CONTRACTING CONSIDERATIONS: QUALITY

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DHCF
Department of Health Care Finance

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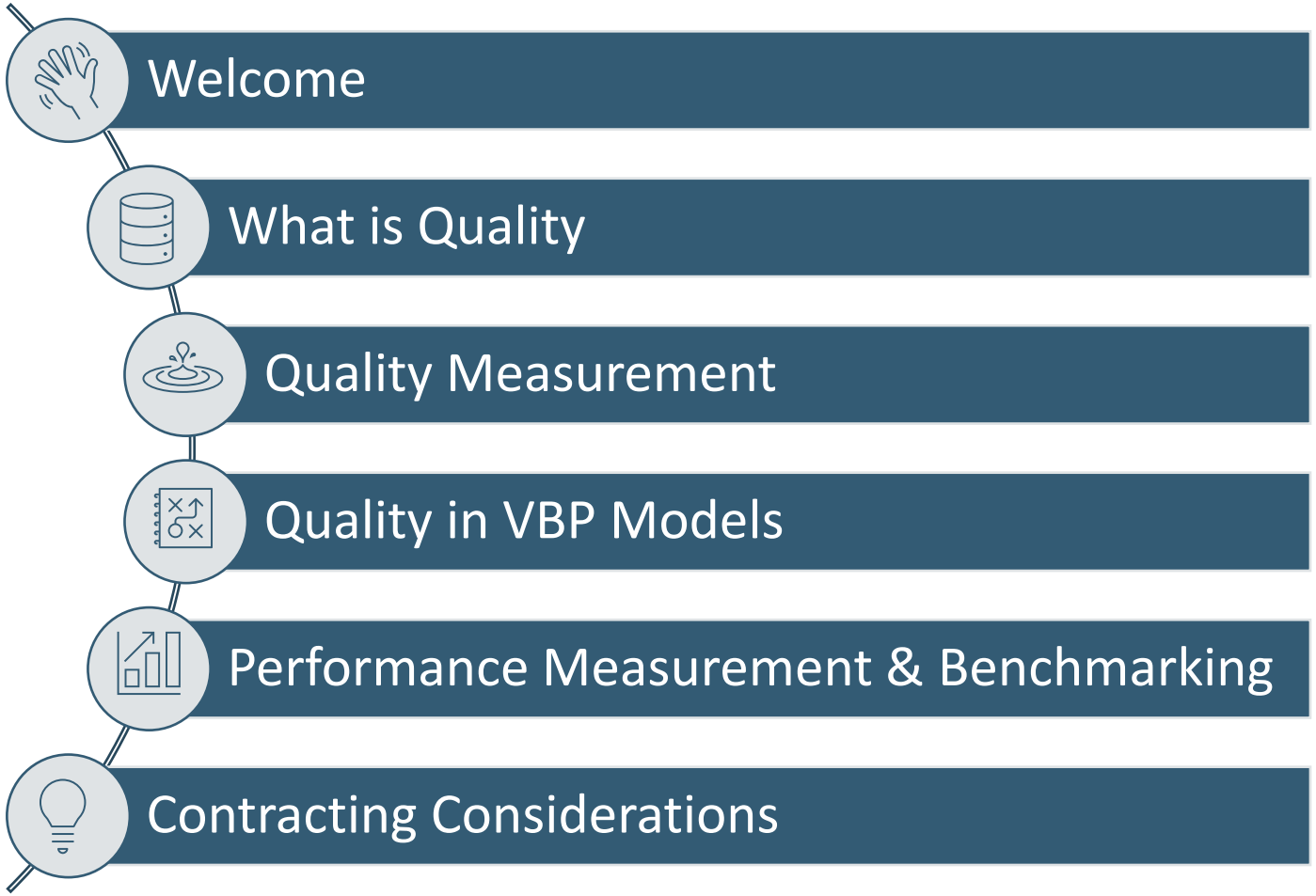
AGENDA



Learning Objectives:

1. Explain the importance of quality in Value Based Payment (VBP)
2. Identify 3 ways data can support your organization in demonstrating performance in VBP arrangements
3. Describe the types of benchmarking
4. Identify 2-3 key meaningful metrics for your organization for VBP
5. Evaluate contract terms that relate to quality initiatives and VBP arrangements

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WHAT IS QUALITY?

WHY QUALITY MATTERS IN VBP FOR PROVIDERS

- In Fee for Service (FFS) models, services are delivered, and the cost has little to do with the outcome.
- In VBP payment is tied to quality outcomes, not just the quantity of care.
- 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.
- 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.

