PHPG

The Pacific Health Policy Group

# OVERVIEW OF VALUE-BASED PURCHASING (VBP) PROGRAMS WITH THE VERMONT AGENCY OF HUMAN SERVICES

## Task 2 Report:

## Identification of Key Components / Standardized Criteria of Well-Developed VBP Programs

***Submitted to:***

**THE DEPARTMENT OF VERMONT HEALTH ACCESS**

***FINAL Report***

***May 31, 2015***

Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

# Table of Contents



Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.

## *Introduction to Overall Project and this Report*

The State of Vermont, Department of Vermont Health Access, contracted with the Pacific Health Policy Group (PHPG) to identify the major programs for which the Agency of Human Services (AHS) procures direct care (as opposed to administrative) services from another entity, examine these programs regarding their utilization of value-based purchasing (VBP) methodologies, and make recommendations to strengthen VBP within these programs.

## Specific Project Tasks

***Task 1: Project Initiation and Status Meetings***

***Task 2: Identify Key Components / Standardized Criteria of Well-developed VBP Programs*** *(September 2014)*

- 2a. Develop clear working definition of VBPs, including characteristics
- 2b. Conduct brief literature review to identify components/criteria
- 2c. Prepare overview for State review, including citations

***Task 3: Inventory and Describe AHS Programs***

- 3a. Develop an initial list of AHS major programs for which AHS procures direct care services from another entity, and the utilization, if any, of VBP by these programs
- 3b. Work with key AHS Leadership staff to identify gaps in program identification and VBP utilization
- 3c. Provide list to State VBP Project staff for prioritization of programs for inclusion in future tasks
- 3d. Meet with VBP program leads (by phone or in-person) to obtain additional insights about the prioritized programs' status, strengths and challenges regarding utilization of VBP
- 3e. Summarize and describe each prioritized program based on information gathered in 3a. through 3d.

***Task 4: Conduct an Objective Assessment of Each Program based on Identified Standardized Criteria*** *)*

- 4a. Conduct an assessment of each identified AHS program as related to the standardized criteria identified in Task 2
- 4b. Identify key considerations, challenges and recommendations for enhancing and advancing each program towards incorporation of all characteristics of VBPs

***Task 5: Develop and Submit Summary Report***

- 5a. Summarize information developed in Tasks 3 and 4 into a Draft Report for State Project Staff Review
- 5b. Prepare and submit a final report that incorporates the feedback received from State staff

This report is in response to Task 2: Identification of key components / standardized criteria of well-developed VBP programs. The report begins with a proposed working definition of VBP to guide the development of all other project deliverables. This is followed by an overview of the three primary models for provider payment (i.e., fee-for-service, bundled payments, and population-based payments); this is important because VBP programs must be designed to work in concert with the effects of the underlying payment model if the VBP program is going to be successful. Section Three of the report reviews three core features of VBP programs and their impact on achieving the VBP goals:

1) Incentive and performance measurement characteristics (i.e., measures, incentive structure, target of incentive, and quality improvement support/resources);
2) Characteristics of the providers and the settings in which they practice; and
3) External factors that may influence VBP success.

Appendix 1 also includes an annotated list of the primary sources utilized by PHPG to identify important design elements of VBP programs.

The report concludes with Section Four which provides a suggested framework for analysis of AHS programs regarding their current and potential VBP program design. Attachment 1 provides a detailed Checklist that could be used to develop new VBP programs or to review existing programs regarding their potential for use or improvement of VBP design.

## *Section 1: Proposed Working Definition of Value-based Purchasing Programs*

PHPG proposes to use the following definition of value-based purchasing to guide the remainder of the project activities:

> *Value-based purchasing (VBP) refers to a broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.*

This definition was derived from two primary sources: the Centers for Medicare and Medicaid Services Roadmap for Implementing Value Driven healthcare[1] and comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP. [2,3] These Rand reports reflect a comprehensive review of existing VBP programs and the published literature on VBP, as well as input from a technical expert panel convened explicitly to inform the reports. (See Appendix 1 for an annotated list of the VBP literature reviewed for a more in-depth description of these sources.)

PHPG proposes to use this definition because it is concise, easy to understand, includes the key elements associated with VBP programs, and links these elements to VBP goals.

---

[1] Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf

[2] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html

[3] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

## *Section 2: Payment Model Types and Characteristics related to Value-based Purchasing*

While there are many variations of healthcare provider payment models and reimbursement mechanisms, they all stem from three predominate payment methodologies: fee-for service, bundled payments and population-based payments. When developing provider payment models and reimbursement mechanisms, payers have a choice of creating the base payment model (i.e., the overall approach to paying for services) without value based enhancements, incentives or other goal oriented performance tools, or the payer can create the payment structure in concert with Value Based Purchasing (VBP) elements. For mature payment models already in operation, payers who wish to implement VBP programs can maintain the base payment model and add VBP elements to it, or they can restructuring the overall payment system as a catalyst to promote and reward high quality, efficient care.[4]

The first step in developing or reviewing a VBP program is to understand the intricacies of the base payment model, its potential unintended consequences and effects on provider service delivery, and its relationship to the goals of the desired change. [5,6] For example, each of the base payment models has its own types of financial risks that are assumed by the payer and /or provider. FFS payment provides financial incentives for providers to over-treat patients and the payer is at full financial risk for paying all the services provided. Bundled payments put slightly more risk on the provider since it is unknown at the beginning of the "episode" exactly what services may be needed. Population-based payments create incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner, but can also put providers at risk if they treat populations that are sicker than average.

Following is a table that provides an overview of the three primary models for provider payment (i.e., fee-for-service, bundled payments, and population-based payments), their potential effect on providers regarding quality and efficiency, rate-setting and payment considerations, and other design factors that should be considered with each payment model. Considerations for quality monitoring and program integrity design also are presented for each type of payment model. A successful VBP program must include design features that address the inherent characteristics and unintended consequences of the base payment model, match the goals of the desired change, and reward providers for quality care and achievement of positive outcomes.

---

[4] Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf

[5] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

[6] Miller HD. (2007). *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund. Can be found at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2007/sep/creating-payment-systems-to-accelerate-value-driven-health-care--issues-and-options-for-policy-refor/miller_creatingpaymentsystemsvalue-drivenhltcare_1062-pdf.pdf

| PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING | | | | |
|---|---|---|---|---|
| **Payment Model** | **Operational Definition** | **Effects on Providers** | **Rate-Setting / Payment Mechanisms** | **Quality Monitoring / Program Integrity Design Implications** |
| ***Fee-for-Service (FFS)*** | Health care providers are paid for each service they render (e.g., an office visit, test, procedure or service).<br><br>Payments are issued retrospectively, after the services are provided.<br><br>FFS is the best approach where the principal or sole problem is underuse of a service, in that it ensures that individuals receive that service (assuming that the fee level is adequate). | Incents providers to provide more treatments and individual units of care regardless of whether that care is efficient or effective because payment is dependent on the quantity of care, rather than quality of care.<br><br>Pays providers for doing things to sick people, rather than getting and keeping people well.<br><br>Financially penalizes health care providers for providing better quality services since providers frequently lose revenues and profits if they keep people healthy, reduce errors and complications, and avoid unnecessary care.<br><br>Puts the provider at risk for the number and cost of processes within each service covered by a separate fee, but nothing else.<br><br>Providers lose revenue if they perform fewer services or lower-cost services, but their costs of delivering the remaining services generally do not decrease proportionately, which can cause operating losses for the providers. | Payers set rates based on the costs of providing the service, based on a percentage of what other payers reimburse for equivalent services, and/or based on negotiations with providers.<br><br>Payment rates may be updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate. | Unintended consequences may include:<br>• Increasing the number of services provided (over-utilization)<br>• Changing coding practices to maximize reimbursement for the service ("upcoding")<br>• Coding for services not delivered<br><br>Program integrity tools such as data mining, chart audits and quality monitoring can be used to mitigate potential negative consequences.<br><br>**FFS and Pay-for-performance (P4P) Programs:**<br>Provide bonus or incentive payments (or more rarely, penalties) on top of FFS payments for providers, based on the rate at which they actually perform specific processes or achieve outcomes viewed as desirable<br><br>P4P does not solve the fundamental problems and disincentives that are built into the underlying FFS payment structure:<br>• The amount of performance bonuses and penalties in most P4P systems is relatively small, |

| PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING | | | | |
|---|---|---|---|---|
| **Payment Model** | **Operational Definition** | **Effects on Providers** | **Rate-Setting / Payment Mechanisms** | **Quality Monitoring / Program Integrity Design Implications** |
| | | Is considered a barrier to coordinated care, or integrated care because it rewards individual clinicians for performing separate treatments. | | reducing the likelihood that they can offset the powerful incentives for volume in the underlying payment system<br>• The cost of implementing a quality improvement initiative may exceed the payment incentives provided through the P4P initiative<br>• May unintentionally result in an overly narrow focus on the specific processes being rewarded, potentially causing providers to lose sight of the true goal—improving individual outcomes |
| ***Bundled Payments***<br><br>*Variants include:*<br>• ***Episode-based Payment***<br>• ***Episode-of-care Payment***<br>• ***Global Bundled Payment***<br>• ***Case rate***<br>• ***Evidence-based Case Rate***<br>• ***Prospective Payment Systems*** | Health care providers are paid a fixed dollar amount based on the expected costs for a clinically defined episode or bundle of related health care services as needed by an individual for a particular condition or treatment.<br><br>Bundles can be defined in different ways, cover varying periods of time (e.g., one year for a chronic condition, the period of the hospital stay), and include single or multiple health care providers of different types (e.g., hospital only, hospital and ambulatory provider).<br>If the goal is to control over- | Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.<br><br>Reduces the incentive for the provider to overuse or provide unnecessary services within an episode of care.<br><br>May provide incentive to provide the lowest level of care possible, not diagnose complications of a treatment before the end date of the bundled payment, or delay care until after the end date of the | The amount of the bundled payment should be prospectively defined (i.e., established before the care actually occurs).<br><br>Historical expenditures are typically used to determine the initial bundled payment rates.<br><br>The bundled payment rate can be set at an amount estimated to increase, decrease, or maintain historical expenditure levels.<br><br>The definition of a bundled payment is largely comprised of three components: | Unintended consequences may include:<br>• Increasing the number of bundles provided (e.g., encouraging surgery for individuals who are ambivalent between medical management and surgical treatment options).<br>• Underutilization or delaying access to appropriate care services that may lead to poorer outcomes for individuals<br>• Avoidance of high-risk (potentially more expensive) individuals<br>• Moving services in time or location to qualify for separate reimbursement (“unbundling”) |

| PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING | | | | |
|---|---|---|---|---|
| **Payment Model** | **Operational Definition** | **Effects on Providers** | **Rate-Setting / Payment Mechanisms** | **Quality Monitoring / Program Integrity Design Implications** |
| | utilization of certain kinds of services, then a single payment for all services controlled by a particular provider could be used. If the goal is to better coordinate decisions among multiple providers, then gain-sharing or bundled payments for those providers could be used.<br><br>Also frequently called a **Case Rate** (i.e., there is a single payment for the case rather than multiple fees for each of the specific services provided within that case.)<br><br>**Prospective Payment System (PPS):** Health care providers are paid based on a predetermined, fixed amount for a particular service, based on the classification system of that service (i.e., diagnosis-related groups for inpatient hospital services or case mix adjusted payments for home health services). For example, CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care | bundled payment.<br><br>Does not provide incentive to control the number of episodes that the person experiences.<br><br>Gives healthcare providers the flexibility to decide what services should be delivered, rather than being constrained by fee codes and amounts.<br><br>Episode-base Payments without Provider Bundling:<br>• There is no financial incentive for multiple providers involved in the same portion of an individual's overall episode of care to coordinate their activities in a value-maximizing way.<br>• There is a financial incentive for each provider to shift costs onto other providers involved in separately-paid portions of the individual's overall episode of care. | 1) Service inclusion criteria<br>2) The episode time window<br>3) Inclusion and exclusion criteria regarding plan enrollees<br>4) Provider inclusion criteria<br><br>Defining when a bundle begins and ends and what services are included can be challenging when considering chronic conditions. In the case of chronic diseases, it has been suggested that an "episode" should defined as all care that occurs during a fixed period of time (e.g. a year).<br><br>Severity adjustment for payment amounts is important (i.e., the payment level for a particular type of episode should be higher if the individual has more complex needs).<br><br>In bundled provider models, providers are encouraged to create joint arrangements for accepting and dividing up the bundled payment among themselves. | Quality measurement and use of best practice standards can be used to mitigate potential negative consequences of bundled payment models.<br><br>Oversight process can also include utilization monitoring, grievance and appeal tracking, adherence to best practice measures and outcome tracking. Other systemic processes may include the use of independent ombudsmen, desk audits and chart reviews.<br><br>Encounter data may include service type and location, wait times, dates of service, and client characteristics such as health status, diagnosis, other related conditions, experience of care and progress.<br><br>**Bundled Payments and Pay-for-performance (P4P) Programs:** The bundled payment amount can be retrospectively adjusted to account for positive or negative performance on quality measures, or a pay-for-performance payment can be made in addition to the bundled payment for providers who performed well on quality and efficiency measures. |

| PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING | | | | |
|---|---|---|---|---|
| **Payment Model** | **Operational Definition** | **Effects on Providers** | **Rate-Setting / Payment Mechanisms** | **Quality Monitoring / Program Integrity Design Implications** |
| | hospitals, and skilled nursing facilities. | | The design of bundled payment programs affects the costs of payment administration, including costs to both providers and payers. More complex bundled payment designs are likely to incur higher administration costs. | Providers can receive payment bonuses or penalties based on (a) health outcomes for individuals, (b) individual satisfaction levels, and (c) individual utilization of major services. |
| ***Population-based Payments***<br><br>*Variants Include:*<br>• ***Total Cost of Care Payment***<br>• ***Comprehensive Care Payment***<br>• ***Global Payment***<br>• ***Capitation***<br>• ***Condition-Adjusted (or Specific) Capitation***<br>• ***Risk-Adjusted Global Fee***<br>• ***Partial Capitation*** | Health care providers are prospectively paid a set amount for all of the healthcare services needed by a specified group of people for a fixed period of time, ***whether or not that person seeks care*** (as opposed to bundled payments which are based on an individual receiving care).<br><br>**Traditional Capitation:** The methodology to determine the amount paid per individual is the same for all individuals, regardless of how well or sick the individual is or how many services are provided.<br><br>**Condition-Adjusted (or Specific) Capitation** or **Risk-Adjusted Global Fee**: The methodology to determine the amount paid per individual is adjusted based on the relative health and other | Providers have incentive to consider the cost of treatment.<br><br>There is no incentive to provide more services simply to increase revenues.<br><br>Gives healthcare providers the flexibility to decide what services should be delivered and the upfront resources to deliver them, rather than being constrained by fee codes and amounts, or waiting for uncertain, after-the-fact shared savings payments to be made.<br><br>The provider has an incentive to ensure that quality care is delivered because they are responsible for providing some or all of the remedial services that may be needed with no added compensation. | The amount of the payment should be adjusted based on the types and severity of conditions, and other characteristics of the individuals being cared for.<br><br>Payments should be set at adequate levels to provide good-quality care.<br><br>Special provisions should be established for unusually high-cost cases, such as outlier payments, reinsurance, etc., to avoid a few expensive cases causing financial problems for providers who are doing a good job of managing typical cases.<br>Theoretically, a provider contracting for a population-based payment is not required to submit claims. Rather the provider is accountable for | Unintended consequences may include:<br>• Activities designed to overinflate caseloads, creating incentives for enrollments or failing to notify the state of deceased members.<br>• Underutilization of appropriate care services that may lead to poorer outcomes for individuals<br>• Avoidance of high-risk (potentially more expensive) individuals<br>• Defining "appropriateness of care" and/or "experimental procedures" in a manner inconsistent with standards of care.<br>• Cumbersome appeal processes for enrollees or providers, ineffective grievance process, inadequate prior authorization "hotline", unreasonable prior authorization requirements |

| PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING | | | | |
|---|---|---|---|---|
| **Payment Model** | **Operational Definition** | **Effects on Providers** | **Rate-Setting / Payment Mechanisms** | **Quality Monitoring / Program Integrity Design Implications** |
| | characteristics of the individuals within the group that may affect the level of services needed (e.g. age, race, sex, location).<br><br>**Partial Capitation Payment:** The provider receives a fixed dollar amount to cover the costs of a pre-defined set of services (e.g. payments for carve outs for high-cost items such as specific drugs or medical devices, like prosthetics) that a specified group of people may receive in a given time period, but other services continue to be paid on a fee-for-service or other basis. | If the provider delivers inefficient, high-cost care, then depending on the structure of the arrangement, it may be held responsible for some of the additional costs incurred.<br><br>Encourages providers to focus on preventive health care, as there is greater financial reward in illness prevention than in illness treatment. | managing the total cost and quality of care.<br><br>If the payer requires claims submission, a provider contracting for a population-based payment does not need to establish claims-payment systems to directly pay other providers delivering care. Rather, the payer could still process claims from other providers using its existing claims-processing system, essentially treating the population-based payment as a debit account. The provider contracting for a population-based payment would be responsible for keeping total costs within the payment amount. | Providers should be expected to collect and publicly report measures of quality of care in order to assure both individuals and payers that there is no inappropriate stinting on care.<br><br>Since a Partial Capitation Payment would give the provider a financial incentive to substitute services (i.e., bill fee for service) that are not covered by the payment for those which are covered, a pay-for-performance system could be used to maintain some level of financial risk for the provider for the costs of all services the individual receives.<br><br>Oversight process can also include utilization monitoring, grievance and appeal tracking, adherence to best practice measures and outcome tracking. Other systemic processes may include the use of independent ombudsmen, quality audits and chart reviews. Encounter data may include service type and location, wait times, dates of service and client characteristics such as health status, diagnosis, other related conditions, experience of care and progress. |

| PAYMENT MODEL TYPES AND CHARACTERISTICS RELATED TO VALUE-BASED PURCHASING | | | | |
|---|---|---|---|---|
| **Payment Model** | **Operational Definition** | **Effects on Providers** | **Rate-Setting / Payment Mechanisms** | **Quality Monitoring / Program Integrity Design Implications** |
| | | | | Quality measurement and use of best practice standards can be used to mitigate potential negative consequences of population-based payment models.<br><br>**Population-based Payments and Pay-for-performance (P4P) Programs:**<br>Providers can receive payment bonuses or penalties based on (a) health outcomes for individuals or the population as a whole, (b) individual satisfaction levels, and (c) individual utilization of major services.<br><br>Population health measures may be regional, statewide or provider specific. |

## *Section 3: Literature Review Regarding Value-based Purchasing (VBP) Program Design*

PHPG conducted a literature search to identify publications that contained descriptions of VBP programs, with a specific focus on documents that identified key components and/or that offered standardized criteria of well-developed VBP programs. The publications that PHPG reviewed are presented in Appendix 1 in alphabetical order by author and include a brief summary description.

