Leveraging the Buying Value Resources to Advance Health Equity Measurement

Tuesday, September 24, 2024

3:00 – 4:00 p.m.

Please stand by, this webinar will begin shortly

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

Leveraging the Buying Value Resources to Advance Health Equity Measurement

Bailit Health

Tuesday, September 24, 2024

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About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare 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 healthcare 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.
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About Bailit Health: Webinar Presenters

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Working with state agencies and their partners
to improve health care system performance for all.
http://www.bailit-health.com/

Housekeeping Details

- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org.**

Agenda

- Overview of Buying Value
- The *Buying Value Measure Selection Tool*
- The *Buying Value Benchmark Repository*
- Leveraging Buying Value for Health Equity
- State Perspectives
- Discussion

Overview of Buying Value

What is Buying Value?

- A suite of publicly available resources to help users:
  1. **Find measures** and associated benchmarks.
  2. **Develop aligned measure sets**.
- Groundbreaking research on the lack of quality measure alignment (2013)
- The *Buying Value Measure Selection Tool* (2015)
- The *Buying Value Benchmark Repository* (2018)

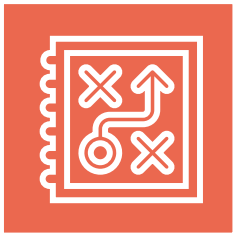
Visit: www.buyingvalue.org

The Buying Value Measure Selection Tool

The *Buying Value Measure Selection Tool*

What is it?

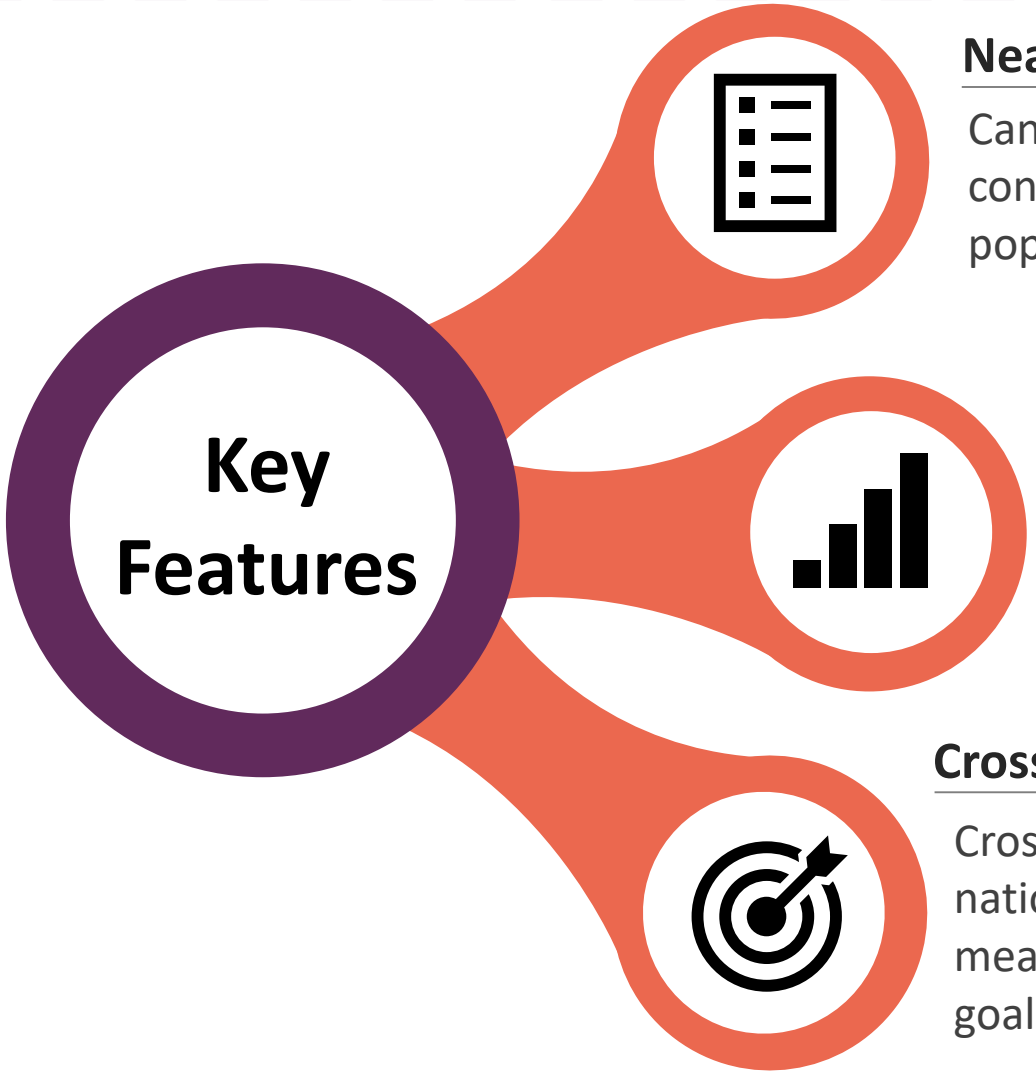
- **A tool** that enables the **sorting of measures** of special interest and development aligned measure sets.



