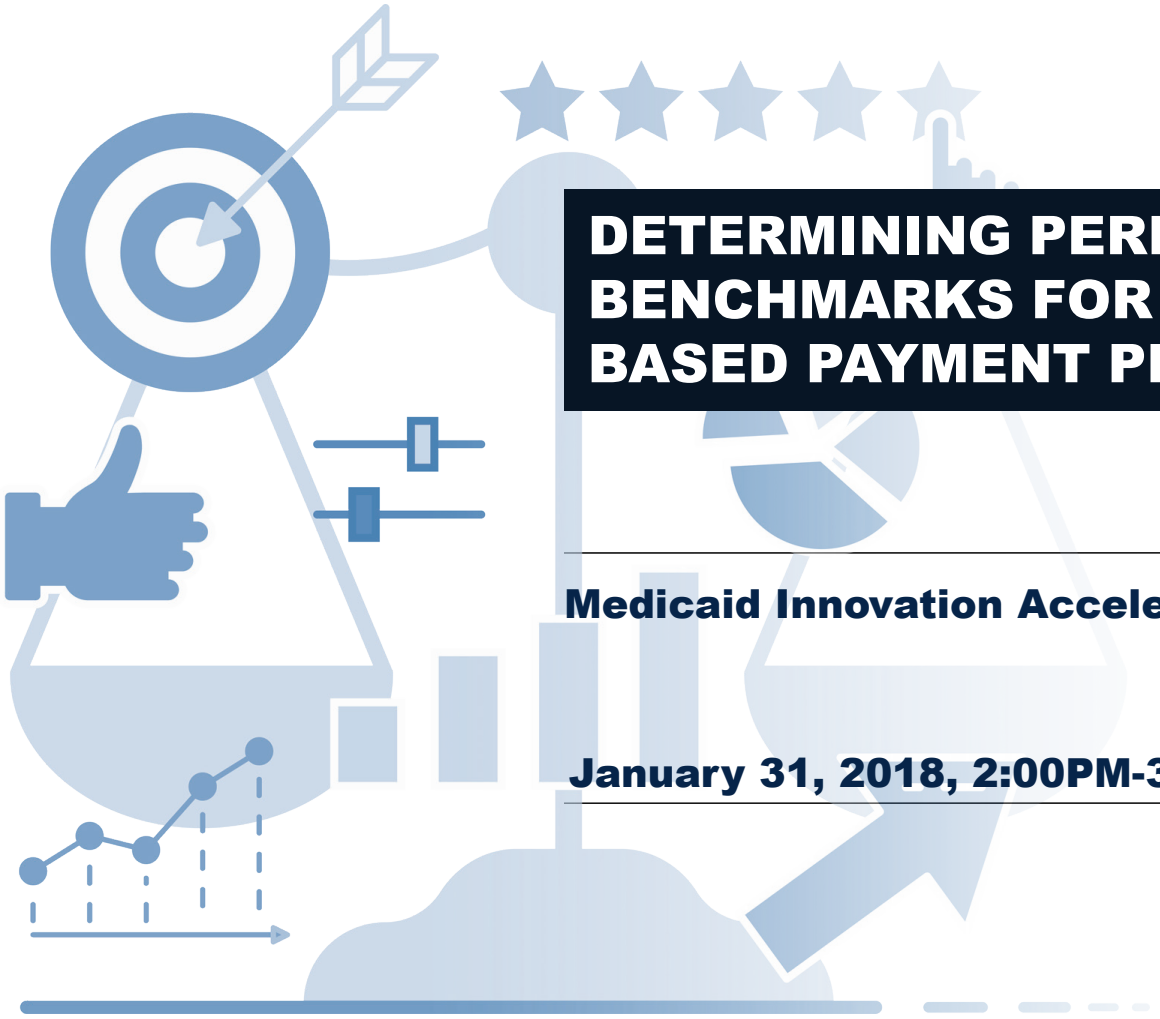
MATHEMATICA Policy Research

IAP Medicaid Innovation Accelerator Program



# DETERMINING PERFORMANCE BENCHMARKS FOR A MEDICAID VALUE-BASED PAYMENT PROGRAM

**Medicaid Innovation Accelerator Program Webinar**

**January 31, 2018, 2:00PM-3:30 PM ET**

# Agenda

| | |
|---|---|
| **1. Welcome and introductions** | |
| 2. Overview of benchmarking purposes and approaches | 2:10-2:25 |
| 3. Oregon's Coordinated Care Organizations P4P Program | 2:25-2:45 |
| 4. Discussion | 2:45-2:55 |
| 5. Vermont's Shared Savings Program | 2:55-3:15 |
| 6. Discussion | 3:15-3:25 |
| 7. Wrap-up | 3:25-3:30 |

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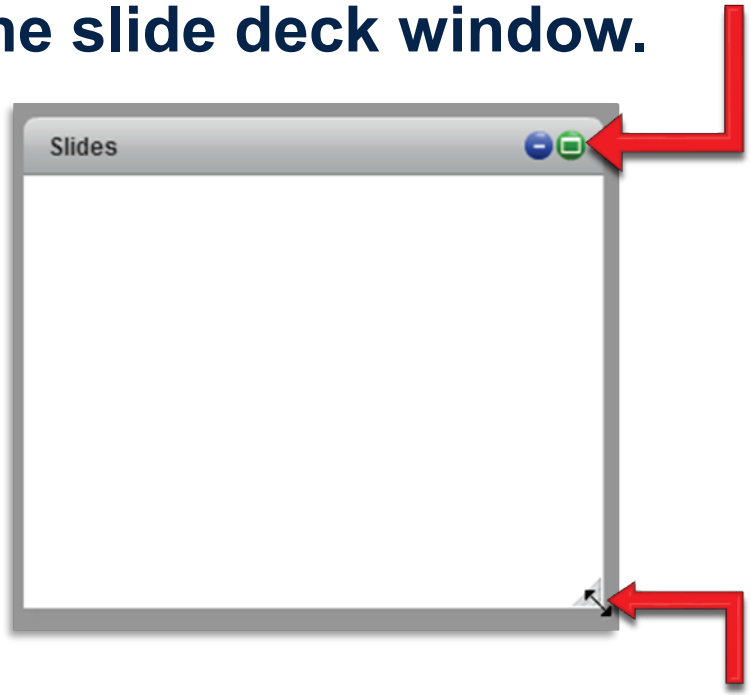


