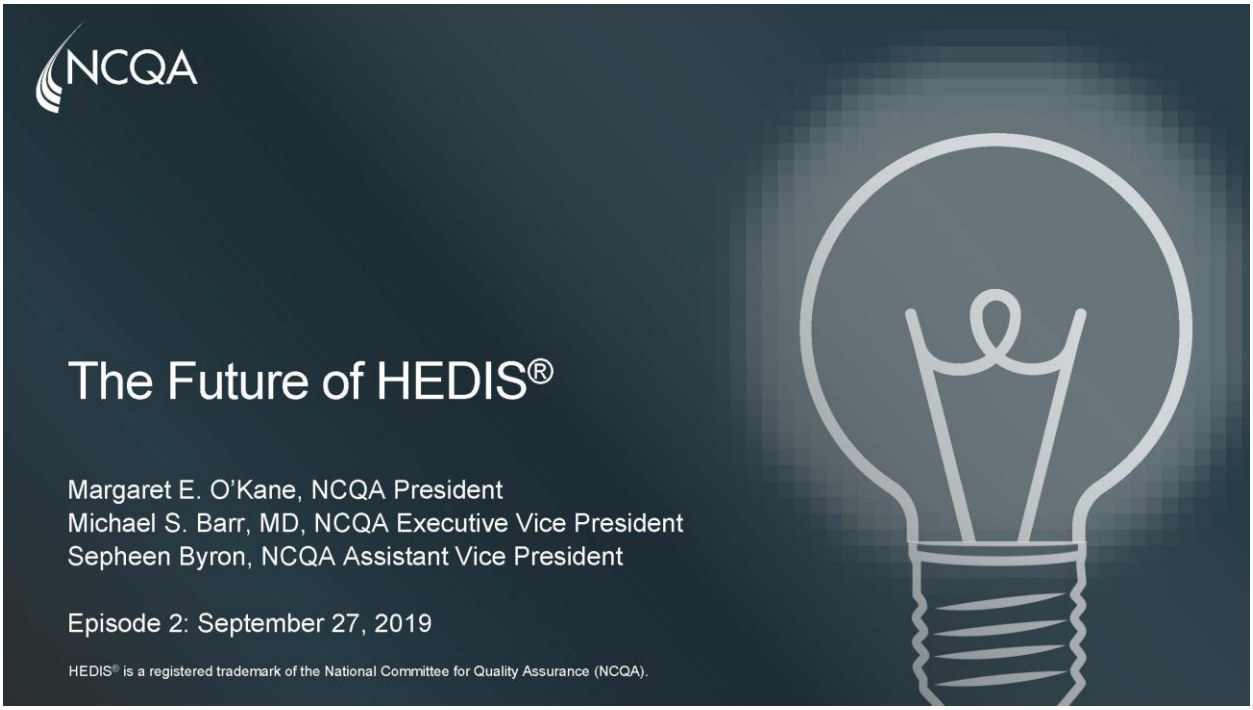
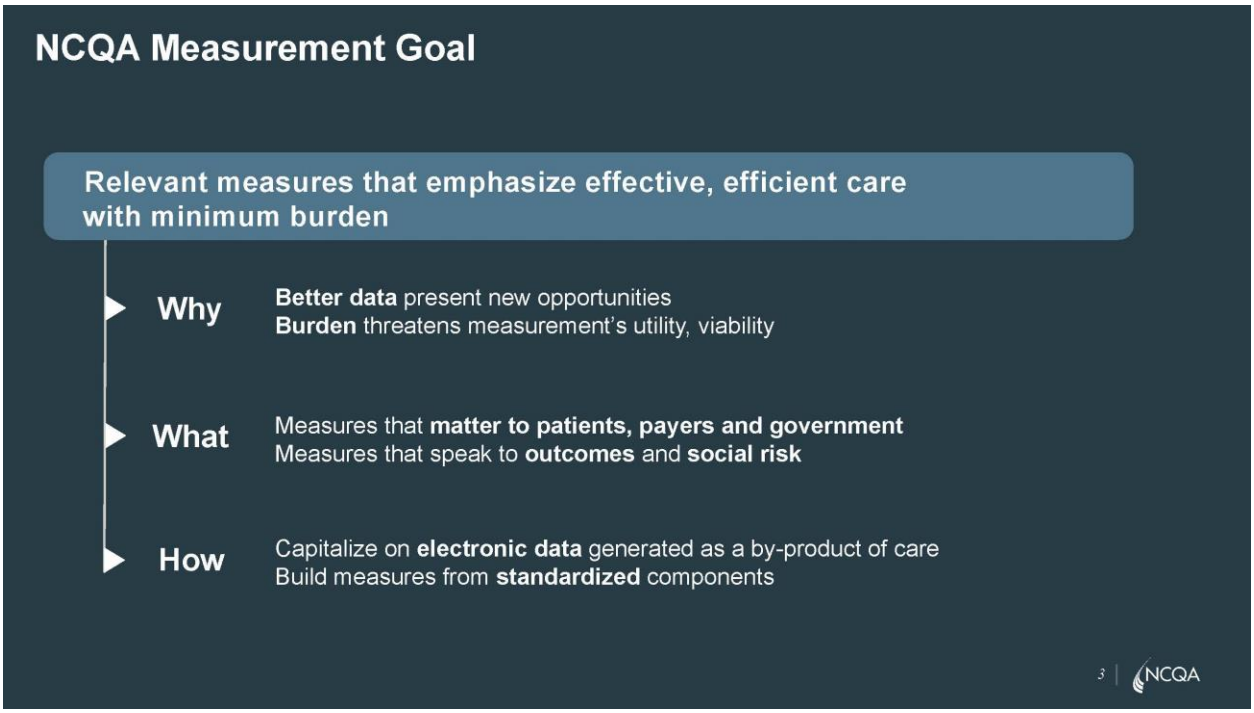
The Future of HEDIS: Episode 2 — September 27, 2019



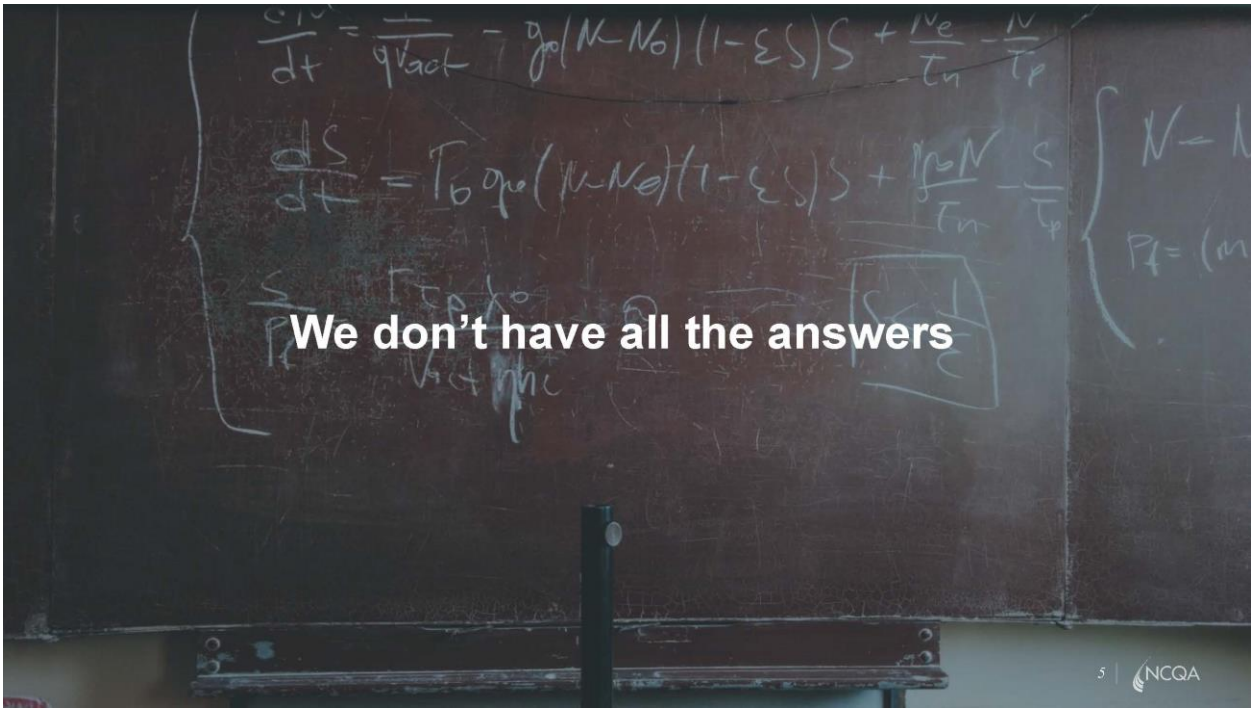
2	Richard:	00:14	Hello, and welcome to today's webinar, The Future of HEDIS. My name is Richard and I will be in the background answering any WebEx technical questions. If you experience technical difficulties at any time during this WebEx event, please submit your technical issue in the Q&A panel and I will assist you. You may also contact our WebEx technical support at 866-779-3239. Please note that as attendee you are a part of a larger audience today. However, due to privacy concerns, the attendee list is not displayed. All attendees will be in a listen-only mode throughout the duration of today's call and as a reminder, this call is being recorded. We will be holding a Q&A session at the conclusion of today's presentation. You may ask a question at any time by entering it into the Q&A panel at the lower right of your screen. And now, I'd like to introduce you to your speakers today, Peggy O'Kane, Michael Barr and Sepheen Byron. Peggy, you have the floor.
18	Peggy O'Kane:	01:10	Thank you very much and welcome to all the people that are on the line. We look forward to having this dialogue with you. This is the second in our Future of HEDIS series. We assume many of you were here before, but we'll be going over some of the information for those of you that weren't here, weren't able to be on the first time.

Peggy O'Kane:	01:30	So, why are we changing HEDIS and why now? Well, I think that we've had a good run with doing HEDIS out of old-fashioned claims data. You may not have the same feeling if you were doing chart chases. But as health care is becoming increasingly digitalized and we have both data and capabilities emerging at the delivery system level that really offer a lot of promise, we want to have a system that's fluid enough that it can go across the delivery system from the frontlines, to the administrative and data people, to the health plan. And we envision an environment where measurement data is also fueling practice. So, measurement, in our minds, is a byproduct of practice. That's what we want to be.
Peggy O'Kane:	02:30	We've also been hearing from many of you over the years about how we need to move HEDIS into the future. We all agree with that and we also know that our ability to measure important aspects of care is limited by the old data sources. So we've been doing a lot of market research; we've spoken to many of you or your colleagues and we are very committed to really trying to make this change management process work for all of us. It means big changes for NCQA and our staff, [it] means big changes for you and your staff, and we want to keep moving the quality agenda forward and the ability to improve quality while we're improving the data aspects or the underlying architecture of quality measurement.



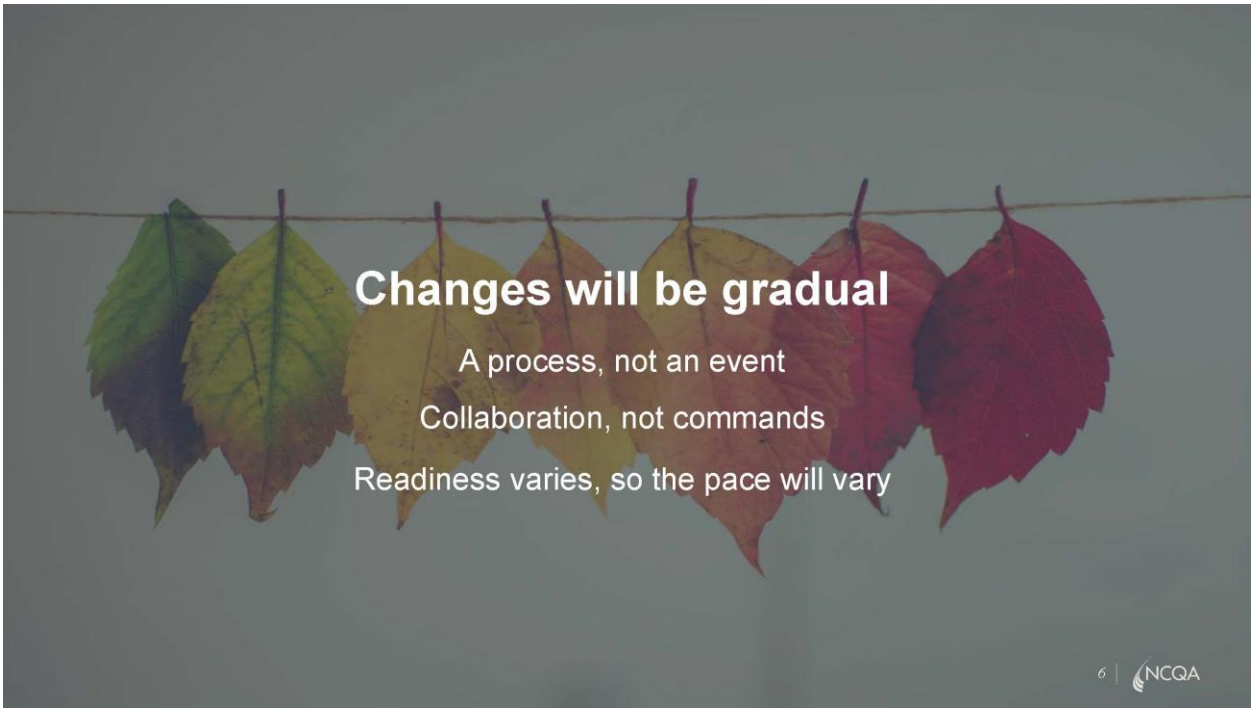
50	Peggy O'Kane:	03:23	We want relevant measures that emphasize effective, efficient care with minimum burden. Why? ... Well, burden threatens the utility of measurement. And it also threatens the motivation of frontline people that must deal with the burden. So, we're very aware of that and we're very committed to trying to lessen that. We want measures that matter to patients, payers and government. They don't all want the same thing [, but] some of them do want the same thing. So, we know that people are very compelled by information on outcomes of care and social risks. So, those things require more sophisticated data than what we've been able to have in the past. And we want to capitalize on the electronic data—generated, as I said before, as a byproduct of care and build measures from standardized components.
64	Peggy O'Kane:	04:17	And as I say the word "standardized," I want to remind you that NCQA standardizes measures, but we're using other people's standards for data. So, we don't want to create a whole separate architecture for quality measurement from what you need in order to run care in your organizations.