The previously mentioned 2013 RAND reports provide a comprehensive overview of VBP program design features; the authors reviewed 129 existing VBP programs, examined the peer-reviewed published literature, and convened a technical expert panel to provide insights into VBP program design.[7,8] As such, PHPG has constructed the following "Overview of Literature Review Findings" using the framework and design features contained in the RAND reports, augmented by VBP program design elements identified in the other reviewed documents.

The RAND study discusses the interplay between the following three core features of VBP programs and their impact on achieving the goal of the VBP contract:

1. Incentive and Performance Measurement Characteristics (i.e., measures, incentive structure, target of incentive, and quality improvement support/resources)
2. Characteristics of the Providers and the Settings in which they Practice that may predispose them to a response
3. External Factors (e.g., other payment policies, other quality initiatives, regulatory changes) that can enable or hinder provider response to the incentive.

This conceptual framework emphasizes the need for VBP program sponsors to consider all three of these features when developing an effective VBP program design. Methodological features of the VBP program must be considered along with the other mediating factors that influence provider response to the incentives and affect the success of the VBP program.

[7] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html

[8] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| ***INCENTIVE AND PERFORMANCE MEASUREMENT CHARACTERISTICS*** [9] | | |
| **Structure of VBP Incentives** | ***Type of Incentive Approach:*** [10]<br>(See Appendix 2 for detailed definitions and examples)<br>• Performance Reporting Approach<br>• Bonus Approach<br>• Step-Up/Step-Down Approach<br>• Hold Back Approach<br>• Gain Sharing Approach<br>• Milestone Approach<br>• Output Approach<br>• Caseload Approach<br>• Outcome Approach<br>• U. S. Federal Government Approach | At least some risk for performance failure should be transferred from contracting agencies to contractors in order to encourage the latter to focus more on performance. [11]<br><br>FFS problems cannot be solved by merely adding bonuses or penalties based on healthcare spending measures on top of the current payment system. A small pay-for-performance bonus may not generate enough revenue to pay for services that are not paid for adequately in the current fee-for-service system or to offset the financial penalties providers currently face in reducing unnecessary services. [12]<br><br>Types of financial incentives offered to providers should expand beyond bonuses that have been commonly used in Pay-for-Performance programs, and which work at the margin, to a stronger set of incentives that more fundamentally alter payment arrangements. |
| | ***Incentive Frequency (e.g., annual, per service)*** | Availability of data refresh is an important factor (i.e., are the data sensitive enough and reported with enough frequency to see change quarterly, yearly or within the contract period). |
| | ***Incentive Magnitude (revenue potential)*** | Absolute incentive size is influenced by the size of the program's incentives (e.g., 1 or 2 percent of base payment), the size of the base payment (e.g., diagnostic-related group [DRG] payment amount), and the number of a provider's clients who are covered by the program, as incentives are often computed on a per capita basis.<br><br>Larger incentives have been found to be associated with a larger impact on performance. Incentives that were large enough to compensate providers for the effort required to obtain them has been identified as one characteristic associated with more successful VBP programs. |

[9] Content derived from following sources unless otherwise noted: Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html and [9] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

[10] Martin L. (2008). Approaches to Performance-based Contracting for Social Services. University of Kentucky. Can be found at: *http://www.uky.edu/SocialWork/qicpcw/documents/PBCsocialservicetypes.pdf*

[11] Ibid.

[12] National Business Coalition on Health. (2011). *Value-based Purchasing: A Definition.* Can be found at: http://www.nbch.org/Value-based-Purchasing-A-Definition

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | | An important policy consideration regarding the size of the incentive relates to the fact that payers typically fund the incentive payment in a budget-neutral fashion, meaning that the winnings of high-quality providers are financed by the loss of revenue from poor-quality providers. In this situation, increasing the size of the incentives could potentially lead to large redistributions of resources among providers and have the undesired effect of de-resourcing low-quality providers who may be most in need of resources to be able to improve quality. |
| | ***Types of Benchmarks/Thresholds (Performance Targets)***<br>• **Absolute performance threshold** (i.e., provider must have at least XX percent performance on measure)<br>• **Relative performance threshold** (i.e., the provider's performance must be in the top 20th percentile of performance and as a result the absolute score required to reach the percentile cut-point changes year to year)<br>• **Improvement (continuous) threshold** (i.e., measures changes from base year)<br><br>**Scoring Models:** [13]<br>• **Opportunity Scoring**: The provider receives scores for each time a measure is provided.<br>• **Appropriateness Scoring**: Measures the percentage of patients who received all of the interventions subject to | Absolute attainment thresholds:<br>○ Preferred by providers, since performance expectations are known ahead of time.<br>○ Removes the motivation for providers to continue to improve once the threshold has been attained.<br>○ Paying all who achieve an absolute attainment target can create budgeting challenges for payers, who will not be able to estimate how many providers they will need to pay; if the payer sets a fixed incentive pool, the more providers who succeed results in a smaller incentive payment per provider.<br>○ Some VBP sponsors have set multiple absolute targets along a continuum to motivate improvement at all levels of performance and to continue to motivate improvement at the top end of the performance distribution.<br><br>Relative thresholds:<br>○ Providers do not know ahead of time what actual level of performance is required to obtain the incentive payment, creating much uncertainty about whether their performance is "good enough."<br>○ VBP programs should not be designed as a "tournament" wherein relative thresholds are used and providers are pitted against each other.<br>○ When topped-out measures are included in the VBP program, providers may have very high performance that does not meet the necessary threshold to receive the incentive, but yet is not meaningfully different from the performance of providers that do receive the incentive payment (e.g., the initial design of Medicare's Premier Hospital Quality Incentive Demonstration (HQID) in Phase 1 of the program's implementation only paid hospitals that were in the top 20th percentile of performance. Performance rates for a large proportion of |

[13] Calikoglu S, Murray R, Feeney D. (2012). *Hospital Pay-For-Performance Programs In Maryland Produced Strong Results, Including Reduced Hospital-Acquired Conditions.* Health Affairs, 31, no.12:2649-2658.

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | measurement that they were supposed to receive— in other words, the share of patients whose care had a perfect score. | the hospitals hovered around 99 percent on a number of the measures, and which hospitals received the incentive payment was based on differences in performance at the second decimal point. In response to this problem, CMS changed the incentive structure in Phase 2 of the Premier HQID to reward *above-average achievement and improvement*).[14]<br>○ A relative incentive structure can promote a "race to the top," creating perverse incentives for providers to allocate resources to improvement on a measure that may not yield the greatest clinical benefit and which may lead to overtreatment of patients.<br>○ Achieving 100 percent performance on a measure also may not be appropriate and may lead to overtreatment, as it is unlikely that any process measure will be applicable to 100 percent of the population.<br><br><u>Improvement (Continuous) threshold:</u><br>○ Can be the most powerful method, as it overcomes many of the issues identified above. [15,16]<br><br><u>Appropriateness Scoring</u>: [17]<br>This scoring better distinguishes provider performance and shifts some focus to the patient as the unit of measurement.<br>○ Supports Opportunity Scoring, in that "topped-off" measures, on which the majority of providers perform at a very high level with very little variation, can be kept in the VBP program.<br><br>It is important to reward both achievement and improvement.<br><br>The reward should be based on objective targets that are defined prior to the start of the measurement year in absolute terms; if a provider hits those targets, it should receive an incentive payment. Providers can then strive to achieve a number of targets along a continuum and compete against themselves rather than competing with other providers for a limited number of "winning |

[14] Centers for Medicare and Medicaid Services. (2014). *Readmissions Reduction Program.* Retrieved on September 22, 2014 from http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/

[15] Ibid.

[16] Nelson L. (2012). Lessons from Medicare's Demonstration Projects on Value-Based Payment. Congressional Budget Office. Can be found at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf

[17] Calikoglu S, Murray R, Feeney D. (2012). *Hospital Pay-For-Performance Programs In Maryland Produced Strong Results, Including Reduced Hospital-Acquired Conditions.* Health Affairs, 31, no.12:2649-2658.