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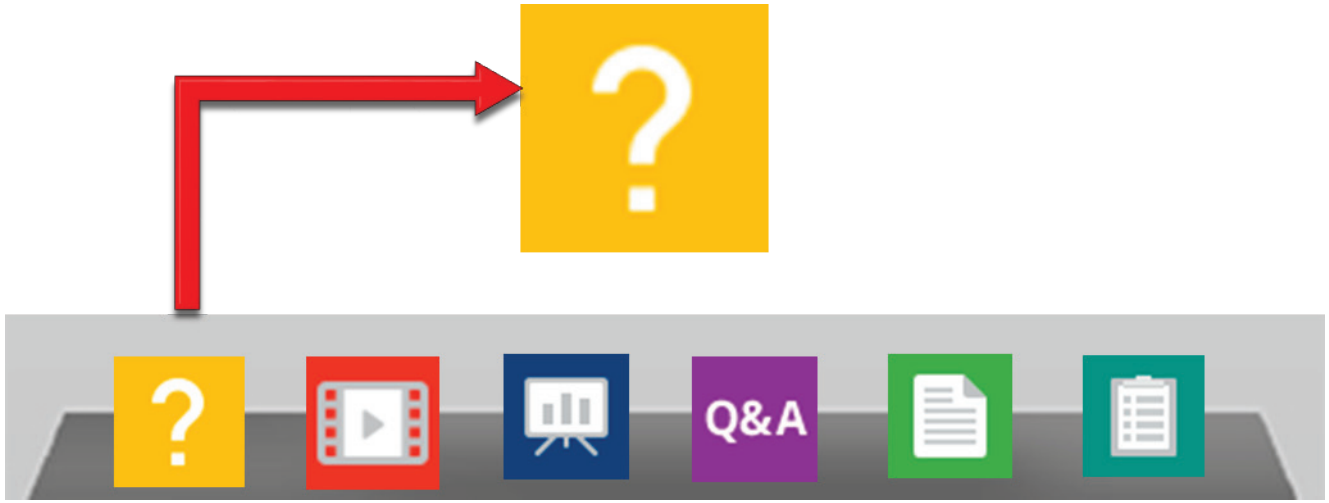
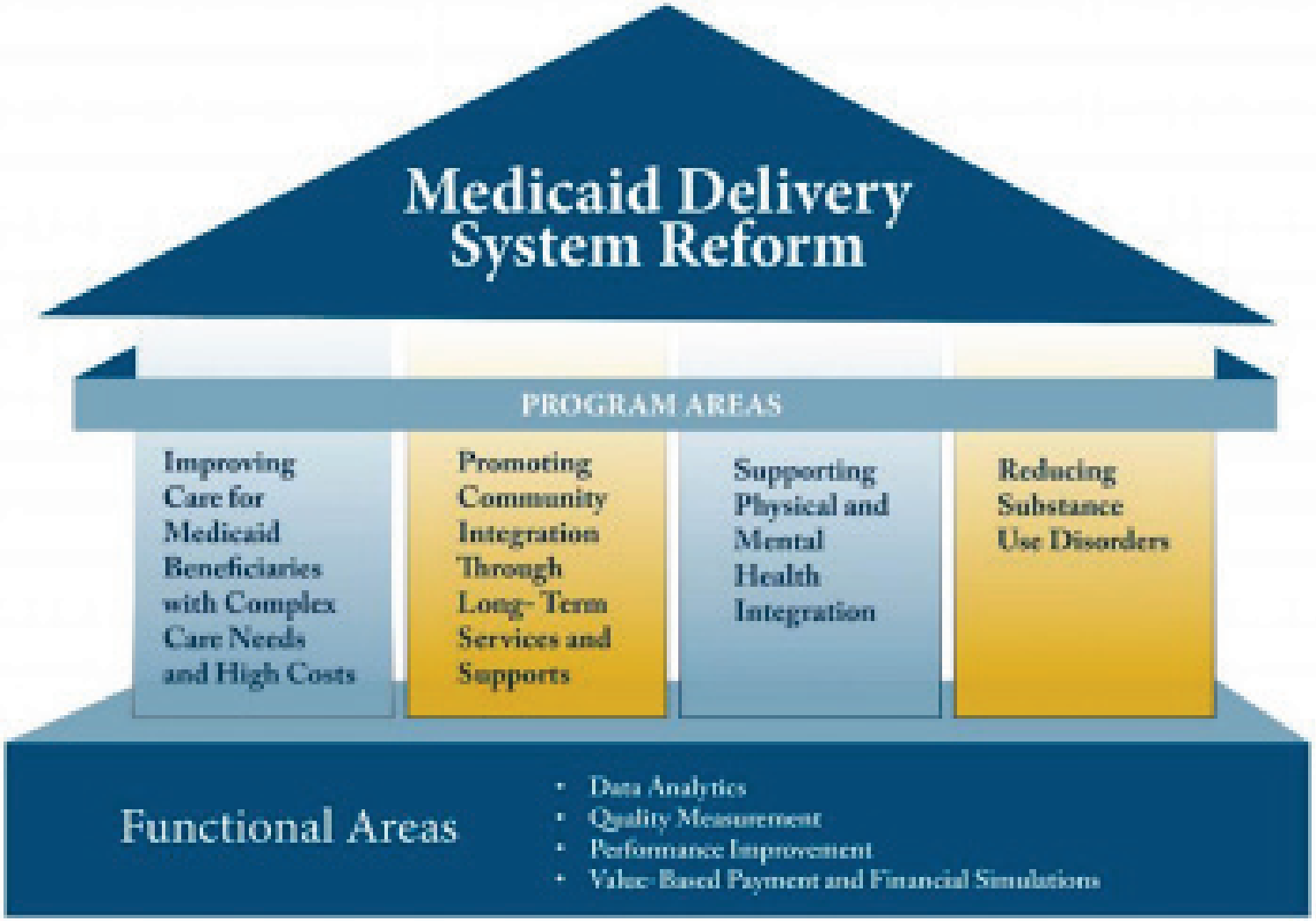


# Today's Speakers

- So O'Neil (Mathematica)
- Ella Douglas-Durham (Mathematica)
- Jon Collins (Oregon Health Authority)
- Pat Jones (Green Mountain Care Board)
- Alicia Cooper (Department of Vermont Health Access)

# IAP Program Areas and Functional Areas



# Setting the Context

- **Volume → value in healthcare**
- **Measures to assess quality in health care**
- **Existing benchmark of where quality provides value**

## What to do when…

- a performance measure lacks a benchmark?
- an existing benchmark is not appropriate for the intended use or setting?

