

- 2 Andy Reynolds: Hello. Welcome to this, the 10th episode in NCQA's webinar series, The Future of HEDIS. I'm  
4 Andy Reynolds, your host. Our topic today: HEDIS performance during the pandemic, plus  
important changes you can expect to see play out in HEDIS long after the pandemic.
- 6 The slides that you'll see will be available to you today. We'll pass along the link for you to  
download those slides. [00:00:30] Then, in one or two business days, we will email everyone who  
registered for this event a link to both the slides and a recording of this webinar.
- 8 We will have Q and A at the end of today's session. Please send us your questions at any time  
using the Q and A button at the bottom of your screen.



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Let me fill you in on who is going to bring you the material today and what we're going to learn. We'll start with the founder. NCQA founder and President [00:01:00] Peggy O'Kane will acquaint us with the big picture. She'll share her observations on where we are with HEDIS, where HEDIS is headed and why we think it's vital to update HEDIS.

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Next, Assistant Vice President for Research and Analysis, Sarah Shih, will fill us in on HEDIS measurement results for last year: Calendar year 2020, measurement year 2020, the year we will all remember as the pandemic year. Sarah will stick around. She will update us [00:01:30] on how NCQA plans to elevate health equity as a permanent pillar or recurring theme in HEDIS.

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Then, Assistant Vice President Anne Smith has some news about digital measures—that is, measures that NCQA writes and releases as software.

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Finally, Chief Product Officer, Doctor Brad Ryan, will acquaint us with digital solutions that can help extend measurement [00:02:00] beyond measuring and reporting health plans' quality. That I, how we can extend measurement beyond the original use case or original use function for HEDIS.

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It's a lot of new material, a lot of important material. Before you jump in, Peggy, let me just mention one thing about Brad: He is in transit. He is at a place at the moment where he cannot connect to Zoom. We planned for that. We recorded his remarks. We will play that recording of Brad's remarks. When we get to Q and A, [00:02:30] we hope and expect he'll be able to patch in and join us for that live discussion.

So with that, Peggy, I'd like to turn things over to you.

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# The Big Picture

by Peggy O'Kane



34 Peggy O'Kane:

36 Good afternoon, everyone, if you're on the east coast. And welcome. So I thought it'd be great if I  
38 could talk at a high level about what's going on with HEDIS, and with healthcare in general, I  
think. [00:03:00] HEDIS has always evolved. You know? The first version of HEDIS focused on  
preventive services. And we've certainly branched out since then into other important areas of  
healthcare.

40 But we are going through a continuous evolution, and we've built out the content of HEDIS. And  
42 for the last several years, as you know, we've been working towards collecting digital data from  
the point of care. And it's actually a whole new [00:03:30] paradigm where quality improvement is  
part of what you do with quality measurement, and where there's a virtuous cycle of learning  
where you are in real time and continuously improving that.

44 In fact, we're at the point of care. And this is really the dream: The practitioner has the information  
46 they need to do the right thing the first time. So we're hoping to move from looking backwards  
[00:04:00] to being in real time and being an assist to the delivery of high-quality healthcare, as  
well as a way of documenting that high quality of care.

48 So we know that digital information exists at the point of care and is generated at the point of  
50 care, but it's not currently in the kind of arrangement that makes it easily retrievable, whether it's  
to deliver care more effectively [00:04:30] or to measure quality. And that is part of the big lift  
52 that's beyond NCQA alone to achieve, but really requires cooperation across the continuum of  
stakeholders.

54 So even today, we know that HEDIS is used for many things beyond measurement. So first of all,  
though, the old ways of measuring are burdensome and have often caused [00:05:00] people to  
56 have to go to practitioner practices to look in records to do very expensive, and tedious, and  
intrusive ways of achieving the results that people count on. And partly, that's because  
58 measurement doesn't take advantage of delivery system data. And again, the delivery system  
data does have to be in a form where it's easily retrievable.

60 So part of the [00:05:30] paradigm, though, is that when you have all of these data that can be  
used to deliver care and to measure care, they also can be the basis for quality improvement.  
62 And really, that's the whole point of quality measurement is to achieve better results. It's not to  
look backwards and say, "Got you! You forgot to do this," or, "You didn't do that." It really is to  
improve the quality of care.

64 So we're very excited about this digital journey. And we're also very... [00:06:00] It poses an  
awesome challenge to try to get to where we need to go in real time. And we know that. We hear  
66 that from many of you a lot of the time.

68 And another point is that a lot of things are happening in healthcare that we currently don't have  
any ability to measure. And that's really a function, partly, of the way the data is stored and  
70 currently used. So we made a big investment in [00:06:30] this country to make sure that we had  
electronic health records. We've invested millions in other electronic ways of delivering care and  
72 achieving results, and we need to be able to see the results of all those investments: The quality  
ROI, if you will.

74 So we have a lot of goals in this digital world to protect patients and promote quality. And we  
know, now, that [00:07:00] care will be delivered in many new ways that are transformational, or  
at least potentially transformational. And we know that we can improve health itself. And that's  
76 always the goal of improving healthcare is to improve health and health equity.

78 And we've had a new commitment to health equity, I think, as a country that came out of the  
events of 2020 and George Floyd. [00:07:30] And it wasn't news to the healthcare system and to  
those of us that work in quality measurement that there were disparities in health outcomes, but  
80 the unbelievable magnitude of the disparities... which actually increased in the time of COVID.  
You know? So years of life lost: One and a half from life expectancy for Whites, three years from  
82 Blacks. Just really unacceptable.

84 And part [00:08:00] of that is not about healthcare, but part of it really is. And so the healthcare  
system has an ethical and moral responsibility to take on its share of those gaps and to correct  
them. So we want to be part of that. We are part of really getting the data so that we can actually  
86 see what is happening in a real-time way in these gaps.