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | | positions" (e.g., top 20th percentile of performance). This approach provides motivation for all providers to move up the scale. |
| **Structure of VBP Measurement** | ***Type and Breadth of Measures (structure, process, outcomes; cost or quality)*** | VBP programs should use a broad set of measures to reduce the likelihood that providers will focus narrowly on improving care for the incentivized measures (often referred to as "teaching to the test").<br><br>VBP programs should have a balanced portfolio of measures (i.e., cost, quality, and patient experience) that includes a mix of measures that assess process, structure and outcomes. [18,19]<br>○ More weight should be placed on outcome measures as opposed to clinical process measures.<br>○ Measures should include lifestyle behaviors that influence health and well-being.<br>Measurement must be able to provide actionable information on cost, quality, and appropriateness of care. [20]<br><br>Starting with evidence-based process measures may be appropriate at the beginning of a VBP program, given that these measures are generally accepted by both the research and provider communities and that these measures do not require more sophisticated and sometimes controversial risk-adjustment methodologies. [21]<br><br>Structural measures should be used to incentivize and help providers build the infrastructure for quality improvement.<br><br>Inclusion of patient experience in value-based purchasing is important, but more work needs to be done on measure development before things like patient-reported functional status can be included. [22]<br><br>Note: Decisions about whether and how to include measures must consider the resources required |

[18] Ibid.
[19] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations.* Santa Monica, CA: RAND Corporation. RR-306/1-ASPE. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html
[20] National Business Coalition on Health. (2011). *Value-based Purchasing: A Definition.* Can be found at: http://www.nbch.org/Value-based-Purchasing-A-Definition
[21] Calikoglu S, Murray R, Feeney D. (2012). *Hospital Pay-For-Performance Programs In Maryland Produced Strong Results, Including Reduced Hospital-Acquired Conditions.* Health Affairs, 31, no.12:2649-2658.
[22] National Business Coalition on Health. (2011). *Value-based Purchasing: A Definition.* Can be found at: http://www.nbch.org/Value-based-Purchasing-A-Definition

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | | to develop the performance measures and the burden to providers and VBP sponsors of collecting and verifying the data. |
| | ***Measurement Validity*** [23] | It is important to be certain that the performance measure is valid, is associated with improved quality and that the data can be gathered appropriately (these three validity considerations form the basis for evaluating, developing and implementing performance measures).<br><br>A performance measure consists of a numerator, a denominator and a frequency – and it is often expressed as a percentage or a rate.<br>○ A performance measure's denominator is the pool of eligibility, or the base number of units, from which measurements (or counts) are taken – the "pool." A valid denominator means that it specifies the right population or the right base number of units from which the count will be made. The denominator must have appropriate inclusion and exclusion criteria for the pool of whom or what is eligible for measurement.<br>○ The numerator is a count taken from the denominator and measures the number of occurrences of the event of interest – the "what." Numerators generally measure events such as something that happens to a patient, something patients receive or something that is done to them – typically this is an outcome, an intervention, a service or a process. Numerators should be based on valid, useful and usable scientific evidence. That the numerator is a valid one means that it can actually measure improvement. Assumptions based on "common sense" should only be substituted for valid, scientific evidence after searching and evaluating the best-available evidence.<br>○ The frequency of measurement should consider health status and other time and utilization factors such as cost, utilization, system impacts and patient inconvenience.<br>○ Data gathering validity pertains to how one actually obtains the data for numerators and denominators. Even with a valid performance measure, invalid results can occur during the data gathering process. Example: In a colon cancer screening quality improvement project, validity was threatened during data gathering because patients with exclusions (e.g., ineligible age, specific comorbidities, patients refusing screening, etc.) were inadvertently included in the denominator.<br><br>The measures should have relative proximity to the target behavior/goal.<br><br>There should be agreement regarding what constitutes a positive change (i.e., lower utilization could be viewed as good or bad, but hospital related infections are always bad). |
| | ***Data Reliability*** | The data source should be reliable in that it produces stable and consistent results (e.g., are they obtained from an objective third party source or review). |

[23] Delfini Group, LLC. (2009). *Evidence-based Performance Measurement: Validity Issues & Avoiding Important Pitfalls*. Can be found at: http://www.delfini.org/Delfini_WhitePaper_Performance%20measures_Short.pdf

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | ***Cost Effectiveness of Data Collection*** | Ease of access to the required data by the Contractor and provider is an important consideration. |
| | ***Baseline Performance on Chosen Measures***<br>• Use of risk/case-mix adjustment (and adjusted for what factors?)<br>• Attribution method | Risk adjustment is a mechanism that is used in an attempt to level the playing field between organizations that are being compared when differences exist in their populations in health status or other patient characteristics. [24]<br><br>When applicable, VBP programs should case-mix-adjust performance measures, particularly for outcome measures such as clinical outcomes, length of stay, and cost measures, to account for differences in patient risk factors associated with the outcome and to counter the incentive for providers to select healthier patients to succeed (often referred to as "cherry-picking").<br>On the other hand, risk adjustment is complex and may not be fairy applied. [25]<br><br>Accurate attribution of patients is critical to bundled and global payment contracts.<br>○ Lags in incurred but not reported claims as well as gaps in health information systems' interoperability make it hard to attribute patients accurately to their managing physician and provider organization. [26] |
| **Support Provided by VBP Sponsor** | ***Provider Engagement in VBP Program Design and Measure Selection*** | VBP programs sponsors should engage providers in the design and implementation of VBP programs, and review measures with providers prior to their implementation. This will promote buy-in so that providers feel comfortable that there is a relationship between measures that are the basis for payment in the VBP program and what they believe represents good care that will positively impact patient outcomes, and that the measures are within their locus of control. It also can help determine where measures may lead to undesired behaviors, such as overtreatment or inappropriate treatment. |
| | ***Data Transparency with Providers /Use of Performance Feedback*** | Contractor and provider access to accurate and timely data is necessary for successful change in care delivery and outcomes. [27, 28,29]<br><br>Regular and timely public reporting can be a significant external motivator for supply side performance improvement, given the importance of community reputation among providers in a market. [30] |

[24] Ibid.
[25] James J. (2013). *Health Policy Brief: Medicare Hospital Readmissions Reduction Program.* Health Affairs, November 12.
[26] Conrad D, Grembowski D, Gibbons C, Marcus-Smith M, Hernandez SE, Chang J, Renz A, Lau B, dela Cruz E. (2013*). A Report on Eight Early-Stage State and Regional Projects Testing Value-Based Payment*. Health Affairs, 32, no.5:998-1006.
[27] Ibid.
[28] Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf
[29] Nelson L. (2012). Lessons from Medicare's Demonstration Projects on Value-Based Payment. Congressional Budget Office. Can be found at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | | If one of the goals associated with Medicaid payment reform is to change the way services are delivered to enrollees, it is important for states to put in place the data infrastructure and processes to actively monitor changes in quality and outcomes. [31]<br><br>Transparency regarding performance measurement calculations is important. [32]<br><br>To minimize the likelihood of undesired behaviors, VBP programs should monitor the data, focusing on key data elements that contribute to the performance score (up-coding of risk factors or under-coding of the outcome that is being measured), to guard against gaming of the data. |
| | ***Implementation Flexibility*** | Securing the participation of provider groups in new accountability standards and payment methods often requires providing these same organizations with flexibility on how to implement changes and to innovate on their own terms. [33] |
| | ***Sharing of Best Practices, Learning Networks, Coaching/Training, Case Management and Care Coordination Resources and Other Technical Assistance*** | VBP programs sponsors should support provider efforts to improve. Examples of technical assistance include providing comparative benchmarking data on variations in practice and factors contributing to differences, infrastructure support, relevant and timely clinical data to facilitate care management, quality improvement support and coaching, and additional staffing support, such as care managers. |
| ***CHARACTERISTICS OF THE PROVIDERS AND PRACTICE SETTINGS*** [34] | | |
| | ***Populations Served*** (payer mix, patient characteristics including socioeconomic mix, insurance status, age, clinical conditions) | |
| | ***Provider Size and Scope*** (i.e., number | |

[30] National Business Coalition on Health. (2011). *Value-based Purchasing: A Definition.* Can be found at: http://www.nbch.org/Value-based-Purchasing-A-Definition

[31] Dybdal K, Blewett L, Sonier J, Spencer D. (2014). *Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States.* Minneapolis, MN: State Health Access Data Assistance Center (SHADAC), University of Minnesota, School of Public Health. Can be found at: https://drive.google.com/viewerng/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTdlZGJhNjMxOTI3M2Y4NA

[32] Ibid.

[33] Ibid.