1. Welcome and introductions ✓

**2. Overview of benchmarking purposes and approaches**

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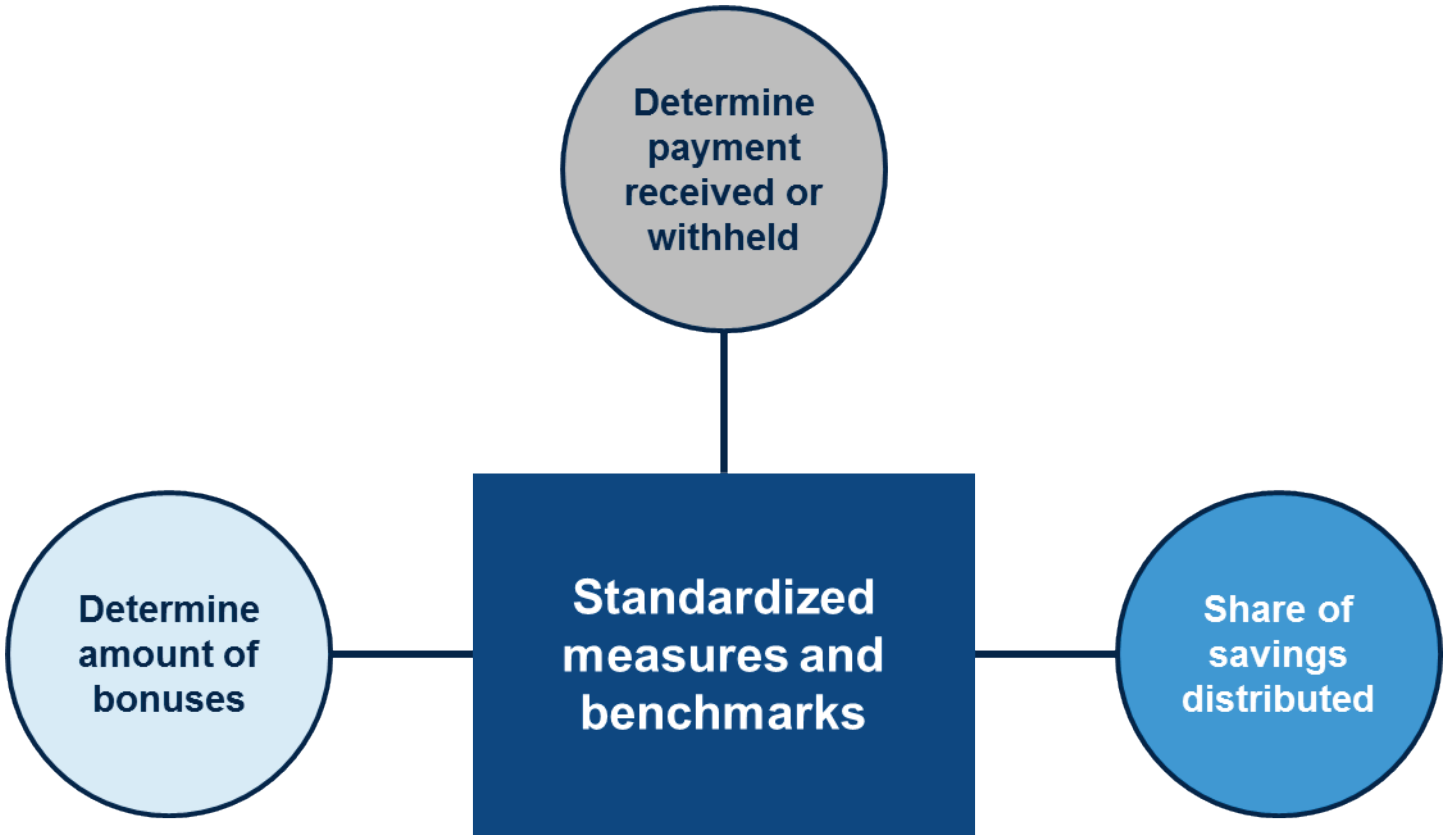
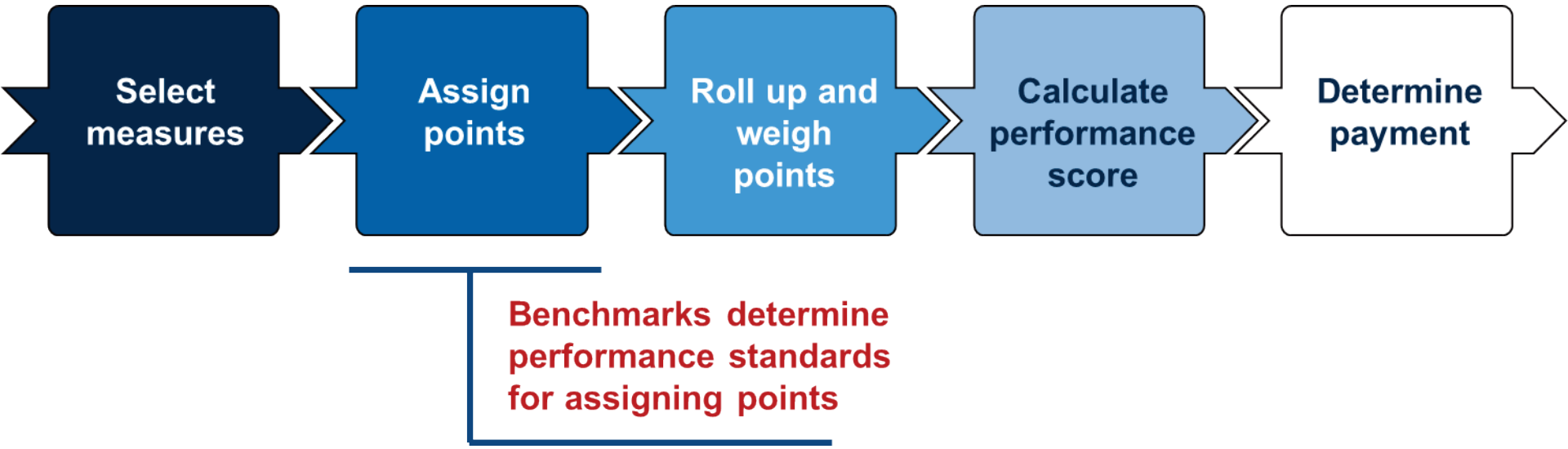
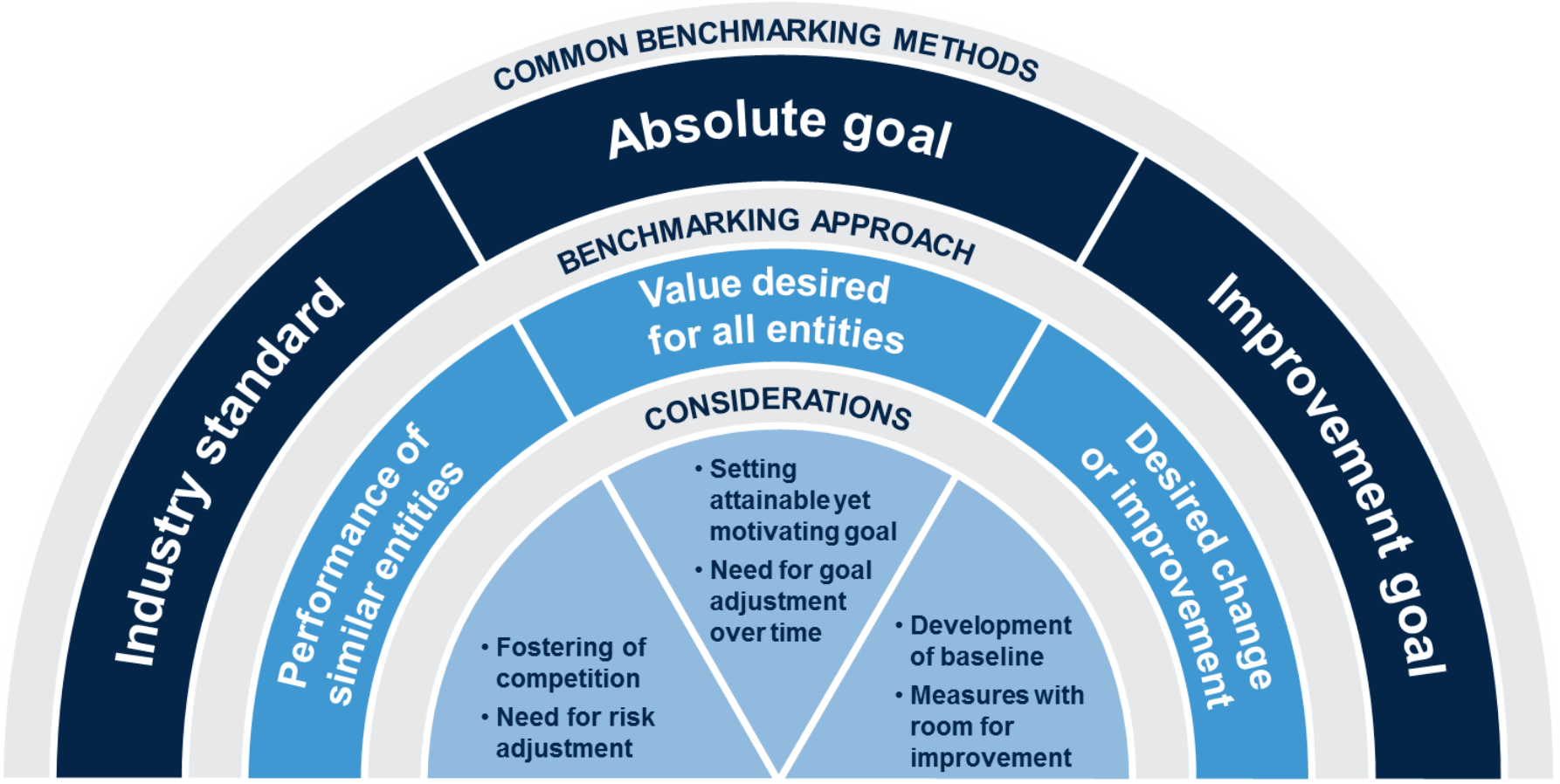
# Uses of benchmarks in value-based payment models



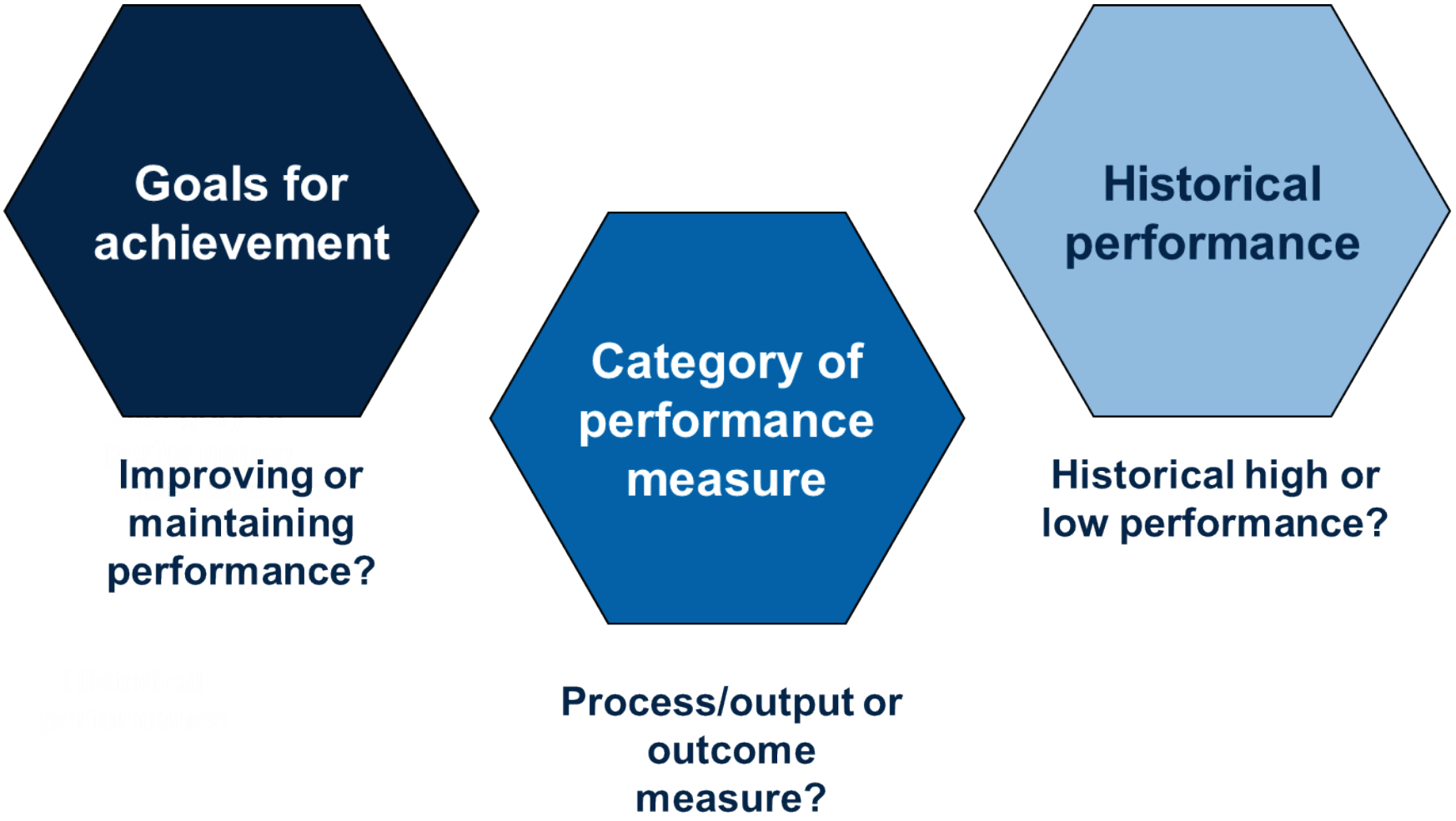
# Illustrative benchmarking approach within the value-based payment process