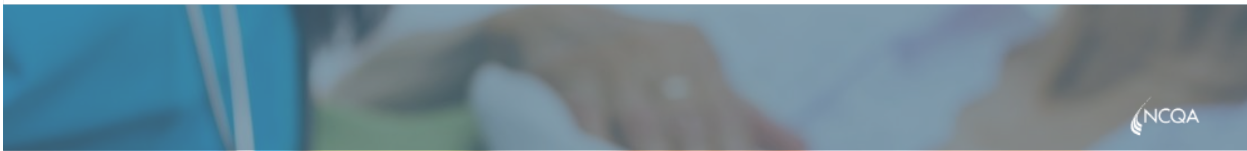
88 I think I always [00:08:30] want to mention that we need to reduce healthcare costs, because  
healthcare is gobbling up 20 percent of the economy. And that means it also takes away from  
other social programs that have been proven to be highly effective. It takes away from education.  
90 It takes away from infrastructure, like parks. So healthcare alone is not the only driver of health,  
and we can't continue to pay for it in the way that we have.

92 [00:09:00] And we need, also, public policy. We work in great synergy with public policy, with  
Medicare and Medicaid programs around the country. And we know that they are really important  
94 drivers. And we see ourselves as facilitators of a value agenda that they are really the major  
implementers of.

96 So with that, we have an exciting program for you today, and we look forward to your questions  
[00:09:30] and comments. And now, I'm going to turn it over to Sarah Shih, who is going to report  
98 to us on the HEDIS results that we've just done for performance year 2020. Thank you.



# HEDIS results amid COVID in 2020



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Sarah Shih: Thank you, Peggy. And I really appreciate the opportunity to share what we've learned so far. Let me advance the slide. [00:10:00]

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## What happened to health plans' performance in measurement years 2018 -2020?

### Adaptation

- Acceleration and Emergence of Virtual or Remote Care
- Policy Changes to Payment
- Reduced Capacity for Social Distancing

### Small shifts in performance

- Some decreases (expected)
- Some increases (surprising)
- Need for continued monitoring



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106 We have been asked, "What happened to the quality of healthcare in 2020?" Especially as the world had to stay closed and our healthcare systems were at the brink of breaking.

108 And the news isn't as bad as one might imagine. It's a mixed story. So I'd like to summarize some of these findings here briefly, and I'll be showing you some examples that we found. We look forward to a conversation and hearing if these findings are consistent with your observations.

110 So, despite reduced capacity, shutdowns, [00:10:30] delayed cares, health clinic performance was resilient in some areas. We obviously saw some decline in performance, which was expected, as well as some surprises, some increases. And there may be a story highlighting a widening disparity, as Peggy alluded about health equity, and other stories that may not be complete because more monitoring is needed.

**NCQA responded early to COVID**

**Special policy for Health Plan Ratings**

- Plans compared to current year benchmarks
- "Better of" 2020 or 2021 overall rating

**Updated telehealth guidance**

- 40 HEDIS measures for MY 2020, 2021 ([ncqa.org/covid/#hedistelehealth](https://ncqa.org/covid/#hedistelehealth))

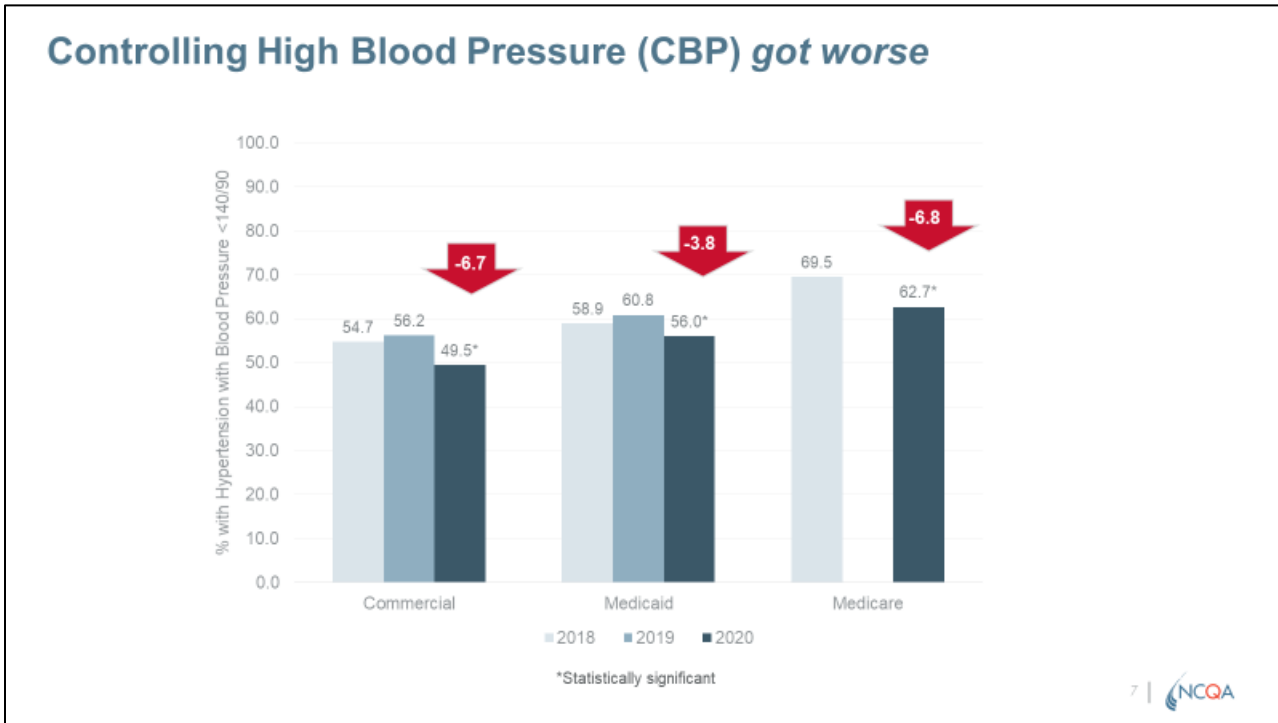


The World Health Organization declared COVID-19 a pandemic on 3/11/20.

116 So a lot changed in 2020 to healthcare, [00:11:00] as well as the way we think about health. In response to the early part of the pandemic, NCQA provided some special policies for measurement year 2020 or reporting in 2021. For HEDIS, specifications for 40 measures were updated to included telehealth guidance. And then for health plan ratings, plan performance would be compared to current year benchmarks, and also given the choice of using the better of 2020 or 2021 overall rating.

122 COVID not only tested the overall healthcare system, [00:11:30] but the pandemic also amplified the inequities of our health and our social system. And so I'll speak a little bit later on how NCQA has been invigorating our efforts to integrate a health equity lens throughout our programs.

