



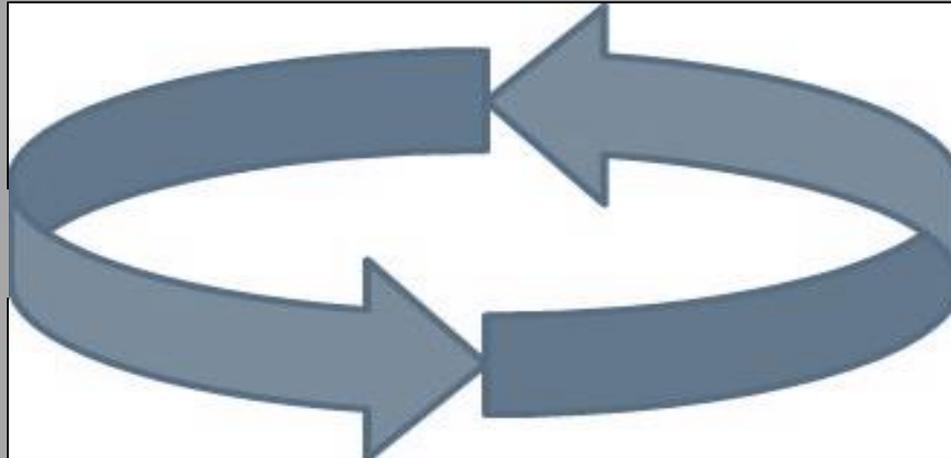
**Session #2:**  
**Developing Performance  
Benchmarks for  
Population-Based and  
Episode-Based VBP  
Models**