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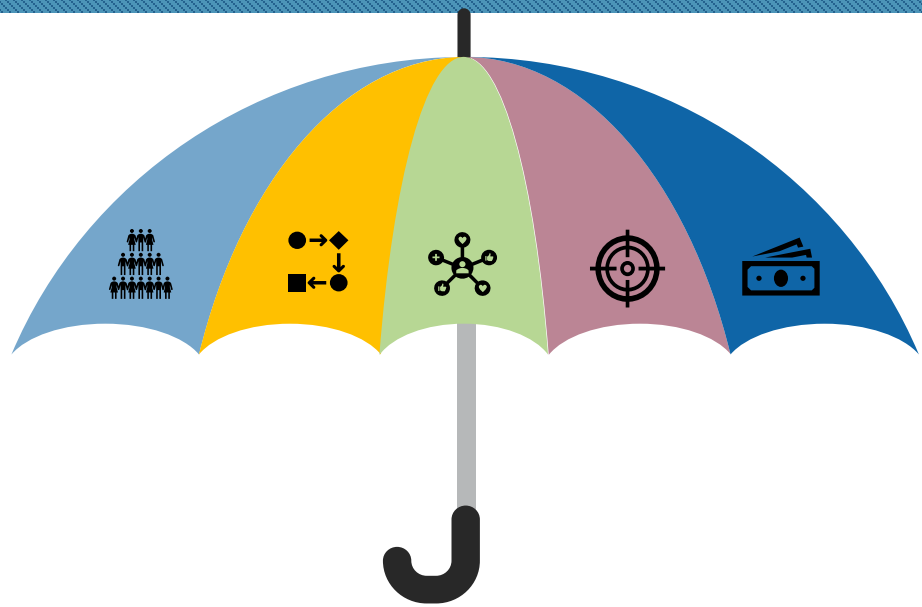
QUALITY STRATEGY UMBRELLA

POPULATION HEALTH OUTCOMES

The use of a deliberate and defined quality improvement process focused on activities that are responsive to the needs of a community, population, or membership panel. This supports the organizational priorities along with other processes like state requirements and accreditation.



VALUE BASED CARE

Value-based care reimbursement strategies represent a shift from quantity of services delivered to quality of services delivered. Measuring and benchmarking outcomes along with other quality improvement practices enhance the culture of quality and the culture of VBC.

CLINICAL PROCESS OPTIMIZATION

A data-driven quality strategy leverages available data to empower leadership, teams, and providers with the ability to continuously analyze and address care gaps and inefficient workflows.

SOCIAL NEEDS

Identifying and addressing social needs support a whole-person approach to health and impact rising costs and low outcomes. Establishing quality metrics and integration of SDOH into clinical workflows are ways to improve social supports and monitor quality performance.

INNOVATIVE INITIATIVES

Promoting an experimental culture through quality provides space to develop new ideas and engage in small tests of change to identify scalable strategies that impact various populations, needs, and outcomes allowing for shared experimental learning

ALIGNING WITH CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) VISION FOR HEALTHCARE QUALITY

Value **for all people.**

- **Care that is the highest quality**
  - **Safe with best outcomes**
  - **Patient-centered**
  - **Equitable**
- **And also affordable**

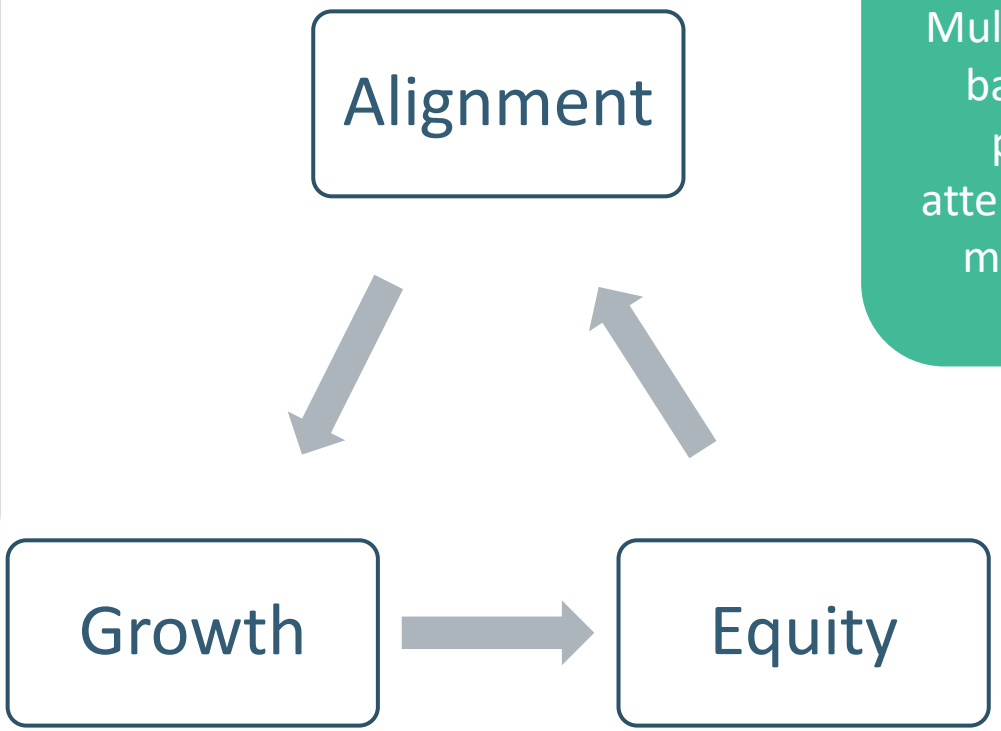
Source: innovation.cms.gov

ALIGNING WITH CMS VISION FOR HEALTHCARE QUALITY

GROWTH

Goal: have all beneficiaries as part of an accountable care relationship by 2030

Growth of accountable care relationships can improve quality, increase savings for Medicare, and promote innovative delivery of services that meet patients' needs.