Why?

- **Alleviate provider burden** of being subject to an overwhelming number of measures from payers and regulators.
- Ability to **focus quality measurement** on priority topics.

The *Buying Value Measure Selection Tool*



Nearly 900 measures

Can be filtered by 17 domains, 20 conditions, 7 measure types, 9 populations and 13 data sources.

Disparities-sensitive status indicator

Allows users to identify measures with evidence of inequity in the provision of care captured by the measure.

Crosswalk and score measures

Crosswalks measures to 19 federal, national and state measure sets and score measures against a state's overarching goals for the measure set.

Buying Value Measure Selection Tool Tutorial

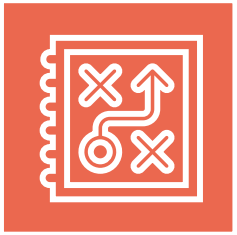
Measure Crosswalk													
BV Library #	Measure Name	CBE ID	CBE Endorsement Status as of May 2	Steward	CMS Quality ID	CMS eCQM ID as of May 2024	Description	Domain	Condition	Measure Type	Populations	Data Source	Disparities-sensitive Status
BV-1	Hospital Harm – Opioid-Related Adverse Events (ORAE)	3501	Endorsed	Centers for Medicare & Medicaid Services			This measure assesses the proportion of inpatient hospital encounters where patients ages 18 years of age or older have been administered an opioid	Hospital	Patient Safety	Outcome	Adult	Clinical Data	
BV-10	Hospital Harm – Severe Hypoglycemia Measure	3503	Endorsed	Centers for Medicare & Medicaid Services		CMS816v2	Inpatient hospitalizations for patients 18 years of age or older at admission, who were administered at least one hypoglycemic medication during the	Hospital	Patient Safety	Outcome	Adult	Clinical Data	
BV-100	Hospital Harm – Severe Hyperglycemia	3533	Endorsed	Centers for Medicare & Medicaid Services		CMS871v2	The number of inpatient hospital days with a severe hyperglycemic event per the total qualifying inpatient hospital days for patients 18 years and older at admission	Hospital	Patient Safety	Outcome	Adult	Clinical Data	
BV-101	Global Malnutrition Composite Score	3592	Endorsed	Academy of Nutrition and Dietetics		CMS986v2	This composite measure of optimal malnutrition care focuses on adults 65 years and older admitted to inpatient service who received care appropriate to	Hospital	Gastrointestinal	Composite	Older Adult	Clinical Data	
BV-102	Appropriate Treatment for ST-Segment Elevation Myocardial Infarction (STEMI) Patients in the Emergency Department	3613	Endorsed	Centers for Medicare & Medicaid Services		CMS996v3	Percentage of ED patients with a diagnosis of STEMI who received appropriate and timely treatment	Acute Care	Cardiovascular	Process	Adult	Clinical Data	
BV-103	Asthma: Assessment of Asthma Control	0001	No Longer Endorsed	AMA-PCPI (American Medical Association-			Percentage of patients who were evaluated during at least one office visit for the frequency (numeric) of daytime and nocturnal asthma symptoms	Chronic Illness Care	Respiratory	Process	Adult and Pediatric	Claims/Clinical Data	
BV-104	Appropriate Testing for Children with Pharyngitis	0002	No Longer Endorsed	National Committee for Quality Assurance			Percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the	Overuse	Infectious Disease	Process	Pediatric	Claims	
BV-105	Initiation and Engagement of Substance Use Disorder Treatment	0004	Endorsed	National Committee for Quality Assurance	305	CMS137v12	Percentage of substance use disorder episodes (SUD) that result in treatment initiation and engagement. Two rates are reported:	Chronic Illness Care	Substance Use Disorder	Process	Adolescent and Adult	Claims	Yes
BV-106	CAHPS® Clinician/Group Surveys v 3.0 – (Adult Primary Care, Pediatric Care, and Specialist Care Surveys)	0005	Endorsed	Agency for Healthcare Research and Quality	321		• Adult Primary Care Survey: 37 core and 64 supplemental question survey of adult outpatient primary care patients.	Other	NA	Patient Experience	Adult and Pediatric	Survey	
BV-107	CG-CAHPS (MHQP Version)	0005 (Modified)	No Longer Endorsed	Massachusetts Health Quality Partners			Composites: Getting Timely Appointments, Care and Information; How Well Providers Communicate; Providers' Use of Information to Coordinate Patient	Other	NA	Patient Experience	Adult and Pediatric	Survey	
BV-108	CAHPS® Health Plan Survey v 5.1H (Medicaid and	0006	Endorsed	Agency for Healthcare	321		39-question survey of adult health plan members and 41-question survey of child	Health/Drug	NA	Patient	Adult and		