70 So, we want to improve the utility of HEDIS and we want to maintain the integrity of measures throughout the system. So
72 those are big goals.



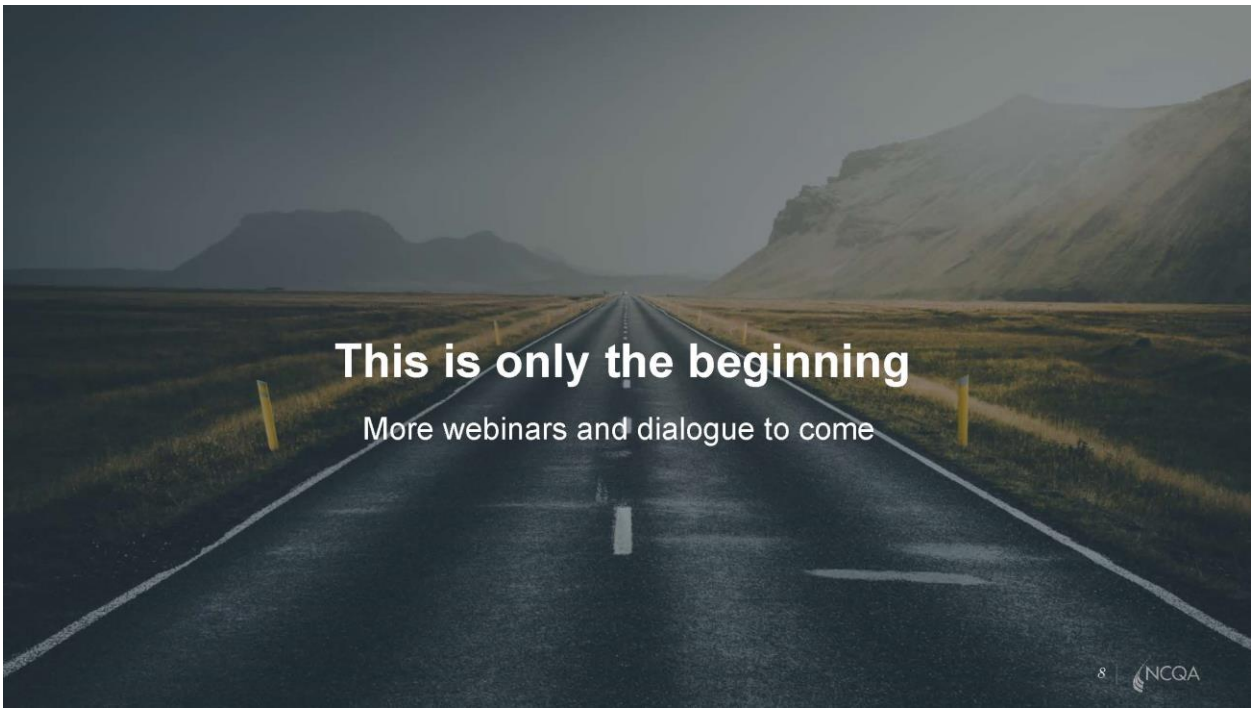
74 And I have to remind you that we have no illusions that we have all the answers; that the feedback from you, that communication

with you, is often where we need the most input. So, as we're trying to walk this journey, we really need to have constant communication with you and hopefully a lot of goodwill about our common purpose to improve the quality of care and lessen the burden on everybody in the system.



Peggy O'Kane: 05:24 So our changes will be gradual. This is not like it's today and tomorrow it will be the new thing. It's a process. It's not an event. It's a collaboration with you. It's not commands from NCQA. And we understand that readiness varies, so the pace will vary. The conditions on the ground in delivery systems are different; plans are different. We will count on you to help us understand that the pace that we're walking is right for you, and there will be different paces for different participants.

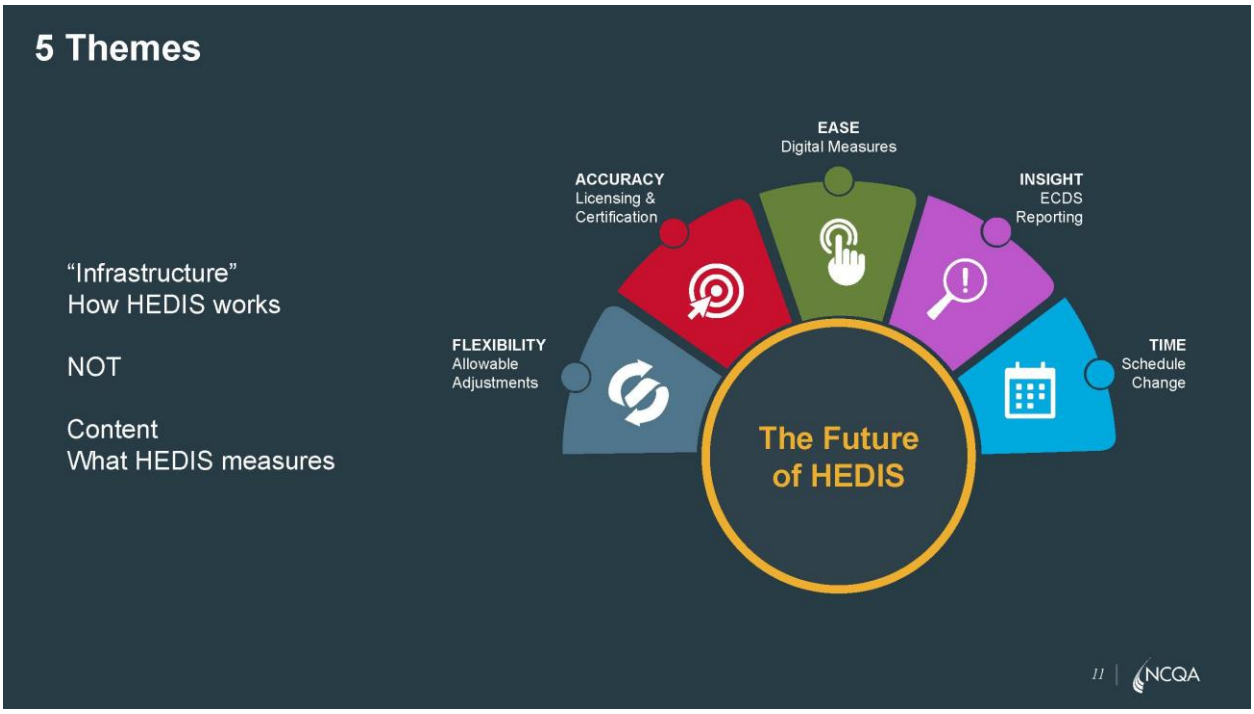
Peggy O'Kane:	06:01	For those of you that weren't at the first one, we will be covering some new material today and you may want to take a look at the earlier one, which you can find at ncqa.org: The Future of HEDIS.



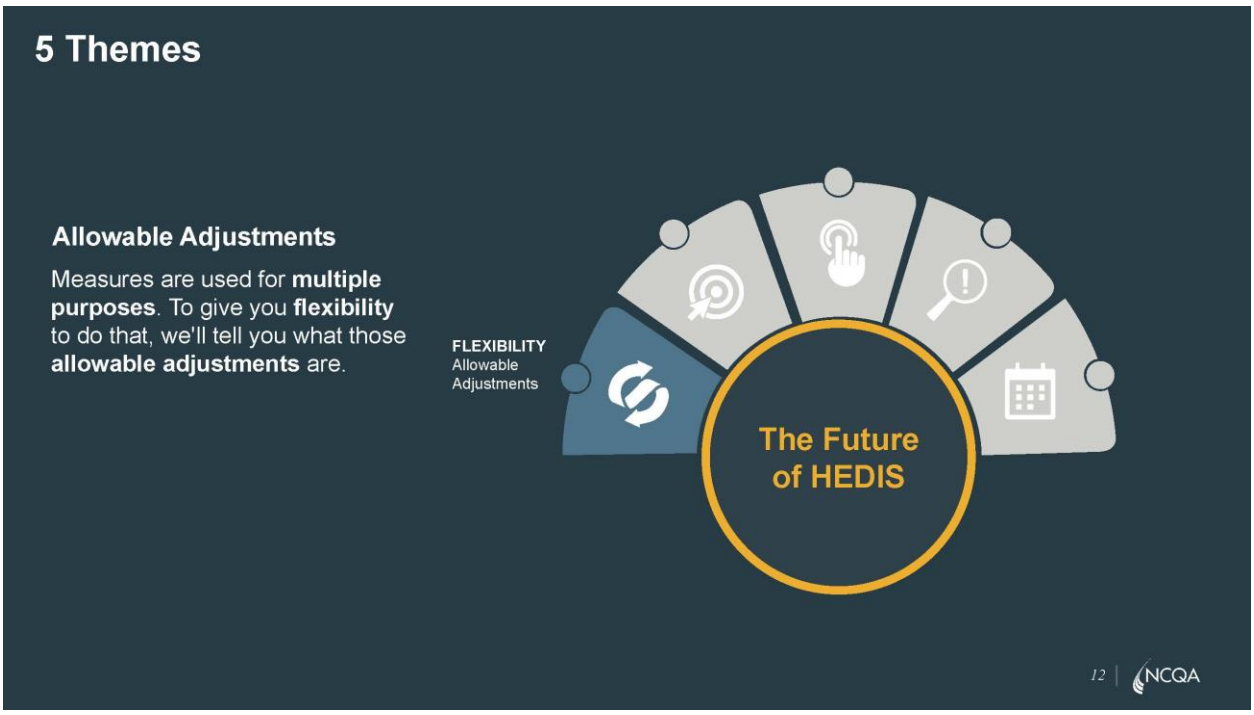
So, we are compelled to continuous communication with you and more webinars and dialogue, and if you have ideas about better ways to communicate, we're all ears about that as well. So, thank you so much for your goodwill and all the efforts you put in. Quality wouldn't be getting better without all the effort that you put in to this enterprise.

Peggy O'Kane: 06:43 And we have two more webinars scheduled this year, October 30th and December 3rd. And so, save those dates and look for invitations for future webinars. With that, I'm going to turn it over to Michael Barr.

108			Dr. Barr is our NCQA, Executive Vice President for Measurement and Research. And take it away, Michael.
110	Michael Barr:	07:08	Well, thank you, Peggy; really appreciate the opportunity to speak with all of you today. As Peggy mentioned, those of you who were involved in the July 12th webinar, here is some of the same material, but we'll make it to the higher level and then turn it over to Sepheen Byron, who's going to answer some of the questions that we received after the last webinar.
112			
114			



Michael Barr: 07:27 So today, we're going to talk about these five topics—the infrastructure, not the content HEDIS measures. Those five topics are allowable adjustments, licensing and certification, digital measures, Electronic Clinical Data System reporting and the schedule change to HEDIS.



Michael Barr: 07:48 So, let's talk about allowable adjustments. We introduced allowable adjustments a year ago when we introduced HEDIS 2019. And we did that because people use our measures for multiple purposes, but don't always maintain the integrity of the measures in doing so and sometimes they don't even realize that they've undermined the integrity. So, therefore, we developed the allowable adjustments that help you adjust the measures without changing the clinical intent. Back to words Peggy used previously, the integrity of the measure. They allow use of the measures at different levels. So, it's not just for health plan reporting. Using our measures for a clinician or practice or a network or ECL reporting is what we intend.

Michael Barr: 08:28 For example, you can filter results by product line, turn off the enrollment criteria that are embedded in a health plan measure or focus on a population subset; for example, in an age range within a particular demographic of those that fall into the measure. So that's an initial conversation or a topic about allowable adjustments.

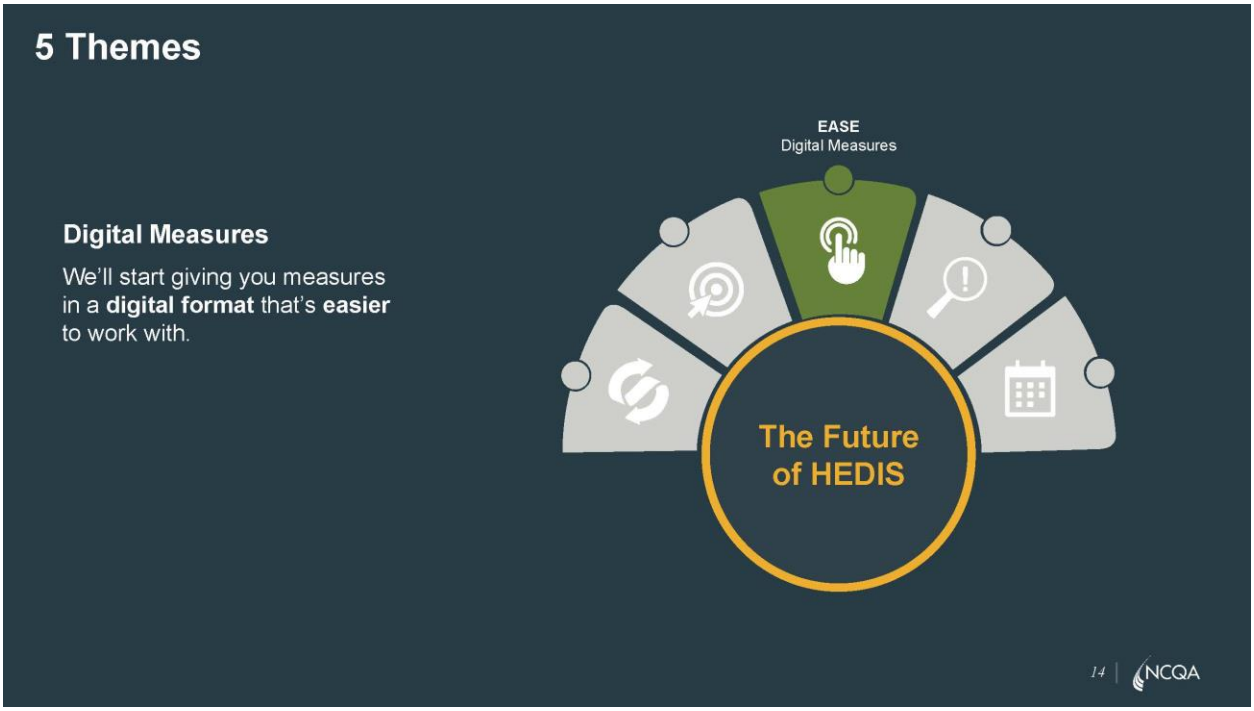
Michael Barr: 08:48 Let's move onto licensing and certification, because at the same time we're opening the door and actually encouraging use of allowable adjustments. We also want to make sure to maintain the integrity. You need to assure that the use of these measures is appropriate and that the results generated are accurate. So using HEDIS measures requires a license agreement with NCQA. If you use HEDIS internally for quality improvement within your health plan or delivery system, you count that as non-commercial use and the standard license agreement you attest to in our store where you buy Volume 2 is all you need.