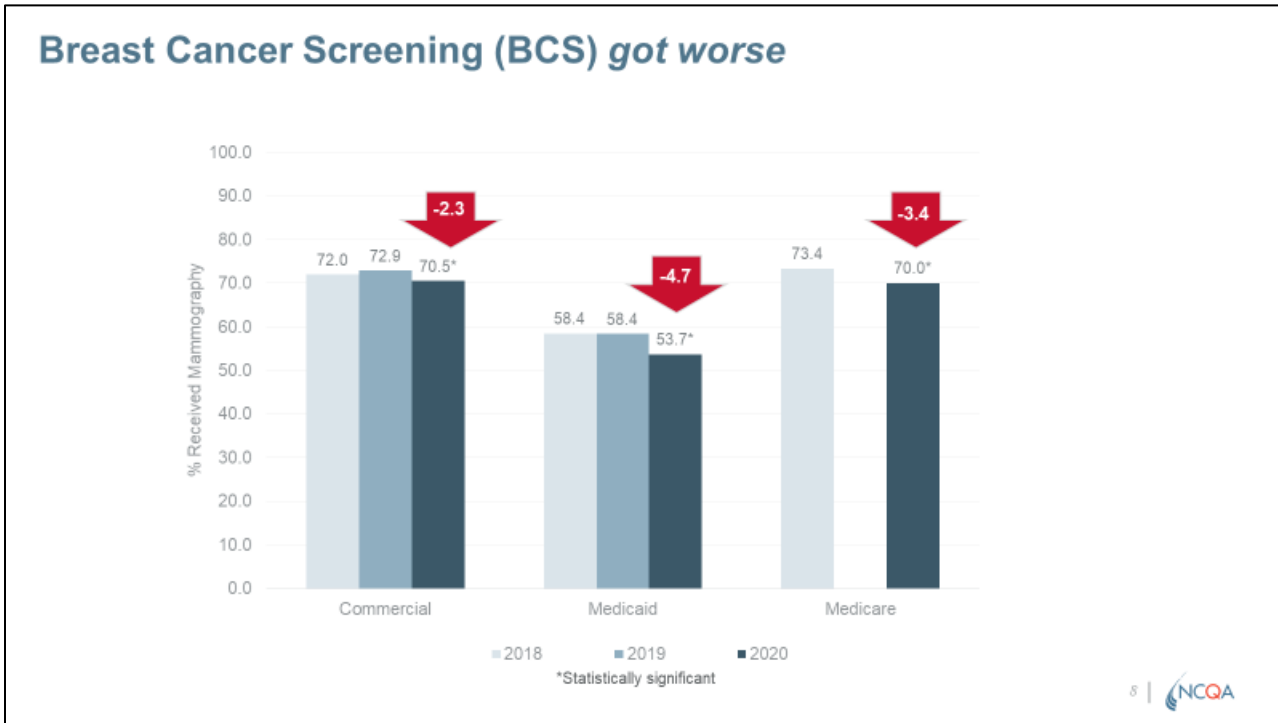
126 So back to what happened in 2020. Starting with this slide, I'm going to be showing some examples of measured performance patterns that we saw.



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Just to orient you to these slides, each graph shows three [00:12:00] years of data for commercial and Medicaid, and two years for Medicare, as reporting year 2019 was not available. Each grouping will show whether the preceding year is statistically significant from the most current year of data available, so that's measurement year 2020 or reporting year 2021. And the arrow highlights the direction and the magnitude of change. The asterisks that you can see in the dark blue bar above with the little number there indicates [00:12:30] statistical significance to prior year.

So several measures that we looked at, we anticipated lower performance. These are ones where in-person visits are likely to be preferred or are the only mode for treatment or care. And this slide shows statistically significant decrease in controlling high blood pressure across all three product lines. We also saw a similar decline or decrease for comprehensive diabetes care HbA1C control [00:13:00] for less than eight percent. This decline for diabetes control and controlling high blood pressure is especially concerning, as these are conditions that also make individuals more susceptible to severe COVID.



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Here's another example where we saw declines in mammography or breast cancer screening. This is a measure that has literally had no change for the past decade until now.

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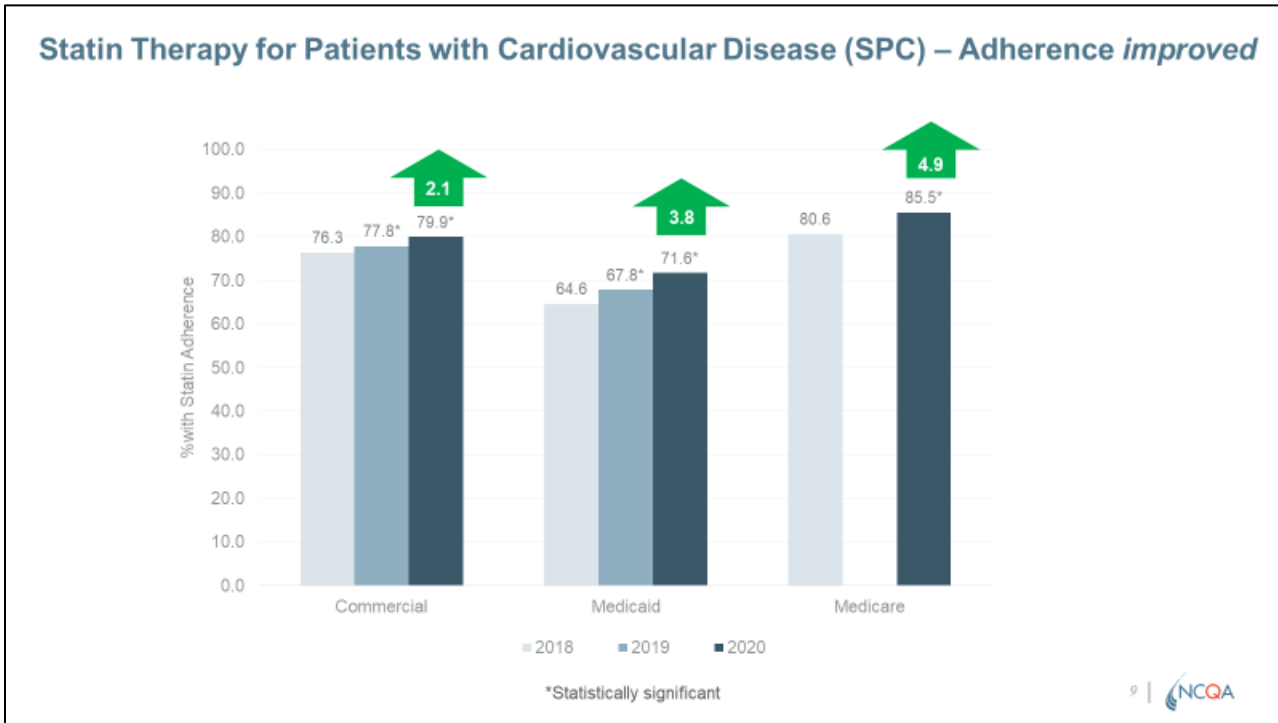
[00:13:30] So for the next two slides, I'm showing examples, measures where we observed increases in performance, which is a surprise as we heard consistently of shortages or reduced care capacity throughout 2020. And the health system was burdened with new requirements of social distancing, initial shortages of personal protective equipment, extensive sanitization or decontamination, or extensive tensing of workers, or shortage of workers before the availability of vaccinations. [00:14:00] So several measures were surprising to see increases during the pandemic here. And in the past, these measures did not have much change.