The Buying Value Benchmark Repository

The *Buying Value Benchmark Repository*

What is it?

- A spreadsheet **repository** that includes **innovative, homegrown measures** as well as performance data on non-HEDIS measures.



Why?

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

The *Buying Value Benchmark Repository*

Key Features:

- Information on **over 60 measures in use by 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.

Leveraging Buying Value for Health Equity

What's New? Innovative Health Equity Measures

- We conducted a **national scan of innovative, homegrown health equity quality measures** that can be or are used in value-based contracting.
- We identified **14 measures for inclusion in the *Buying Value Measure Selection Tool*** according to a set of criteria.
- The measures are listed in the *Buying Value Measure Selection Tool* in the **Health Equity and Social Determinants of Health** domain.

Note About Health Equity Measures

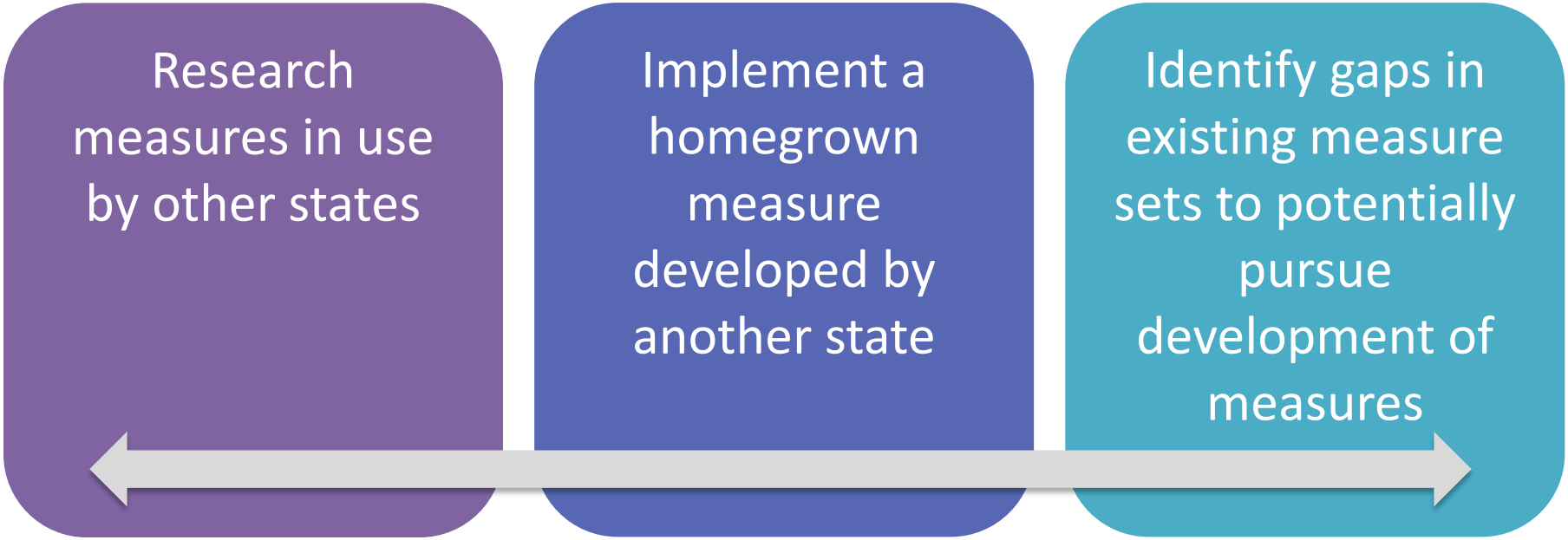
- **Note:** Since health equity measurement is nascent, the **health equity measures do not meet the same standards** for inclusion in the Tool as are typically applied to other, more traditional quality measures.
- Such standards include:
  - Valid and reliable measurement methods.
  - Measured structure, process, or outcome having evidence of improved patient health and/or reduced health disparities.