ALIGNMENT

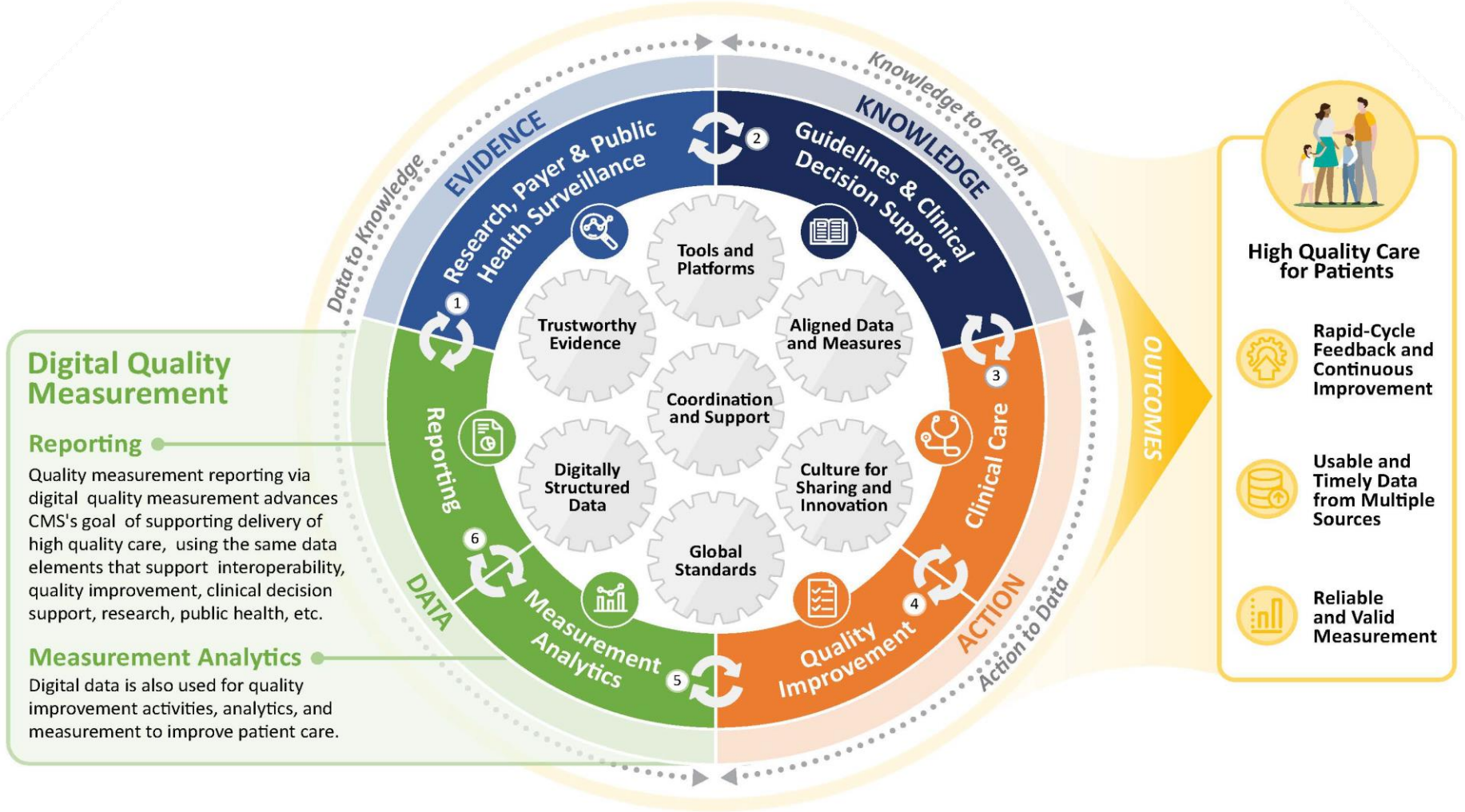
Multi-payer alignment is critical. If value-based arrangements are not aligned, providers face challenges focusing attention on the right quality metrics and making the investments necessary to improve care

EQUITY

Profound inequities exist across our healthcare system. The design of value-based arrangements can be a key way to advance equity. Quality care for all is not possible if care is not equitable

Source: Jacobs, Douglas, Elizabeth Fowler, Lee Fleisher, and Meena Seshamani. The Medicare Value-Based Care Strategy: Alignment, Growth, and Equity. Health Affairs Forefront. July 21, 2022. 10.1377/forefront.20220719.558038

USE OF STANDARDIZED DATA TO DRIVE HEALTHCARE



Sponsoring HL7 Workgroups: Clinical Decision Support (CDS) | Clinical Quality Information (CQI) | Public Health (PH)

Adapted from HL7 Clinical Quality Information (CQI) Workgroup by Maria Michaels, Centers for Disease Control and Prevention

Source: eCQI

HOW DO WE MEASURE IT?

