Highlights of the Buying Value Benchmark Repository: Innovative Homegrown Measures
Bailit Health
June 22, 2021

STATE Health & Value Strategies
Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation
About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.
Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at www.shvs.org.
About Bailit Health: Webinar Presenter

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Working with state agencies and their partners to improve health care system performance for all.

http://www.bailit-health.com/
Agenda

1. Why Do States Develop Their Own Measures?
2. The Buying Value Suite of Resources
3. State Experiences Developing and Implementing Innovative Homegrown Measures
4. Discussion
WHY DO STATES DEVELOP THEIR OWN MEASURES?
The Need for Performance Measures in Value-based Purchasing

Value-based purchasing is a **strategic approach** focused on improving performance for a set of goals.

Purchasers can use **financial incentives and/or penalties to motivate contractors** to improve performance on these targeted goals.

To attach financial consequences to performance, purchasers **need objective and reliable ways to measure performance**.
Focus on Quality in Medicaid Managed Care

36 states (90%) had any quality initiative in place
34 states (85%) made MCO quality data publicly available for comparison
25 states (63%) used quality in pay-for-performance arrangements
24 states (60%) used quality in a capitation withhold
11 states (28%) used quality for their auto-assignment

Map of Medicaid Managed Care Programs with Any Quality Initiatives (SFY 2019)

Key
- Yes
- No
- N/A

https://www.kff.org/medicaid/state-indicator/medicaid-managed-care-quality-initiatives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
Challenges With Finding the “Right” Measures

• States’ priorities may not always align with available measures

• For example, as of June 2021, there are no nationally-endorsed measures designed for use in state-payer or payer-provider contracts focused on:
  – Health equity
  – Outcome-focused obesity measures
  – Utilization of services for high-need sub-populations (e.g., individuals with mental illness)

• In these circumstances, some states begin to innovate and develop their own measures to address their program priorities
What Are Homegrown Measures?

What are homegrown measure?

- Measures developed by states and other entities to address gaps in the current measure universe
- Homegrown measures are new measures. They do not include modifications to existing measures.

What are the benefits of using homegrown measures?

- Measures are created to a) directly address state priorities and needs and b) use data sources that are feasible to access within the state

What are the challenges of using homegrown measures?

- Developing homegrown measures is resource-intensive, especially given that measures must be tested and validated prior to implementation
- Homegrown measures are not aligned with national measures and measures in use with other states
- There are rarely external data sources against which to benchmark performance
### When Should One Use Homegrown Measures?

<table>
<thead>
<tr>
<th></th>
<th>Use Homegrown Measures</th>
<th>Use Existing Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no nationally-endorsed, validated measures on the topic.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>There are nationally-endorsed, validated measures on the topic, but the measures use <strong>data sources that are challenging</strong> to implement.</td>
<td></td>
<td>✓ ✓</td>
</tr>
<tr>
<td>There are existing measures on the topic, but the <strong>measures are not aligned</strong> across programs.</td>
<td></td>
<td>✓</td>
</tr>
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*State Health & Value Strategies*
THE BUYING VALUE SUITE OF RESOURCES
What is Buying Value?

- A suite of publicly available resources for state purchasers to a) find standard measures, as well as innovative non-HEDIS or homegrown measures and associated benchmarks, and b) develop aligned measure sets
  1. Groundbreaking research on the lack of quality measure alignment (2013)
  2. The Buying Value Measure Selection Tool (2015)
  3. The Buying Value Benchmark Repository (2018)

- Visit: www.buyingvalue.org
The Buying Value Measure Selection Tool

A suite of resources that enables state agencies, private purchasers, and other stakeholders to select measures and develop aligned measure sets

Key Features

• Over **800 measures** that can be filtered by 17 domains, 20 conditions, 7 measure types, 9 populations and 12 data sources

• A **disparities-sensitive status** indicator that allows users to identify measures with an evidence of inequality in the provision of care captured by the measure

• Functionality to **crosswalk measures to 19 federal, national and state measure sets** and **systematically score** measures against a state’s overarching goals for the measure set
The Buying Value Benchmark Repository

States have had difficulty finding measures that address their program priorities and implementing non-HEDIS measures into value-based arrangements due to the lack of national benchmarks against which to assess performance.