Health Equity Measure Highlights

- The *Measure Selection Tool* now includes some of the latest health equity measures, including:
  - **Oregon:** Meaningful Access to Health Care Services for Persons Who Prefer a Language Other than English and Persons Who are Deaf or Hard of Hearing.
  - **Rhode Island:** Race, Ethnicity, and Language Measure (performance on state-selected contractual quality measures when stratified by variables).
  - **North Carolina:** Rate of Screening for Health-Related Resource Needs.

Ways to Use the New Health Equity Measures

- How can you use the *Measure Selection Tool* to research and implement health equity measures?



Re-Cap

- The Buying Value tools include:
  - **The *Measure Selection Tool*** (over 900 measures).
  - **The *Benchmark Repository*** (homegrown and non-HEDIS measures and performance).
- These tools can specifically help states **advance health equity through quality measurement**.

State Perspectives

About Our State Presenters

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AHCCCS Targeted Investments - Addressing Social Risk

Buying Value Webinar, State Health and Value Strategies Program
9/24/2024

AHCCCS
Arizona Health Care Cost Containment System

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Presentation Agenda

- Context
- Milestone #2: CLAS Standards
- Milestone #3: Health-Related Social Needs Screening
- Milestone #5: Reduced Identified Inequities

Context: AHCCCS Targeted Investments 2.0

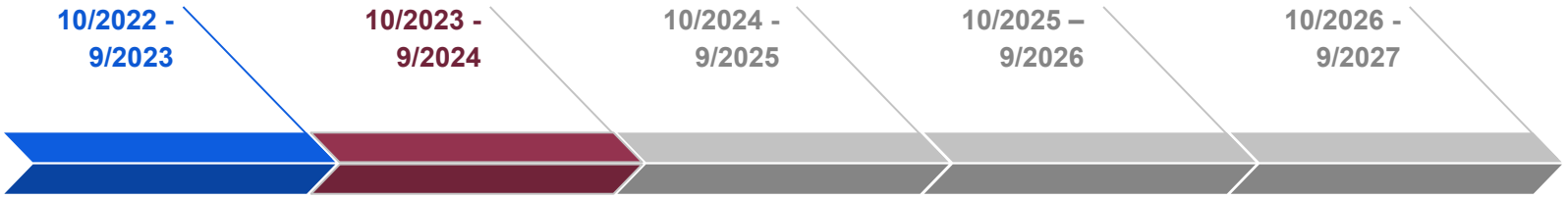
SDP Incentive Program

- 1115 Waiver: 5 Years, $250m.
- Reduce fragmentation of BH, PCP, and health related social needs (HRSN)
- Increase provider coordination with community partners
- Population Health: Identify and address health inequities
- Support providers and system throughout CLRS implementation

Participation

Category	TINs	Clinics
Adult PCP	56	397
Adult BH	57	583
Peds PCP	43	279
Peds BH	49	458
Justice	17	58
Unique	**147**	**866**

Context: TI 2.0 Timeline



Year 1	Year 2	Year 3	Year 4	Year 5
Onboarding/Application	Establish new systems and processes	Implementation and evaluation of systems and processes	Meet targets on performance measures	Meet targets on performance measures

Context: TI 2.0- Payment

All Milestones Are Optional:

- #2: CLAS: 15% of Payment
- #3: HRSN Screening: 20% of Payment
- #5: Reduce Inequities: 15% of Payment

Y2 and Y3 Process Milestones MUST Include Required Elements:

- Participants attest to implementing/developing processes
- Participants submit processes and protocols per requirements
- AHCCCS and ASU partners validate

Annual Payment = [volume] x [annual rate] x [% of milestones met]