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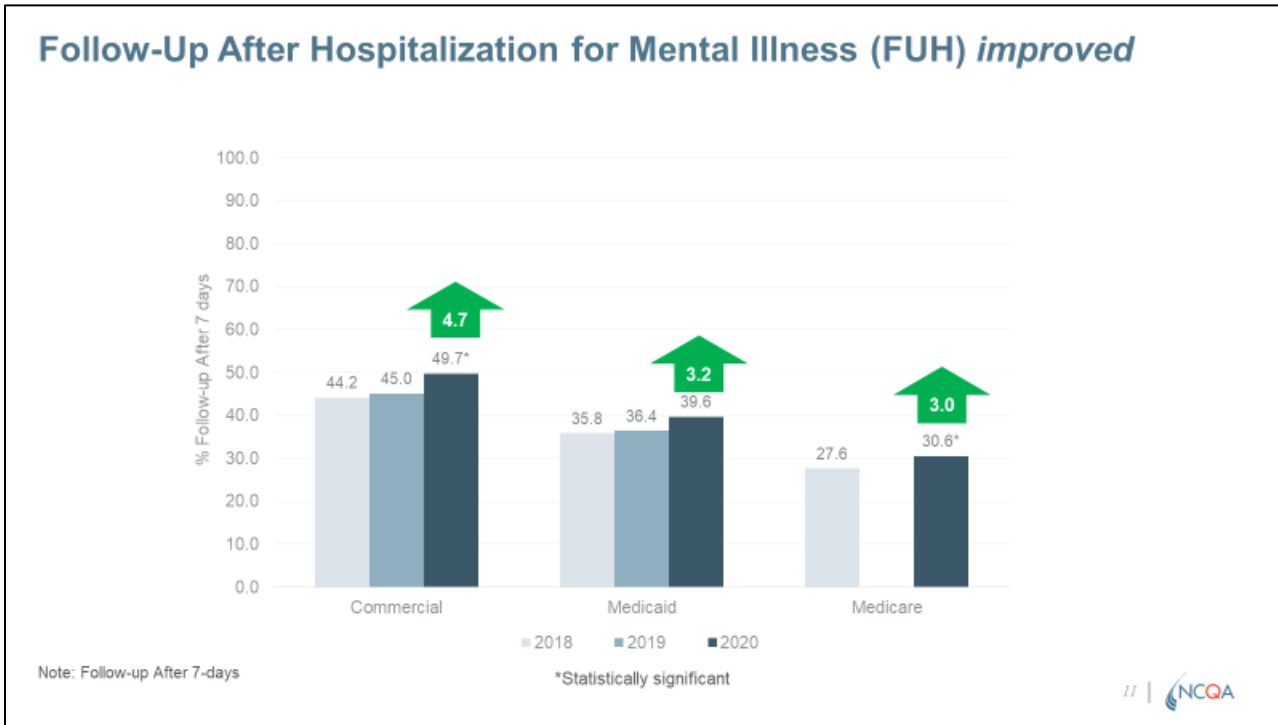
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This slide shows statin therapy for patients with cardiovascular disease adherence. And we saw a similar pattern for statin therapy for patients with diabetes. And you might wonder why we might see an increase. We're just speculating here. What might be a potential lift?

Potentially, it's because health systems were able to [00:14:30] adapt to a more virtual or remote care environment to tie patients over until the care settings could reopen. Other possibilities for facilitating this increase is potentially payment policy for virtual care follow-up, home delivery of medications, waiver of a visit for medication renewal or expanded allowance, and potentially expanded allowance for a medication supply, for example, from a 30-day to a 90-day supply.

[00:15:00] And here is another example showing increase in performance here where we're not expecting improvement.