TYPES OF MEASURES

STRUCTURE

Inputs/Resources

-People
-Infrastructure
-Materials
-Information
-Technology

PROCESS

Activities

- What is done
- How it is done
- How much of it is done

OUTCOMES

Outputs

-Change in health behavior
-Change in health status
-Patient satisfaction
-Change in cost
-Return on investment

(Avedis Donabedian, MD)

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TYPES OF MEASURES

STRUCTURE	PROCESS	OUTCOMES
Inputs/Resources	**Activities**	**Outputs**
-People -Infrastructure -Materials -Information -Technology	- How much of it is done - How it is done	-Change in health behavior -Change in health status -Patient satisfaction -Change in cost -Return on investment

95% of measures used to assess quality as the basis for APM incentives are ***process*** measures

(Avedis Donabedian, MD)

Source: RTI Health Advance

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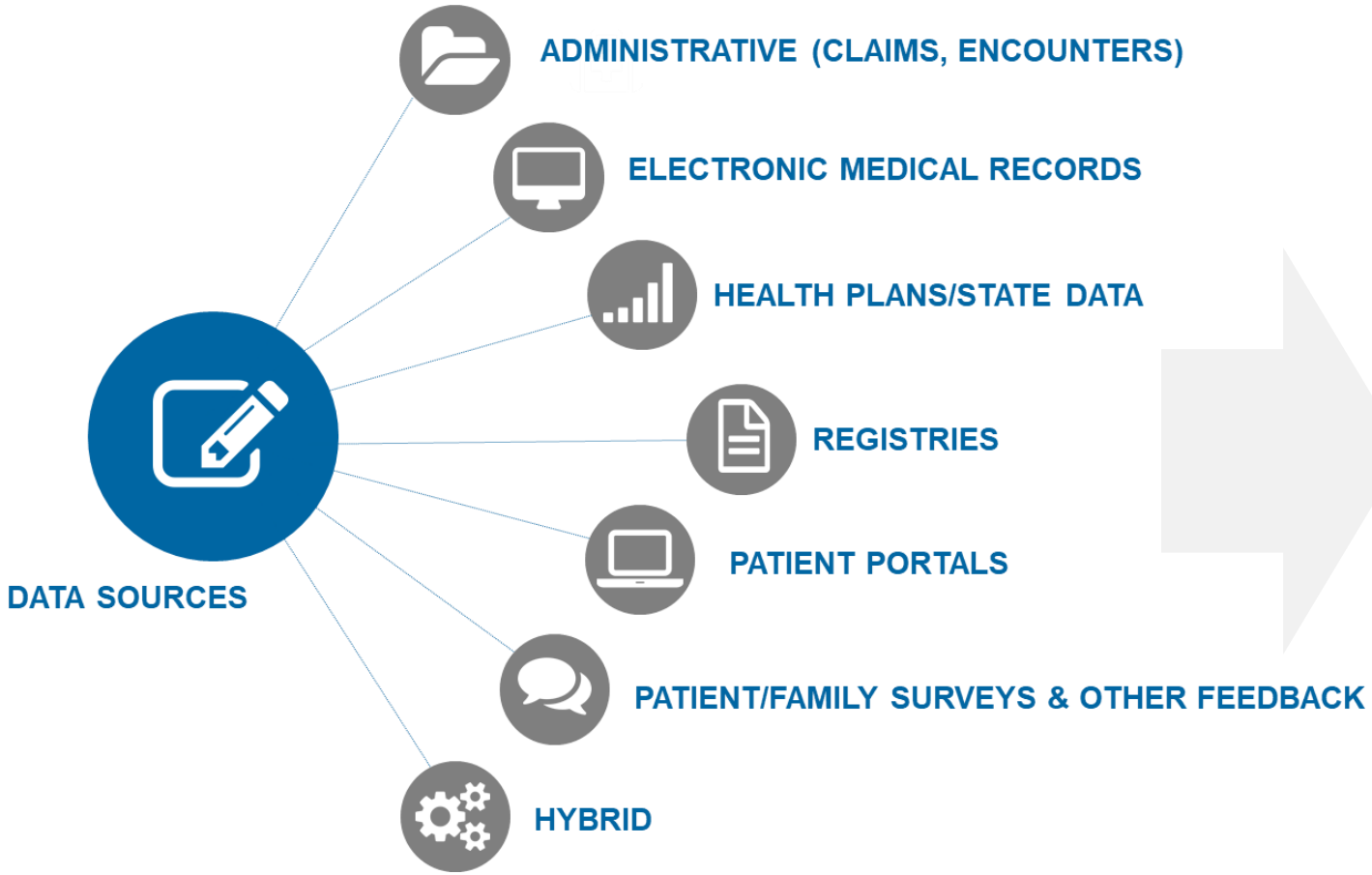
DATA SOURCES AND MEASURES