# Common benchmarking methods



# Considerations when choosing a method

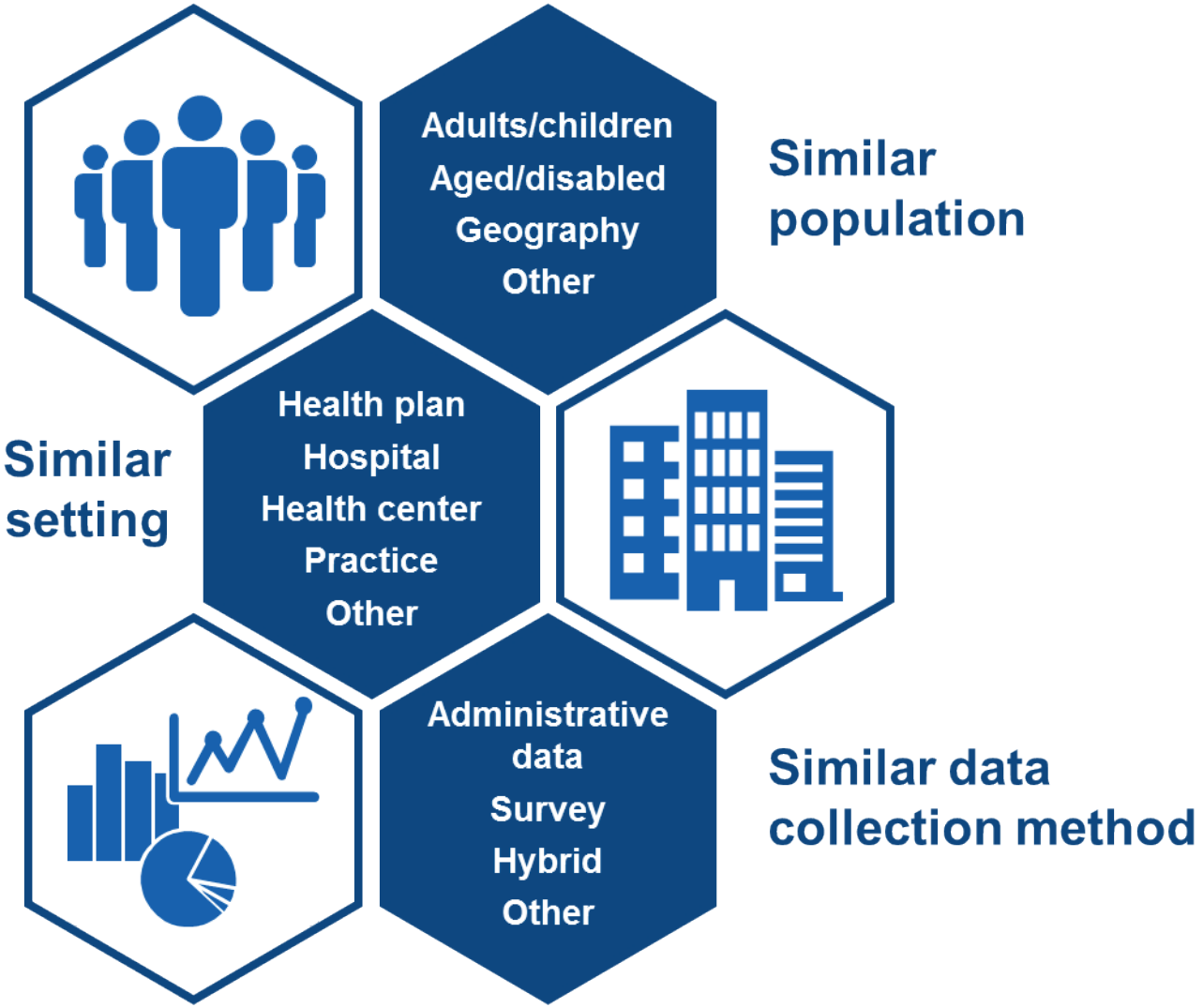


# Setting benchmarks

- Value(s) against which to assess performance
- External benchmarks
  - Healthcare Effectiveness Data and Information Set (HEDIS)®
  - National surveys and surveillance systems
  - Medicaid
  - Other (e.g., National Quality Forum, Healthy People 2020)
- Internal data sources for benchmarks
  - Electronic health records
  - Encounter and claims administrative data
  - Payments or invoices
  - Annual reports
  - Intake surveys
  - Other data-generating activities

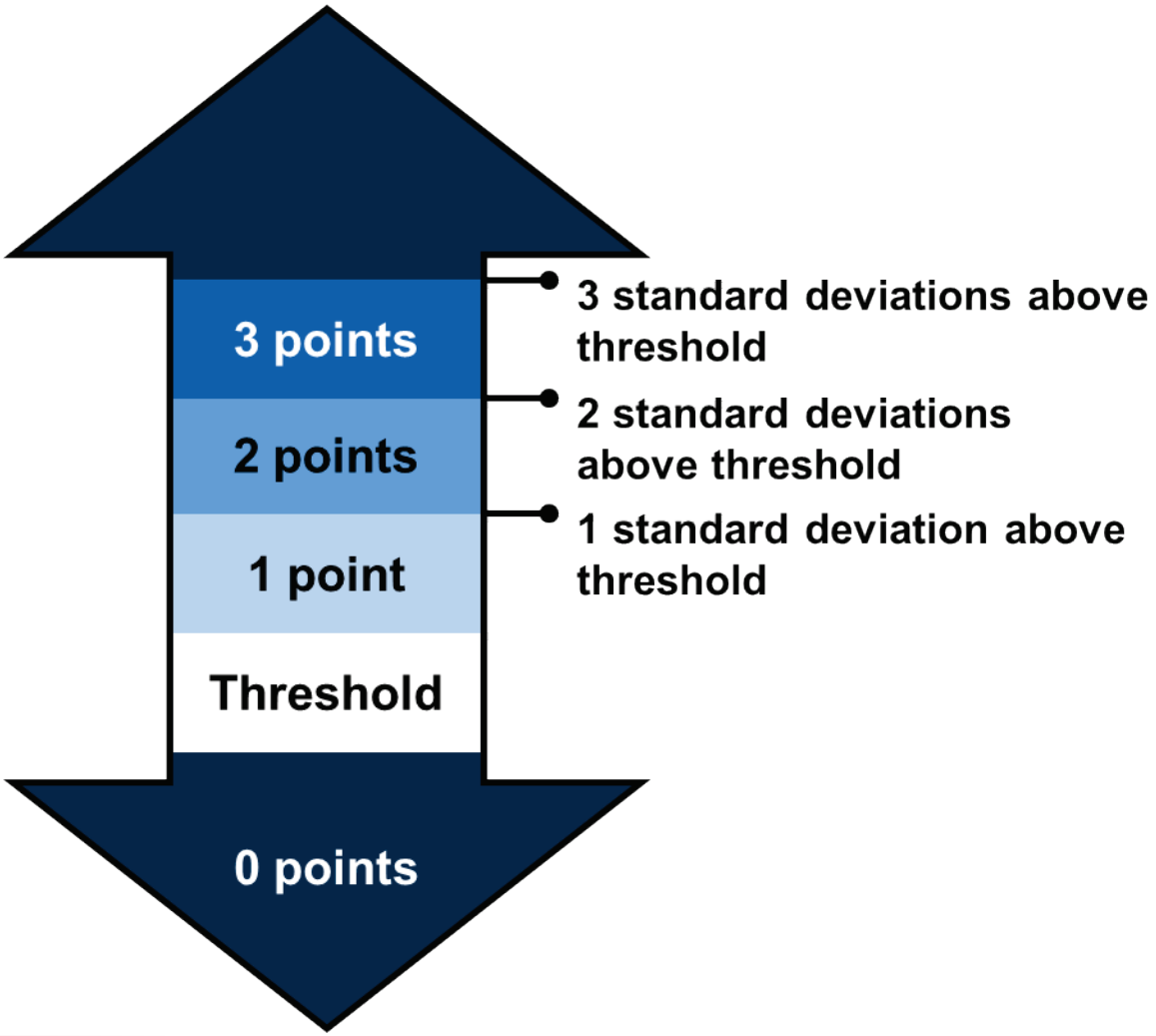
**Most benchmarking approaches can use either internal or external data sources**