**August 24, 2021**

# VBP CREATES OPPORUTNITIES FOR NEW MODELS OF CARE

**Payment Reform *without*  
Practice Transformation  
doesn't change outcomes.**

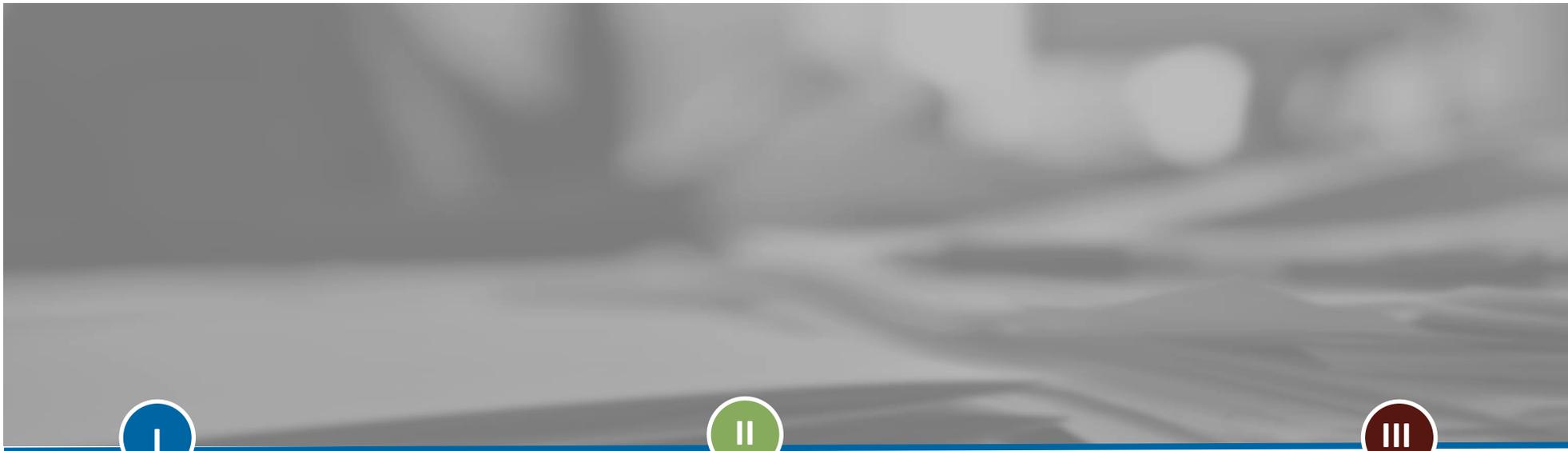
**Delivery System  
Transformation**



**Payment System  
Transformation**

**Practice  
transformation  
*without a*  
financial model  
*is not*  
sustainable.**

# AGENDA



**CHALLENGES IN  
SETTING BENCHMARKS**



**CONSIDERATIONS  
IN SETTING  
PERFORMANCE  
TARGETS**



**ENSURING  
MEASURE  
BENCHMARKS DO  
NOT CREATE  
DISINCENTIVES**

## ■ PERFORMANCE MEASURES AND BENCHMARKS

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- A common component across value-based payment models is the use of standardized measures and benchmarks.
- Performance and quality measures are powerful catalysts for quality improvement and promoting innovation.
- Benchmarking determines the standards against which the performance is assessed.
- The benchmarking method can differ depending on the type of performance improvement desired.
- It is important to continually assess benchmarks to adapt to changes and lessons learned and ensure standards for performance are set at optimal levels to incentivize ongoing progress.
- Understanding the composition of a providers patient population is integral to ensuring the measures will not exacerbate existing disparities in health status.
- Engaging with your providers is important in communicating goals, developing action- oriented provider level feedback reports, and soliciting input on setting targets and improving the VBP program.

## ■ CHALLENGES: IMPROVING VALUE IN VBP - FOR WHOM?

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- VBP programs are often designed to improve **value for the payer rather than providers and patients.**
- Claims-based measures, such as preventable hospitalizations or readmissions, create challenges for real-time quality improvement because of **lag in measuring and reporting.**
- Outcomes that patients value, such as quality of life and functional status, are not often measured. In the **absence of patient reported outcomes** we are limited in our ability to meet patients' core needs.
- **Overly complex approaches in measurement** create challenges for practices.
- Inadequate risk adjustment or other measurement that **fails to account for important patient factors**, such as functional impairment and poverty, which influence clinical outcomes. This can lead to clinicians who serve the most medically and socially vulnerable patients being penalized by a flawed measurement system to incentives that avoid patients who most need treatment.
- Design of the improvement targets can **exacerbate existing health disparities** by masking current performance or establishing improvement targets that perpetuate inequities.

Johnston, KJ et al. "Building a Better Clinician Value-Based Payment in Medicare" December 2020 available at: <https://jamanetwork.com/journals/jama/fullarticle/2774534>



The  
Challenges  
are Varied



**TYPE OF MEASURE**

Process, structural or outcome



**TYPE OF BENCHMARK**

Maintenance, improvement or attainment



**MULTI-YEAR GOALS**

Considerations to encourage quality improvement



**SIZE MATTERS**

Small populations or groups of populations require specific approaches

## ■ SETTING PERFORMANCE BENCHMARKS – CHOSING QUALITY METRICS

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Aligning metrics across payers, when possible, makes it easier for providers to transform their practice workflows and increase quality efforts.

- For community health centers, consider alignment with the Uniform Data System (UDS) measures.
- Consider alignment with other quality improvement initiatives such as Medicare's accountable care organizations (ACOs) and/or the CMS Hospital VBP Program.
- Consider whether the metrics align with other health plans or other CCO efforts in the region.

Assess annually whether the selected metrics are the right combination to incent improvement in quality while not impacting access or creating unintended disparities in care.

Monitor performance and engage with providers to identify measures that can be retired, new measures to be added, or necessary changes in improvement targets.

## SETTING PERFORMANCE BENCHMARKS – CHOSING QUALITY METRICS

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Quality measures have been developed nationally for many care area VBP models and include:

- **Process measures** focus on identification of need and can help identify systemic barriers to receiving care.

*Examples: Screenings for \_\_\_\_\_ (cancer, hypertension, diabetes, etc.)*

*Following up with a patient who utilizes the ED.*

- **Structural measures** indicate the capacity of a provider group or hospital system to respond to the needs of care.