Michael Barr: 09:26

If you are a health plan that uses internal software to record HEDIS, your plan software must be certified by NCQA or you must contract with a certified software vendor no later than 2021 for HEDIS reporting 2022. Any software you use to calculate or report HEDIS measure rates must have a separate HEDIS license to be certified by NCQA. But if you sell services and software that use HEDIS measures, you must first receive NCQA measure certification to demonstrate that how you use our measures meets our standards. The point of licensing and certification [is] to help you ensure HEDIS results are accurate, reliable and can be used for all the purposes you intend, most importantly, of course, to improve clinical care.

Michael Barr: 10:13

Now, measure accuracy should be a priority because value-based payment models use quality measurement results to direct billions of dollars in payments and it's vital that all parties to value-based contracts trust the underlying calculations. That also means that everyone wants to do apples-to-apples comparison. So, this licensing and certification is a way to ensure that.



Michael Barr: 10:36

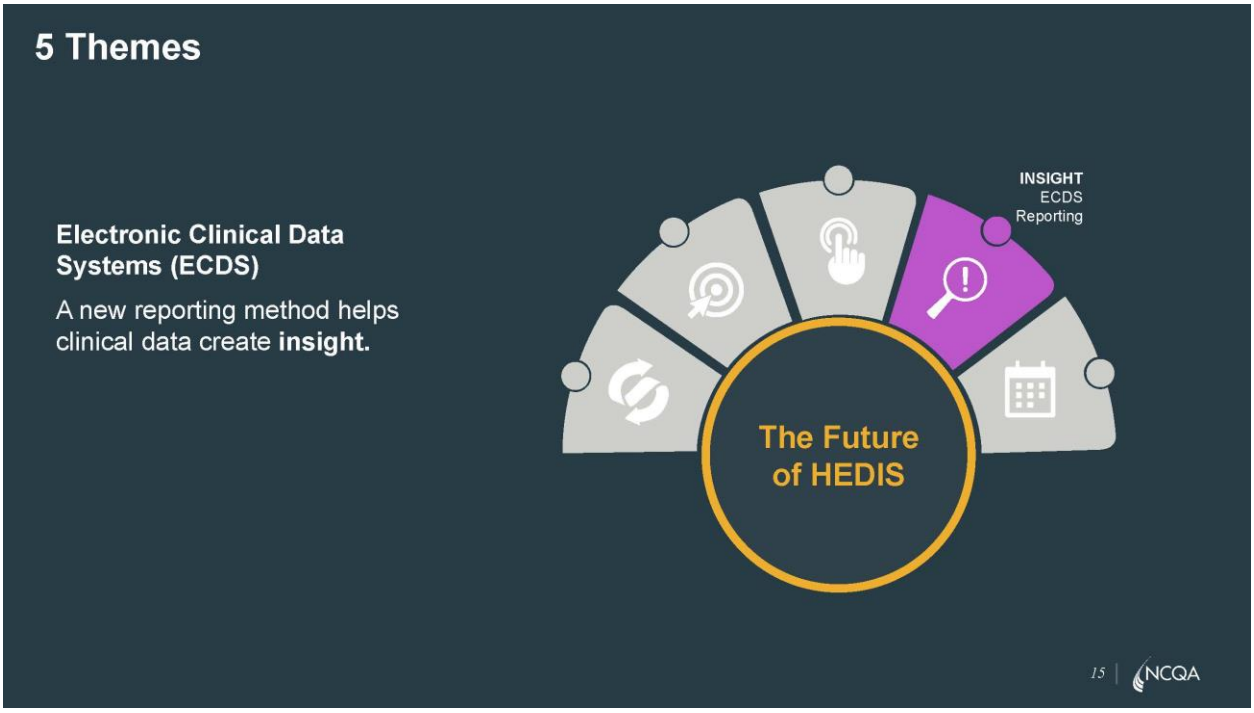
Let's move on to digital measures. What do we mean when we talk about digital measures? I'm specifically talking about digitalized versions of our existing HEDIS measures that many health plans currently report traditionally, in the traditional way. In a few minutes, I'll talk about Electronic Clinical Data Systems measures, which are also digital but are reported differently. In October, NCQA will release the first HEDIS 2020 digital measures for traditional reporting.

Michael Barr: 11:07

These will be machine-readable and downloadable from the NCQA store. And we plan to release more measures in this format for traditional reporting each year. And digitalization means NCQA writes the measures; it's computer code, so it is easier then for you to read, interpret and basically program the measures from the PDF or line to specification. And this helps avoid interpretation errors or human errors and non-standardization back to the integrity of the measure.

Michael Barr: 11:38

And as Peggy also said, we are following industry standards. We're not creating any NCQA-specific standards. So, like these measures, we're using quality data model HL7s, standards, clinical quality language and CQL logic that ties together elements inside the quality data model. Now, many of you [are] probably wondering if we're exploring additional standards, and we are, such as FHIR, so stay tuned on that.

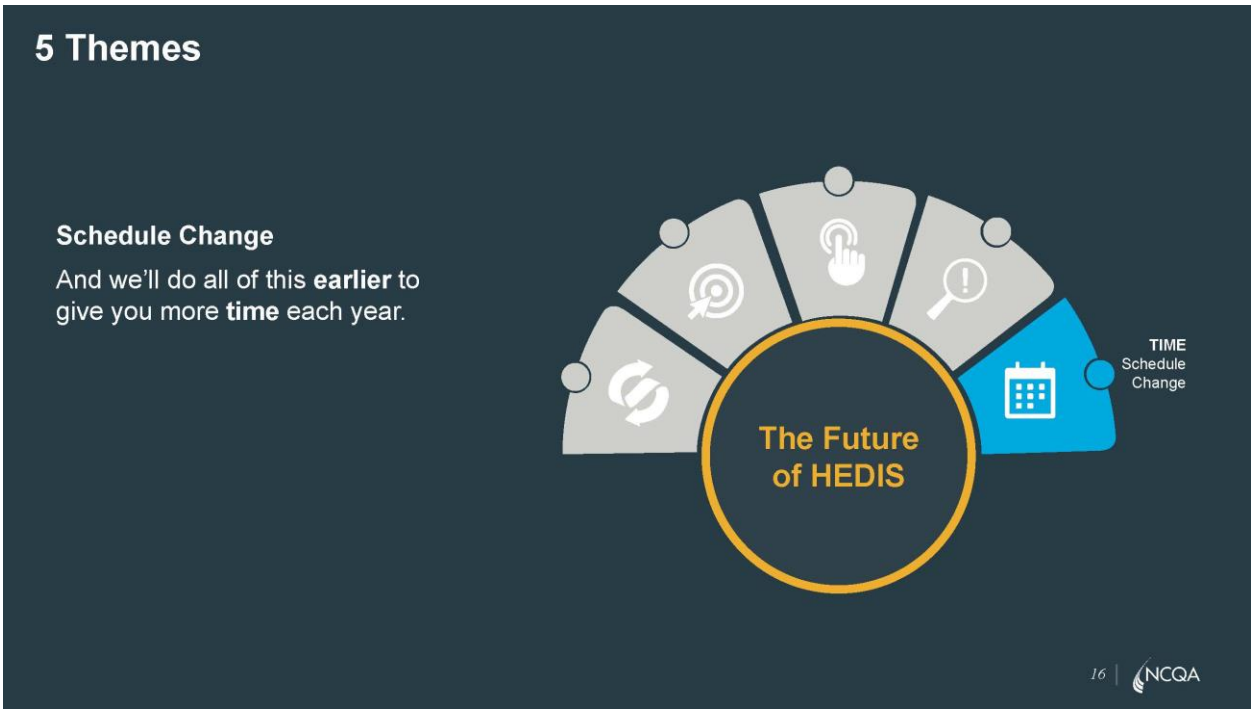


Michael Barr: 12:07

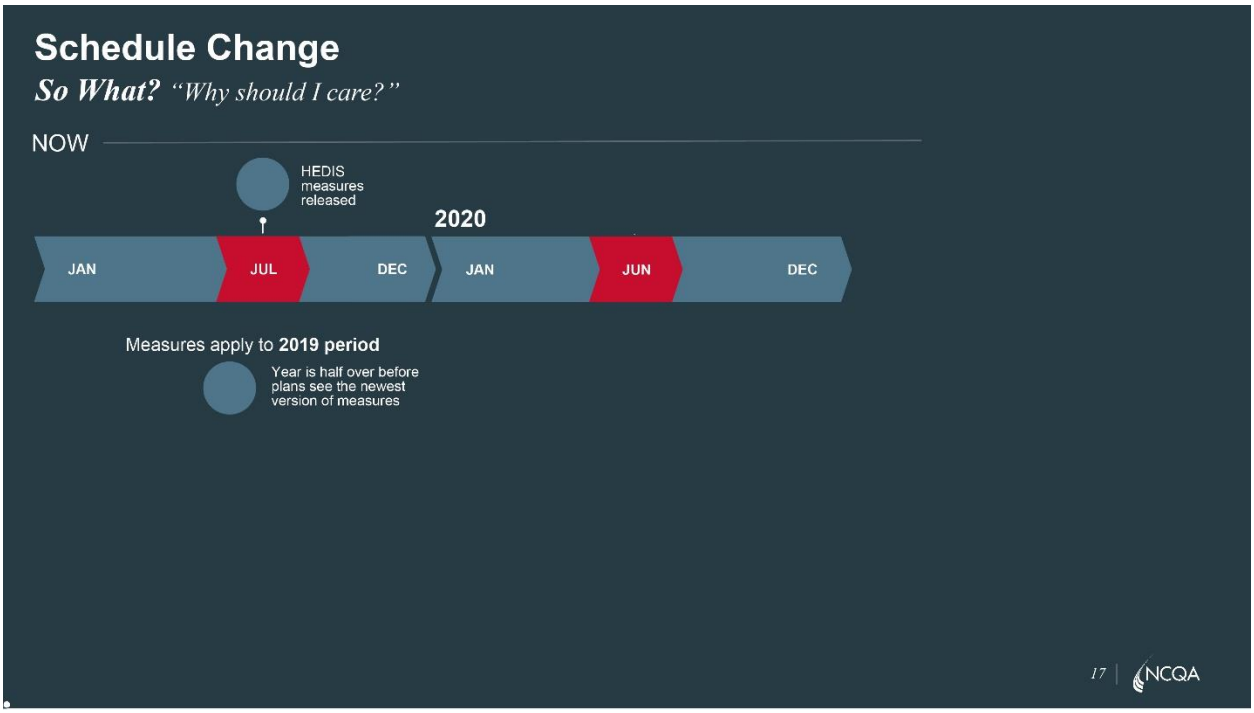
Let's move to Electronic Clinical Data Systems, or ECDS. We believe that ECDS measures will help generate new insights about quality from data generated as care, back to earlier comments by Peggy. Now, ECDS measures are at subset of our digital measure portfolio. To put it bluntly or as clearly as possible, ECDS measures are digital, but not all digital measures are ECDS. ECDS measures rely more extensively on the data that clinicians and patients generate as care is delivered. And the data are reported in the ECDS reporting methodology in four categories.

206	Michael Barr:	12:45	First is EHRs, second is registries or health information exchanges, the third is case management systems and the
208			fourth is administrative files. ECDS brings all the efficiencies of the digital measures I spoke about previously; lack of need for
210			programming, machine readability, increased errors, more standardization reorients the quality measurement towards
212			greater use of electronic clinical quality data or electronic clinical data to generate quality measures.
214	Michael Barr:	13:15	Now, many of the data sources are those you are likely already using for traditional leads. This is just a different reporting
216			methodology and moves us closer to patient-specific measures, and we believe combining claims data with data from the EHRs,
218			HIEs and other electronic sources can provide more complete results and better insights into the quality care being delivered to
220			individuals and groups.
	Michael Barr:	13:39	An example we've cited before is [that] the current Breast Cancer Screening measures specifies an age range who's
222			exclusions do not account for risk profiles or patient preferences very well. An ECDS measure could include all the logic
224			associated with available clinical guidelines, so we can assure with one measure [that] women get the screening appropriate to
226			their unique clinical conditions. Medicine is moving towards more customized clinical guidelines and our views of the future are to
228			reflect that.
230	Michael Barr:	14:11	Now, we know several health plans already have connections to electronic health records, data aggregators or health information
232			exchanges, immunization registries and case management systems to support traditional HEDIS reporting, and that's going
234			to help you as we segue into the ECDS reporting. We also know, as Peggy alluded [to], that many plans may not have the same
236			ability or the same connections right now and may only be able to access data and parts of their network. That's why we are
238			collaborating with you to help clients to understand, and your experiences with ECDS, and one of the reasons ECDS measure
240			reporting is voluntary.
	Michael Barr:	14:47	Now, we also invite you to report on the 11 ECDS measures for volunteer reporting that are now available in the NCQA store.
242			Among those 11 are 3 existing ECDS measures which we've added [to the] ECDS reporting methodology: Breast Cancer
244			Screening, Colorectal Cancer Screening and Follow-Up Care for Children Prescribed ADHD Medication. We're particularly
246			interested in having health plans report these measures. We have both the traditional and ECDS methodologies to help inform
248			our ECDS strategy.
250	Michael Barr:	15:18	We also urge you to join our Digital Measurement Community. That's a forum we're starting up early next year, where you can
252			share ideas and best practices about using clinical data in quality measurement, and we'll also announce future opportunities to

engage with NCQA through that channel. You can register so you get the updates through ncqa.org/dnc.