# Setting external benchmarks



# Setting internal benchmarks

# Setting benchmarks: Illustrative tiered point assignment from a benchmark



# Summary of key considerations for setting benchmarks

| Key considerations | Benchmarking implications | Tiered point assignment implications |
|---|---|---|
| **Measure application** | | |
| • Population<br>• Service delivery setting | Achievable value within population/setting | Reasonable distribution and variation in measure within population/setting |
| **Reporting frequency** | | |
| • Time period feasible to observe change<br>• Degree of change anticipated | Achievable performance improvement for time period | Reasonable distribution and variation in performance improvement within time period |
| **Data availability** | | |
| • Data source<br>• Sample size | Allowance for quality of measures generated from data source | Reasonable distribution and variation based on sample size and data source |

# Benchmarking and YOU

**1. How does your agency or organization use benchmarks? (Please select all that apply)**

A. To assess program performance and quality

B. To determine payments

C. Our organization does not use benchmarks

**2. What is your experience developing benchmarks? (Please select all that apply)**

A. I've used HEDIS benchmarks

B. I've developed internal benchmarks

C. I've identified external benchmarks (non-HEDIS)

D. I have not been involved in developing benchmarks

1. Welcome and introductions ✓

2. Overview of benchmarking purposes and approaches ✓

**3. Oregon's Coordinated Care Organizations P4P Program**

**4. Discussion**

5. Vermont's Shared Savings Program

6. Discussion

7. Wrap-up

# Coordinated Care Organization Metrics 101

Jon C. Collins, PhD
Director of Health Analytics


OFFICE OF HEALTH ANALYTICS
Health Policy & Analytics

# Health System Transformation: Achieving the Triple Aim

1. Better health.
2. Better care.
3. Lower costs.

# Oregon's Medicaid Program Commitments to CMS

- Reduce the annual increase in the cost of care (the cost curve) by 2 percentage points.
- Ensure that quality of care improves.
- Ensure that population health improves.
- Establish a 1 percent withhold for timely and accurate reporting of data.
- Establish a quality pool.

# Measurement Strategy

# OHA Accountability in the Waiver to CMS

| 2012-2017 waiver | 2017-2022 waiver |
| --- | --- |
| **State Performance Measures**<br>• Annual assessment of statewide performance on 33 measures.<br>• Ensure quality of and access to care for Medicaid beneficiaries does not degrade during transformation.<br>• Financial penalties to the state if quality goals are not achieved. | **State Quality Measures**<br>• Annual assessment of statewide performance on about 33* measures.<br>• Ensure quality of and access to care for Medicaid beneficiaries does not degrade during transformation.<br>• Because no money from CMS with this waiver → no financial penalties to the state if quality goals are not achieved.<br>*Final details of measurement strategy / list of measures yet to be approved. However, a lot of crossover with previous State Performance Measures. |

# Coordinated Care Organization Accountability to OHA

### Coordinated Care Organization (CCO) Incentive Measures

- Annual assessment of CCO performance on selected measures.
- Measures selected by public Metrics & Scoring Committee.
- CCO performance tied to bonus $
- Compare annual performance against prior year (baseline), to see if CCO met benchmark or demonstrated certain amount of improvement

Measure specifications and guidance documents online at:
http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Oregon Health Authority

# Quality Pool Structure

- CCOs must meet either the benchmark or an improvement target annually for each of the incentive measures to earn quality pool funds.
- Quality pool = percentage of actual CCO paid amounts during calendar year.
- Pool has increased annually:
  - 2% in 2013
  - 3%  in 2014
  - 4% in 2015
  - 4.25% in 2016
  - 4.25% in 2017 (not to exceed 5%)

# Quality Pool Distribution

**To earn their full quality pool payment in 2016, CCOs had to:**

- ✓ Meet the benchmark or improvement target on at least 13 of the 18 measures; and
- ✓ Have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from the quality pool goes to a **challenge pool**. To earn the challenge pool payments, CCOs had to meet the benchmark or improvement target on the four challenge pool measures.

All money in the pool is distributed every year.

# Measure Selection: A Public Process


Nine member committee, public process, select measures and set benchmarks

Ad hoc workgroup with CCO representatives, operationalize metric specifications, make recommendations to Committee

http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx and
http://www.oregon.gov/oha/analytics/Pages/Metrics-Technical-Advisory-Group.aspx

# CCO Incentive Measures since 2013

| CCO Incentive Measures | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|
| Adolescent well-care visits | x | x | x | x | x | x |
| Alcohol or other substance misuse screening (SBIRT) | x | x | x | x | [1] | |
| Ambulatory care: Emergency department (ED) visits | x | x | x | x | x | x |
| CAHPS composite: Access to care | x | x | x | x | x | x |
| CAHPS composite: Satisfaction with care | x | x | x | x | x | |
| Childhood immunization status | | | | x | x | x |
| Cigarette smoking prevalence | | | | x | x | x |
| Colorectal cancer screening | x | x | x | x | x | x |
| Controlling high blood pressure | x | x | x | x | x | x |
| Dental sealants | | | x | x | x | x |
| Depression screening and follow-up plan | x | x | x | x | x | x |
| Developmental screening (0-36 months) | x | x | x | x | x | x |
| Disparity measure: ED visits among members with mental illness | | | | | | |
| Early elective delivery | x | x | | | | |
| Diabetes: HbA1c poor control | x | x | x | x | x | x |
| Effective contraceptive use | | | x | x | x | x |
| Electronic health record adoption | x | x | x | | | |
| Follow-up after hospitalization for mental illness | x | x | x | x | x | |
| Follow-up for children prescribed ADHD medication | x | x | | | | |
| Health assessments within 60 days for children in DHS custody | x | x | x | x | x | x |
| Patient centered primary care home enrollment | x | x | x | x | x | x |
| Timeliness of prenatal care | x | x | x | x | x | x |

# Measure Selection in the Future:
## Senate Bill 440 (2015)

- Establishes Health Plan Quality Metrics Committee (HPQMC)
- Requires committee to develop a menu of health outcome and quality measures for CCOs and plans offered by Public Employees' Benefit Board, Oregon Educators Benefit Board, and the Insurance Exchange.
- Any metrics used for these plans must be on the menu developed by the Committee.
- Metrics & Scoring Committee now a subcommittee of the HPQMC.
- Will affect measure selection beginning with 2019 metrics (which are selected during 2018)

# Benchmarks and Targets

# Incentive Benchmarks

Incentive measure benchmarks are selected by the Metrics and Scoring Committee

Benchmarks are meant to be aspirational goals and are intentionally selected quite high, e.g. national Medicaid 75$^{th}$ or 90$^{th}$ percentiles.

When no national percentile is available, other sources are used, e.g. CCO top performers.