We have developed a spreadsheet repository that includes innovative homegrown measures as well as state and regional health improvement collaborative performance on non-HEDIS measures.
The Buying Value Benchmark Repository

Key Features

- Information on **nearly 60 measures in use by other states and performance data** (when available), including:
  - Innovative homegrown measures
  - Non-HEDIS measures that are *not* homegrown and for which benchmark data are not otherwise available
## Case Examples: Reasons to Use the Repository

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find and implement an innovative measure related to social determinants of health (SDOH)</td>
<td>Utilize a homegrown measure (e.g., ED Utilization Among Members with Mental Illness) in a Medicaid managed care performance incentive program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is unclear if there are any measures that are focused on SDOH</td>
<td>This is a new measure for the state and there are no external data for the state to consider when setting its MCO performance targets</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Solution</th>
<th>Solution</th>
</tr>
</thead>
</table>
| 1. Visit [www.buyingvalue.org](http://www.buyingvalue.org) and download the Repository  
2. Navigate to either the “High-Level Summary” or “Detailed Responses” tab and key-word search for “SDOH” to find measures of interest | 1. Visit [www.buyingvalue.org](http://www.buyingvalue.org) and download the Repository  
2. See if other states are utilizing the measure, and if so, utilize the states’ performance to inform setting a benchmark  
3. Once benchmark data are available, submit your state’s performance on that measure to the Repository |
### Buying Value Benchmark Repository - High-Level Summary

<table>
<thead>
<tr>
<th>#</th>
<th>Submitting Organization</th>
<th>Measure Name</th>
<th>NQF Number</th>
<th>Condition</th>
<th>Deviations from Measure Steward</th>
<th>Coverage Type</th>
<th>Performance Level Reported to the Repository</th>
<th>Availability of Performance Data</th>
<th>Performance Period Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>MN Community Measurement</td>
<td>Depression Care - Remission at 6 Months</td>
<td>0711</td>
<td>Mental Health</td>
<td>No deviations from the measure steward (2018 report year 11/1/2015 to 12/31/2017) <strong>See comments for dates of service definition.</strong></td>
<td>Medicaid, Medicare, Commercial, Dual Medicaid/Medicare, Other</td>
<td>State</td>
<td>Performance data are available.</td>
<td>11/01/2015</td>
</tr>
<tr>
<td>23</td>
<td>Integrated Healthcare Association</td>
<td>Cervical Cancer Over Screening</td>
<td>No NQF Number</td>
<td>Cancer</td>
<td>Not applicable - measure is homegrown</td>
<td>Medicaid, Commercial</td>
<td>Aggregated rate for providers (e.g., primary care practices, hospitals)</td>
<td>Performance data are available.</td>
<td>01/01/2017</td>
</tr>
<tr>
<td>24</td>
<td>Oregon Health Authority Health Analytics</td>
<td>Disparity Measure: Emergency Department Utilization Among Members with Mental Illness</td>
<td>No NQF Number</td>
<td>Mental Health</td>
<td>Not applicable - measure is homegrown</td>
<td>Medicaid, Dual Medicaid/Medicare</td>
<td>State</td>
<td>Performance data are available.</td>
<td>01/01/2017</td>
</tr>
<tr>
<td>39</td>
<td>NYS Department of Health</td>
<td>Adolescent Preventive Care - Assessment or Counseling or Education for Depression</td>
<td>No NQF Number</td>
<td>NA</td>
<td>Not applicable - measure is homegrown</td>
<td>Medicaid, Commercial</td>
<td>Aggregated rate for health plans</td>
<td>Data are expected to be available by: September 2018</td>
<td>Performance data are not available at this time.</td>
</tr>
<tr>
<td>45</td>
<td>Office of the Health Insurance Commissioner</td>
<td>Developmental Screening in the First Three Years of Life</td>
<td>1448</td>
<td>NA</td>
<td>Measure does deviate from the steward (Included the use of the &quot;Survey of Well-being of Young Children [SWYC]&quot; tool as an acceptable screening tool because it was being used as part of a Department of Health Program, and implementation by a primary care provider)</td>
<td>Medicaid, Medicare, Commercial</td>
<td>Aggregated rate for providers (e.g., primary care practices, hospitals)</td>
<td>Performance data are available.</td>
<td>10/01/2016</td>
</tr>
</tbody>
</table>
STATE EXPERIENCES DEVELOPING AND IMPLEMENTING INNOVATIVE HOMEGROWN MEASURES
State Experiences with Homegrown Measures

• Today, we’ll hear from two states that have developed and implemented homegrown measures to address their program priorities.

• Both state’s have submitted these measures to the Buying Value Benchmark Repository.

OR

- ED Utilization for Individuals Experiencing Mental Illness
- Meaningful Language Access to Culturally Responsive Health Care Services

MA

- ED Visits for Adults with Mental Illness/Substance Use Disorder
- Health-Related Social Needs Screening
Oregon’s Measures

- Oregon developed its measures in 2018 and 2020 for use with its coordinated care organizations (CCOs)

**ED Utilization for Individuals with Mental Illness**

Number of ED visits for adult members experiencing mental illness per 1,000 member months

**Meaningful Access to Health Care Services for Persons with Limited English Proficiency**

Measure 1 (2021): CCO language access self-assessment survey
Measure 2 (2022+): Percent of member visits with interpreter need in which interpreter services were provided
About the Oregon Health Authority
Webinar Presenters

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Disparity Measure: Emergency Department Utilization Among Members with Mental Illness (EDMI)
Why Did OHA Create the EDMI Measure?