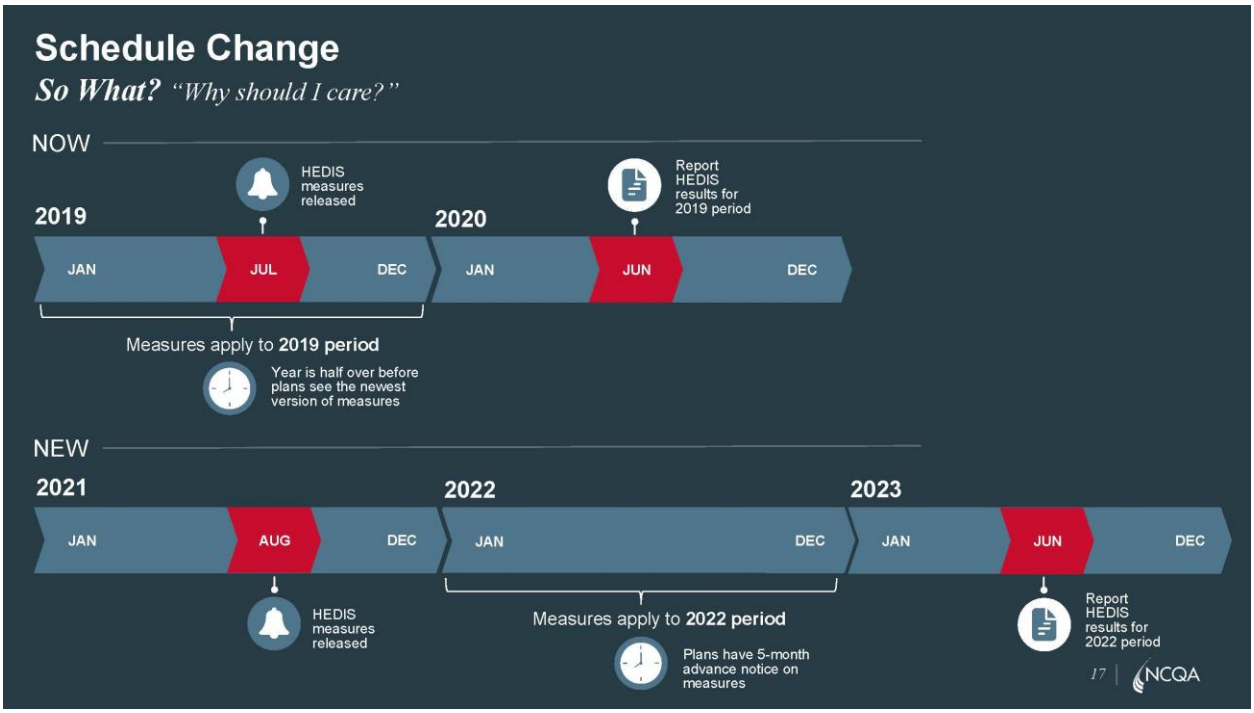


Michael Barr: 15:40 I'll move to the last topic I'm going to cover before I turn over to Sepheen, and that's the schedule change. So, we're going to give you all the information we just talked about earlier in the cycle and changing when we specify the measures that apply to a measurement period. And the next line will explain how I'm going to do that—or [how] *we're* going to do that (not me).



264 A traditional schedule is to release measure specs and HEDIS halfway through the year of specifications that are to be used.

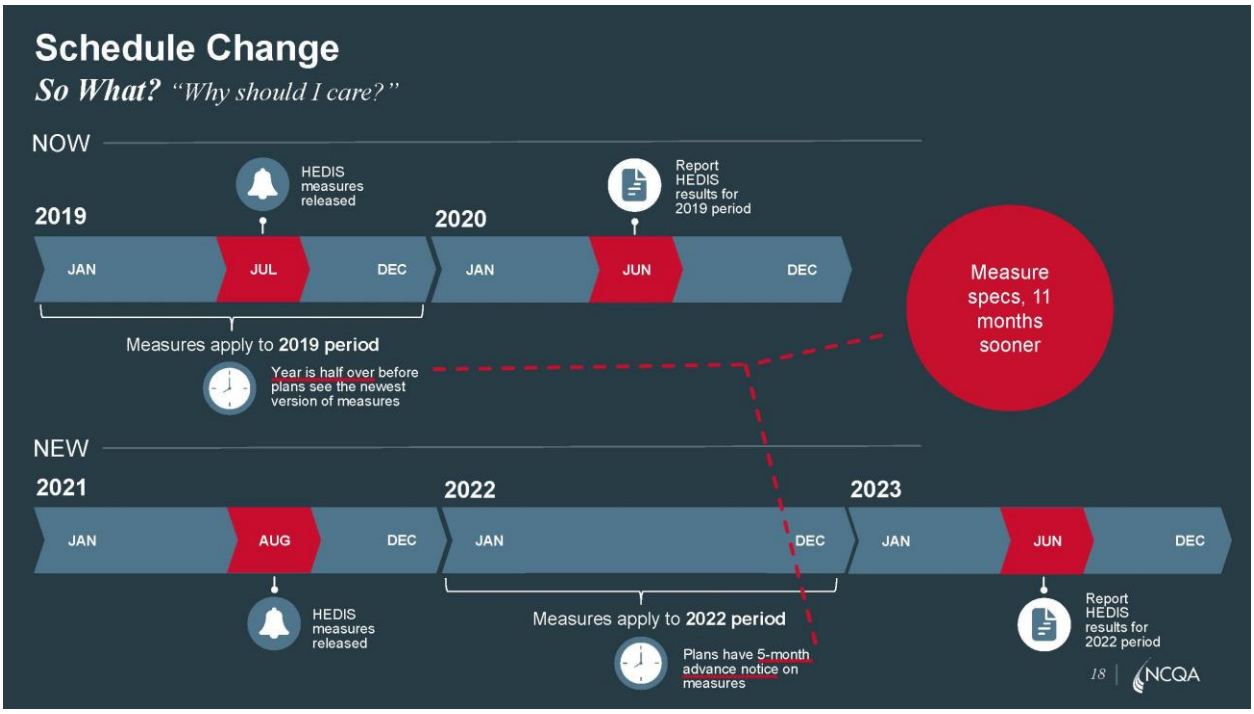
266 Michael Barr: 16:08 For example, the measures we released in July 2019 apply to services this entire calendar year, January 1st–December 31st of
268 2019. That means that the measurement year is half over before plans know what they are expected to report. The six-month lag
270 time has been long-standing feature of the HEDIS cycle and we think we can do better.



Here's the new way. On August 1, 2021, we will release measures, but these measures will apply to services in 2022. Health plans will have a five-month lead time of what measures will be available.

Michael Barr: 16:48

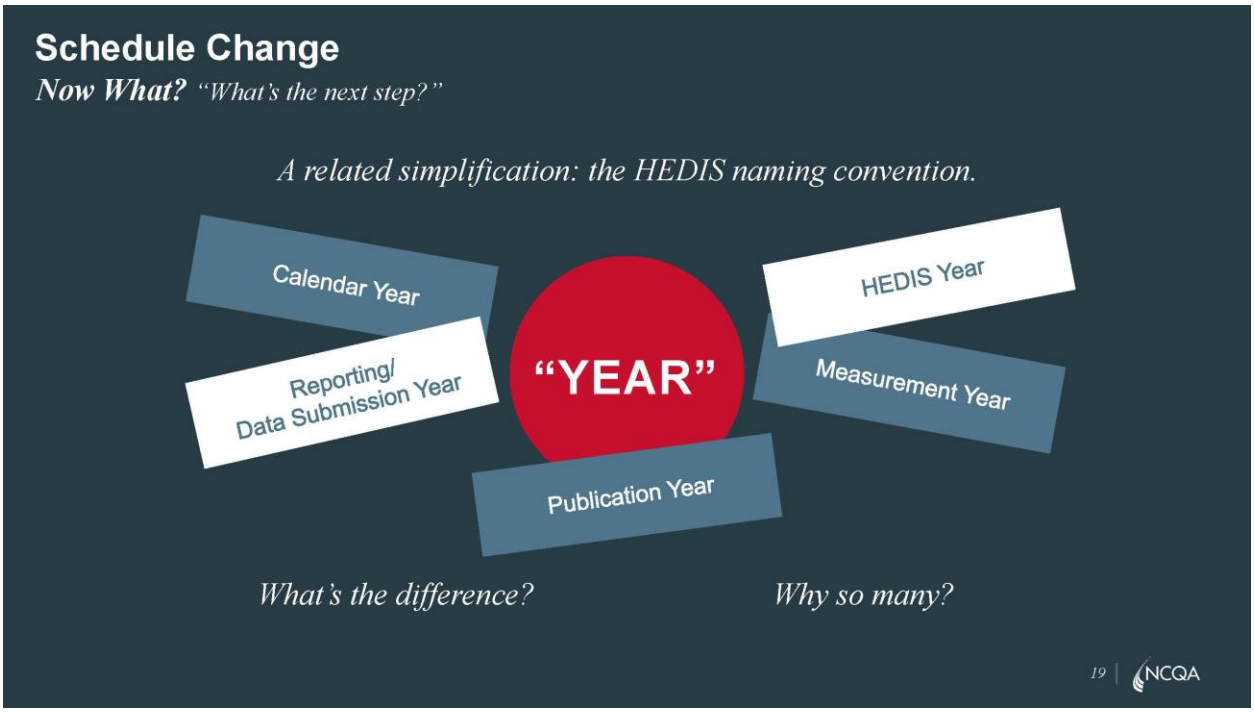
Now, we're not changing when the HEDIS submission deadline is. Reporting the data will still happen in June the year after the measurement year, same as it always has.



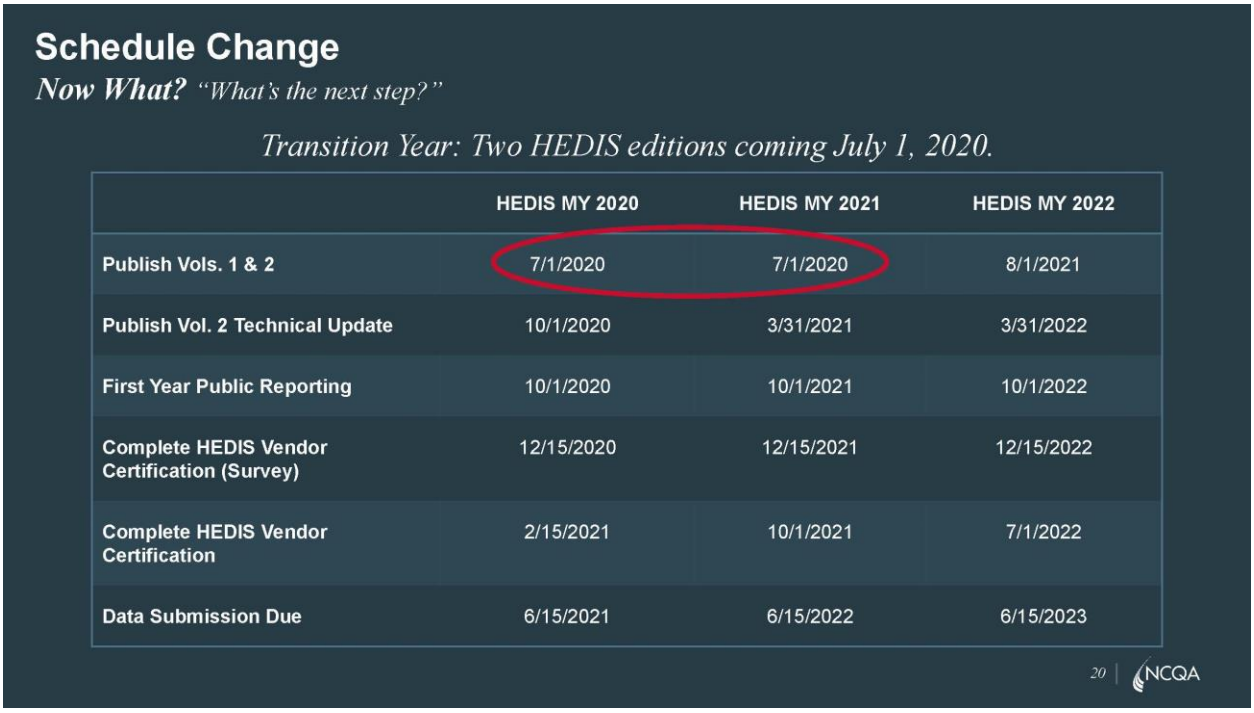
280

282 The shift in the schedule will bring you certainty about measure[s] sooner, about 11 months sooner than you currently get them, and we know that that'll be welcomed to the industry.