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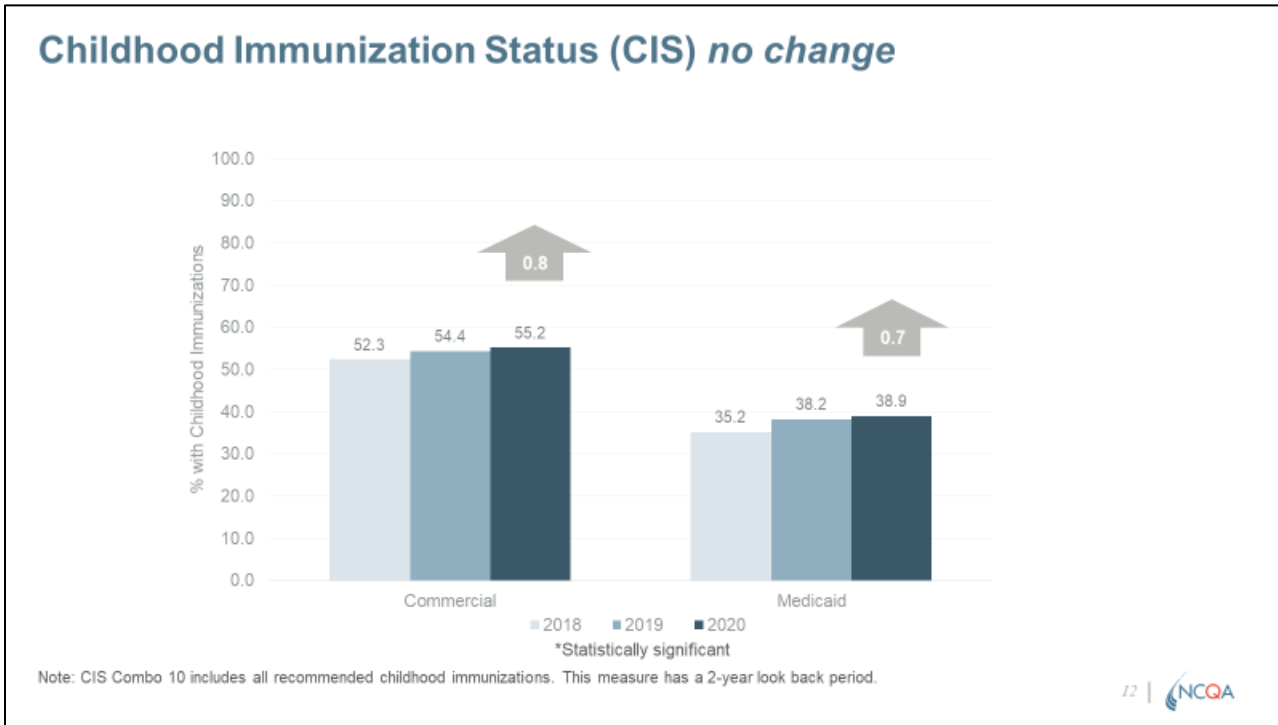
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This graph is showing the measure for follow-up after hospitalization for mental illness after seven days. We saw a similar significant increase for 30 days follow-up, also. And it is surprising because this measure has not shown improvement in the past.

We can speculate here that maybe some of this increase may be due to fewer mental health hospitalization, [00:15:30] or potentially more attention to follow-up, or potentially the inclusion of virtual care visits or virtual care post-hospitalization. That may have had a positive impact. So we would be interested to hear your experiences and observations on similar measures.



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During the first year of COVID, many have raised concerns that childhood and adolescent immunizations would suffer during the shutdown and further jeopardize the health of young children as primary care [00:16:00] visits or preventive care were delayed or decreased. In this measure that you're seeing on this slide, childhood immunizations—and this is for combination 10, which includes all recommended immunizations—we see little change or a slight increase, which we think is really surprising, because we would think that this would drop dramatically. We also saw a similar pattern for adolescent immunizations.

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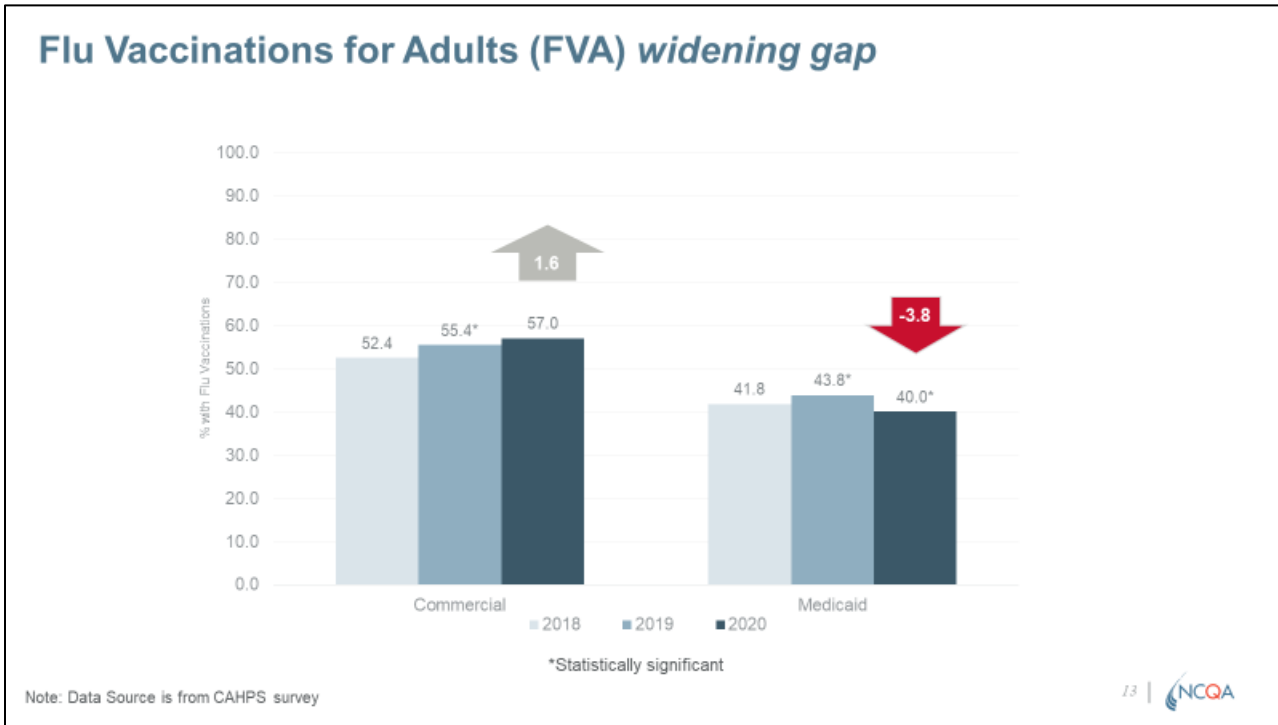
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So one might speculate maybe the healthcare system paid extra attention to these preventive measures of childhood [00:16:30] and adolescent immunizations when schools tried to reopen in the fall of 2020. Or another consideration is the design of this measure allows for a two-year look-back period, which may mask or delay the impact of forgoing primary care or preventive care in 2020. So we need to continue to monitor the immunization for potential change for measurement year 2021.

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[00:17:00] In contrast to childhood vaccinations, flu vaccinations for adults is a mixed story. Here, you can see little to no change for commercial members, while there are statistically significant lower performance for Medicaid members. And though there has always been a gap between commercial and Medicaid plans, in flu vaccinations the widening gap between commercial and Medicaid populations is concerning, especially as some states observed increased enrollment [00:17:30] in Medicaid in 2020 as employment rates increased.