# Improvement Targets

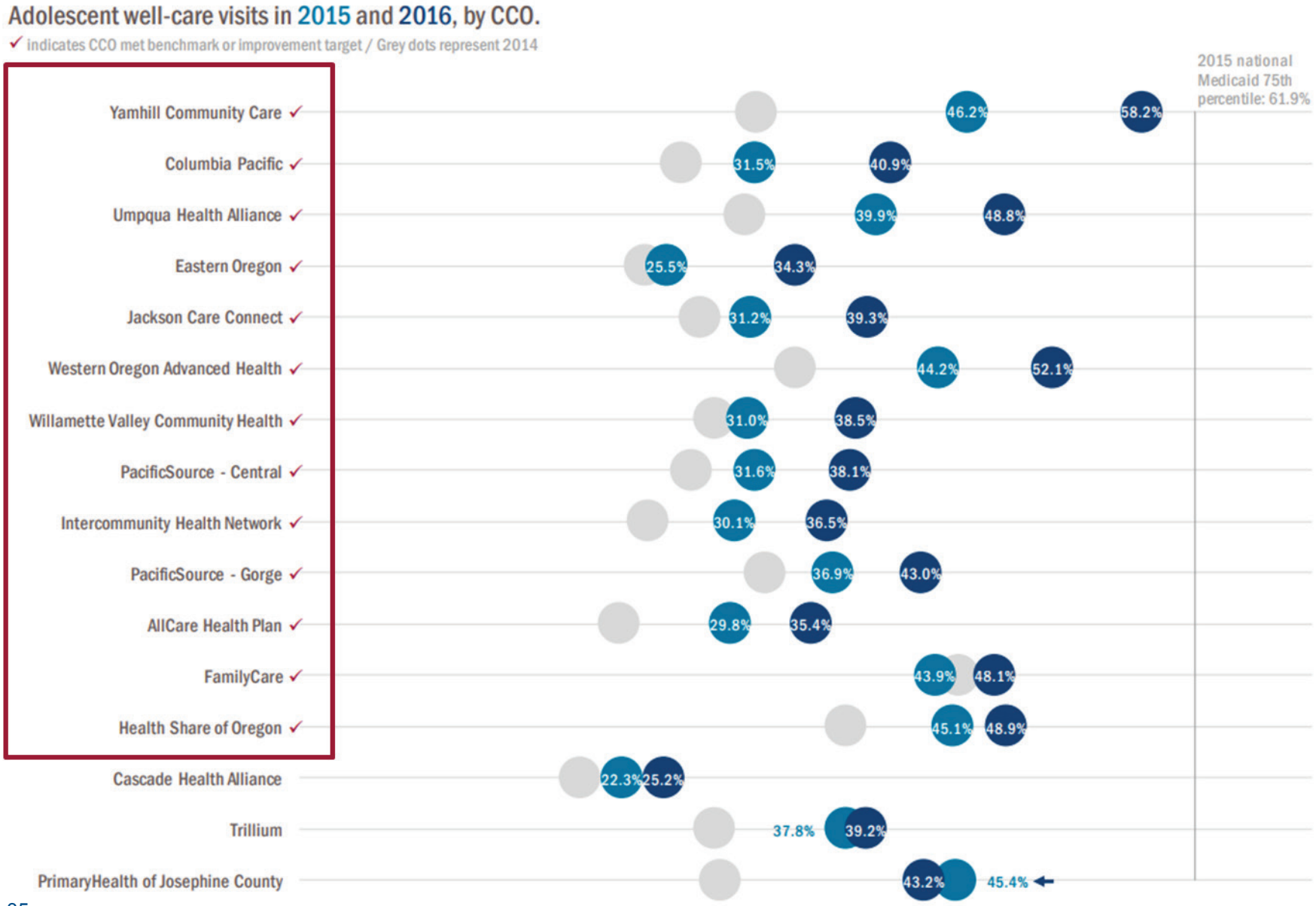
CCOs are not expected to meet the benchmark each year but rather to *make improvement toward* the benchmark.

To demonstrate this, CCOs can earn quality pool payment by

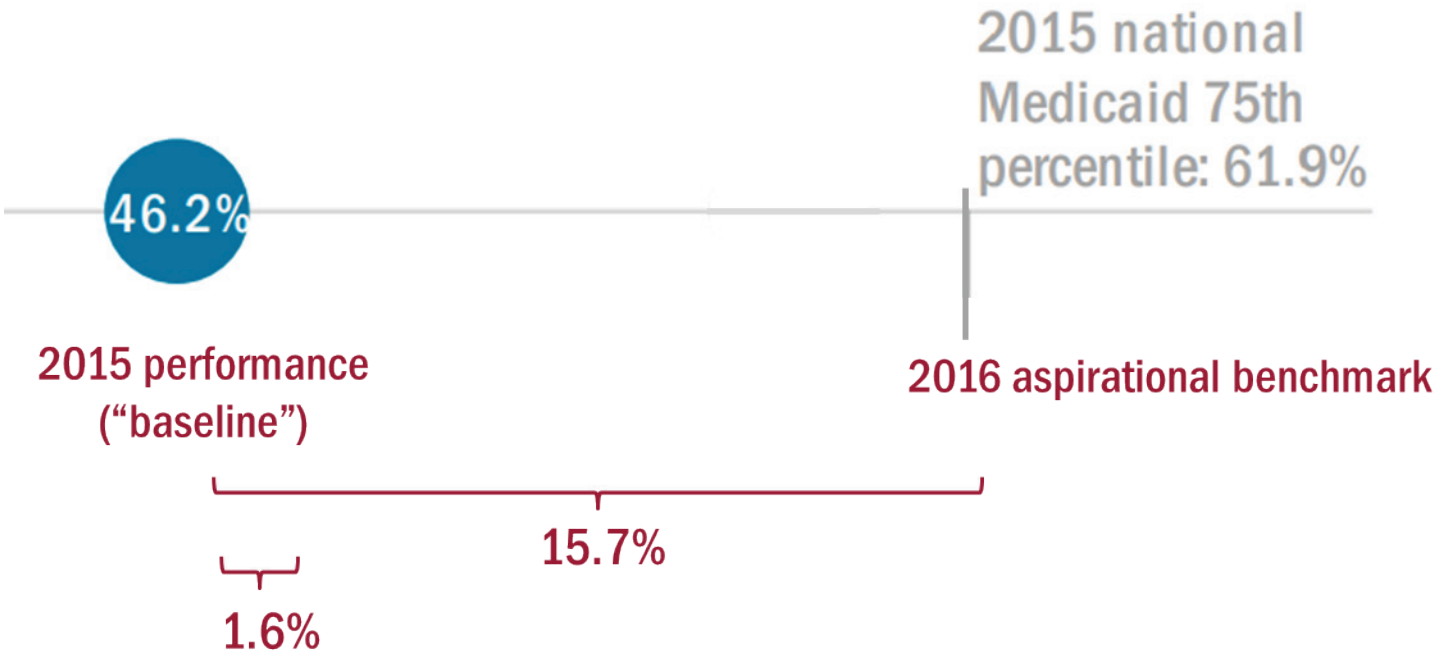
- achieving the benchmark *or*
- achieving their individual improvement target

**Improvement targets** require at least a 10 percent reduction in the gap between the CCO's prior year's performance ("baseline") and the benchmark to qualify for incentive payments.

# ADOLESCENT WELL-CARE VISITS



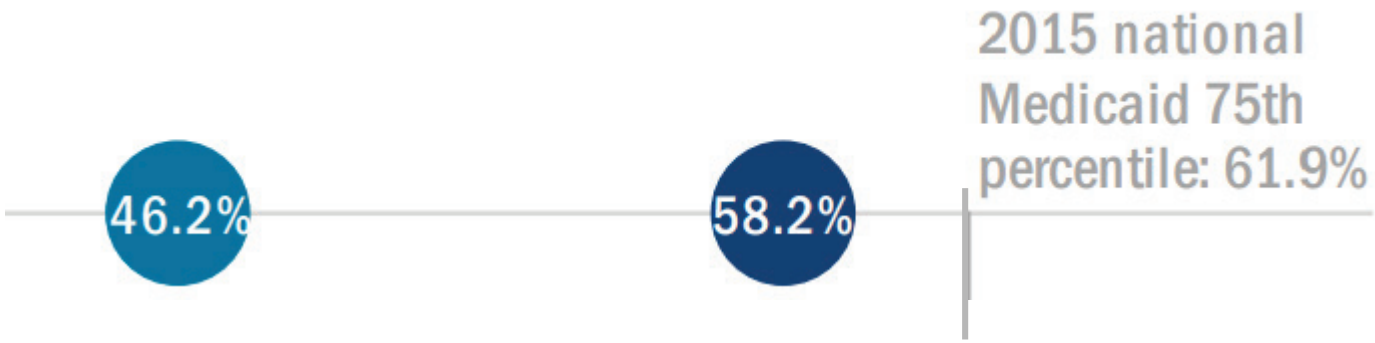
# Improvement target formula




The CCO must achieve 46.2% + [improvement target] in order to achieve the measure.