284 That's the timeline change.



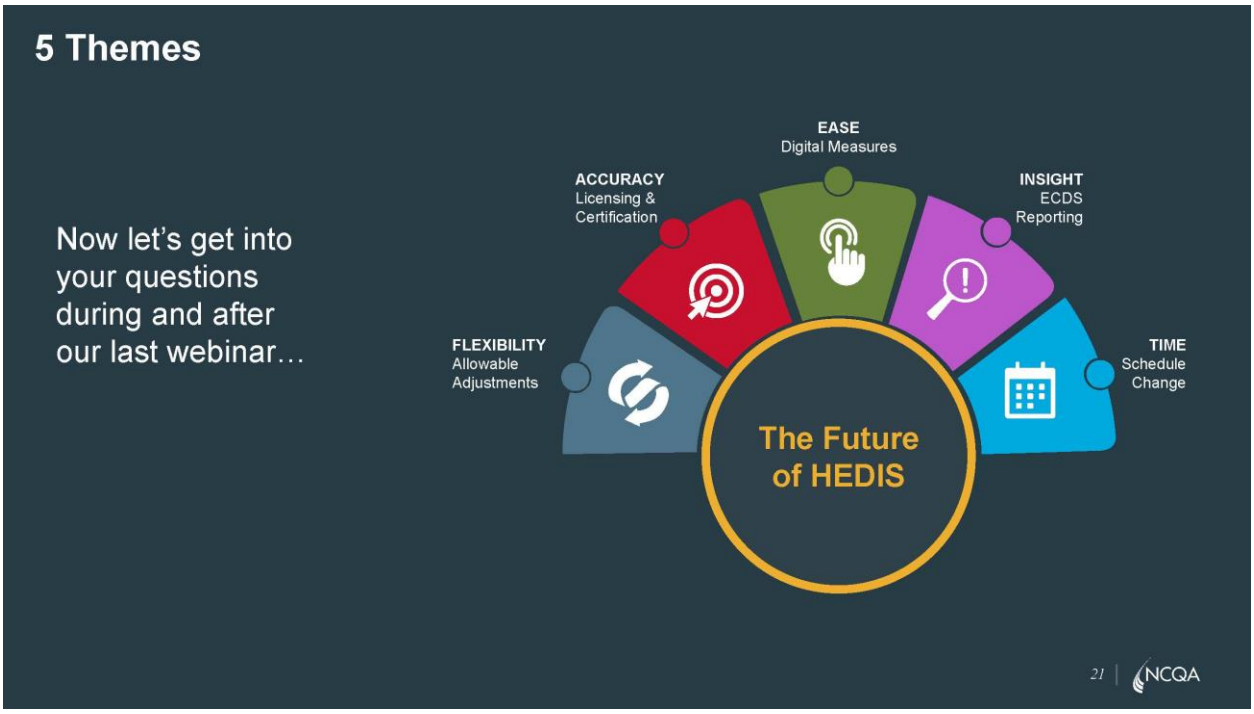
We have one more bonus, and that's what we are talking about in terms of the name and the naming convention. We know that the year can name at least five things in connection with HEDIS. You probably can think of several more. So, while we're shifting the HEDIS schedule, we're also going to hopefully simplify the naming convention and start it in calendar year 2020. The HEDIS following will be made based on the measurement year.



	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022
Publish Vols. 1 & 2	7/1/2020	7/1/2020	8/1/2021
Publish Vol. 2 Technical Update	10/1/2020	3/31/2021	3/31/2022
First Year Public Reporting	10/1/2020	10/1/2021	10/1/2022
Complete HEDIS Vendor Certification (Survey)	12/15/2020	12/15/2021	12/15/2022
Complete HEDIS Vendor Certification	2/15/2021	10/1/2021	7/1/2022
Data Submission Due	6/15/2021	6/15/2022	6/15/2023

Michael Barr: 17:38

Now, this table shows how various parts of the annual HEDIS cycle will evolve, and we recognize there's a lot of information on this one slide. So, after this webinar, you should be able to download slides; take a look at them, they'll be available. And I want to focus on what you see in the red circles here. On July 1, 2020, we will publish measures that will apply to measurement years 2020 and 2021 and that will be the transition year to this new strategy. So with that, I'm going to turn this over ...



Oh, wait; I've got one more slide summarizing it all up—and now I'm going to turn it over to Sepheen Byron, who's going to take it from here.

Sepheen Byron: 18:18 Great. Thanks, Michael. Hello, everyone. I'm Sepheen Byron. I'm an Assistant Vice President for Performance Measurement here

at NCQA. In this section, I will be focusing on NCQA's efforts around the Electronic Clinical Data Systems, or ECDS, reporting methods.

Sepheen Byron: 18:35

At the end of the last webinar, we received a host of questions regarding NCQA's ECDS strategies. This section is built from those questions. In addition to the slides I will be presenting, I did want to let you know the NCQA is updating our website and our frequently asked questions in order to respond to the remaining questions that are not addressed in this webinar. In addition, we are planning a more focused webinar for the end of October for those questions we received that were more technical in nature.

Sepheen Byron: 19:09

All right, so what is NCQA doing to understand the landscape? And I wanted to start with this high-level overview to really expand on what Peggy noted about the fact that we want to make sure we are in continuous dialogue with plans and other stakeholders about this digital measures roadmap. So, we've engaged in a range of activities; first, the ECDS analysis reporting. Each year, NCQA conducts a comprehensive analysis of all the ECDS measures in order to understand trends and reporting performance rates and the types of data sources that were used to report these measures.

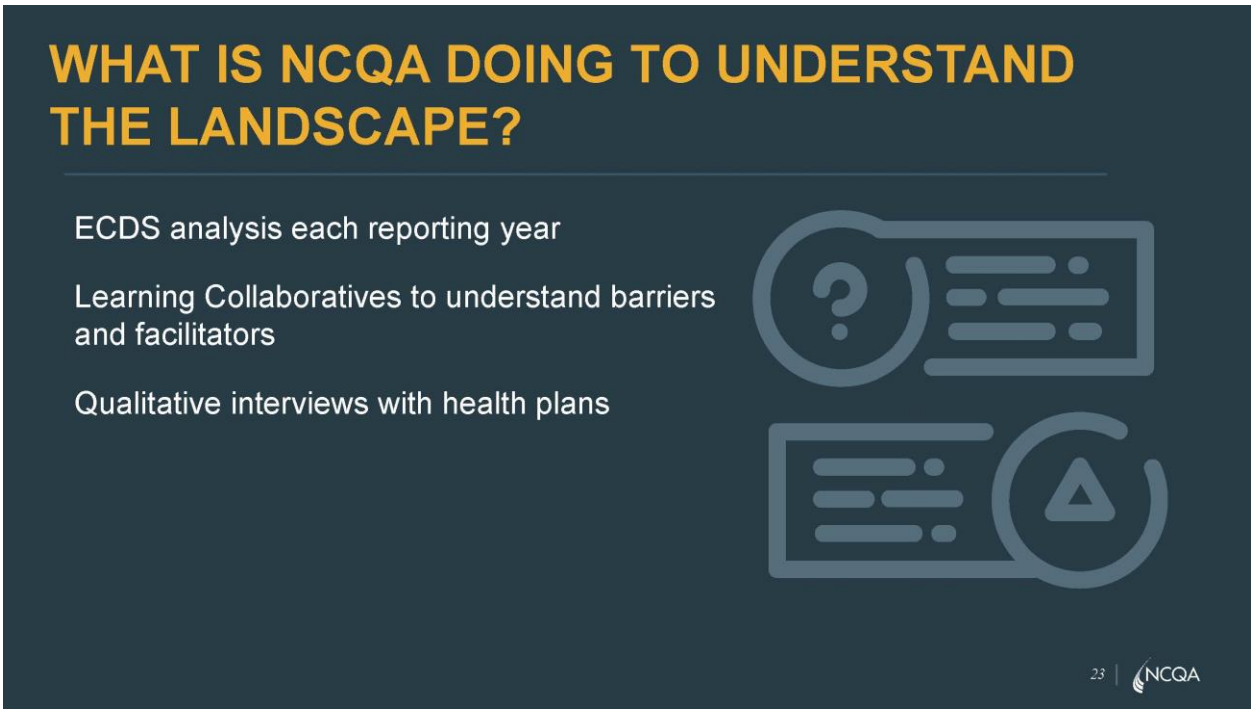
Sepheen Byron: 19:48

We have seen an increase in the number of submissions year over year, and this latest year, representing performance from the 2018 measurement year, we saw increased reporting as well as an increase in the diversity of plans reporting. So, we saw reporting from integrated plans, but also from network plans. We

also saw data coming from a variety of sources. So, while plans did use claims data to report the measures—and remember that claims are part of the ECDS reporting method—we saw data coming from registries and electronic healthcare records as well. So, we felt very good about that.

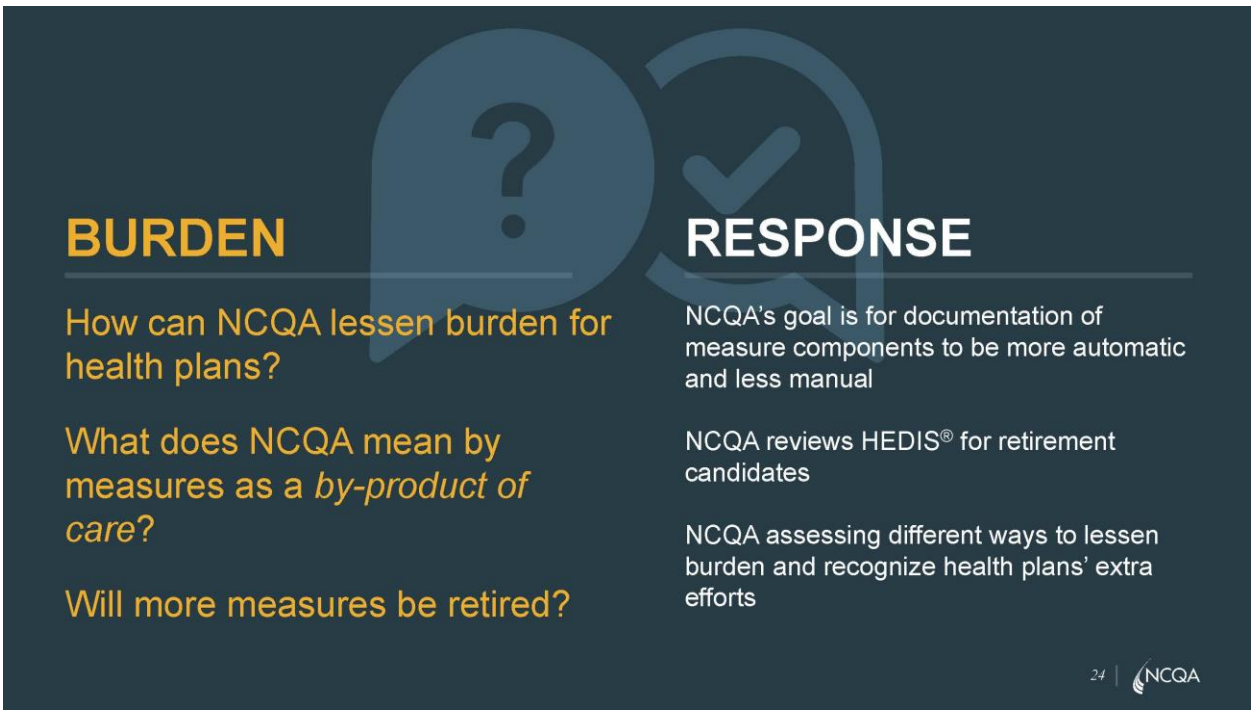
Sepheen Byron: 20:31 We're also in the midst of two ECDS learning collaboratives with health plans: one exploring the alcohol screening and follow-up measure and one exploring the adolescent population within the depression management measures. Challenges to reporting ECDS included difficulty obtaining clinical data for calculating the measures, clinicians who are unfamiliar with the alcohol misuse and depression assessment tools and issues like a lack of behavioral health integration.

Sepheen Byron: 21:00 However, the learning collaboratives did reveal several successful strategies for overcoming the barriers. For example, some health plans leveraged health information exchanges or worked with clinicians to develop workflows that integrated alcohol and depression screening more seamlessly into clinical care. Plans also used educational resources and innovative ways to engage patients, such as through apps and other technology, and health plans implemented case management processes to improve follow-up and management when patients did screen positive for alcohol misuse or depression.

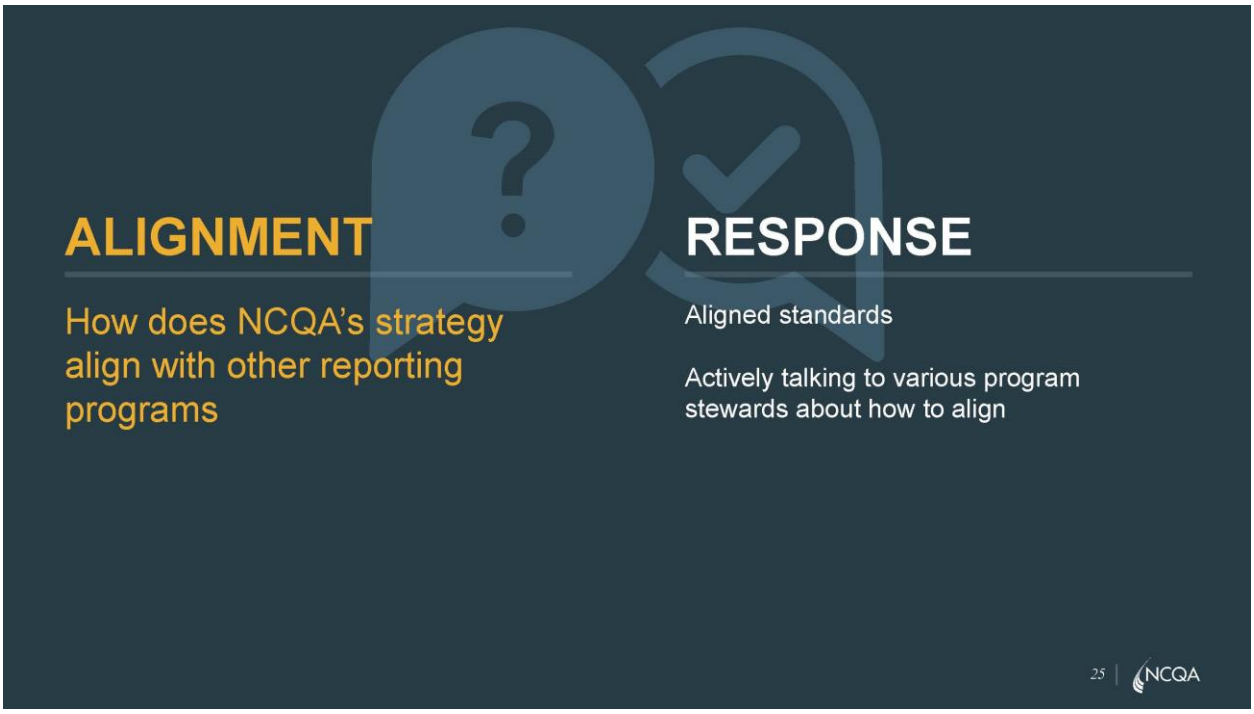


Sepheen Byron: 21:40 This summer, we engaged health plans in a series of qualitative interviews in order to gain more depth of understanding into how health plans are working towards ECDS reporting. We talked to health plans of varying product lines, structure, geographic location and experiences with ECDS reporting. Health plans shared their challenges, which were similar to what we heard during the learning collaborative, and they also talked about strategies for promoting the sharing of electronic clinical data, which included partnering with provider networks to set up data exchange processes and also engaging senior leaders in these efforts.