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So unlike previous measures shown, just wanted to highlight that primarily relying on claims or medical records, this measure is collected through the CAHPS survey, and is a member self-reported measure of receiving the flu vaccination. And we wonder if this is a story of health equity in need for further exploration as well as monitoring.

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## Future of HEDIS

### *What's next?*

- **Continue to monitor closely** – Will there be delayed performance changes?
- **Potential deeper dive** – How has health care adapted with virtual or remote care?
- **Identifying Disparities** – Can we detect unwarranted differences?
- **Share your stories and findings**

[00:18:00] We have some hypothesis of what might be happening and look forward to hearing what you may have been observing or learning. We recognize that the COVID pandemic is not yet over. 2021 is experiencing a resurgence of hospitals being overwhelmed in various parts of the country.

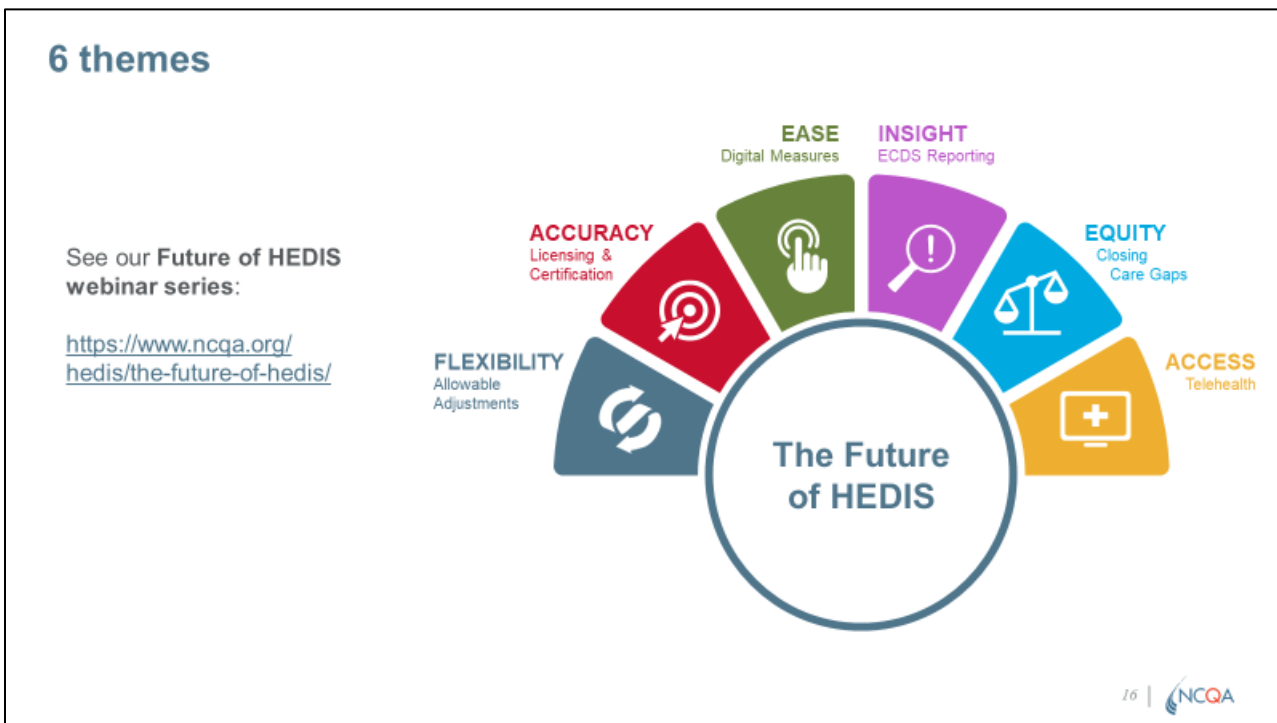
But we want to continue to monitor closely, especially where there may be delays in performance of measures with greater than a one-year look-back period, i.e., the childhood [00:18:30] and adolescent immunizations. And we look forward to seeing if the increases we saw will continue. Did the acceleration of virtual remote care or emergency policies help with care follow-up?

And, though we don't have full visibility into health disparities with the current results, we know there are disparities in care. And we'll look to healthcare systems and plans willing to share their experiences with data disaggregation and stratification of HEDIS measures.



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So with that, [00:19:00] now, I'm going to switch to looking forward in the coming years and our focus on health equity.



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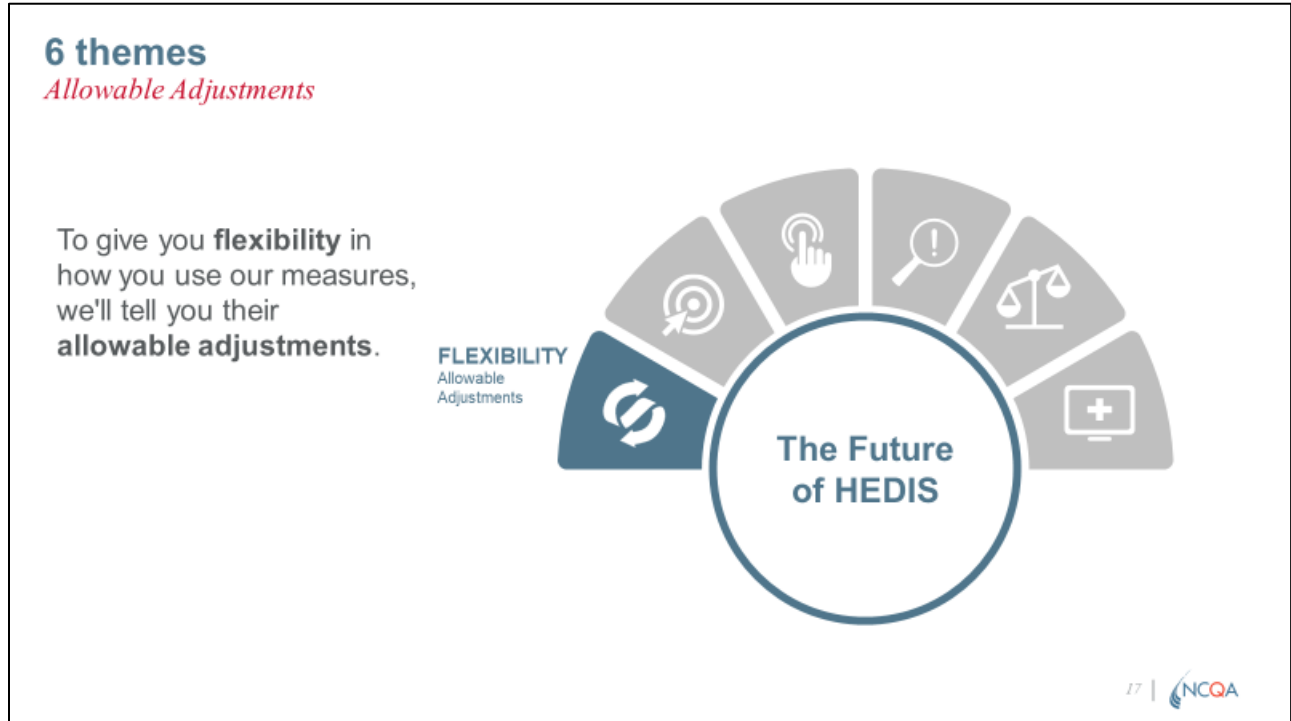
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If you are among those who have attended our Future of HEDIS webinar series over the past two years, what I'm about to show will look familiar. It has been several months since we shared this information, so seeing it again could be a useful refresher. And if you haven't seen our Future of