Use Standardized Measures from Existing Sources:

- **P4P** reported by health plans
- **HEDIS** reported to DC/health plan
- **UDS** reported to HRSA
- **Core Set** reported to CMS
- **GPRA** reported to SAMHSA
- **NOMS** reported to SAMHSA
- **CRISP** data/metrics

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EXAMPLE MEASURES

Type	Metric	Description	Alignment
Outcome	Depression remission at 12 months	Percentage of patients 12+ years of age with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an initial event	UDS
Outcome	Plan All Cause Readmission	The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge among adults aged 18 and older	AmeriHealth P4P; HEDIS; Core Set
Outcome	Low Acuity Non-Emergent (LANE) ED Visits	Percentage of avoidable, low-acuity non-emergent, emergency department visits	DHCF VBP
Process	Screening for trauma-related experiences	The intent of this question is to reinforce the importance of screening clients for experiences of violence or trauma that may impact their recovery journey	NOMS
Structure	Number and percentage of work group/advisory group/council members who are consumers/family members	Assesses the number and percentage of work group/advisory group/council members who are consumers/family members to assess consumer involvement in the planning of mental health services	GRPA

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PERFORMANCE MEASURES AND BENCHMARKS

PERFORMANCE MEASURES AND BENCHMARKS

- Benchmarks are predetermined standards and benchmarking is the process of defining and setting those standards
- A common component across value-based payment models is the use of standardized measures and benchmarks
- Performance and quality are powerful catalysts for quality improvement innovation
- Benchmarking is the process of determining the standards against which performance is assessed
- Benchmarking methods may differ depending on the type of performance improvement desired
- Continual assessment of benchmarks is crucial to adapting changes, mitigating challenges, and ensuring standards for performance are set at optimal levels to incentivize ongoing progress
- Understanding the composition of the provider landscape to the patient population is integral to adequate disparity tracking

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WHAT ARE WE ACCOUNTABLE FOR IN QUALITY?

1) Quality Reporting, 2) Quality Improvement, 3) Payment Based on Quality Performance

Type	Medicaid Providers	Behavioral Health Providers	FQHCs
Regulatory (Federal)	CMS: States must **report** Adult and Child Core Set metrics and T-MSIS States must also require their Health Plans to report measures, conduct performance improvement projects (overseen by EQRO)	SAMHSA: BH providers must **report** NOMS and GRPA (if grantees) BH providers are responsible for ongoing quality **improvement** related to certain grants CMS: must **report** T-MSIS BH-specific measures	HRSA: FQHCs must **report** UDS metrics FQHCs must have ongoing quality **improvement**/assurance (QI/QA) system
District of Columbia	In 2019, DHCF set 5-year strategic priorities for managed care quality in the 2019-2023 Quality Strategy Oversees measures, performance **improvement** projects Adopted the CMS Core Set as required by CMS	DBH: requires **reports** on MHEASURES, 14 Key Performance Indicators	DHCF: FQHCs must **report** UDS metrics (once approved by HRSA) ; and must **report** and get **paid** for additional P4P metrics (bonus pool) FQHCs must provide their HRSA-approved quality **improvement** plan to DHCF (to be included in P4P)
Medicaid MCOs	MCOs: Required to **report** on quality (HEDIS) Conduct performance **improvement** projects Get **paid** on Quality (P4P: Plan All-Cause Readmissions, Potentially Preventable Hospitalizations, Low Acuity Non-Emergent (LANE) ED Visits)	MCOs: must **report** on BH-specific quality	Must **report** additional P4P metrics
Providers	MCOs involve providers in performance **improvement** MCOs **pay** providers for Quality (VBP)	Some MCOs **pay** providers for Quality (VBP) specific to BH	FQHCs **report** UDS; meet performance expectations Identify areas for **improvement** in outcomes DHCF **pays** for performance related to FQHC-specific P4P metrics

TYPES OF BENCHMARKING

External Benchmarking

- Compares an organization's process or outcome to a set external published standard
- Compares an organization's process or outcomes metrics to another provider or standard established by an accrediting body or payer

Internal Performance Benchmarking

- Uses organizational knowledge to answer questions
- Compares base rate performance of a team or clinician on specific metrics to another team or clinician within the same organization

Strategic Benchmarking

- This type of benchmarking can be leveraged when the process is attempting to problem-solve a hard to identify issue
- The goal is to identify best-in-class performance standards which often means looking to other companies, industries, cultures, etc. to develop a new standard for achievement

DETERMINING PERFORMANCE BENCHMARKS AND TARGET SETTING

Different types of performance targets will be used for individual practice metrics and may include focus on high-risk groups or conditions, priority populations, and/or 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 screening for _____
  - 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.