Goal: Address disparities in physical health outcomes among members experiencing mental illness and encourage better care coordination
2017 ED Utilization by Adults with Mental Health Diagnosis

Measure Development Approach

• Direction for measure set by public committee
• Measure uses the HEDIS Ambulatory Care, ED Utilization submeasure, stratified to members with mental illness
  • NCQA does not allow organizations to modify its specifications unless the change falls under NCQA’s list of Allowable Adjustments
  • Oregon is in conversation with NCQA to determine whether the ED Utilization submeasure meets the Allowable Adjustments
Challenges

• Subsequent analysis of the equity impacts of the measure has identified further challenges, such as
  • Lack of numerator credit for culturally specific care
  • Denominator missing members because of different rates of formal diagnosis
  • Lack of availability of culturally specific services and shortage of diverse mental health care workforce
Added to the CCO Quality Incentive Program in 2018

6.68% decrease from 2017 to 2019
Rate measured per 1,000 member months
Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency (HEM)
Why Did OHA Create the HEM?

OHA adopted a common definition of Health Equity in 2019 and set its singular goal of eliminating health inequities by 2030.

Need for meaningful access to health care voiced by community members from CCO 2.0 outreach sessions; measure direction set by Oregon Health Policy Board.

**Measure Goal: Evaluate meaningful access to health care services for CCO members who need spoken and sign language interpreter services.**

**What is meaningful access?** Access that is not significantly restricted, delayed or inferior as compared to programs or activities provided to English proficient individuals. (Department of Justice, 2012).
Measure Development

Measure selection process for 2020

- OHA proposed measure concept in early 2019 with two components, HCI and THW
- CCO TAG review draft specs
- OHA revised specs to focus on HCI
- Metrics and Scoring Committee rejected the measure for incentivizing in 2020
- CCOs participated pilot testing in late 2019, in preparation for the new contract reporting
- OHA included interpreter services quarterly reporting as a contract requirement for CCO 2.0 starting 2020

Measure selection for 2021

- OHA revised specs to provide reporting flexibility, allow system building and data collection glidepath
- Strong community stakeholder support
- Metrics and Scoring Committee selected the measure for incentivizing starting in 2021

Committee rejected the measure for incentivizing in 2020
Challenges: Getting to C / A (%)

A. Visits by all members with interpreter needs

B. Visits with interpreter services provided

C. Visits provided with high quality interpreter services (interpreters are qualified or certified)

Not all members identified interpreter needs in Medicaid application

Data collection gaps for interpreter services provided; when, where, how, by whom, for whom

Interpreter or bilingual staff/provider credentials are not tracked
Measure Components

1. **Language Access Self-Assessment** provides a road map for identifying gaps in service structures, workflows, and for developing improvement plans.

2. **Quantitative reporting of stratified data** measures the quality of language services based on the proportion of spoken and sign language interpreter needs fulfilled by working with OHA certified and qualified health care interpreters (HCIs).

   Other required stratifications:
   - Bilingual staff/providers
   - Interpreters NOT certified or qualified by OHA.
   - Care domain and setting
   - Modality of interpreter services
   - Patient refusals
Measure Components and Glide Path

Component 1: Language Access Self-Assessment
- MY2021: Must pass 46/89 points
- MY2022: Must pass 56/89 points
- MY2023 and on: Must pass 77/89 points

Component 2: Quantitative Interpreter Service Report
- MY2021: None (system building year)
- MY2022: Hybrid sampled report
- MY2023 and on: Full population report, must meet benchmark or improvement target

RED = Incentive requirements

Must report but ‘rate’ does not affect payment; MY2022 rate will become the baseline for MY2023 and provide reference for M&SC to set the benchmark
Progress

• CCO language service contract reporting gradually improving

• Designated coordinator for language access/interpreter services at CCOs and large medical groups

• More conversation for service provision, training and credential requirements

• CCOs revisit utilization of out-of-state, none certified/qualified service vendors

• More utilization for OHA certified/qualified HCIs

• Conversation for bilingual providers, in-language visits
Massachusetts’ Measures

- Massachusetts developed its measures in 2018 for use with its accountable care organizations (ACOs)

#### ED Visits for Adults with Mental Illness/Substance Use Disorder

Risk-adjusted ratio of observed ED visits to the expected number of ED visits for members 18-64 years with a diagnosis of serious mental illness and/or substance addiction

#### Health-related Social Needs Screening

Percentage of ACO-attributed members 0-64 years of age who were screened for health-related social needs
About the Massachusetts Executive Office of Health and Human Services Webinar Presenter

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Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar
Thank You

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