*Example: The number of primary care physicians certified to prescribe Medication Assisted Therapies.*

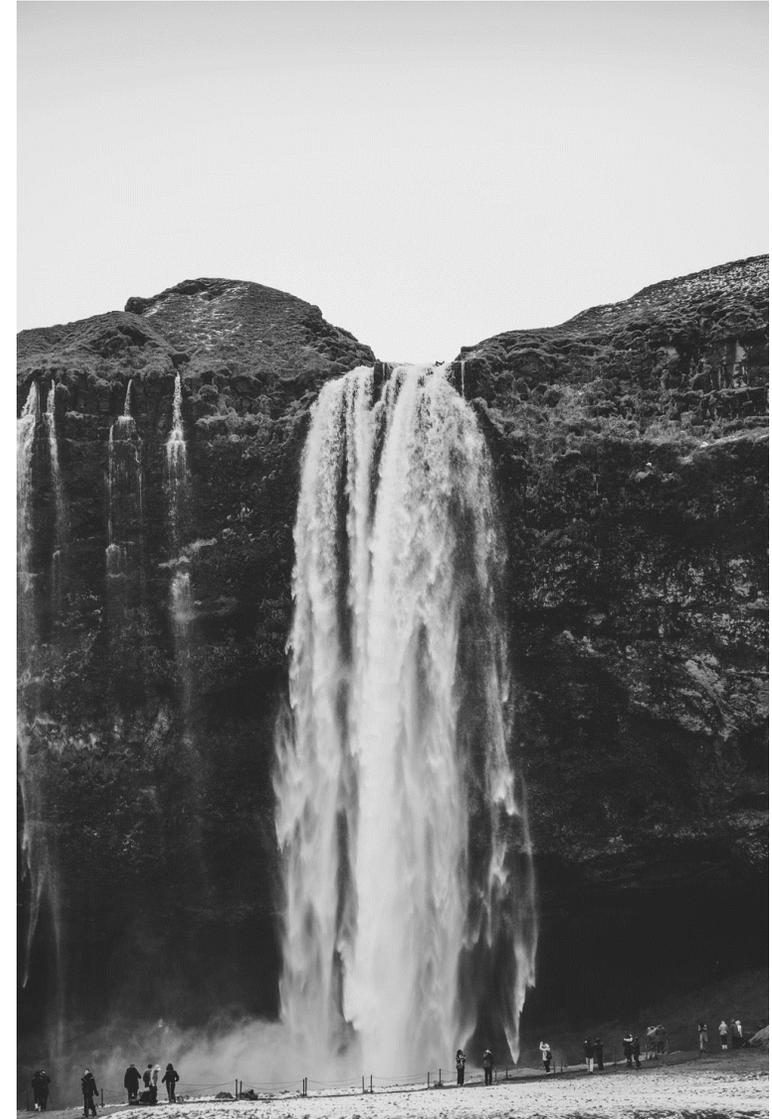
- **Outcome measures** signify the impact of an intervention on improving health care outcomes of patients.

*Example: The number of patients with diabetes with hemoglobin A1c > 9.0% (poor control).*

While most quality measures used in VBP models are considered process measures, many national organizations such as CMS, The Joint Commission and the National Association for Healthcare Quality have ongoing efforts to move to more outcome-based measures.

## TIME FOR SOME INPUT: CHATTER FALL INSTRUCTIONS

- We will walk through each question as a group.
- You will take a minute to type your response in the Zoom Group **Chat**, but **don't click enter** until instructed.



What types of measures are the most challenging for you in setting benchmarks?

- Process
- Structure
- Outcomes

Type your response and  
**don't click enter.**



What types of measures are the most challenging for you in setting benchmarks?

- Process
- Structure
- Outcomes

**Click Enter.**



Picture from Unsplash

# Which care delivery areas (CDAs) are most challenging?

- Hospital
- Behavioral Health
- Maternity Care
- Children's Health
- Oral Health

Type your response and  
**don't click enter.**



Picture from Unsplash

# Which care delivery areas (CDAs) are most challenging?

- Hospital
- Behavioral Health
- Maternity Care
- Children's Health
- Oral Health

**Click Enter.**



Picture from Unsplash

The background of the slide is a grayscale, slightly blurred photograph of a hand holding a pen, poised to write on a document. The document has some faint, handwritten text and lines, suggesting a professional or academic setting. The overall tone is serious and focused.

# **CONSIDERATIONS FOR SETTING PERFORMANCE TARGETS**

HEALTH MANAGEMENT ASSOCIATES

## ■ CONSIDERATIONS FOR SETTING PERFORMANCE TARGETS

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Determine what type of performance targets will be used for individual practice metrics and what impact the target has on priority populations and eliminating health disparities.