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HOW PERFORMANCE TARGETS MAY BE SET IN A VBP ARRANGEMENT

- Improvement targets may be structured based on the Minnesota Department of Health's Quality Incentive Payment System ("Minnesota method" or "basic formula")* which is used by several states in their VBP strategies
- 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: **[Provider Group's Baseline] + [X] = Improvement Target**

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/QIPSReport051012final.pdf

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DETERMINING PERFORMANCE BENCHMARKS: MAINTENANCE AND IMPROVEMENT TARGETS

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

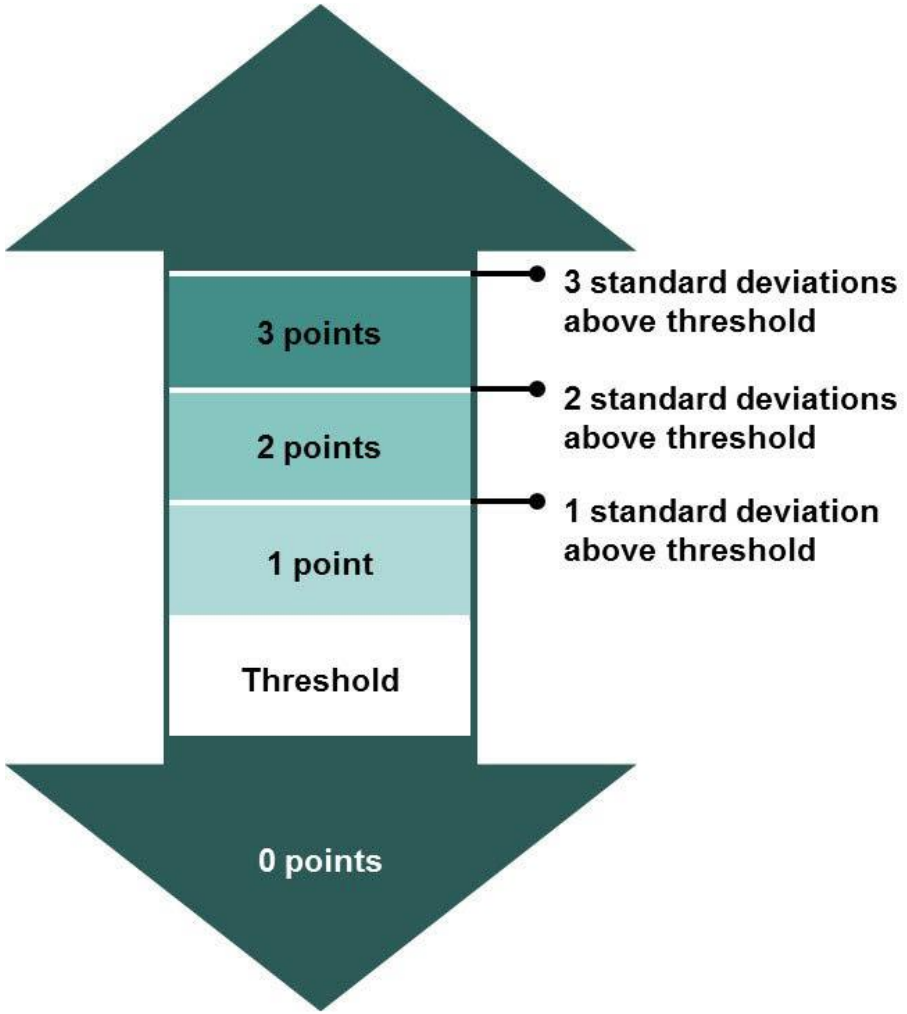
Quality Measures	Maintain Quality	Improve Quality 5%	Improve Quality 10%	Quality Points	Points Possible
Percentage of members who receive influenza vaccine	1			1	3
Percentage of enrolled children 3-17 who have weight screening and counselling on nutrition and physical activity	1	1		2	3
Percentage of enrolled adolesents 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
TOTAL POINTS				9	18
MINIMUM PASSING SCORE				7	

EXAMPLE: CONNECTICUT PATIENT CENTERED MEDICAL HOME PLUS PROGRAM

	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
Total Points				9.5	19.0
Aggregate Quality Score (Total Quality Points/Total Possible Points)					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.

DETERMINING PERFORMANCE BENCHMARKS: TIERS OF PERFORMANCE



- Developing tier of performance is the practice of identifying thresholds for point assignment.
- The actual distribution of performance across participating organizations will factor into the decision to use a tiered approach and the particular point levels.
- This is an example of a tiered point assignment in which performance is sufficiently distributed by standard deviations from the benchmark (sometimes the mean).
- In this case, the higher the standard deviation from the benchmark, the better the performance; thus, performance up to one standard deviation above the benchmark earns one point, one to two standard deviations above earns two points, and more than two standard deviations earns three points.

Source: 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

SPECIAL CONSIDERATIONS

SPECIAL CONSIDERATIONS: EXACERBATING INEQUITY

- 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?