[34] Content derived from following sources unless otherwise noted: Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html and [34] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

| OVERVIEW OF LITERATURE REVIEW FINDINGS REGARDING VALUE-BASED PURCHASING (VBP) PROGRAM DESIGN | | |
|---|---|---|
| **VBP Component** | **Design Elements** | **VBP Program Evaluation Considerations from Literature Review** |
| | served, range of services provided) | |
| | ***Percentage of Provider's Clients for Whom the Incentive is Relevant*** | Small sample size often results in validity problems due to chance or selection of patients who are not similar to "usual" patients or patients in other practices to which an provider is being compared. [35] Small sample size results in insufficient power to compute statistically significant differences. [36] |
| | ***Oversight or Regulatory Requirements Currently Present in the Practice Setting*** | |
| ***EXTERNAL FACTORS*** [37] | | |
| | ***Other Incentives Faced by the Provider (e.g., for utilization) and magnitude of those incentives*** | Multiple incentives from multiple VBP programs that are not aligned for a provider may detract from the ability of the provider to be success in any of the VBP program. |
| | ***Alignment of Measures across VBP Programs within a Market*** | In some cases, measuring alignment across VBP programs is useful to give providers a clear signal of what is important. However, if different VBP programs cover different patient populations, then it is more important for measures to align with the population's conditions than with other VBP programs.<br><br>If programs are measuring an area where established measures exist, they should use the measures as defined and not tweak the measures to promote alignment. |
| | ***State Regulations and Policies that Impact VBP Program Design and/or Effectiveness*** | |
| | ***Funding Policies for Programs/Services that Impact VBP Program Design and Effectiveness*** | |
| | ***Funding to Support the VBP Program (i.e., Staffing, IT and Incentive Payments)*** | |

[35] Delfini Group, LLC. (2009). *Evidence-based Performance Measurement: Validity Issues & Avoiding Important Pitfalls*. Can be found at: http://www.delfini.org/Delfini_WhitePaper_Performance%20measures_Short.pdf

[36] Ibid.

[37] Content derived from following sources unless otherwise noted: Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html and [37] Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

## *Section 4: Summary Recommendations for Analysis of AHS Programs: Current and Potential for Value-based Purchasing (VBP) Design*

Significantly, all of the documents reviewed noted that VBP in health care and human services is in its infancy; thus, empirical evidence about the specific methodologies and measurement characteristics of successful VBP program is not readily available. The reader should keep this important fact in mind when reviewing the current literature. Nonetheless, strengthening the delivery system by aligning payments to support performance and quality improvement is a key factor in reform efforts to improve the health well-being of Vermonters, and control the growth in health care costs.

Based on the literature review, PHPG has created a Value Based Program Checklist (See Attachment 1) which provides policy leaders and operations staff a common template of items to consider when developing or assessing the opportunity for VBP enhancements in the Vermont Medicaid program. In creating this checklist, PHPG used key areas identified in the literature which are summarized below. PHPG proposes to pilot the use of this checklist tool to review the current, or potential for, VBP design in the AHS programs that DVHA prioritizes for inclusion in subsequent project tasks.

Areas that have been included in the Value Based Program Checklist are summarized below.

1. **Payment Model:** PHPG will provide a description of the underlying payment model and any data used in rate setting. Specifically, PHPG will describe any variants of the underlying payment model and document any specific factors that are unique to the model or may be linked to federal or State requirements at the time they were developed. Additionally, PHPG will review the base payment model underlying each AHS prioritized program to identify the effects on providers regarding the delivery of quality and efficient service delivery. .

2. **Rate Setting and Quality Oversight Model:** PHPG will review the financial and caseload assumptions used to create the model and also determined if the VBP sponsor has:
    - Created rates that are reasonable to assure enrollee access to care
    - A rate setting and process that aligns with the State budgeting timelines and methods
    - Created quality oversight structures that monitor for potential unintended consequences and also mitigate the risks of potential fraud, abuse and waste.

3. **Incentive and Measurement Methodology**: For each AHS prioritized program, PHPG will review the structure of the VBP incentives and performance measurement, the support provided by the VBP program sponsor, and whether the methodological design includes mechanisms to mitigate against unintended consequences. Considerations will include:
    - Matching Incentive Design ) to the Desired Behavior, such as:
        - Incentive type
        - Incentive frequency
        - Incentive magnitude
        - Performance targets

- Performance Measurement Strength , such as:
  - Type and breadth of measures
  - Measurement validity and reliability
  - Cost Effectiveness of Data Collection
  - Baseline Performance Data
- Support Provided by VBP Sponsor and Design Alignment with Goals, such as:
  - Provider Engagement in VBP Program Design and Measure Selection
  - Data use, performance feedback and transparency with providers
  - Implementation Flexibility
  - Sharing of Best Practices, Learning Networks, Coaching/Training and Other Technical Assistance

4. **Alignment between Provider, Setting and Service Type and the VBP Program Goal:** PHPG will review whether provider characteristics align with the emerging best practices defined in the literature and with the intent and goals of the program it is designed to support. Considerations will include:
   - Populations Served (payer mix, patient characteristics including socioeconomic mix, insurance status, age, clinical conditions)
   - Size of the Provider (i.e., number served) and scope of services provided
   - Percentage of Provider's Clients for Whom the Incentive is Relevant
   - Oversight or Regulatory Requirements Currently Present in the Practice Setting

5. **External Factors:** PHPG will review whether or not other external factors have influenced the VBP design and/or whether there are policies, regulatory or legislative processes that can help or hinder the adoption of strong VBP models across AHS programs. Considerations will include:
   - Other Incentives Faced by the Provider (e.g., for utilization) and Magnitude of Those Incentives
   - Alignment of Measures across VBP Programs within a Market
   - Vermont Regulations and Policies that Impact State VBP Program Design and Effectiveness (e.g., pre-existing rules that must be changed in order to implement the VBP program)
   - Funding Policies for Programs / Services that Impact VBP Program Design and Effectiveness (e.g., appropriation caps for the provider, legislative appropriation directly to the provider)
   - Funding to Support VBP Programs (i.e., Staffing, IT, and Incentive Payments)

## *ATTACHMENT 1:*
## *Value-based Program Review Checklist*

| VALUE-BASED PURCHASING PROGRAM CHECKLIST 2015 | | | | |
|---|---|---|---|---|
| **AHS PROGRAM NAME:** | | | | |
| **SECTION I A: DESCRIPTION OF BASE PAYMENT MODEL:** | | | | |
| | | | | |
| **SECTION I B: DESCRIPTION OF VALUE BASE INCENTIVE & MEASUREMENT SYSTEM** | | | | |
| | | | | |
| **SECTION II: RATE SETTING AND QUALITY OVERSIGHT MODEL** | | | | |
| **Review Element** | **Yes** | **No** | **N/A** | **Rational/Reference Materials** |
| Does the VBP sponsor have access to financial, caseload and service information needed to establish rates? | | | | |
| Does the VBP sponsor have written documentation of the rate setting process? | | | | |
| Does the rate setting model include reasonable caseload and service utilization assumptions? | | | | |
| Does the VBP sponsor's rate setting process include provisions for budget adjustments and subsequent year budgeting that align with State budgeting timelines and methods? | | | | |
| Are the rates reasonable to assure enrollee access to needed services? | | | | |
| Does the quality oversight structure allow for monitoring of potential unintended consequences? | | | | |
| Does the quality monitoring structure include monitoring for potential fraud, waste and abuse? | | | | |

| VALUE-BASED PURCHASING PROGRAM CHECKLIST 2015 | | | | |
|---|---|---|---|---|
| **SECTION III: INCENTIVE STRUCTURE & MEASUREMENT MODEL** | | | | |
| **Review Element** | **Yes** | **No** | **N/A** | **Rational/Reference Materials** |
| Is a financial incentive model being employed? | | | | |
| Is the incentive large enough to compensate the provider for the effort required to obtain the reward? | | | | |
| Does a risk arrangement exist between the provider and State? | | | | |
| Does the measure align with the behavior or systems change that is incentivized? | | | | |
| Does the incentive mitigate the negative impact of de-resourcing low-quality providers who may be most in need of resources to be able to improve quality? | | | | |
| Does the incentive mitigate any possible unintended consequences or "cherry picking" of clients to gain reward and/or lower provider costs? | | | | |
| If the program uses an "absolute attainment" threshold, is there sufficient motivation for providers to continue to improve once the threshold is attained? | | | | |
| If the program uses a "relative incentive structure" does it mitigate against providers allocating resources to improvement on a measure that may not yield the greatest clinical benefit and which may lead to overtreatment of patients? | | | | |
| If the program uses a "fixed incentive pool" does it include a mechanism that assures that if more providers succeed they do not get penalized by smaller incentives? | | | | |
| Does the program avoid use of "100%" attainment thresholds that may promote over utilization of services? | | | | |

| VALUE-BASED PURCHASING PROGRAM CHECKLIST 2015 | | | | |
|---|---|---|---|---|
| **Review Element** | **Yes** | **No** | **N/A** | **Rational/Reference Materials** |
| Has the purchasing model or incentive changed provider behavior? | | | | |
| Is the data sensitive enough and reported with enough frequency to measure change quarterly, yearly or within the contract period? | | | | |
| Does the model include an "appropriateness of care" measure? | | | | |
| Does the model reward achievement and improvement? | | | | |
| Is there agreement on what constitutes positive change? | | | | |
| Does the design include a mix of measures (process, structure, quality, patient experience of care and outcome)? | | | | |
| Do the denominators have proper inclusion and exclusion criteria? | | | | |
| Are the numerators valid, useful and supported with evidence? | | | | |
| Is the data gathering reliable and valid? | | | | |
| Are the data easily obtainable for the provider and the State? | | | | |
| Has the VBP sponsor identified unintended consequences and created a plan to monitor and mitigate? | | | | |
| **SECTION IV: SUPPORT PROVIDED BY THE VBP SPONSOR** | | | | |
| **Review Element** | **Yes** | **No** | **N/A** | **Rational/Reference Materials** |
| Where providers engaged in the design of the VBP program? | | | | |
| Where measures reviewed with providers prior to implementation? | | | | |