Sepheen Byron: 22:21 Finally, NCQA continues to engage stakeholders such as state Medicaid agencies and the Centers for Medicare & Medicaid Services to understand their priorities in the area of digital measurement and to learn about their efforts to improve electronic data use and exchange.



380 382 384 386 388	Sepheen Byron:	22:42	All right, so now to get to some of the questions we heard. So many listeners asked us to elaborate on how the digital measure strategy relates to our efforts to reduce the burden of measurement. Overall, our vision is that measurement becomes a byproduct of care as it is delivered, and Peggy talked a little bit about some of this. Our goal is for the documentation of measure components to be invisible to clinicians and care teams at the point of care. In the ideal case, the information that clinicians would ordinarily document as they're caring for a patient will be automatically calculated for measures, rather than requiring a separate and perhaps cumbersome data entry process.
390 392 394 396	Sepheen Byron:	23:27	We know this is an ideal state that will take time to become a reality. In the meantime, we continuously review HEDIS for measures that may be candidates for retirement. The criteria we use to evaluate and measure are continued relevance to stakeholders, continued feasibility and redundancy or other considerations, such as whether a better measure now exists. As the data available for measurement improves, this last criterion becomes even more central to our consideration.
398 400 402 404	Sepheen Byron:	24:00	Last, NCQA is assessing different ways we can lessen the burden to health plans and incentivize the use of electronic clinical data. In talking to health plans this summer, suggestions included fee waivers for conferences or other activities, credit for related measures or standards, as well as the importance of recognizing plans for their extra efforts in building an infrastructure to support the use of electronic clinical data. So NCQA is exploring all these suggestions.



406

Sepheen Byron: 24:33

We received a number of questions regarding whether and how NCQA's approach to digital measurement aligns with other reporting programs, such as electronic clinical quality measures used for reporting in [the] Centers for Medicare & Medicaid Services program. The HEDIS measures have been digitalized using the same standards; the quality data model and clinical quality language the CMS measures used in provider-level programs, such as the merit-based incentive program. In this way, we hope to support reporting alignment. We also have been talking to other stakeholders, such as state Medicaid agencies, about whether there are ways we can align measures across the program, such as the Medicaid Adult and Child Core Set. NCQA is actively reaching out to CMS to further the alignment of measures, given [that] measures are used at different levels of accountability. We welcome your ideas on your end long-term strategies.

Sepheen Byron: 25:36

So, next, several listeners asked us about how NCQA will address current barriers to ECDS reporting, such as varying levels of access to electronic data and varying levels of availability or familiarity with health information technology across the country; for example, in rural areas. NCQA introduced the first ECDS measures into HEDIS in 2015 and has evaluated these measures each year to assess plans' progress in using this data collection method.

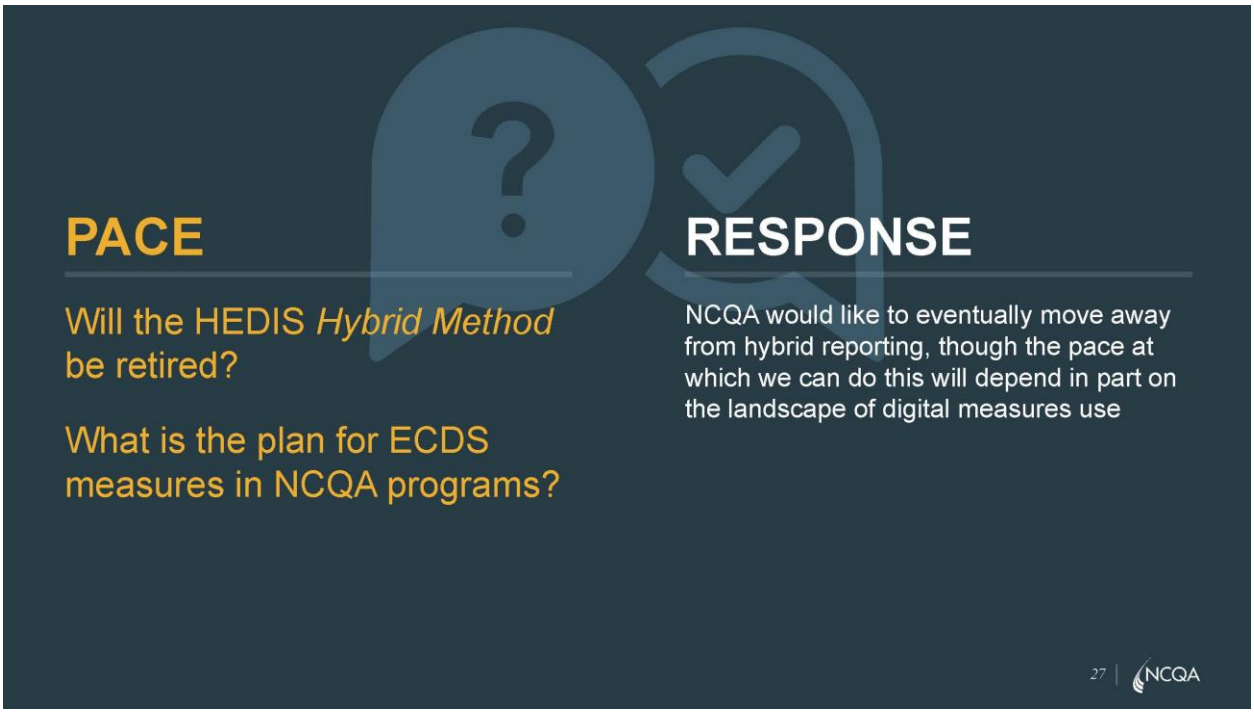
Sepheen Byron: 26:08

As I talked about earlier, NCQA has seen increased submissions of ECDS measures year over year, and the data we are seeing is very promising. We've seen increased use of data sources to just registry and electronic health records. For example, for the

adult immunization status measure, which assesses whether adults receive up to four routinely recommended vaccines at various points in time, health plans use claims data, registry data and data from electronic health records. Registry data were useful for vaccines with long look-back periods, such as the tetanus, diphtheria and acellular pertussis shot.

Sepheen Byron: 26:51

Meanwhile, health information technology is becoming more widespread. The latest figures from the Office of the National Coordinator for Health Information Technology show that as of 2017, 86% of office-based physicians had adopted an EHR; 96% of non-federal acute care hospitals had certified health information technology, 93% of small rule and critical access hospitals had this; and 99% of large hospitals and 97% of medium sized hospitals had certified health information technology. We know that health information technology penetration is only one piece of the puzzle and that the sharing of electronic data remains a challenge. However, we are talking to data aggregators, data vendors and other contributors such as the Immunization Registry Association to brainstorm ways to make data flow better.



Sepheen Byron: 27:56

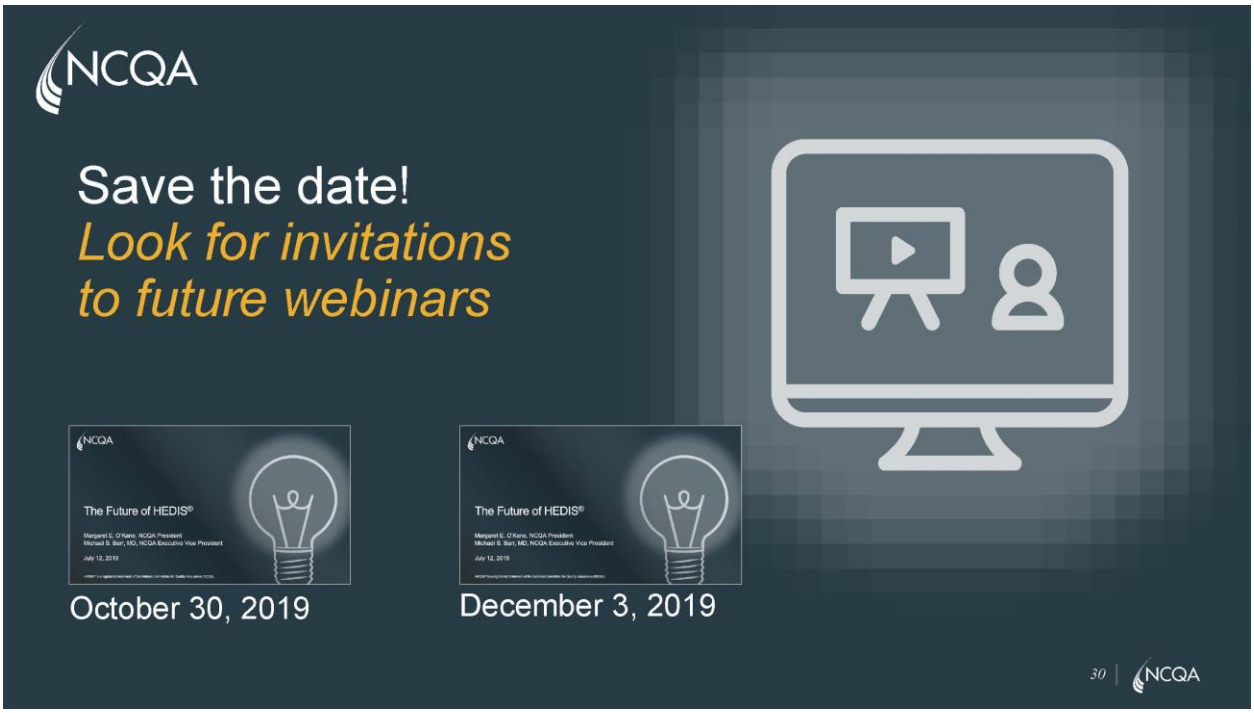
So, last, we heard many questions from listeners about the pace of our ECDS measure use, such as when the measures will be publicly reported, when the HEDIS Hybrid Method might be retired or phased out. So, let me address the question about the hybrid data collection [method] first. The HEDIS Hybrid Method uses administrative data, but also requires [that] a sample of medical records be reviewed for information that we would not ordinarily find in claims data. This method is manual,

retrospective and burdensome. We would like to move away from this method, but our pace here will depend upon the progress being made towards use of electronic clinical data. So, as I mentioned, we are monitoring this every year. As we introduced new measures into HEDIS, we have been assessing whether they can be reported as ECDS measures rather than as hybrid measures, and whether they make more sense being specified that way. But we will continue to monitor the landscape.

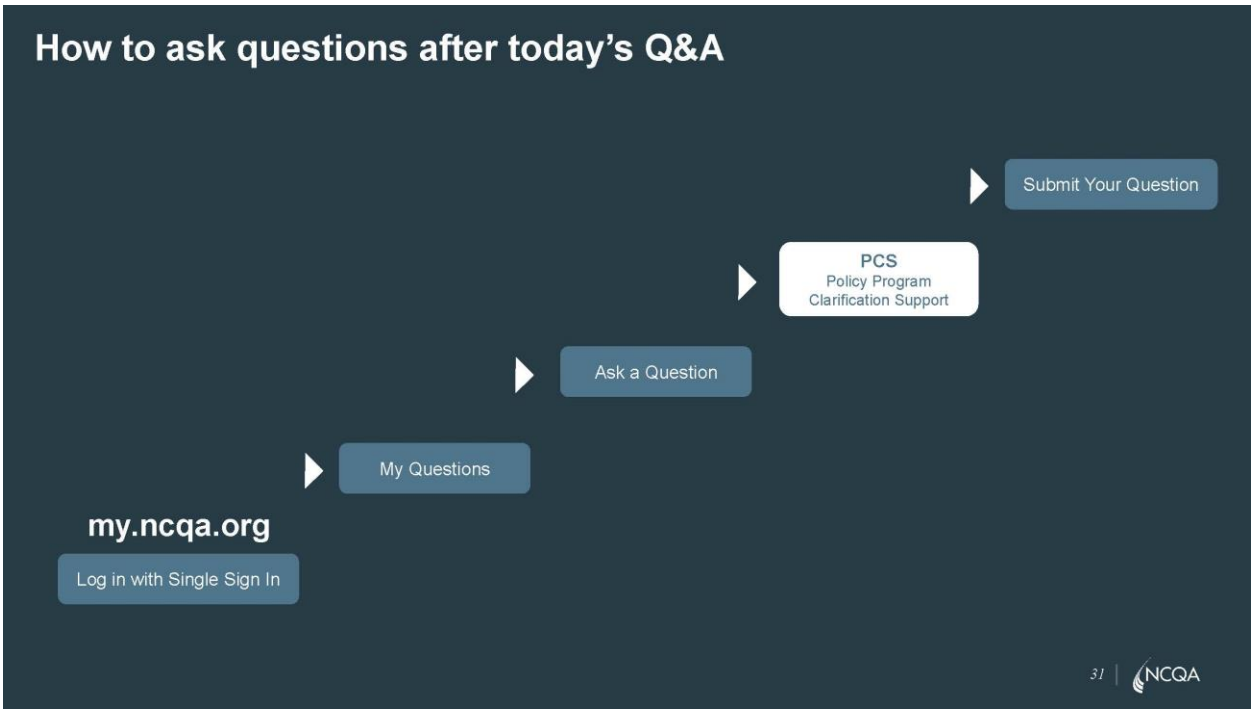
Sepheen Byron: 28:58 Currently, no ECDS measures are included in Quality Compass or other NCQA evaluation programs.