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SPECIAL CONSIDERATIONS: SMALL NUMBERS

Providers with small populations or panel sizes may need to consider:

- 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 payers may group small providers together for purposes of measurement or encourage them to align efforts under a VBP arrangement.

SPECIAL CONSIDERATIONS: PREVENTING EXACERBATION OF INEQUITY

- 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?

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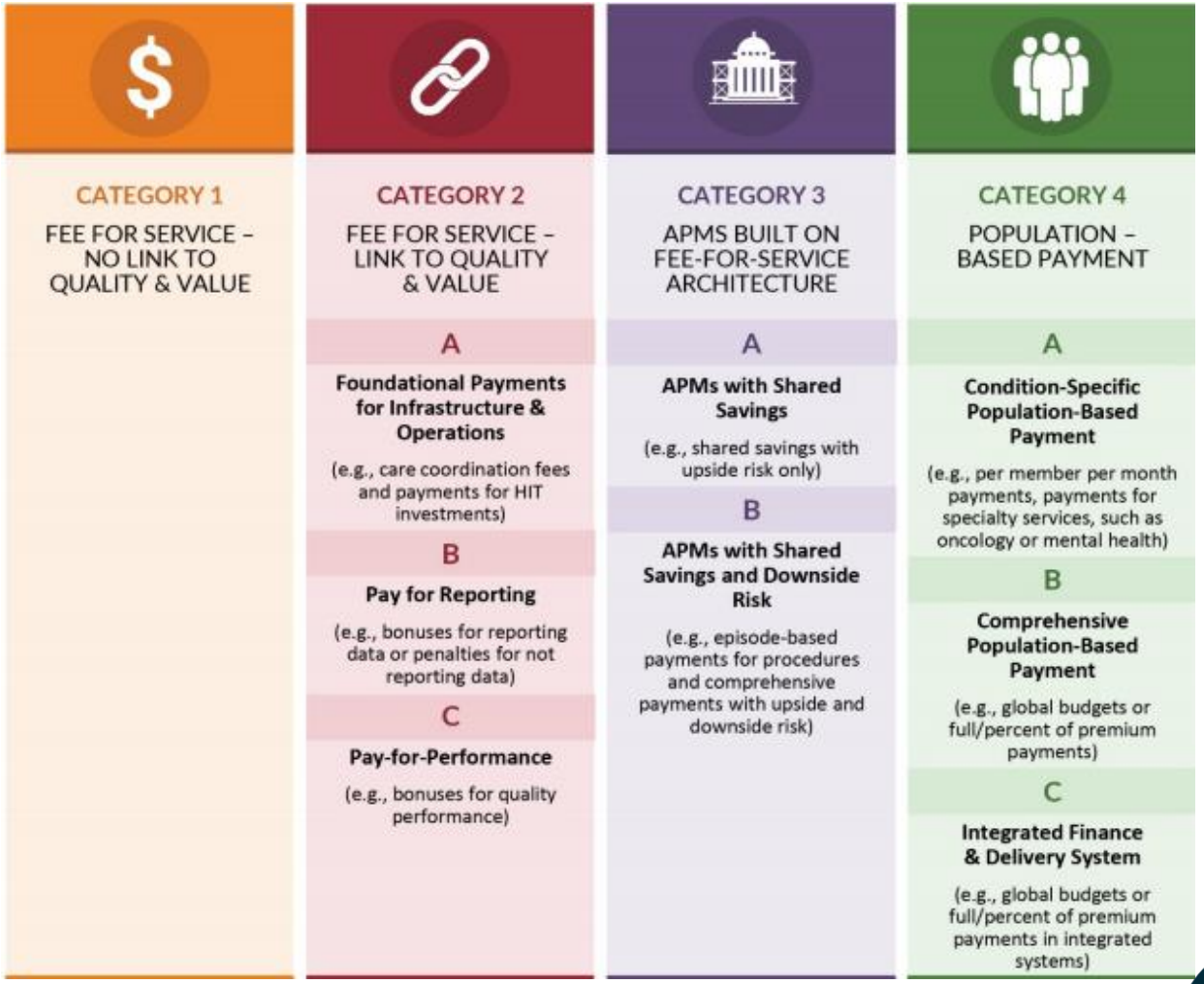
CONTRACTING CONSIDERATIONS

VALUE-BASED PAYMENT MODELS

- The Health Care Payment Learning & Action Network (HCP-LAN) was created to **drive alignment** in payment approaches across the public and private sectors of the U.S. health care system.
- The HCP-LAN created a **common framework** for adoption and measurement of VBP across all payer types (Medicare, Medicaid, and Commercial).



Source: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

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HCP-LAN CATEGORY 2

- Category 2: FFS payments linked to quality and value.
- FFS payments are adjusted based on other factors, such as infrastructure investments, whether providers report quality data (pay-for-reporting), and/or performance on cost and quality metrics (pay-for-performance).
  - **Category 2A (Foundational Payments):** Payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics.
  - **Category 2B (Pay for Reporting):** Positive or negative payment incentives to report quality data.
  - **Category 2C (Pay-for-Performance):** Payments that reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality.

