influence?”

Advice from an MCO: HCBS providers should articulate how their services **assist with preventative care that can impact medical spend**, as well as managing LTSS trendlines. We need to understand how the incentives will be funded or cost-neutral

# Q&A



# Thank you!

## Key Links

[Showcase Application Form – Due April 17<sup>th</sup>](#)

[Showcase Information](#)

[Pending CHC-MCO 2026 Agreement](#)

[MLTSS Association Report - Advancing Value-Based Contracting in MLTSS: Strategies for Better Outcomes and Care Quality](#)

*Stay in touch with us on this and other topics at: [info@mltss.org](mailto:info@mltss.org)*