Value Based Care Benchmarking Table

Aim: Develop VBC model benchmarks that

1. Incentivize providers to control costs while delivering coordinated, high-quality, equitable, and patient-centered care.
2. Support ongoing investment in care delivery innovations that improve quality, address equity issues, and control costs.
3. Build toward the attainment of predictable and sustainable long-term health care spending trends.

Principles	Primary Drivers and Actions
Collaborative: VBC benchmarks should be designed with a collaborative approach that includes input from all stakeholders involved; including providers, payers, patients.	**Driver – Design Phase:** VBC model designers should include provider, patient, and community perspectives in the design and operation of VBC benchmarks. The benchmark reflects the goals and desired outcomes of the model. Including feedback from all stakeholders helps to ensure benchmark strategies balance a range of interests and improves buy-in and support for the model. ***Actions*** • *Convene a multi-stakeholder committee with representation from providers, patient/member groups, and other payers (in the case of multi-payer alignment efforts).* • *Establish shared goals and priorities for care delivery and quality improvement across stakeholder groups.* • *Engage multi-stakeholder committees throughout the design process to guide benchmark development and early implementation.*

	Driver – Operations Phase: Payers should establish systems for ongoing communication and collaboration between payers, providers, and patient advocates to gather feedback on VBC model operations and quickly identify and address any unforeseen issues with/unintended consequences of a model benchmarking strategy. *Actions* • *Create dedicated communication channels for providers and members/patient groups to offer feedback on VBC operations and issues related to benchmarking.*
Transparent: VBC benchmarks methodologies should be transparent to all stakeholders involved, including providers, payers, and patients.	**Driver – VBC Methodology:** VBC model designers should provide participants with clear information on the goals and objectives informing the development on benchmarks and the details of all relevant methodologies that impact benchmark design. *Actions* • *Develop public facing educational materials designed to offer providers and members/patients a baseline description of the VBC model and information on the payment and quality strategy. This includes how the benchmark baseline period is determined, data used for establishing benchmarks, factors used in trending spending and rebasing, risk adjustment methodologies, and the process for patient attribution.* • *Offer providers concrete examples of benchmark calculations using sample data to assist in modeling financial impacts.* **Driver – Model Policy Changes**: VBC model designers should ensure open communication with providers and other stakeholders about the rationale for benchmarking decisions and allow participants time to provide feedback on benchmarking methodologies and their impact on care delivery. *Actions* • *Establish a standard process and timeline for publicly announcing planned changes to VBC benchmarking and quality strategies.*

	• *Provide model participants with methodological details and access to any data used to inform benchmarking policy changes.* • *Create dedicated communication pathways to gather input from stakeholders including providers and members/patient groups.* **Driver – Data Reporting:** VBC model designers should develop mechanisms for the regular monitoring and reporting of model benchmark performance and outcomes information to participants. *Actions* • *Establish standing meetings to engage with providers to ensure that the bi-directional data exchange necessary to support the model is occurring successfully.* • *Develop public facing reports designed to provide members/patients with details on the performance of the VBC models operated by the payer.*
Sustainable: VBC benchmarks should be sustainable for payers, providers, and patients over the long-term.	**Driver – Model Size and Benchmark Reliability:** VBC model designers should account for practice size and the impact of statistical significance when designing benchmark methodologies. Small patient panels increase the potential for chance variation among a small number of attributed patients to have disproportionate impacts on cost and quality performance measures. VBC model designers should incorporate safeguards to insulate providers from these random events or limit participation to practices with a minimum threshold count of patients sufficient to reduce the impact of small number issues. *Actions* • *Evaluate potential impacts of small n issues on benchmark designs.* • *Engage with model participants regarding strategies to mitigate risks such as minimum attributed patient panel sizes, outlier management methodologies, stop loss policies and reinsurance options.* **Driver – Establishing Initial Benchmarks:** VBC benchmarks should be designed to offer providers, especially those new to risk-based payments, reasonable spending targets.

	Actions
	- *Engage with multi-stakeholder committee to discuss/identify anticipated resource needs and provider concerns around implementing the model.*
	- *Ensure that benchmarks are designed to account for input costs for care coordination, population health management, and other strategies not captured in the FFS payment system that improve quality and reduce costs and lay the foundation for long-term VBC success.*
	
	Driver – Trending/Rebasing: VBC benchmark methodologies for trend updates (regional/national) and rebasing should account for the resource requirements necessary for supporting prior care delivery reform efforts (i.e., staffing changes, IT, etc.) and ongoing investment in care delivery innovations.
	    Actions
	- *Engage with model participants to gather input on: 1) the resource requirements necessary to support ongoing care delivery reforms, 2) goals for quality improvement, and 3) spending targets.*
	- *Account for ongoing costs for activities such as care coordination, population health management, and other strategies that improve quality and reduce costs and lay the foundation for long-term VBC success.*
	