- **Attainment** – this target is set at the value that is desired for all providers to reach.
  - It should be set at a level that is feasible but not too easy to reach.
  - Some studies\* suggest that providers prefer attainment targets with a fixed or “absolute” goal.  
*Example: Provider must have at least 70 percent performance on mammography screening.*
  - Some payers are concerned that this approach removes the motivation for providers to continue to improve once the threshold has been attained.
- **Maintenance** – this target is established when performance should be maintained.
- **Improvement** – this target sets a desired change (percentage or absolute value) for improvement from a baseline.
  - Used when continuous improvement is possible and desired, current levels of achievement are far from ultimate targets, or baseline performance among practices varies greatly.
  - Improvement targets encourage continued, incremental year-over-year improvement toward an attainment goal over time, such as a statewide benchmark.

IAP: Medicaid Innovation Accelerator Program: Determining Performance Benchmarks for a Medicaid Value-Based Payment Program July 2018 available at: <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/vbp-benchmarking-brief.pdf>

## ■ CONSIDERATIONS FOR SETTING PERFORMANCE TARGETS

- What types of performance targets should be set?
  - All three targets (maintenance, improvement and attainment)?
  - Maintenance and Improvement only?
- VBP programs can also incentivize providers with a combination of attainment and improvement.

### *Example: Improvement and Attainment of Performance Targets*

Attainment Goal (75 <sup>th</sup> percentile)			80%
Improvement Goal over Baseline			5%
	Baseline Score	Performance Target	
<b>Practice #1</b>	40%	42%	
<b>Practice #2</b>	60%	61%	
<b>Practice #3</b>	90%	80%	

## ■ CONSIDERATIONS FOR SETTING PERFORMANCE TARGETS – IMPROVEMENT TARGETS

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- Improvement targets could be structured based on the Minnesota Department of Health’s Quality Incentive Payment System (“Minnesota method” or “basic formula”)\* which is used by the State of Oregon for the CCO Performance Incentive program.
- This method requires at least a 10 percent reduction in the gap between baseline and the aspirational goal benchmark to qualify for incentive payment.

$$\frac{[\text{State Benchmark}] - [\text{Provider Group's Baseline}]}{10} = X$$

**Then:**  $[\text{Provider Group's Baseline}] + [X] = \text{Improvement Target}$

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**Example:**  $\frac{[\text{Well Child State Benchmark} = 70] - [\text{Provider Group's Baseline} = 30]}{10} = 4$

**Provider Group's Improvement target = Baseline of 30 + 4 = 34**

- The Provider Group could either meet the state benchmark *or* the improvement target.

\*More info re Minnesota method: <http://www.health.state.mn.us/healthreform/measurement/QIPReport051012final.pdf>

## CONSIDERATIONS FOR SETTING PERFORMANCE TARGETS

Example of a practice's total score across several metrics based on maintenance and improvement targets:

Quality Measures	Maintain Quality	Improve Quality 5%	Improve Quality 10%	Quality Points	Points Possible
Percentage of members who receive influenza vaccine	1			1	3
Percentage of enrolled children 3-17 who have weight screening and counselling on nutrition and physical activity	1	1		2	3
Percentage of enrolled adolescents and adults screened for clinical depression and follow-up plan	1	1	1	3	3
Percentage of patients with hypertension with controlled blood pressure	1			1	3
Percentage of diabetic patients with poorly controlled HbA1c or not tested during the year	1			1	3
Cervical cancer screening	1			1	3
<b>TOTAL POINTS</b>				<b>9</b>	<b>18</b>
<b>MINIMUM PASSING SCORE</b>				<b>7</b>	

## EXAMPLE FROM THE CONNECTICUT PATIENT CENTERED MEDICAL HOME PLUS PROGRAM

Quality Measures	Maintain Quality	Improve Quality	Absolute Quality	Quality Points	Points Possible
Adolescent Well-Care Visits	1.0	1.0	1.0	3.0	3.0
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	1.0	0.0	0.0	1.0	3.0
Developmental Screening in the First Three Years of Life	1.0	1.0	1.0	3.0	3.0
Diabetes HbA1c Screening	DNQ	DNQ	DNQ	0.0	0.0
Emergency Department Usage	1.0	1.0	0.0	2.0	3.0
PCMH CAHPS	0.0	0.0	0.0	0.0	3.0
Prenatal Care	DNQ	DNQ	0.0	0.0	0.5
Postpartum Care	DNQ	DNQ	0.5	0.5	0.5
Well-child Visits in the First Months of Life	0.0	0.0	0.0	0.0	3.0
<b>Total Points</b>				9.5	19.0
<b>Aggregate Quality Score (Total Quality Points/Total Possible Points)</b>					50%