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HEDIS webinars in the past and would like more [00:19:30] detail about anything I touch on today, you can learn more by watching the previous webinars at the web address shown here. And I'll briefly cover each of these six themes.



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The first theme in the future of HEDIS is allowable adjustments. We know people want to use HEDIS measures for the purposes other than health plan reporting. And that's why we have HEDIS allowable adjustments. Allowable adjustments provide the flexibility to [00:20:00] modify certain aspects of the measures without undermining their clinical integrity. Several examples of allowable adjustments include narrowing a specified age range, focusing on a sub-population within a specified eligible population, or turning off requirements for continuous enrollment.

**6 themes**  
*Licensing & Certification*

We'll make sure uses of our measures are **accurate** and **reflect quality** of care.

18 | NCQA

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The next theme is licensing and certification. These provide the accuracy needed to make sure the use and input of our measures reflect [00:20:30] the quality of care provided.

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**6 themes**  
*Digital Measures*

We'll give you measures in a **digital** format that's **easier** to work with.

19 | NCQA

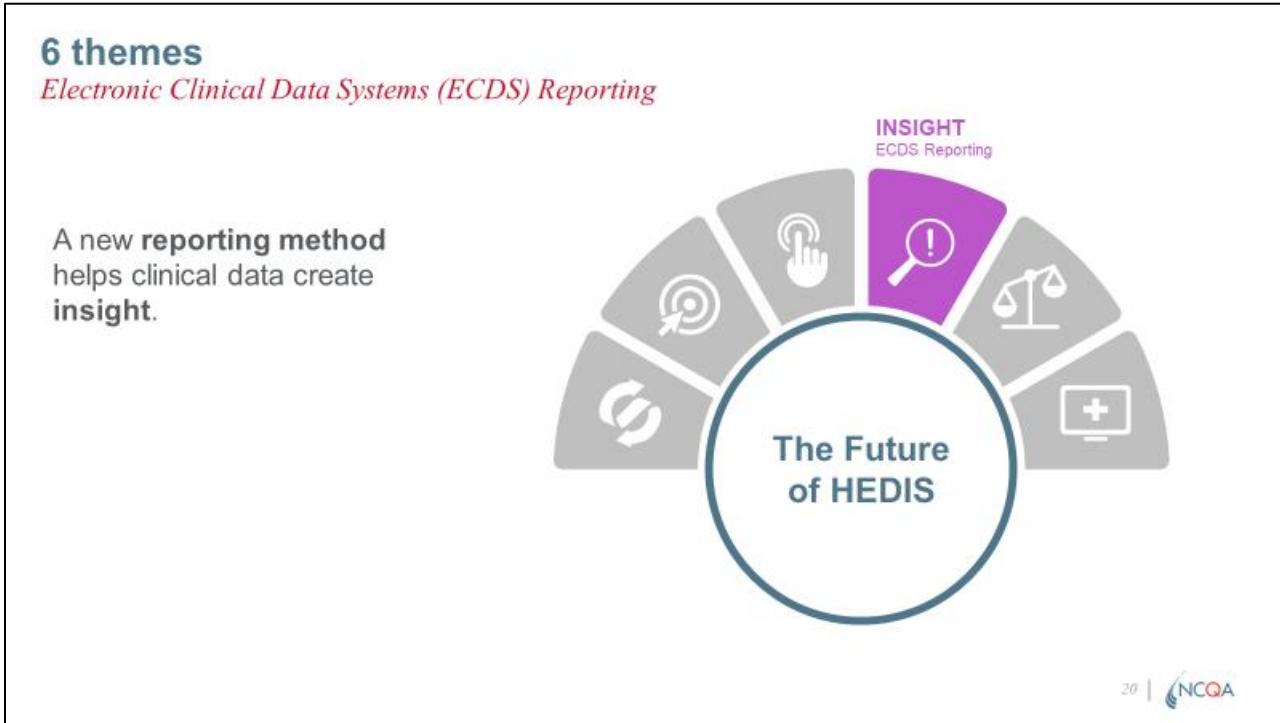
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The next theme here is digital measures. When we say, "digital measures," we mean that NCQA writes measures as a computer code so you don't have to. And using digital measures reduces human error, implementation time, and non-standardization. So NCQA digital measures are

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downloadable and machine readable from the NCQA store. For organizations that can [00:21:00] download the measures directly into an execution environment, the benefit of digital measures is lower programming costs and faster implementation.