	Driver – Model Timelines: VBC model teams should prioritize/encourage stability and predictability for payers and providers.
	    Actions
	- *Design VBC models to include long-term (multi-year) contract agreements whenever feasible.*
	- *Include the potential for extended model contracts as an explicit component of negotiations between payers and providers.*

Outcomes-Based: VBC benchmarks should be designed to align with clearly defined goals and these goals should include a focus on quality and patient experience measures.	**Driver – Goal Setting:** Payers should engage with providers and patient advocacy groups to ensure that there is a clear understanding and agreement on the goal of a VBC benchmarking methodology. *Actions* • *Convene a multi-stakeholder committee with representation from providers, patient/member groups, purchasers, and other payers (including Medicaid and Medicare the case of multi-payer alignment efforts) to gather input on the VBC model and seek consensus from participants on the mutually beneficial goals of the model.* **Driver – Performance Measurement:** VBC model benchmarks should strive to use valid, reliable, evidence-based, and standardized performance measures for tracking participant performance on quality and patient experience measures. *Actions* • *Evaluate the current set of measures that your organization is reporting on or requiring others to report.* • *Convene, or join an existing, multi-stakeholder working group to assess the current landscape of clinically meaningful, valid outcome measures and identify limited data sets that payers can adopt. Prioritize the selection of a small number of metrics, aligned across payers, that represent a mix of process & outcome measures (e.g., aligned with the CMS quality framework or other multi-stakeholder alignment initiatives). Ideally, outcome measures would be risk-adjusted measures such as those in many specialty data registries (e.g., society for thoracic surgeons & other registries used in BPCIA registry-based measure sets).* **Driver – Data Sharing:** VBC model participants should have access to the data and analytics infrastructure necessary to track performance on patient experience, quality measure, and financial performance, and identify opportunities for quality improvement. *Actions* • *Incorporate detailed discussions about the process for data sharing, the data elements included and the frequency of data sharing in contract negotiations. Payers and providers should work together to establish data sharing agreements, that allow for all pertinent cost,*

	utilization & outcome data to be shared for their attributed patients. In addition, payers should provide benchmarking data to help providers identify opportunities for improvement. Data should be as timely as possible (i.e., ideally daily but at a minimum monthly), given the realities claims lag and runout. • *Develop a recurring meeting cadence between staff responsible for managing data to identify and address issues with data sharing.* • *Explore partnership opportunities with data registries to support data sharing that is clinically meaningful but does not require duplicative reporting requirements for providers.* • *In the event that registry data is not available (for a given specialty or due to lack of partnership), still make efforts to go beyond claims-based measures wherever possible, while bearing in mind the potential added burden on providers. For example, risk-adjusted mortality data, patient-reported outcomes in CAHPS and data sets employed by QPP could be considered.*
Risk-Adjusted: VBC benchmarks should be risk-adjusted to account for variations in patient populations.	**Driver – Demographic/Clinical Factors:** VBC benchmarks should be adjusted to account for differences in patient demographics acuity/complexity of conditions that impact service utilization and cost of care. *Actions* • *Implement claims-based risk adjustment based on broadly accepted risk scoring standards such as Hierarchical Condition Categories HCCs and incorporate HCC weights, not just HCC counts (although regression model can include both).* • *Avoid risk score caps or ensure that any risk score cap methodologies allow for exceptions to avoid unfairly penalizing providers caring for more acute patient population or historically underserved populations where lack of access to care means that needs have not been properly documented.* **Driver – Social Determinants of Health/Risk Factors/Needs:** VBC benchmarks should incorporate adjustments designed to account for the variation in social determinants of health (SDOH), risk factors, and needs of patient populations. *Actions*

	• *Evaluate the availability and reliability of patient-level SDOH/risk factor/need data (e.g., screening data or self-reported by patients to provider or payer).*
	• *If these data are available, evaluate strategies for incorporating social factor adjustments into model benchmark designs.*
	• *If data is not available, explore options for developing patient-level data sources and evaluate the feasibility of using proxy datasets based on population characteristics, rather than individual patients while patient level data collection efforts improve.*
	
	Driver – Health Equity Factors: VBC benchmarks should incorporate adjustments designed to account for disparities in health outcomes and promote health equity.
	    Actions
	• *Evaluate the availability and reliability of patient-level data for assessing health equity (e.g., data on patient factors including disability status, race, ethnicity, language, sexual orientation, and gender identity).*
	• *If these data are available, evaluate strategies for incorporating equity adjustments into model benchmark designs.*
	• *If data is not available, explore options for developing patient-level data sources and evaluate the feasibility of using proxy datasets based on population characteristics, rather than individual patients while patient level data collection efforts improve.*
	
	Driver – Collaboration/Continuous Improvement: VBC models should incorporate systems for continuous improvement, and provider and payer engagement to identify and address gaps/issues in risk adjustment methodologies.
	    Actions
	• *Provide model participants with access to data to confirm risk adjustment results.*
	• *Develop clear processes for ongoing monitoring and refinement risk adjustment models.*