1. **Maintain Quality points** are awarded if a Participating Entity's (PE's) 2018 rate is greater than or equal to its 2017 rate.
2. **Improve Quality points** are awarded for a PE's 2018 improvement trend over 2017 on a sliding scale based on the participating entities improvement trend.
3. **Absolute Quality points** are awarded for a PE's ability to reach 2018 Absolute Quality targets.
4. DNQ (Does Not Qualify) values occur when a denominator count is less than 30.

## CHATTER FALL

Are you considering or using attainment, improvement or maintenance targets?  
A combination?

Type your response and  
**don't click enter.**



Picture from Unsplash

Are you considering or using attainment, improvement or maintenance targets?  
A combination?

**Click Enter.**





# **EXACERBATING INEQUITIES**

HEALTH MANAGEMENT ASSOCIATES

## ■ PREVENTING EXACERBATION OF INEQUITIES

- Oregon requires that VBP strategies should benefit members with complex health care needs and priority populations such as racial, ethnic and culturally based communities, people who identify as lesbian, gay, bisexual, transgender and queer (LGBTQ), persons with disabilities; people with limited English proficiency; immigrants or refugees, and members with complex health care needs, as well as populations at the intersections of these groups.
- VBPs may inadvertently disadvantage culturally specific providers and those who serve more complex populations.
- The lack of patient-level information regarding race, ethnicity, education, social economic status and other markers of vulnerable populations prone to disparities may make it difficult to determine whether VBP programs work to reduce or increase disparities.
- Performance measures designed for a dominant culture may not address the values of Black, Indigenous and People of Color (BIPOC) and other communities.
- If we adjust performance incentives (either baseline or performance targets) for providers who serve patients experiencing health disparities, are we “baking in” poorer performance and outcomes for the patients?

## ■ SMALL NUMBERS ISSUES & CONSIDERATIONS

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Payers need to also consider the challenges associated with small panel sizes

- The “small” issue isn’t just that the provider entity is small (1-2 providers/few overall patients) but also that a CCO might have few patients attributed to the provider entity.
- Uncertainty in measurement is also greater in practices that serve patients with more diverse medical needs.
- This can result in “false positives” – no change actually occurred and “false negatives” – no observed change where there was true improvement.

Some plans will group small providers together for purposes of measurement or encourage them to align efforts under a VBP arrangement.

**Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance.**

<https://www.shvs.org/resource/tricky-problems-with-small-numbers-methodological-challenges-and-possible-solutions-for-measuring-pcmh-and-aco-performance/>

## ■ PREVENTING EXACERBATIONS OF INEQUITIES

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To prevent exacerbating inequities, it is critical at the outset of establishing performance and quality metrics.

- Baseline metrics may result in reinforcing or masking a disparity.
  - Performance improvement targets may exacerbate the disparity.
  - Should we have different metrics (or different targets?) for culturally-specific providers?
- 

### EXAMPLE TO DISCUSS:

#### **Provider Group ZZZ**

90% insured patients overall with 30% covered by Medicaid, rest by commercial insurance  
Demographics predominately white, not Hispanic or Latino, high literacy level  
Overall provider performance on adult quality measures = 75%

#### **Provider Group XXX**

70% insured patients overall with the majority covered by Medicaid  
Demographics predominately multi-cultural, non-English speaking, low literacy level  
Overall provider performance on adult quality measures = 47%

The background of the slide is a grayscale, slightly blurred photograph. It shows a hand holding a pen, positioned as if about to write on a document. The document has some faint, handwritten text, including what appears to be a question mark and some illegible words. The overall tone is professional and focused on the act of writing or reviewing documents.