| Review Element | Yes | No | N/A | Rational/Reference Materials |
|---|---|---|---|---|
| Is there alignment between provider characteristics, scope of practice and VBP program objectives? | | | | |
| Does the VBP sponsor provide routine performance (data-driven) feedback to the provider? | | | | |
| Does the VBP sponsor have staff, data collection and reporting systems that support monitoring VBP programs? | | | | |
| Do providers have flexibility on how to implement changes and to innovate on their own terms? | | | | |
| Does the VBP sponsor have resources to support provider efforts to improve? (TA on comparative benchmarking; infrastructure support; clinical data feedback loops; quality improvement support and coaching, and additional staffing support, such as care managers). | | | | |
| **SECTION V: EXTERNAL FACTORS** | | | | |
| **Review Element** | **Yes** | **No** | **N/A** | **Rational/Reference Materials** |
| If multiple incentives exist for the same provider network, are they aligned? | | | | |
| If providers are being tracked on multiple measures from different VBP programs, are they aligned? | | | | |
| Do current regulations and laws support the VBP program design? | | | | |
| Are there State regulations and policies that impact the VBP program design? | | | | |
| Are there State funding policies that impact the VBP program design and effectiveness? | | | | |
| Does the VBP sponsor account for VBP funding needs (IT, staffing and Incentive payments) in the State budget process? | | | | |

## SECTION VI: SUMMARY OF ANALYSIS AND OBSERVATIONS

| | Name: | Title: |
|---|---|---|
| **Program Reviewers:** | _____ | _____ |
| | _____ | _____ |
| **Program Respondents:** | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

**Date Range of Program Review:** _____

# APPENDIX 1:
# Value-based Purchasing and Payment Model Resources

## *Annotated List of Value-based Purchasing Program Literature and References*

1. Calikoglu S, Murray R, Feeney D. (2012). *Hospital Pay-For-Performance Programs In Maryland Produced Strong Results, Including Reduced Hospital-Acquired Conditions.* Health Affairs, 31, no.12:2649-2658.

   This article describes how the State of Maryland crafted two pay-for performance programs applicable to all hospitals and payers—a Quality-Based Reimbursement Program similar to Medicare's value-based purchasing program and a separate program that compared hospitals' risk-adjusted relative performance on a broad array of hospital-acquired conditions. In the first program, all clinical process-of-care measures improved from 2007 to 2010, and variations among hospitals decreased substantially. As a result of the second program, hospital-acquired conditions in the state declined by 15.26 percent over two years, with estimated cost savings of $110.9 million over that period. The article highlights the strong and consistent financial incentives used by the state to motivate hospitals' efforts to improve quality.

2. Centers for Medicare and Medicaid Services. (2014). *Readmissions Reduction Program.* Retrieved on September 22, 2014 from http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/

   The Affordable Care Act established the Hospital Readmissions Reduction Program which requires the Centers for Medicare and Medicaid Services (CMS) to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. This website provides an update to the program and a link to all the program proposed and final regulations, including methodological changes made by CMS to improve the impact of this VBP program.

3. Centers for Medicare & Medicaid Services (2009). *Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program*. Can be found at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/VBPRoadmap_OEA_1-16_508.pdf

   This paper provides an inventory and status of key projects, programs and demonstrations that CMS has undertaken to transform itself from a passive payer of services into an active purchaser of higher quality, affordable care. It also provides a roadmap, having a 3- to 5-year roadmap for continuing the work already begun to move towards VBP-based payments in the major Medicare FFS payment systems. This roadmap is focused on completion of ongoing activities including implementation of requirements found in DRA and MIPPA, completion of open

comment periods in the regulatory process, and completion of key demonstration programs that would be critical to implementing VBP in the current payment systems.

4. Conrad D, Grembowski D, Gibbons C, Marcus-Smith M, Hernandez SE, Chang J, Renz A, Lau B, dela Cruz E. (2013*). A Report on Eight Early-Stage State and Regional Projects Testing Value-Based Payment*. Health Affairs, 32, no.5:998-1006.

   With funding from the Robert Wood Johnson Foundation, eight grantees in six states across the country are designing and implementing value-based payment reform projects. This article describes the foundation's rationale for funding the projects and its methods for soliciting proposals and selecting which of them it would fund; briefly describes the projects' objectives, strategies, progress, and early stages of implementation; and provides an overview of the projects as a group and presents some broad preliminary lessons.

5. Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions.* Santa Monica, CA: RAND Corporation. RR-306-ASPE. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html

   Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations.* Santa Monica, CA: RAND Corporation. RR-306/1-ASPE. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

   These two companion reports were prepared by the Rand Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS). HHS is advancing the implementation of value-based purchasing (VBP) across an array of health care settings in the Medicare program in response to requirements in the 2010 Patient Protection and Affordable Care Act. To inform future policymaking by HHS, RAND reviewed the learnings over the past decade related to VBP and the elements of successful VBP programs, and identified gaps in the knowledge base that, if addressed, could improve the design and functioning of VBP programs moving forward.

   The authors reviewed information that was publicly available for 129 existing VBP programs [91 Pay-for-Performance (P4P) programs, 27 Accountable Care Organizations (ACOs), and 11 bundled payment programs] sponsored by private health plans, regional collaboratives, Medicaid agencies or states, and the federal government; examined the peer-reviewed published literature for studies that evaluated the impact of P4P, ACO, or VBP-type bundled payment programs; and convened a technical expert panel (TEP), composed of VBP program sponsors, providers from health systems who have been the target of VBP programs, and health services researchers with expertise in

examining the effects of VBP programs, to help address many of the study questions where the literature was void of information.

The first report provides a detailed description of the analytic methods and findings. The second report outlines a set of recommendations regarding the design, implementation, and monitoring and evaluation of these programs, which if pursued could help policymakers better understand where and under what conditions VBP works and how to strengthen program design and implementation so that these programs achieve improved value for patients and for payers
.

6. Delfini Group, LLC. (2009). *Evidence-based Performance Measurement: Validity Issues & Avoiding Important Pitfalls*. Can be found at: http://www.delfini.org/Delfini_WhitePaper_Performance%20measures_Short.pdf

   This White Paper provides a simple, evidence-based approach for evaluating the strengths and weaknesses of performance measures, with a focus on three validity considerations of a measure.

7. Dybdal K, Blewett L, Sonier J, Spencer D. (2014). *Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States.* Minneapolis, MN: State Health Access Data Assistance Center (SHADAC), University of Minnesota, School of Public Health. Can be found at: https://drive.google.com/viewerng/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTdlZGJhNjMxOTI3M2Y4NA

   This report summarizes the work conducted under a project funded by the Medicaid and CHIP Payment and Access Commission (MACPAC) and conducted by both MACPAC staff and staff at the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health. The purpose of the project was to better understand specifics of different state approaches to Medicaid payment and delivery system reform (e.g., shared savings programs, episode-based payment initiatives, global budgeting), and to identify common themes across states. The project involved site visits to four states (Arkansas, Minnesota, Oregon and Pennsylvania) in the fall of 2013. The report summarizes the payment and delivery system approaches being used by these state Medicaid programs and discusses key themes in the areas of program design, administration, and expected outcomes.

8. James J. (2013). *Health Policy Brief: Medicare Hospital Readmissions Reduction Program.* Health Affairs, November 12.

   This brief describes the Medicare Hospital Readmissions Reduction Program (HRRP) established in the Affordable Care Act (ACA) that provides a financial incentive to hospitals to lower readmission rates. It identifies the technical issues in the program design and potential flaws in the program's methodological approach that have been identified and are being addressed by CMS, and discusses the unintended consequences for safety-net hospitals that may threaten care for vulnerable populations.

9. Martin L. (2008). Approaches to Performance-based Contracting for Social Services. University of Kentucky. Can be found at:
*http://www.uky.edu/SocialWork/qicpcw/documents/PBCsocialservicetypes.pdf*

This paper describes the differences between PBC and incentive contracting; identifies various approaches to performance-based contracting (PBC) for social services that have been, or are currently being, utilized; identifies approaches to PBC from other service areas that may have implications for social services; and catalogs the eleven identified approaches to PBC according to the degree of risk for performance failure that is transferred to contractors. The paper does not attempt to determine which of the eleven approaches constitutes best practices for VBP.

10. Miller H. (2014). *Measuring and Assigning Accountability for Healthcare Spending: Fair and Effective Ways to Analyze the Drivers of Healthcare Costs and Transition to Value-Based Payment.* Center for Healthcare Quality and Payment Reform. Can be found at:
http://www.chqpr.org/downloads/AccountabilityforHealthcareSpending.pdf.

This Report describes six fundamental problems with the current attribution and risk adjustment systems that are being used to measure healthcare spending in value-based purchasing programs and also describe how these problems can be solved. The report presents a detailed methodology for assigning accountability to healthcare providers for the services they actually can control or influence and for identifying which aspects of those services might be changed in order to achieve the same or better outcomes for patients at lower cost. The report shows how these improved methodologies can use existing data to produce more valid, reliable, comprehensive, and actionable measures than those commonly used today.