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PAY-FOR-PERFORMANCE PROGRAMS

» **Advantages** of performance-based payment incentives:

- Provides a financial reward for achieving clinical benchmarks or outcomes.

» **Disadvantages** of performance-based payment incentives:

- Staff time and process investments to track and report data to MCOs.
- Multiple and inconsistent measurement sets across MCOs.

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PAY-FOR-PERFORMANCE PROGRAMS

- **P4P Programs:** A provider is not usually placed at any financial risk to participate in APM Category 2C (P4P) VBP incentive arrangements
  - Even if the provider does not qualify for incentive payments, participation in those arrangements may "kick-start" internal delivery changes and partnerships with other providers to qualify for future payments
- **Practice Pointers:** During negotiation of contracts (and contract amendments!) with MCOs, providers should affirmatively request participation in an MCO's P4P programs to maximize overall reimbursement
  - If an MCO is not willing to permit participation in P4P programs at the point of contracting, a provider should seek language that entitles the provider to participation at a future date, upon meeting eligibility requirements, or otherwise

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VBP PERFORMANCE MEASURES

- To facilitate participation in multiple VBP arrangements, providers should seek performance measures that have standard definitions and methodologies for calculating scores (*e.g.*, HEDIS measures).
  - Ideally, the Medicaid measure sets, and incentives would align with those used by Medicare and commercial payers.
- Providers should:
  - Be familiar with the performance measures applicable to MCOs (particularly Medicaid MCOs)
  - Understand the financial rewards available to MCOs (if any)
  - Prioritize internal operations to score high on those performance measures and
  - Leverage those results for favorable VBP arrangements with MCOs

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VBP PERFORMANCE MEASURES

» Practice Pointers:

A provider's terms of participation in VBP arrangements should contain clear language regarding the population of patients subject to the performance measures, the definitions and methodology for calculating scores, and the financial rewards available.

The MCO should not be permitted to change the performance measures (or methodology) after they have been established for any given performance year, at least without the provider's consent.

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ACCESS TO DATA

- **Access to Claims Data and Reports:** Providers need timely, accurate, and usable data to be successful in VBP arrangements
  - Timely receipt of patient health information related to emergency room visits, hospitalizations, and physical health care is essential for performing well on P4P incentives and managing the total costs of care of the attributed population
- Many VBP contracts are silent on furnishing data to a provider or allow the MCO to decide which reports it will share with a provider
- "Real-Life" Example:
  - *Reports. [Health Plan] will provide ACO with monthly standard reports. [Health Plan] reserves the right to revise, replace and discontinue reports from time to time. [Health Plan] will not provide to ACO any reports or data which would cause [Health Plan] to be out of compliance with any obligations, contractual or otherwise, regarding confidentiality of information.*

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ACCESS TO DATA

Contracting Pointers:

- The contract should contain clear language that requires the MCO to furnish all information necessary to do well under the VBP arrangement, on a real-time basis
- Contracts should specify the type of data that the provider is entitled to receive, the timeliness of such data, and the frequency in which the MCO must provide the data to the provider (See next slide)
- If the MCO fails to meet its data sharing obligations, the provider should be held harmless from any loss of revenue arising from unearned payment withholds or downside financial risk

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EXAMPLE: SAMPLE REPORTS

REPORT NAME	DATA	FREQUENCY
Attribution	Attributed Medicaid Members with demographic and contact Information.	Monthly
Emergency Department Utilization Overview	Overview of emergent and non-emergent utilization that will include a Summary Report and Member Level Detail Report for members with 3+ non-emergent ED visits.	Monthly
Inpatient Utilization Overview	Overview of inpatient utilization that will include a Summary Report and Member Detail Report for members with the greatest number of inpatient admissions, and a Readmission Report.	Monthly
Quality Threshold Targets	A report that tracks the quality threshold targets.	Monthly
Performance Measures	A report that tracks performance measures; includes current rate (numerator and denominator) as compared to benchmark and previous time period.	Quarterly
Budget Tracking Report (Financial Reporting)	Shows at service category level, budget, actual performance and variance to the budget.	Quarterly - by the 15th of the second month following the end of the quarter
Claims Data	Member-level claims data.	Monthly
IBNR	IBNR for Attributed Members.	Monthly

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Q&A

WRAP-UP/NEXT STEPS

BRIEF EVALUATION

1. Overall rating:

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

2. Content Level:

1. Too Easy 2. Just Right 3. Too Advanced

3. Which TA modalities are you interested in for additional TA? *(Select all that apply)*

1. Webinars 2. Individual Coaching 3. Group Coaching

4. Which domains are you interested in receiving additional TA in? *(Select all that apply)*

1. Financial 2. Clinical 3. Legal 4. Business

UPCOMING SESSIONS & MORE INFORMATION

Upcoming Cohort Sessions:

- **Key Considerations for Value Based Payment Arrangements**
  (Sept. 19, 12 – 1 pm ET)

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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September 21st

VBP Virtual Learning Collaborative

HMA

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