However, as NCQA announced on Wednesday, for the 2018 measurement year, the Prenatal Immunization Status met our criteria for public reporting. Many plans reported this measure and performance rates varied and reflected expected rates as evaluated by our analysis team and our multi-stakeholder advisory panel. While we see this measure as being ready now, as I mentioned earlier, health plans told us during the interviews and in other venues that more communication is needed about our digital measure strategy. Therefore, to give plans more notice, we are announcing now that the Prenatal Immunization Status measure will be publicly reported. However, rather than releasing that information in this October's Technical Specifications Update for our usual process, we are announcing the figure ahead of time. So, the measure will be publicly reported in 2021, which will reflect data from measuring year 2020.

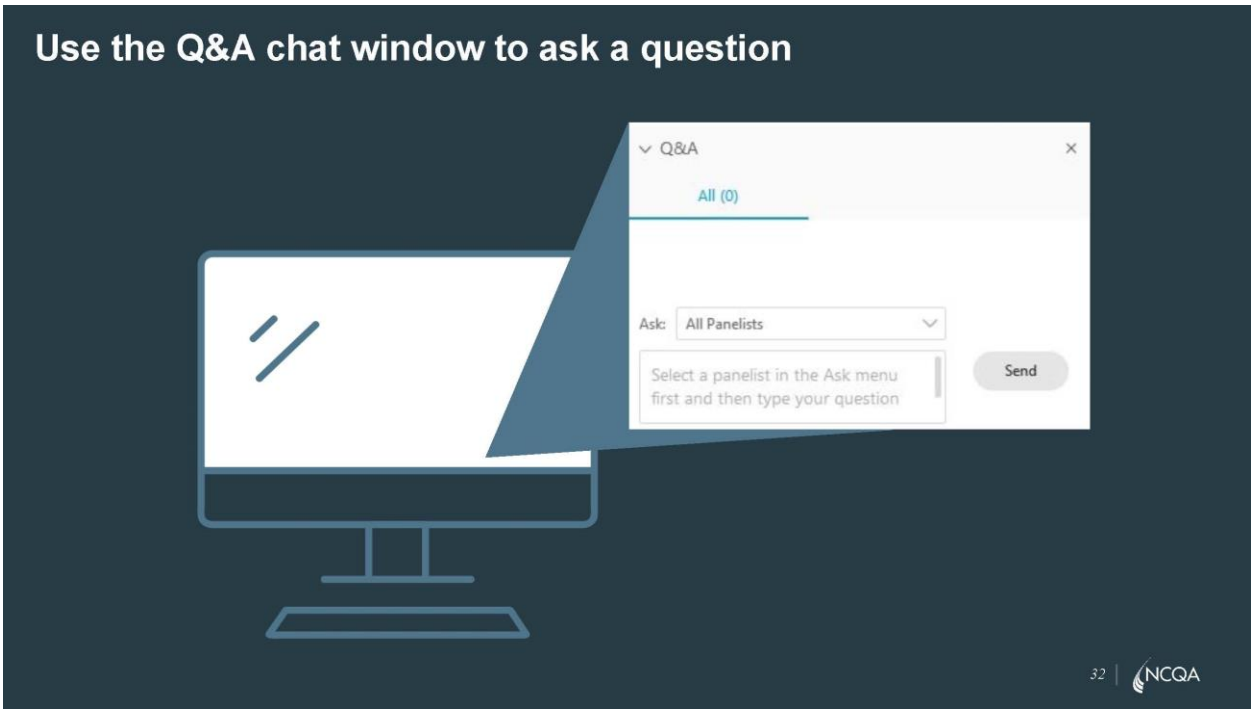
Sepheen Byron: 30:13 All right, so that ends the themes that came out of the Q&A. We really want to thank you for taking the time to send us in questions and let us understand what's been burning in your mind. As noted, we have our earlier webinar posted in case you would like to go back and look at that, and we have future webinars planed, as I mentioned, in October.



We would like that one to be of more of a technical nature, based on a lot of the questions that we received. Then we'll have another one in December and we will continue to look at questions that we received and, based on topics that we have with stakeholders, to assess the best things that we might address on those future webinars. But as Peggy mentioned, we want this to be an open dialogue and so we really appreciate all the input that people have given us thus far.

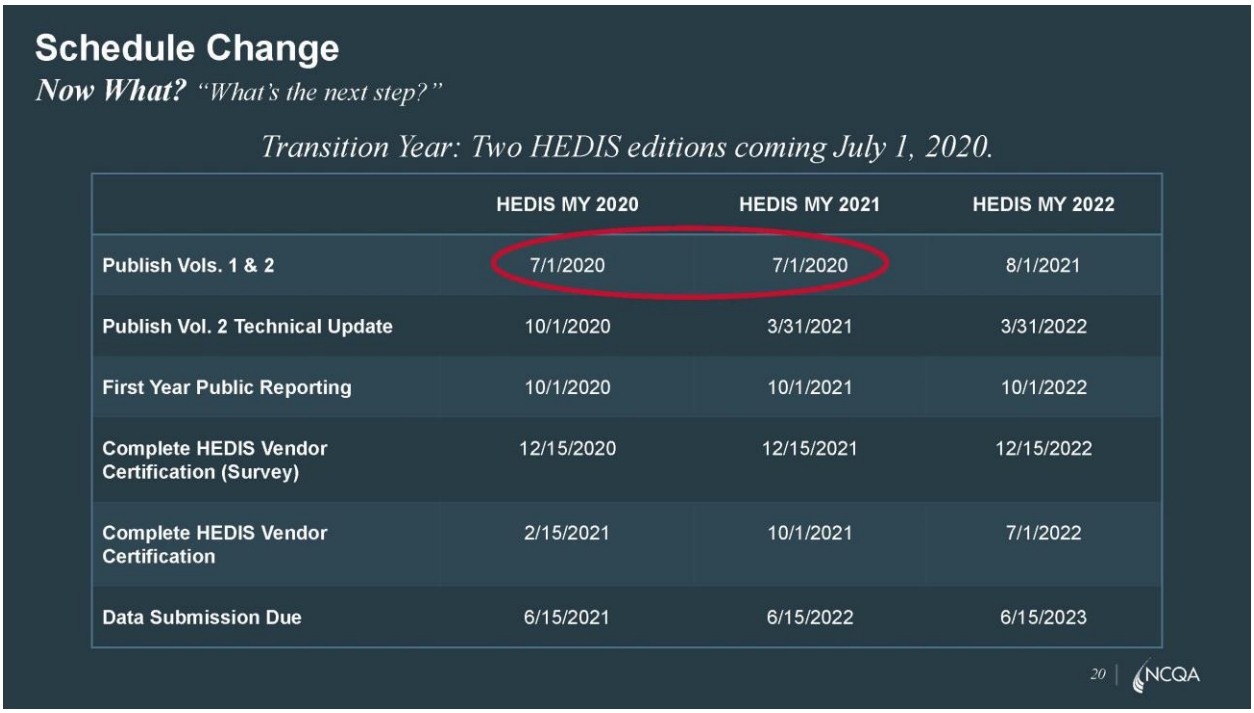


Andy Reynolds: 31:20 Hello, everyone; this is Andy Reynolds. I'm Assistant Vice President for External Relations and we'd like to get to your Q&A here. After today's Q&A, we suggest that you give us your questions using this process that I know many of you are familiar with, the PCS process.



514

516 Here is how we welcome your questions right now. I am looking over the questions that some of you have submitted. I'll ask those or read those aloud for my colleagues to answer it here in
518 a moment. I just took the clicker back from Sepheen because one of our first questions essentially asked us to back up a little
520 bit, to the slide about the dates and the release.



	HEDIS MY 2020	HEDIS MY 2021	HEDIS MY 2022
Publish Vols. 1 & 2	7/1/2020	7/1/2020	8/1/2021
Publish Vol. 2 Technical Update	10/1/2020	3/31/2021	3/31/2022
First Year Public Reporting	10/1/2020	10/1/2021	10/1/2022
Complete HEDIS Vendor Certification (Survey)	12/15/2020	12/15/2021	12/15/2022
Complete HEDIS Vendor Certification	2/15/2021	10/1/2021	7/1/2022
Data Submission Due	6/15/2021	6/15/2022	6/15/2023

So, all the way back, here we go. Okay. the question is: Is there a contradiction at work here? Can somebody explain exactly what the spectrum, at least on July 1, 2020, will be for?

Patrick Dahill: 32:23 Thank you for that question. It's not a contradiction, but it is a confusing year in that we're releasing two measurement years at once, essentially, to get through the transition Dr. Barr talked about. So, we'll have measurement year 2020 and measurement year 2021 next summer, and then a year after that will be on the schedule that was the main emphasis of Dr. Barr's presentation, that we'll have specs out before the measurement year starts.

Andy Reynolds: 32:53 And who are you?

Patrick Dahill: 32:54 I'm Patrick Dahill, Assistant Vice President of Policy.

Andy Reynolds: 33:03 I suggest we hold on this slide a little longer so that people can see if there are other questions that come to mind. While we're here, we'll knock out a question that I can answer directly and that is: What time is the October 30 webinar going to be and what time is the December 3 webinar going to be? We don't know yet. We will establish that and announce that to you as soon as we have the topics and speakers lined up.

Andy Reynolds: 33:38 Here's another question. Can we say more about how we're working with immunization registries to improve data?

Sepheen Byron: 33:48 Yeah; so actually, that's a timely question. We just had a conversation with the American Immunization Registry Association and we've also talked to some state Medicaid agencies to understand how they are using registries. One thing we want to do is identify some of the frequently asked questions that we might be able to help clear up together. We've also talked about perhaps releasing a white paper or information that might be able to help health plans and others understand how they can work through an immunization registry. We would love to build on the successes that we have seen for the child registry and we know that there's a lot of work to be done for the adult registries, knowing that adults tend to get their immunizations from all over the place. We see a lot of opportunity here and so we will continue to work with these organizations and other stakeholders to move that forward in whatever way we can. So, I'll say, stay tuned on that.

Andy Reynolds: 35:02 Another question about ECDS and that is: When will NCQA's Prenatal Immunization measure be required for Health Plan Accreditation?

Sepheen Byron: 35:12 So, that's a great question. We do not know at this point because as I said, we want to be able to learn from everything that we are doing as we go. However, hearing from all of you that communication and advance notice is really important, as you can see with what we're doing with the timeline change and

568			other efforts, we are trying to make sure that whatever we do, we provide advance notice for it. So you would know about it
570			hopefully far in advance of when we would do it. But we do want to make sure that what we're seeing in terms of the data coming
572			in continues to be strong and that we would go through our ordinary process for considering measures for Accreditation and
574			other NCQA programs, which includes multi-stakeholder review, lots of discussions with health plans and others.
576	Andy Reynolds:	36:05	More on ECDS. By committing to reporting the first ECDS metric in 2021, does that mean that the others will be reported after
578			2021? Or do you reserve the right to add more measures to the 2021 ECDS set?
580	Sepheen Byron:	36:22	Yeah, great question. I think we would want to keep our eye on the field, but a guiding principle for us is to really provide advance notice to health plans and others.
582	Peggy O'Kane:	36:36	And this is very burdened. So, what that means is that we will not add any other public reporting for 2021, other than what we've
584			already announced, but thereafter we can't really say, as you said; we're going to keep our eye on the field and I mean, we're
586			talking close to the stake holders.
588	Andy Reynolds:	36:58	With the new schedule, when would the update be for the specs? In other words, when would the final spec updates be released?
590	Patrick Dahill:	37:06	This is Patrick again. So, we're anticipating that would be moved to March of the measurement year, which is obviously much
592			better than the current October of the measurement year. That allows us to get a lot of the coding updates that come out in the
594			first quarter of the year. So, we'll be as accurate as possible, but still ending earlier in the year.
596	Andy Reynolds:	37:31	Will NCQA publish administrative rates for certain measures that are traditionally only reported using the Hybrid Method? For
598			example, CDC or CDT admin rates would likely tell you how well health plans utilize electronic clinical data in their current state.
600			So, the question again is, will NCQA publications publish administrative rates for certain measures that are traditionally
602			only reported using the Hybrid Method?
604	Sepheen Byron:	37:56	So, that's an interesting question. I think it's something that we can consider. It is something that we look at; in addition to
606			looking at administrative rates, we also look at the effect of supplemental data on some of these rates. We look at how
608			medical record review might impact measures, as well. Whether or not we would publish that, I think we would have to think through that, but that's a good suggestion.
610	Andy Reynolds:	38:26	Can you explain what you consider a digital measure and how ECDS is a subset of digital measures?