Milestone #2: CLAS Standards

Purpose: Ensure culturally and linguistically appropriate services are available, build infrastructure, engage community, evaluate

Year 2:

- Complete the CLAS Standards Implementation Checklist
- Implement standards 2-4 (Governance, Leadership, and Workforce)
- Provide plan to implement standards 5-13 by 9/2025:
  - Activities to be completed
  - Resources needed
  - Person responsible

Milestone #2: CLAS Standards

Year 3:

- Continue implementing standards 2-4
- Implement standards 5-13 by 9/30/2025
  - Communication and Language Assistance (Standards 5-8)
  - Engagement, Continuous Improvement, and Accountability (Standards 9-13)

Milestone #3: HRSN Screening

Purpose:

- Identify HRSN(s) using any tool that includes (8) minimum domains
- Educate patient & family
- Offer referral to nearby services
- Refer to community service provider per mutually developed protocols
- Document screening results and if referral is made: EHR, Claims, and CLRS (if applicable)

Milestone #3: HRSN Screening

Year 2:

- Develop internal processes for screening, education, and documentation
- Collaborate with community partners to develop closed loop referral protocols (CLRS or otherwise)
- Maintain a registry of community service providers
  - CommunityCares: Statewide CLRS with 211 service providers
  - ACO/CIN case management: ACO or CIN
  - None of the above: Provider maintains a list
- Document in EHR and claims, follow up at next visit

Milestone #3: HRSN Screening

Year 3: Random Sample Audits

- **Patients seen 10/1/2024 - 3/31/2025**
  - HRSN screening was offered and results documented for 85% of patients
  - Follow mutually developed protocols to refer and close loop with community partners
- **Patients seen 4/1/2025 - 9/30/2025**
  - HRSN screening, referral, and follow up was completed for 85% of patients

Milestone #3: HRSN Screening

All Years: Documenting HRSN via Claims

- Require no-pay G codes (add-on procedure codes) to identify full screening and referral results:
  - **G9919:** Patient desires a referral for at least one HRSN
  - **G9920:** HRSN identified, but patient does not want a referral
  - **G9921:** Full screening complete, no HRSN identified
- Use Z codes to list identified HRSNs
  - Z55 - Z65
  - Desk Aid for common codes

CLAIMS LINES ARE DENIED BUT STILL ENCOUNTERED TO AHCCCS

Milestone #5: Address Health Inequities

Purpose:

- Collect patient demographic data
  - AHCCCS reviewing Federal guidance vs. AZ Values
  - Providers may adopt in the meantime:
    - OMB: Race/ Ethnicity
    - CMS: Gender assigned at birth, gender identity, sexual orientation
- Internally stratify quality measures
- Develop action plan to address identified disparities
- Evaluate and update action plan annually

Milestone #5: Address Health Inequities

Year 2- Create Processes to:

- Collect patient demographic data (e.g., payer, intake forms)
  - Reconcile differences (e.g., race provide by payer)
  - Roll-up to Federal standards
- Internally stratifying quality measures, such as:
  - NCQA HEDIS measures (most advanced)
  - Asthma screening (ACO/CIN initiative)
  - Well-gap reports (least advanced)

Explore opportunities to coordinate health equity activities across sectors: Policymakers, MCOs, ACOs/CINs, Providers, Universities

Milestone #5: Address Health Inequities

Year 3:

- Identify health disparities via Y2 processes
- Create and implement health equity plan to address them
- Submit plan for routinely evaluating efficacy and revising health equity plan

Milestone #5: Address Inequities

All Years- Collaboration and Support

Arizona State University- TIPQIC

- Hands-on EHR training
- Enriching data from other sources (HIE, birth/death records)
- Rolling-up data from various sources to Federal Categories
- Stratified Performance Measure Dashboards
- Quality Improvement Collaboratives, Projects (e.g., process map)

MCOs, ACOs, and CINs

- Provide demographic information on monthly reports (e.g., rosters)
- Coordinate community interventions

MassHealth Quality and Equity Incentives Program

Buying Value Webinar
September 24, 2024

Agenda

- MassHealth Basic Facts
- Overview of Quality & Equity Incentive Programs
- QEIP Measures
  - Demographic Data Completeness
  - Disability Accommodation Needs
  - Achievement of External Standards for Health Equity

MassHealth

MassHealth, Massachusetts' Medicaid & Children's Health Insurance Program (CHIP), is a cornerstone of the health insurance landscape in the state