# **SUMMARY AND RESOURCES**

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HEALTH MANAGEMENT ASSOCIATES

## ■ SUMMARY

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- Metric alignment across payers is valuable to assist providers in making improvements in their practices.
- Most quality measures used in VBP models are process measures, but efforts are ongoing to move to move to outcome-based measures.
- Important considerations in setting performance benchmarks include:
  - Whether to choose attainment, improvement or maintenance targets, and
  - How to encourage continued, incremental year-over-year improvement toward an attainment goal, such as the statewide benchmark.
- Payers should take a balanced approach to setting and measuring performance targets to:
  - Increase the likelihood that the provider's performance is accurately captured, and
  - Minimize the likelihood of inaccurate measurement of performance.
- VBPs may disadvantage culturally specific providers and those who serve more complex populations.
- It is important to continually assess benchmarks to adapt to changes and lessons learned and ensure standards for performance are set at optimal levels to incentivize ongoing progress.
- Engaging with your providers is important to communicate goals, development of action-oriented provider feedback reports, and to solicit input on setting targets and improving the VBP program.

## RESOURCES

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- Oregon Health Authority. “*Value-Based Payment Roadmap for Coordinated Care Organizations*”. Guidance on value-based payments for Medicaid program offered by CCOs. Available at: <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf>.
- Center for Medicare and Medicaid Services (CMS) “The Hospital Value-Based Purchasing Program”. Describes how CMS rewards acute care hospitals with incentive payments for the quality of care provided in the inpatient hospital setting.
- CMS “*Provider ACO Engagement Toolkit*”. Information provided includes using data to identify and address opportunities for improving care among other topics. Available at: [https://comagine.org/sites/default/files/resources/2020\\_Provider%20Engagement%20Toolkit\\_508.pdf](https://comagine.org/sites/default/files/resources/2020_Provider%20Engagement%20Toolkit_508.pdf).
- “*Medicaid Innovation Accelerator Program (IAP) Determining Performance Benchmarks for a Medicaid Value-Based Payment Program*”. The article provides considerations for determining benchmarks when a performance metric lacks a benchmark, or an existing benchmark is not appropriate for the intended use or setting. Available at: <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/vbp-benchmarking-brief.pdf>.

## RESOURCES

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- Agency for Healthcare Research and Quality (AHRQ) “Practice Facilitation Handbook: Module 7. Measuring and Benchmarking Clinical Performance”. Part of a toolkit of resources created for practices on performance measurement. Available at: <https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod7.html>
- McCall, Nancy and Peikes, Deborah. “*Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance*”. Information regarding how to measure performance accurately with small panel sizes and across small number of organizations is provided. Available at: <https://www.shvs.org/resource/tricky-problems-with-small-numbers-methodological-challenges-and-possible-solutions-for-measuring-pcmh-and-aco-performance>.
- Johnston, KJ et al. “*Building a Better Clinician Value-Based Payment in Medicare*”. (JAMA, December 18, 2020). Provides an overview of the challenges with value-based payment programs. Available at: <https://jamanetwork.com/journals/jama/fullarticle/2774534>
- RAND Health Quarterly. “*Measuring Success in Health Care Value-Based Purchasing Programs*”. The article is a review of the published literature available about Value Based Purchasing (VBP) programs and includes a discussion with an expert panel on several topics including benchmarks used by VBP programs. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161317/>

## RESOURCES

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- Rosenbaum, S. Milbank Quarterly *“Eliminating Inequity in Health Care Demands Measurement in Real Time”*. Summary of the issues of health inequity, links to past research studies, and discussion of need for real-time information grounded in actual practice. Available at: <https://www.milbank.org/quarterly/opinions/eliminating-inequity-in-health-care-demands-measurement-in-real-time/>
- Smedley, Brian D. et al. *“Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care”*. Institute of Medicine. Washington, DC: The National Academies Press. A panel of experts documents the evidence and explores persons of color experience with health care. Available at: <https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>.
- The Path Forward. *“The Path Forward for Mental Health and Substance Use – Health Equity for All Americans”*. Five evidence-based reforms to improve early detection and access to effective behavioral healthcare. Available at: <https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward>.
- Schulman, M.D., Kevin A. et al. *“The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization”*. (New England Journal of Medicine 1999; 340:618-626). Study using actors as patients in scripted and recorded interviews discussing their symptoms and the physicians' recommendation for care. Available at: <https://www.nejm.org/doi/full/10.1056/NEJM199902253400806#t=article>.

## ■ RESOURCES

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- Please complete the evaluation that will be sent out after the webinar.
- Slides, webinar recording will be available at:  
<https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx>
- Follow-up questions?  
Contact: [OHAVBPQuestions@healthmanagement.com](mailto:OHAVBPQuestions@healthmanagement.com)