612	Ben Hamlin:	38:33	Sure. This is Ben Hamlin. So, a digital measure is, as Michael alluded to, our way of representing the current paper specifications. So, [in] the HEDIS administrative specifications, we take and we write in the QDM CQL format that's machine readable, so you essentially don't do that translation. ECDS measures are digital. But the reason ECDS measures [are] digital is because to have good person-specific measures, they're more complex and more data is needed. So, they take advantage of the fact that these digital standards for measurement allow us to do that for you. So, we can provide you these digital specifications. So, we can get to these next levels of measures. There are two different types of digital measures: There's the HEDIS traditional and there's the HEDIS ECDS.
	Andy Reynolds:	39:28	How is NCQA using standards to define measures in terms of different data sources? For example, traditional HEDIS measures don't allow political data in the non-traditional. But the quality of data model doesn't identify whether data came from claims or clinical data. So again, the question is how is NCQA using standards to define measures in terms of different data sources?
632	Ben Hamlin:	39:51	One of the reasons that we have those four source categories for ECDS reporting is because they are well within the realm of our ability to set standards around data provenance. We are working in the standards communities to understand data provenance and how we might leverage what they're doing, but right now it's not something that we currently specify. We rely on our HEDIS auditors to help us with the data provenance questions and issues that we currently have, but we are working to increase the specificity of our definitions in the measures, to include that information. Right now, there's not a universally accepted standard for this.
	Andy Reynolds:	40:34	How often are case management systems used for ECDS reporting?
	Ben Hamlin:	40:39	Not as frequently as claims, but they actually were used in the last submission. We did have a couple of plans that are using case management systems to report.
648	Andy Reynolds:	40:49	I understand that the adoption of EHR technology is high. There is still a data quality problem with the data being generated; much of it is not codified to a standard. Do you see this as a barrier to expanding HEDIS to clinical data?
652	Ben Hamlin:	41:04	I don't. I see it as a challenge.
	Peggy O'Kane:	41:14	Have you said your name, Ben?
654	Ben Hamlin:	41:15	Yes, earlier. They should recognize my voice by now (laughs). These wonderful models that we have in the standards community allow us to continue to specify better and better

			assessments of the data through the quality. And so, what we're looking at right now is using a fire CQL or CQL model to help us understand the quality of the data that the HEDIS measures are being run against. Because again, the use of a standard definition for the data elements gives us something to benchmark against.
	Ben Hamlin:	41:47	And so, however, you're ETL-ing your data up to a HEDIS environment. Currently, the auditors have to do that mostly manually. And we're hoping that in the future we'll be able to specify that in our quality measures, because we're using these standards that are used for other purposes, not just for quality measurement. And we think there's a lot of opportunity in the future for us to be able to, including much more guidance and much more electronic specification for assessing data quality.
	Andy Reynolds:	42:15	Another schedule question: Will the certification timing deadlines be the same for HEDIS measurement year 2020 and HEDIS measurement year 2021? Again, will the certification deadlines be the same?
	Patrick Dahill:	42:28	So, with the transition, we will have two separate processes—again for reasons I mentioned earlier—getting those coding sets eligible for the second year will be important. So, there will be that duplicate test-deck process that will happen once the technical updates are released each year. Once we get back on track, that's expected to be the March Update we talked about, and test decks and certification would happen that period right after that.
	Andy Reynolds:	43:01	What is the relationship between the five broad topics that Dr. Barr outlined, and do they depend on each other or can some of them advance independently?
	Michael Barr:	43:12	I can start and then turn it over to others. The allowable adjustments are out there currently, so those have started. The time change is independent, although the schedule of use is independent of the others. And licensing and certification is certainly something we are currently on point [with]. Digital measures and the ECDS as described that they are related, they could pursue separately. So, we currently have 11 ECDS measures available in the store. Those eight generation two or digital measures, traditional measures that are digitalized are going to be in the store in a few weeks. The relative proportion of those in the store going forward will be determined by how much interest there is in each of those and the bandwidth of the team to make sure we're responding to where the market is and where the market goes.
	Andy Reynolds:	44:00	I just want add one more thing to that. What we don't have in our store right now is digital allowable adjustments.
	Michael Barr:	44:06	Correct.

704	Andy Reynolds:	44:06	But we would love to hear from our stakeholder base; if there are specific ones that you would like to see, we can certainly think about a way to work that into our process and how that would be measured.
708	Michael Barr:	44:18	Let me build on that. I think the opportunity is just like the digital measures, say time and programming those adjustments, which can be almost infinite within the realm of the allowable adjustments. If there's 20% that represent 80% of uses, we could start providing those in the store too. So, you could download the HEDIS specification and an adjustment that you can make to that specification directly from the store.
714	Michael Barr:	44:47	We'd be very curious to know how much interest there is and has been to what types of adjustments would actually satisfy the market.
718	Andy Reynolds:	44:58	Can you explain more about how electronic data is tracked using ECDS specifications? For example, are clinics responsible for tracking ECDS data and submitting it?
720	Ben Hamlin:	45:12	Right. So, as I stated earlier, the measure specifications do not cover the data extraction—transformation, loading to the HEDIS environments, that is a future ideal state. The categorization is set up now such that if the data is standard at each of these points of care, so if it is at the front line of care it's being pulsed in the EHR without the transformation of the ETL; it's just being extracted and loaded directly. That's why that categorization exists. We consider that the clinicians are producing standard data. There are so many ways this can be done and so we're not going to be prescriptive and specify how they have to do it, because we're trying to reduce the burden on the frontline of measurement people.
732	Ben Hamlin:	46:01	We're not trying to increase the burden and measurement burden on these people. Really, we're working with a lot of the different vendors in HIEs who are doing this with each of the clinicians, such that if the HIE is doing this standardization and normalization, that would be the ECDS category and therefore we can rely on them and all their existing relationships to help reduce the burden on the clinicians in terms of calculating the measure results, sending us the information directly and also providing information back to their clinicians that they're extracting information from. It has a much higher value, more use, but right now we do not include in our digital measures the framework for how to extract native data up to a standard environment.
746	Andy Reynolds:	46:44	Do you have any recommendations for data capture and format transmission from a physician office, EHR to health plan?
748	Ben Hamlin:	46:54	[We] highly recommend trying to use the standard formats that are available and not creating unique ones. There are several

			out there that are transmission format. HL7 has a few; others as well. Again, the more you can standardize the data closer to the point of data collection and data origin, the better. You'll find more uses for it.
	Andy Reynolds:	47:25	Will health plans need to create datasets for additional metric codes to read in order to calculate HEDIS rates? If so, will the file layouts be provided?
	Ben Hamlin:	47:35	So, the only scenario [in which] I would see health plans creating specific internal registries would be something like case management. That's why I say that exists as a separate data source category. If plans are filling gaps in their data using internal programs like case management programs or hiring out population health—two specific vendors to help them manage and collect this data—we're documenting that through the SSoR, or the source category through ECDS. We don't anticipate that as interoperability succeeds in the future, that plans will have to backfill information through various specific programs. We're hoping that they'll be able to access existing data that's from other people or they'll have it themselves.
	Andy Reynolds:	48:28	When we report the new ECDS Prenatal Immunization measure, how soon will we see the benchmarks? How long will the benchmarks be available before you consider adding a measure to other programs such as HEDIS ratings?
	Ben Hamlin:	48:42	So, like our current process, when a plan submits the measure, they will see all the relevant information in benchmarking, which we will then use to publish our Quality Compass, for example.
	Andy Reynolds:	49:05	Can you say more about the Digital Measurement Community that is coming up next year?
	Ben Hamlin:	49:11	Yes. We are trying to create a very interactive community to help us get the message out about our strategies, but also to interact more frequently with our stakeholders, wherever they may be or whoever they may be, to help us understand what they're struggling with. So we're hoping that the peer-to-peer communication in this community will be very efficient and very helpful to members. We hope that the information flow on a 365 basis from NCQA through discussion forums or through webinar content is recorded and stored, or the library of resources that we're planning on putting up there will be helpful to get people up to speed. By directional information flow, it helps us; you don't have to wait for the next quarterly webinar to find out what's going on.
	Ben Hamlin:	50:00	We also are thinking about creating zones or areas within this community for people who are in different phases. If they're highly technical, they probably are going to belong with a specific group and we don't want to create a unique, separate group for them. But we want them to have a space where they can work

			while others are catching up. And again, creating a community
796			that is interacting amongst themselves, like we do at the Digital
			Quality Summit, but sort of an online, interactive, continuous
798			conversation, a continuous learning environment—and again, try
			to create something where the information can flow up, down,
800			sideways, triangular[ly], back and forth, whatever.
	Andy Reynolds:	50:40	And since you mentioned the Digital Quality Summit, it's great to
802			announce this about next year's, but I think this community may very well help build the content-
804	Ben Hamlin:	50:49	Right.
	Andy Reynolds:	50:49	... momentum leading into this Summit.
806	Ben Hamlin:	50:51	If there's a group within the community that really wants to work
			on something in person—they want to build a section—we would
808			certainly consider that for the next Digital Quality Summit
			agenda, to have them meet face to face and allow them to work
810			through it to accelerate.
	Andy Reynolds:	51:06	Is the overall intent of ECDS to phase out medical record
812			review?
	Ben Hamlin:	51:11	Retrospective manual medical record review, absolutely.
814	Andy Reynolds:	51:17	That was a quick answer.
	Ben Hamlin:	51:18	Yeah.
816	Andy Reynolds:	51:20	The next question is: How many health systems are resistant to
			working with health plans to share electronic data, especially if
818			the health plan is outside of that system? Does NCQA have a
			strategy to help plans deal with these difficulties? Again, can we
820			help systems and now the sharing of data?
	Ben Hamlin:	51:45	So we're going to send Peggy out to talk about the health plan
822			(laughs).
	Peggy O'Kane:	51:49	(laughs).
824	Ben Hamlin:	51:49	We've heard some of that.
	Andy Reynolds:	51:50	There is resistance, but I think we're trying to support better
826			communication between the payers and the different entities
			within the health care networks, and not just measure them on
828			their ability to do so is getting traction. I don't know of any
			absolute information on a health care system that is absolutely
830			refusing to share any information.
	Peggy O'Kane:	52:18	But I'm hearing a lot of reference-

832	Andy Reynolds:	52:20	Right.
	Peggy O'Kane:	52:20	... and I think it's the real issue.
834	Andy Reynolds:	52:20	But it's definitely real issue.
836	Peggy O'Kane:	52:23	I think we need to dig into and understand better and see. We can't force them to bring it up.
838	Peggy O'Kane:	52:29	If you're planning on having to deliver a service and you're not able to get it, certainly NCQA is a cheerleader here.
840 842 844 846	Michael Barr:	52:37	I think we ought to look at the causes because sometimes it may very well be that in the current environment, it's a burden on the systems of the plans, and we're trying to alleviate some of that burden. And other cases may be cultural, financial—it's probably not very technical in terms of barrier. It's just breaking through some of the interoperability issues, which the standards are there, but It's a matter of recognizing that doing so will lead to better care.
848	Andy Reynolds:	53:03	And things like the information-blocking rule we're helping to meet; again, they're kind of getting it from all angles.
	Michael Barr:	53:09	Right.
850 852	Andy Reynolds:	53:09	So again, I think the barriers probably do exist and they are very serious. I don't want to minimize that at all, but I do think that people are moving towards this direction that they see value in the sharing of this information, as opposed to just, "it's a drain."
854 856	Michael Barr:	53:23	So I'll invite the folks [who] have specific stories or use cases that we can help, that will help inform our evaluation and how we can address it from a strategic perspective. We'll welcome that feedback.
858	Peggy O'Kane:	53:36	Yeah. I've put that into the PCM. (laughs).
	Andy Reynolds:	53:38	Yeah.
860	Michael Barr:	53:40	You can do that and we'll pull it out and use it. Okay. Is there another suggestion?
862	Andy Reynolds:	53:44	When we have the DFC up and running.
	Michael Barr:	53:46	Yeah.
864	Andy Reynolds:	53:46	... if you want to wait, go CCTS.
	Michael Barr:	53:54	We'll do PCS and Ben is going to look at them.

866	Ben Hamlin:	53:54	Well, and we'll look at that for sure.
	Michael Barr:	53:55	Please do so.
868	Andy Reynolds:	53:57	With the new schedule, do plans participating in ASCR have to meet the vendor certification deadline or will allowance be made, considering measure year 2021 will be the first year that plans not using a vendor will have to go through ASCR?
870			
872	Ben Hamlin:	54:14	Luckily, our director of software certification is online and answered that question for me. They do choose to do the ASCR process. They must meet the same deadline as the regular certification process.
874			
876	Andy Reynolds:	54:27	Is the vendor required to have measures be certified for allowable adjustments or can you say more about the relationship between the allowable adjustments and vendors? We do not currently certify and allowable adjustments because again, there are rules for how you can adjust the measures, but they're not things we're specifying digitally. So we cannot push out a digital measure for you to consume and then ask to certify you against that.
878			
880			
882			
884	Andy Reynolds:	55:06	Against the level of adjustments of the measure, right?
	Ben Hamlin:	55:07	And we're looking into that further.
886	Andy Reynolds:	55:08	Right.
	Ben Hamlin:	55:09	Stay tuned on that topic.
888	Andy Reynolds:	55:12	Are you planning on creating certified software to measure non-HEDIS Core Set measures such as C-section and subsequently creating benchmarks or percentiles with CNS?
890			
	Peggy O'Kane:	55:29	You're raising a really interesting point on something that we need to give some consideration to. So, thank you for the question, but I don't think we're prepared to answer it.
892			
894	Michael Barr:	55:40	If I can generalize, we are an authorized testing lab for eCQMs. And so we do certify measures on our eCQMs. But I think the question was more pertinent to health plans. I think that's something we do need to look at.
896			
898	Andy Reynolds:	55:56	I think we have time for two more questions. One is about the Healthcare Quality Congress: Can you remind us when and where it is? That is October 2nd to October 4 in Dallas. And the final question is: Often, the inability to share data is due to state-based privacy laws. Is there anything NCQA can do to work at the state level?
900			
902			

904	Peggy O'Kane:	56:18	I think we would be pleased to have our state affairs team—if you will let us know about this, the particulars of the situation—
906			we can communicate and explain how this is getting in the way of appropriate patient care as well as quality measurements.
908			We're happy to try to play a constructive role in that kind of problem.

910

	Peggy O'Kane:	56:49	I want to thank everyone for being part of this today and, we look
912			forward to further communication with you and just thinking about better ways to communicate with you as we go forward. I
914			find that the webinar format feels a little awkward. I can't tell if we're answering your question. And so, we'll, we're committed to
916			making this not a monologue but a dialogue in the future. So, thank you so much for being here.
918	Richard:	57:22	The slides and the recording of the webinar will be available on the NCQA website next week. We'll be offering webinars on this
920			topic in the future, so check that. And ladies and gentlemen, that will conclude today's event. You may now disconnect your lines.
922			Thank you.