Nearly **1 in 3 Massachusetts residents** is covered by MassHealth - over 2 million people

More **than half** of MassHealth members have income at or below 86% FPL ($19,806 per year for a family of 3 in 2022)

Quality & Equity Incentive Program (QEIPs)

- In September 2022, MassHealth launched the Quality and Equity Incentive Programs, a $2+ billion initiative over 5 years
  - MA received authority under an 1115 waiver extension (for 2022-2027) to make equity a pillar of value-based care alongside quality and cost through implementation of its health equity incentives program for acute hospitals
  - Parallel incentive programs for Accountable Care Organizations (ACOs)/ Managed Care Organizations (MCOs), the MassHealth Behavioral Health Vendor (MBHV), and Community Behavioral Health Centers (CBHCs)

QEIP Measures

Demographic & Health-Related Social Needs (HRSN) Data

- Demographic Data Completeness
- HRSN Screening

Equitable Quality & Access

- Quality Performance Disparities Reduction
- Equity Improvement Interventions
- Language Access
- Disability Competent Care
- Disability Accommodation Needs

Capacity & Collaboration

- External Standards for Health Equity
- Patient Experience
- Joint Collaboration

QEIP Measures

Demographic & Health-Related Social Needs (HRSN) Data

- Demographic Data Completeness
- HRSN Screening

Equitable Quality & Access

- Quality Performance Disparities Reduction
- Equity Improvement Interventions
- Language Access
- Disability Competent Care
- Disability Accommodation Needs

Capacity & Collaboration

- External Standards for Health Equity
- Patient Experience
- Joint Collaboration

Demographic Data Completeness

Measure Summary

This measure assesses the percentage of members with self-reported **Race, Ethnicity, Preferred Spoken/Written Language**, Disability, Sexual Orientation, and Gender Identity (RELD SOGI) data collected by hospitals during inpatient stays and/or ED visits in the measurement year. The goal is to reach 80% of self-reported data completeness rates by Year 5.

	Performance Trajectory	Measure Requirements	

Year 1	P4R	• Submit a RELD SOGI Assessment (data collection practices & data completeness)	• Submit RELD SOGI Mapping & Verification deliverable
			• Submit:
			  • Enhanced Demographics Data File (member-level demographic data collected)
			  • Update Date and/or Verification Date (optional submission in Years 3 & 4 and required submission in Year 5)
			Note: update & verification dates <u>not used</u> for calculating data completeness

Year 2	P4R		
Year 3	**P4P**		
Year 4	**P4P**		
Year 5	**P4P**		

P4R – Pay for Reporting
P4P – Pay for Performance

Disability Accommodation Needs

Measure Summary

This measure assesses whether patients with disabilities with acute hospital inpatient discharges and radiology encounters were 1) screened for accommodation needs related to a disability, and 2) for those patients screened positive, a corresponding accommodation need was documented in the medical record.

	Performance Trajectory	Measure Requirements	
Year 1	P4R	• Report current screening approaches & documentation of needs • Submit a plan to improve screening & documentation	
Year 2	P4R	• Report screening tool/ question(s) & modality	• Report rates: 1. Accommodation Needs Screening 2. Accommodation Needs Related to a Disability Documented in the Medical Record
Year 3	**P4P**		
Year 4	**P4P**		
Year 5	**P4P**		

P4R – Pay for Reporting
P4P – Pay for Performance

External Standards for Health Equity

Measure Summary

This measure assesses whether acute hospitals have achieved standards related to health equity established by The Joint Commission (TJC) for its "Health Care Equity Certification." External health equity certification independently and objectively assesses attainment of relevant health equity goals (e.g., creation of structures that support a culture of equity) to ensure that healthcare organizations are providing a comprehensively high standard of equitable care.

	Performance Trajectory	Measure Requirements
Year 1	P4R	• Comply with TJC's six new elements of performance in Leadership (LD), Accreditation Standard LD.04.03.08
Year 2	P4R	• Initiate the process with TJC to achieve Health Care Equity (HCE) Certification
Year 3	**P4P**	• Achieve HCE Certification
Year 4	**P4P**	• Maintain of HCE Certification
Year 5	**P4P**	• Achieve of HCE Re-Certification

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Massachusetts QEIP Webpage: MassHealth Quality and Equity Incentive Programs | Mass.gov

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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