46.2% + 1.6% = 47.8%

# Improvement target formula

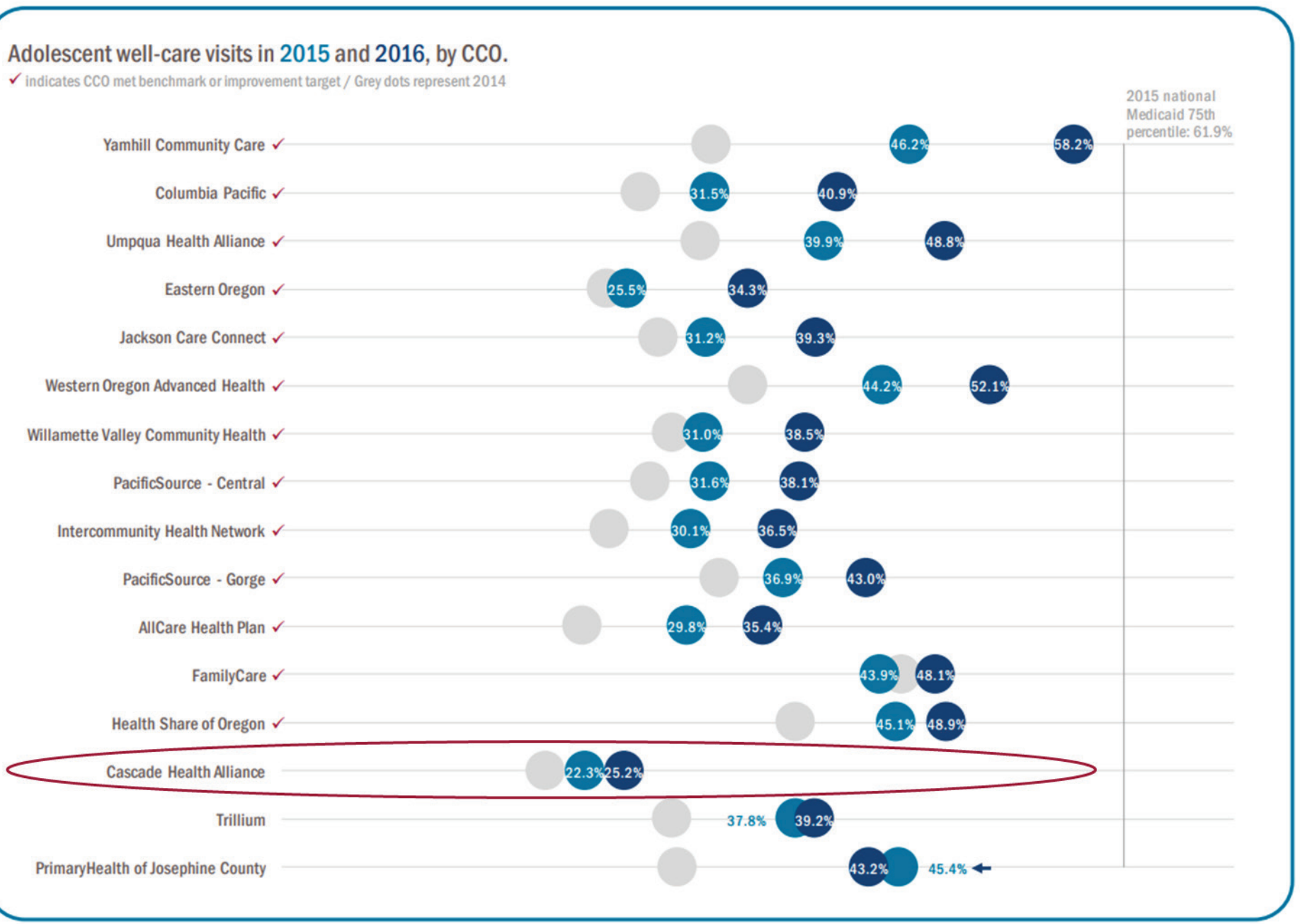



The CCO improved at least 1.6 percentage points, and thus earned the measure “by improvement target” without actually reaching the aspirational benchmark.

# Improvement target floor

- There is one caveat: The Metrics and Scoring Committee also establishes an **improvement target FLOOR**, meaning that an improvement target cannot be less than X percentage points above baseline.
- Typically, the floor is 2 or 3 percentage points.
- In the previous example, the improvement target was just 1.6 percentage points, which is less than the 3 percentage point floor.
- Thus, the CCO actually needed to achieve [46.2% + 3 = ] 49.2% in 2016.

# ADOLESCENT WELL-CARE VISITS



# Improvement target floor

2016 benchmark: 61.9%

Cascade Health Alliance


Cascade Health Alliance's 2016 improvement target per the formula is:

$$\frac{\text{[Benchmark] – [CCO baseline]}}{10} = \frac{61.9 - 22.3}{10} = 4 \text{ percentage points}$$

However, the FLOOR for this measure is 3 percentage points.

Thus, Cascade had to achieve 22.3 + 3 = 25.3 in 2016 to earn the measure

(They achieved 25.2... ouch!)

# Questions?

**Jon C. Collins, PhD**
Director of Health Analytics
jon.c.collins@state.or.us

1. Welcome and introductions ✓

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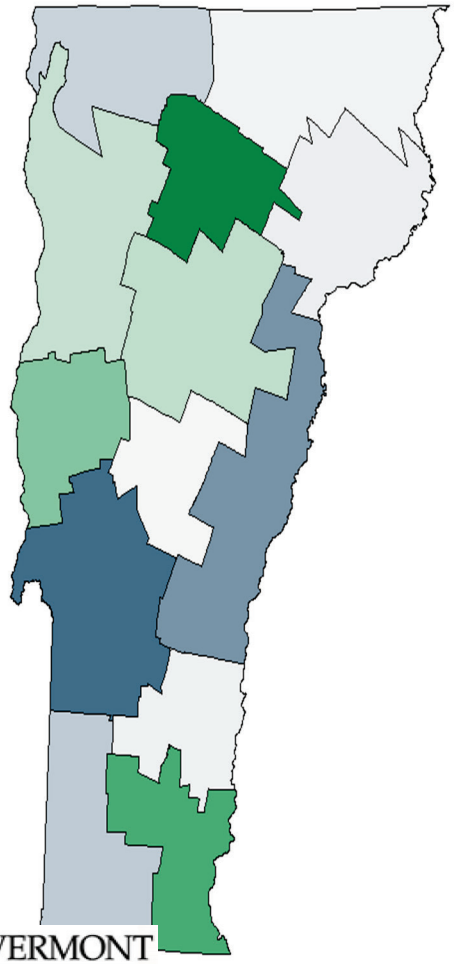

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# Vermont's Medicaid Accountable Care Organization (ACO) Shared Savings Program: Background and Performance Benchmarks

Alicia Cooper, Director of Payment Reform
Department of Vermont Health Access

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# Vermont ACO Shared Savings Program Background

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# SIM Testing Grant Supported Development of Vermont's ACO Shared Savings Programs

**2013**: VT Awarded $45 million State Innovation Model (SIM) Testing Grant from CMMI

- Used to Design, Implement, and Evaluate alternative multi-payer payment models in support of the Triple Aim

**2014**: VT Launched Commercial and Medicaid Shared Savings Programs

- Department of Vermont Health Access (DVHA) administers the Vermont Medicaid Shared Savings Program (VMSSP)
- Green Mountain Care Board (GMCB) and Blue Cross Blue Shield of Vermont (BCBSVT) administer the Commercial Shared Savings Program (XSSP)

# ACOs and SSPs

- Accountable Care Organizations (ACOs) are composed of and led by health care providers who have agreed to work together and be accountable for the cost and quality of care for a defined population
- ACOs can participate in a variety of payment arrangements – including Shared Savings Programs (SSPs)
- SSPs are payment reform initiatives developed by health care payers. SSPs are offered to providers (e.g., ACOs) who agree to participate with the payers to:
  - Promote accountability for a defined population
  - Coordinate care
  - Encourage investment in infrastructure and care processes
  - Share a percentage of savings realized as a result of their efforts
- Participation in ACOs and SSPs is voluntary

# Shared Savings Programs in Vermont

Shared Savings Program standards in Vermont, including performance benchmarks, were developed as a result of collaboration among payers, providers, and stakeholders, facilitated by the State

ACO SSP standards include:

- Attribution of Patients
- Establishment of Expenditure Targets
- Distribution of Savings
- Impact of Performance Measures on Savings Distribution
- Governance

# Vermont's ACO Participation in SSPs

| ACO Name | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| **Community Health Accountable Care (CHAC)** | Commercial SSP<br>Medicaid SSP<br>Medicare SSP | Commercial SSP<br>Medicaid SSP<br>Medicare SSP | Commercial SSP<br>Medicaid SSP<br>Medicare SSP | Commercial SSP<br><br>Medicare SSP |
| **OneCare Vermont (OneCare)** | Commercial SSP<br>Medicaid SSP<br>Medicare SSP | Commercial SSP<br>Medicaid SSP<br>Medicare SSP | Commercial SSP<br>Medicaid SSP<br>Medicare SSP | Commercial SSP<br>DVHA NextGen<br>Medicare SSP |
| **Vermont Collaborative Physicians/Health*first* (VCP)** | Commercial SSP<br><br>Medicare SSP | Commercial SSP | Commercial SSP | |

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# Beneficiary Attribution to an ACO SSP

People see their Primary Care Provider (PCP) as they usually do

If their PCP belongs to an ACO, the ACO can share savings based on the cost and quality of services provided to that person