11. National Business Coalition on Health. (2011). *Value-based Purchasing: A Definition.* Can be found at: http://www.nbch.org/Value-based-Purchasing-A-Definition

The National Business Coalition on Health (NBCH) is a national, non-profit, membership organization of purchaser-led health care coalitions. This website is provided by the NBCH Value-based Purchasing Council as a resource to its members to describe the rationale for VBP programs. The NBCH notes that purchasers of health care must be leaders in implementing VBP: "Purchasers buying on quality, service, and cost, rather than cost alone, will catalyze the re-engineering of health care toward a system of population health improvement and management, and a value-driven system in which ever-increasing quality of care is achieved at the lowest possible cost." This web-site also provides a framework for effective VBP programs, which includes four elements: 1) Standardized Performance Measurement; 2) Transparency and Public Reporting; 3) Payment Innovation; and 4) Informed Consumer Choice.

12. Nelson L. (2012). Lessons from Medicare's Demonstration Projects on Value-Based Payment. Congressional Budget Office. Can be found at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/WP2012-02_Nelson_Medicare_VBP_Demonstrations.pdf

    This paper summarizes the results of Medicare demonstrations of four value-based payment programs, three which utilized pay-for-performance (i.e., Physician Group Practice Demonstration, Premier Hospital Quality Incentive Demonstration, Medicare Home Health Pay-for-Performance Demonstration ) and one which utilized bundled payments (i.e., Medicare Participating Heart Bypass Center Demonstration). It also includes an analysis of the strengths and weaknesses of the demonstration designs.

## *Primary Sources for Overview of Payment Model Types and Characteristics*

1. Bailit Health Purchasing. (February 2013). *Payment Matters: The ROI for Bundled Payments*. Can be found at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563/subassets/rwjf404563_1

2. Bailit Health Purchasing. (February, 2013). *Payment Matters: The ROI for Population-based Payment*. Can be found at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563/subassets/rwjf404563_4

3. Burns M and Bailit M. (2012). *Bundled Payment across the U.S. Today: Status of Implementations and Operational Findings.* Can be found at: http://www.hci3.org/sites/default/files/files/HCI-IssueBrief-4-2012.pdf

4. Catalyst for Payment Reform. (2013). *National Compendium on Payment Reform: Definitions of Payment Model Terms*. Retrieved December 8, 2014 from: http://compendium.catalyzepaymentreform.org/compendium-search/definitions-pmt

5. Center for Healthcare Quality and Payment Reform. *Setting Payment Levels.* Retrieved December 3, 2014 from: http://www.chqpr.org/downloads/SettingthePaymentLevel.pdf

6. Center for Healthcare Quality and Payment Reform. *Transitioning to Comprehensive Care Payment.* Retrieved December 3, 2014 from: http://www.chqpr.org/downloads/TransitioningtoComprehensiveCarePayment.pdf

7. Center for Healthcare Quality and Payment Reform. *Transitioning to Episode-Based Payment*. Retrieved December 3, 2014 from: http://www.chqpr.org/downloads/TransitioningtoEpisodes.pdf

8. Center for Healthcare Quality and Payment Reform. *Which Healthcare Payment System is Best?* Retrieved December 3, 2014 from: http://www.chqpr.org/downloads/WhichPaymentSystemisBest.pdf

9. Centers for Medicare and Medicaid Services. *Fee-for-Service*. Retrieved November 17, 2014 from http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/fee-for-service.html

10. Centers for Medicare and Medicaid Services. *Prospective Payment Systems - General Information*. Retrieved November 17, 2014 from: http://cms.gov/site-search/search-results.html?q=Prospective%20Payment%20Systems%20-%20General%20Information

11. Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Healthcare Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306.html

12. Damberg CL, Sorbero ME, Lovejoy S, Martsolf GR, Raaen L, Mandel D. (2013). *Measuring Success in Health Care Value-Based Purchasing Programs: Summary and Recommendations*. Santa Monica, CA: RAND Corporation. Can be found at: http://www.rand.org/pubs/research_reports/RR306z1.html

13. Hussey PS, Mulcahy AW, Schnyer C, Schneider EC. (2012). *Bundled payment: Effects on health care spending and quality*. Rockville, MD: Agency for Healthcare Research and Quality. Can be found at: http://www.ahrq.gov/research/findings/evidence-based-reports/gapbundtp.html

14. Miller HD. (2007). *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund. Can be found at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2007/sep/creating-payment-systems-to-accelerate-value-driven-health-care--issues-and-options-for-policy-refor/miller_creatingpaymentsystemsvalue-drivenhltcare_1062-pdf.pdf

15. Miller, HD. (January, 2009). *Better Ways to Pay for Health Care: A Primer on Healthcare Payment Reform.* Network for Regional Healthcare Improvement and Robert Wood Johnson Foundation. Can be found at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2009/01/better-ways-to-pay-for-health-care.html

16. National Business Coalition on Health. (2011). *Value-based Purchasing: A Definition.* Retrieved September 10, 2014 from: http://www.nbch.org/Value-based-Purchasing-A-Definition

17. Oregon Office for Health Policy and Research. (2013). Healthcare Payment Reform: Alternative Payment Methodologies. can be found at: http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/upload/APM-White-Paper_FINAL_June-2013.pdf

18. Satin DJ, Miles J. (2009). *Performance-based bundled payments: potential benefits and burdens.* Minnesota Medicine 92 (10): 33–5. Can be found at: http://www.minnesotamedicine.com/Past-Issues/Past-Issues-2009/October-2009/Special-Report-Oct2009

19. Wikipedia. *Capitation (healthcare)*. Retrieved November 17, 2014 from: http://en.wikipedia.org/wiki/Capitation_(healthcare)

20. Wikipedia. *Fee-for-service*. Retrieved November 17, 2014 from http://en.wikipedia.org/wiki/Fee-for-service

# APPENDIX 2:
# Incentive Contracting Approaches: Definitions and Examples

Excerpted from: Martin L. (2008). *Approaches to Performance-based Contracting for Social Services*. University of Kentucky. (8)

## PERFORMANCE REPORTING APPROACH

Performance measures (output, quality, outcomes) included in contracts, baselines determined, and targets either negotiated or pre-determined by state. Reporting required, but performance not tied to compensation and/or contract extensions.

**State of Florida Child Welfare Performance Measures**

| Performance Measure | Baseline | 6/30/15 Target |
|---|---|---|
| 1. 95% of children will not be abused or neglected | | |
| 2. No more than 1% of children served in out-of-home care will experience maltreatment | | |
| 3. No more than 9% of children will be removed with 12 months of a prior reunification | | |
| 4. The % of children reunified within within 12 months of the latest removal shall equal at least 76.2% | | |

## BONUS APPROACH

Contractors may earn additional compensation or contract extensions by meeting or exceeding defined performance levels.

The state of Alaska establishes specific levels of minimum performance (benchmarks) for each performance measure (shown below). Contractors can earn predetermined bonus payments when they exceed any of these benchmarks.

**State of Alaska Temporary Assistance Program**
**Performance Measures**

1) Percent of adults who obtain employment within 60 days,
2) Percent of adults with earnings,
3) Percent of employed adults who retain employment for four months,
4) Percent of employed adults with earning progression,
5) Percent of cases closed with earnings,
6) Percent of cases closed with earning that do not return to Temporary Assistance within six months.

Arizona took a unique "variable targets" approach. The contractor's performance on five measures was compared to a similar program operated directly by a department within the governmental contracting agency. For the contractor to earn any bonus payments, it had to beat the government's performance by 30%.

**Performance Measures for Arizona Works Project**

1. Number of individuals placed in jobs.
2. Number of individuals placed in highest and most appropriate jobs.
3. Reduction in welfare caseload.
4. Reduction in length of stay on public assistance.
5. Number of individuals placed in jobs who continue in those jobs for at least 90 days.

## STEP UP/STEP DOWN APPROACH

Performance levels are stepped-up and stepped-down from a baseline that represents minimal acceptable performance. Performance above or below the baseline has associated positive or negative financial implications. The following example is from a help desk services contract for the city of Charlotte, North Carolina.

**Step-Up/Step-Down Approaches**

| Bonus | Performance Level | |
|---|---|---|
| 2.0 % Bonus | 92% and Above | |
| 1.5 % Bonus | 90% - 91% | |
| 1.0 % Bonus | 88% - 89% | |
| 0.0 % Bonus | 86% - 87% | |
| **- - - - - - - - - - - - - - - - - - - 85% Baseline - - - - - - - - - - - - - - - -** | | |
| | 84% | 1% Reduction |
| | 83% | 2% Reduction |
| | 82% | 3% Reduction |
| | 81% and Below | 4% Reduction |
| | | **Penalty** |

## HOLD BACK APPROACH

Hold back approaches retain a portion of the contractor's compensation and release it only if performance is acceptable. For instance, a one year contract may include 13 payments. Payment may be made each month and the last (13$^{th}$) payment would be paid if the performance is determined to be acceptable. Clear definitions of acceptable performance are established up front.