ACO

Providers bill as they usually do

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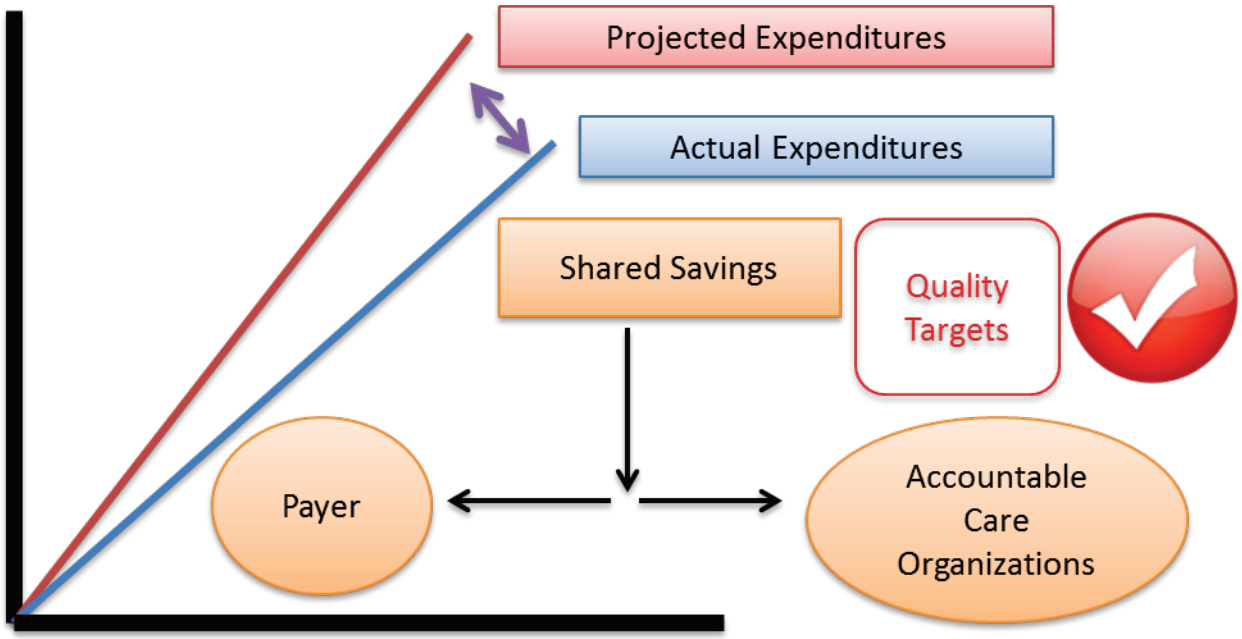
# Expenditure Targets in an ACO SSP

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# Multi-Stakeholder Process to Establish Quality Measures and Benchmarks

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# Convening Stakeholders: Quality Measures Work Group Members

Nearly 30 members from a wide variety of organizations, plus many additional participants, including representatives from:

- Vermont's three ACOs
- State agencies and programs
- Provider organizations
- Commercial insurers
- Consumer organizations
- Other organizations (e.g., Vermont Information Technology Leaders, Vermont Program for Quality in Health Care)

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# Work Group Objectives

To identify standardized measures that could be used to:

- Evaluate the performance of Vermont's ACOs relative to state objectives
- Qualify and modify shared savings payments
- Guide improvements in health care delivery

# Measure Selection Process for Year 1 (2014)

Over the course of nine months (January 2013-October 2013), the ACO Measures Work Group met about every two weeks.

Two sub-groups also held several meetings:

- Patient Experience of Care Survey Sub-group
- End-of-Life Care Measures Sub-group

Created “crosswalk” of more than 200 measures from numerous national, state (including Vermont), health plan and other measure sets

# Measure Selection Process for Year 1 (cont'd)

Using an intensive process, Work Group participants:

- Identified their priority measures for consideration
- Developed consensus criteria for measure evaluation
- Eliminated measures through application of criteria and extensive discussion
- Expressed support for and concerns about measures
- Focused on measures of various types, in various domains, with national specifications, with benchmarks, and with opportunities for improvement
- Compromised!
- Identified 31 measures for Commercial SSP and 32 measures for Medicaid SSP; further identified as Payment or Reporting
- Expressed widespread support, but not unanimity

# Impact of Payment Measure Quality Targets

## "Gate and Ladder" Approach:

- For most measures, compare to national benchmark and assign 1, 2 or 3 points based on whether ACO is at the national 25th, 50th or 75th percentile for the measure.
- For measures without national benchmarks, compare each measure to VT benchmark or baseline performance, and assign 0, 2 or 3 points based on whether ACO declines, stays the same, or improves relative to benchmark/baseline.
- The Medicaid SSP also allows additional points when performance improves over time.
- If ACO does not achieve required percentage of maximum available points across all payment measures, it is not eligible for any shared savings (this is the "Quality Gate").

# Measure Review Process for Year 2 (2015)

Continued to adhere to transparent process and obtain ongoing input from Work Group participants and others. Process more streamlined than in Year 1.

***March-June 2014***

- Interested parties presented ~20 measure changes for consideration for Year 2
- Work Group reviewed and finalized criteria to evaluate proposed changes
- Work Group discussed proposed measure changes

***June-July 2014***

- Using Robert Wood Johnson Buying Value Measure Selection Tool, Work Group Co-Chairs and Staff scored each measure change against approved criteria and developed proposals for Year 2 measure changes
- Work Group reviewed and discussed proposals; voted to approve 30 measures, including some proposed changes

# 2016 VMSSP "Quality Ladder"

**Quality Gate** →

| Percentage of available points | Percentage of earned savings |
|---|---|
| 55% | 75% |
| 60% | 80% |
| 65% | 85% |
| 70% | 90% |
| 75% | 95% |
| 80% | 100% |

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# 2016 VMSSP Payment Measure Results

| Measure | CHAC Rate / Percentile / Points* | OCV Rate / Percentile / Points* |
|---|---|---|
| All-Cause Readmission | 15.82/**/2 Points | 11.42/**/2 Points |
| Adolescent Well-Care Visits | 48.82/Above 50th/3 Points | 51.27/Above 50th/3 Points |
| Mental Illness, Follow-Up After Hospitalization | 39.69/Above 25th/1 Point | 52.30/Above 50th/2 Points |
| Alcohol and Other Drug Dependence Treatment | 29.51/Above 50th/2 Points | 27.56/Above 50th/2 Points |
| Avoidance of Antibiotics in Adults with Acute Bronchitis | 24.63/Above 50th/2 Points | 32.46/Above 75th/3 Points |
| Chlamydia Screening | 44.47/Below 25th/0 Points | 50.51/Below 25th/0 Points |
| Developmental Screening | 30.13/**/3 Points | 57.15/**/3 Points |
| Rate of Hospitalization for People with Chronic Conditions (per 100,000) | 449.87/**/2 Points | 504.12/**/2 Points |
| Blood Pressure in Control | 64.74/Above 75th/3 Points | 68.42/Above 75th/3 Points |
| Diabetes Hemoglobin A1c Poor Control (lower rate is better) | 21.52/Above 90th/3 Points | 18.77/Above 90th/3 Points |

*Maximum points per measure = 3 **No national benchmark; awarded points based on change over time

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# Summary of SSP Financial and Quality Results 2014-2016

| | Vermont Medicaid Shared Savings Program (VMSSP) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Actual PMPM | | | PMPM Savings (Loss) | | | Quality Score | | |
| | 2014 | 2015 | 2016 | 2014 | 2015 | 2016 | 2014 | 2015 | 2016 |
| CHAC | $189.83 | $182.06 | $180.53 | $24.85 | $7.03 | $0.75 | 46% | 57% | 70% |
| OneCare | $165.66 | $171.55 | $168.88 | $14.93 | $(2.18) | $(3.41) | 63% | 73% | 77% |
| VCP | | | | | | | | | |

**NOTE:** 2014 and 2015 results based on 6 months of claims runout; 2016 based on 4 months.

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# Ongoing Assessment of Measure Impact

- Additional monitoring measures related to utilization and cost can help identify unintended consequences
- Review of trends over time and among ACOs can highlight variation (e.g., “Data Summit” for ACOs, payers and QI leaders)
- Annual measure review ensures that specifications are current and evidence changes are addressed (e.g., LDL screening, mammography)
- Ongoing stakeholder feedback (e.g., from providers) can identify issues that arise at the working surface

# Thank You

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1. Welcome and introductions ✓

2. Overview of benchmarking purposes and approaches ✓

3. Oregon's Coordinated Care Organizations P4P Program ✓

4. Discussion ✓

5. Vermont's Shared Savings Program ✓

6. Discussion ✓

**7. Wrap-up**

# Key Takeaways

- Carefully consider stakeholders for inclusion in developing and setting benchmarks
- Choose the method for benchmarking that suits the context and goals for measurement
- Set benchmarks to motivate, not demoralize
- Allow opportunities for adjustment to benchmarks over time

# Additional Resources

- **Webinar Slides and accompanying issue brief**

**https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/index.html**