## GAIN SHARING APPROACH

Contractors generate a portion (or possibly all) of their compensation through either savings achieved or additional revenue generated. There are two variations of gain-sharing: 1)sharing in savings approaches allow the contractor to keep a portion of the savings, which encourages contractors to reduce service delivery costs, and 2) revenue sharing approaches allow contractors to earn incentives payments (bonus payments or other forms of increased compensation), tied to increased revenue generation.

An example of a share-in-savings approach tied to performance and applied to a social service is the Wisconsin Works (W-2) program. The W-2 program is Wisconsin's approach to job training and placement services under the federal "Temporary Assistance for Needy Families" (TANF) program. Under the W-2 program, contractors that generate contact savings (while meeting all 1st bonus levels) are allowed to keep as "unrestricted profits" any amounts up to two percent of the contract budget. Contractors are allowed to keep an additional two percent if they met the 2nd bonus levels).

**Wisconsin Works (W-2) Use of Share-in-Savings Approach**

| Performance Standards | Base Level | 1st Bonus Level | 2nd Bonus Level |
|---|---|---|---|
| Entered Employment | 35% of participants | 40% | 45% |
| Average Wage Rate | Equal to or Greater than base year | Base + 2% | Base + 5% |
| Job Retention (30 days) | 75% of participants | 80% | 85% |
| Job Retention (180 days) | 50% of participants | 55% | 60% |
| Health Insurance Provided | 30% of participants | 35% | 40% |

Revenue sharing approaches are the opposite of the share in saving approach, in that contractors have increased compensation tied to revenue generation. This approach has been used under the federal Title IV-D Child Support Enforcement Program allowing collection agencies to share in revenue related to the amount of delinquent child support payments collected.

## MILESTONE APPROACH

The contract is essentially treated as an individual project, with a definable start point and end point and identifiable major milestones along the way. Contractors receive fixed rate "progress payments" as the milestones are accomplished.

Under the Kansas approach, a case rate (based on the average cost of care) was negotiated with contractors who received a proportion of that case rate (a progress payment) when they accomplished any of four major milestones. However, only one of the four major milestones adopted by Kansas was actually performance related (child permanency placement); the other milestones were essentially process measures.

**Kansas Milestone Approach for Child Welfare Services**

| **Milestone Case Rate** | |
|---|---|
| 1. Child referred to contractor (process) | 25% |
| 2. 60 day report to state (process) | 25% |
| 3. 180 day report to state (process) | 25% |
| 4. Child achieves permanent placement (performance) | 25% |

The State of Oklahoma utilized a milestone approach for job training and placement services for persons with disabilities.

**Oklahoma Milestone Approach**

**Milestone Case Rate**

1. Determination of Need (process) 10%
2. Vocational Preparation (process) 10%
3. Job Placement (output) 10%
4. Job Training (process) 10%
5. Job Retention (quality/outcome) 15%
6. Job Stabilization (outcome) 20%
7. Case Closure (outcome) 25%

An experimental jobs program in Pennsylvania called "Community Solutions," utilized a milestone approach, but rather than being tied to a case rate, contractors were compensated at a fixed-fee or fixed rate for each milestone accomplished.

**Pennsylvania Milestone Approach**

| **Milestone** | **Fee** |
|---|---|
| 1. Client Assessment Completed (process) | $1,000 |
| 2. Job Placement (output) | $1,000 |
| 3. Medical Benefits Included (quality) | $ 400 |
| 4. Job Retention: clients remain employed for 12 months (outcome) | $1,600 |

## OUTPUT APPROACH

Contractors are paid a fixed-fee, fixed price or fixed rate (identified in the contract) for each output, or unit of service, provided. In order to qualify as VBP, the defined outputs must be representative of program goals (e.g., number of meals delivered), not discrete staff activities (e.g., units of case management).
The state of Arizona has utilized output approaches to PBC for social services for several years. Arizona has developed a dictionary and taxonomy of human services that includes standardized service definitions as well as standardized output, or unit of service, definitions.

**Output Approach**

| Social Service | Output Performance Measure | Price or Unit Cost |
|---|---|---|
| Home Delivered Meals | One Meal | $ _____ |
| Outreach | One Hour Of Staff Time | $ _____ |
| Transportation | One Trip Per Person One-Way | $ _____ |
| Information & Referral | One Request | $ _____ |

## CASELOAD APPROACH

Caseload approaches utilize targeted reductions in client caseloads as an outcome performance measure where case closures also represent appropriate outcome performance. Contractors that do not close the appropriate number of cases must continue to provide care and services to those clients with attendant cost implications. For example, in child welfare a child permanency placement represents both a case closure as well as an appropriate outcome performance measure.

In the following example, the contractor (Cook County) enters the new contract term with a baseline number of cases. Under the terms of the new performance-based contract, the contractor agrees to accept 24% increase in cases during the next 12 months and to close 24% of its caseload (child permanency placements) during the same time period. In the first scenario (S1), the contractor receives a 24% increase in new cases and meets contract outcome expectations by also closing 24% of existing cases. In this instance (S1), the contractor's overall caseload remains the same. In the second scenario (S2), the contractor receives a 24% increase in new cases, but only closes 15% of existing cases. In this instance (S2), the contractor's overall caseload increases by 9% In the third scenario (S3), the contractor receives a 24% increase in new cases and closes 30% of existing cases. In this instance (S3), the contractor's caseload decreases by 6%. By achieving more child permanency placements (outcomes),

the contractor can actually reduce its overall caseload, something that does not necessarily happen in other approaches to PBC for social services.

**Illinois Caseload Approach**

| Current Caseload | New Referrals | Cases Closed | New Caseload |
|---|---|---|---|
| S1. Baseline | 24% | 24% | Same |
| S2 Baseline | 24% | 15% | 9% |
| S3 Baseline | 24% | 30% | 6% |

## OUTCOME APPROACH

Outcome approaches to PBC tie contractor compensation directly and exclusively to results, accomplishment, or impacts. Outcome approaches constitute major risk to contractors for performance failure because they are only paid for the outcomes actually achieved. The state of North Carolina experimented with an outcome approach to PBC for adoption services, in which a case rate was tied to outcome milestones.

**North Carolina Outcome Approach**

| Milestone | Average Placement Cost |
|---|---|
| 1. Child Placed for Adoption (outcome) | 60% |
| 2. Adoption Finalized (outcome) | 20% |
| 3. Adoption Intake for one year (outcome) | 20% |

## U.S. FEDERAL GOVERNMENT APPROACH

The Federal government has its own unique approach to PBC. The policy and procedural guidance governing the federal approach to PBC is set forth in the *Federal Acquisition Regulation* (FAR). The FAR states that it is the policy of the federal government that all service contracts be performance-based to the greatest extent possible. The FAR applies equally to social service contracts and non-social service contracts entered into by departments and agencies of the federal government. Contractor risk for performance failure is major under the federal approach to PBC due to the general complexity of federal contracts as well as the precise specification of contractor expectations.

According to the FAR, and as set forth by the Office of Federal Procurement Policy (OFFP), for a federal contract to be considered FBC, it must contain four critical elements.

**Federal Requirements for PBC**

1. **Performance Requirements** that define in measurable terms the work to be accomplished or the service to be provided.

2. **Performance Standards** that define the allowable deviation, if any, from the performance requirements. Also called the AQL (acceptable quality level).

3. **Quality Assurance Plan** that specifies the means by which contractor performance will be determined and documented. Acceptable methods include:
   - 100% inspection
   - Random Sampling
   - Periodic Inspection
   - Customer Input
   - Third Party Certification

4. **Positive & Negative Incentives** that are tied to the quality assurance plan (If critical to agency mission or if large expenditures of federal funds are involved).

A hypothetical example of what a federal performance-based contract for a social service (adoption services) might look is illustrated below.

**For Adoption Services**

| Specifications of Tasks/ Statement of Objectives | Performance Measures/ Performance Requirements | Performance Standards | Incentives and Penalties | Monitoring/ Quality Assurance Plan |
|---|---|---|---|---|
| To provide quality adoption services (process) | Accreditation by Council on Accreditation (COA) | 100% | Incentive = Reimbursement for cost of accreditation<br>Penalty = no new referrals/ loss of contract | Third Party Certification |
| To server parental rights (process) | All children to be adopted have parental rights severed | 100% | Incentive = none<br>Penalty = No new referrals/ loss of contract | 100% Inspection |
| To conduct home studies (process) | All adoptive parents have a completed home study with a favorable adoption recommendation | 100% | Incentive = none<br>Penalty = no new referrals/ loss of contract | 100% Inspection |
| To place children for adoption (output) | All children to be adopted are placed in adoptive homes | 100% | Incentive = $1,000 bonus | 100% Inspection |

| | | | | |
|---|---|---|---|---|
| To secure final decrees of adoption (outcome) | All children to be adopted have finalized decrees of adoption | 100% | Incentive = none<br>Penalty = loss of contract | 100% Inspection |
| To finalize adoptions: adoption intact for 12 months (outcome) | All adopted children remain with their adoptive families for a minimum of 12 months | 90% | Incentive = $5,000 bonus | 100% Inspection |