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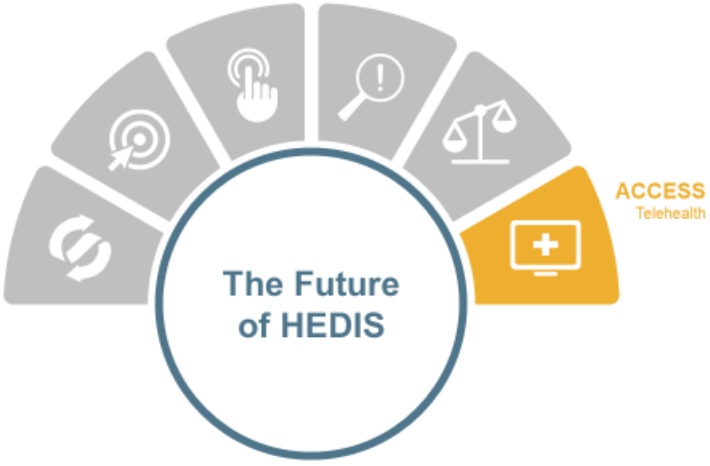
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The next theme that's related to digital measures is our Electronic Clinical Data Systems, or ECDS. ECDS reporting is NCQA's newest reporting method. As digital measures, these have all the efficiencies that I mentioned in the last slide. This reporting method was designed [00:21:30] to use data and clinical information from many sources, not just electronic health records, to generate new quality insights from data first created as care is delivered.

**6 themes**  
*Telehealth*

Align. Adapt. Innovate.

See recommendations of our Taskforce on Telehealth Policy: [ncqa.org/telehealth](https://ncqa.org/telehealth)



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And I'm going to skip to the sixth theme for now, because I want to come back to equity. First, telehealth. The use of telehealth has expanded dramatically, providing much needed access to care. We added telehealth codes to HEDIS measures and are exploring [00:22:00] how to support and sustain telehealth as a modality for delivering high-quality care.

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Three words capture what NCQA is doing in telehealth: Align, adapt, and innovate. And we are working to align policies that enhance telehealth, adapt the quality enterprise to optimize and promote telehealth, and innovate new ways that integrate and enable telehealth. We think telehealth is here to stay and needs to be incorporated thoughtfully into high-value, quality [00:22:30] care.

**6 themes**  
*Equity*

Closing care gaps to make care **equitable** makes **care better**.

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And coming back to equity: I just want to highlight that today; we are announcing that improving health equity is a pillar and a recurring theme in the future of HEDIS just like the other themes I shared. So I want to say a little bit more about the principles that drive and situate in our thinking about equity.

**EQUITY**  
**principles**  
**that drive us**

High quality care is equitable care

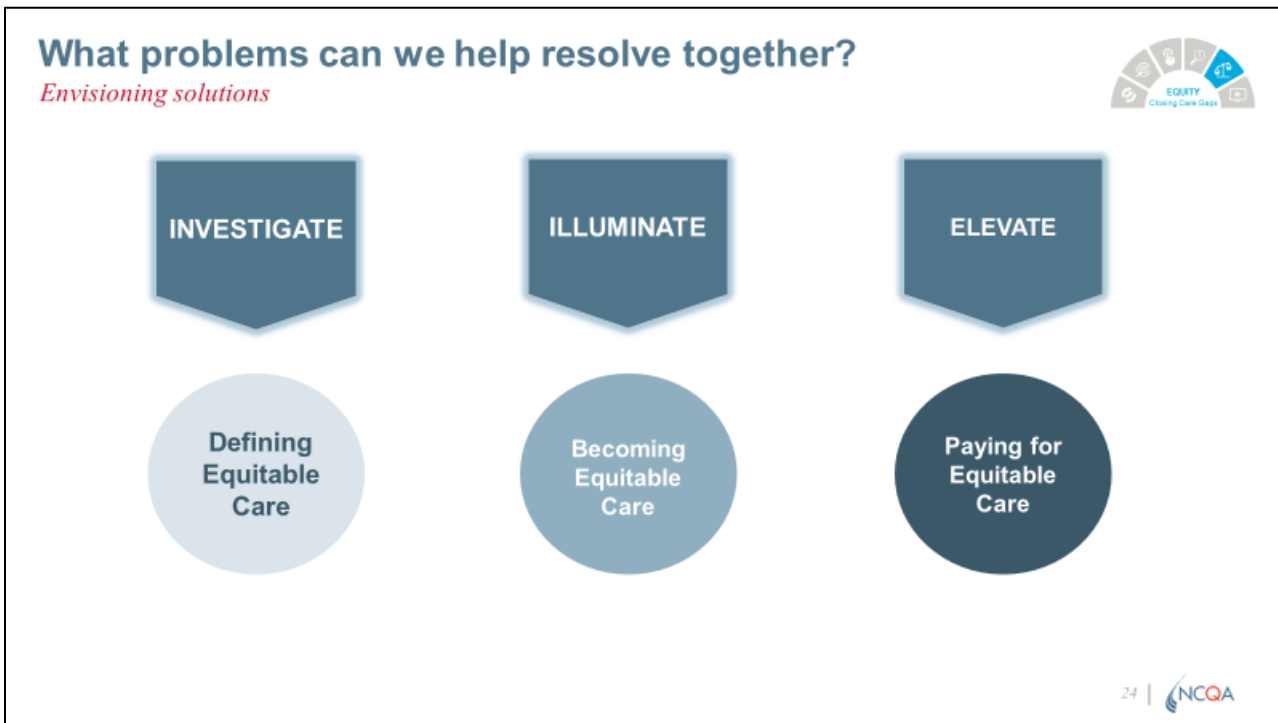
No quality without equity

Build equity into all NCQA programs

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As Peggy mentioned, [00:23:00] the pandemic and the events of 2020 amplified the disparities of health and healthcare for many people. These are unwarranted differences that should not continue. And over our past year, we want to reinvigorate our commitment. And this is our mantra: High quality care is equitable care. There is no quality without equity, and we will continue to build and elevate equity in all of NCQA's programs. So how [00:23:30] does NCQA build equity into our programs?



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In our effort to reinvigorate the concepts of health equity across our programs, we've identified three ways of bringing solutions to questions many of our customers, stakeholders, policy makers, and friends in healthcare are seeking. We recognize that these solutions require collaboration by not only listening but involving the individuals and communities that have been marginalized.

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So [00:24:00] three strategies to integrate equity into healthcare quality include: Investigate, illuminate, and elevate. As part of investigate, we are working to define, "What is equitable care?" How are we defining data, methods for measurement, and creation of measures to detect disparities or areas of healthcare in need of change?

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As part of Illuminate, we are looking for successful examples of eliminating disparities. What changes do healthcare [00:24:30] organizations need to make to become a more fair and equitable system?

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And then as part of Elevate, this is to incentivize and pay for equitable care. What do policymakers or other payers need to scale up or sustain to eliminate disparities?

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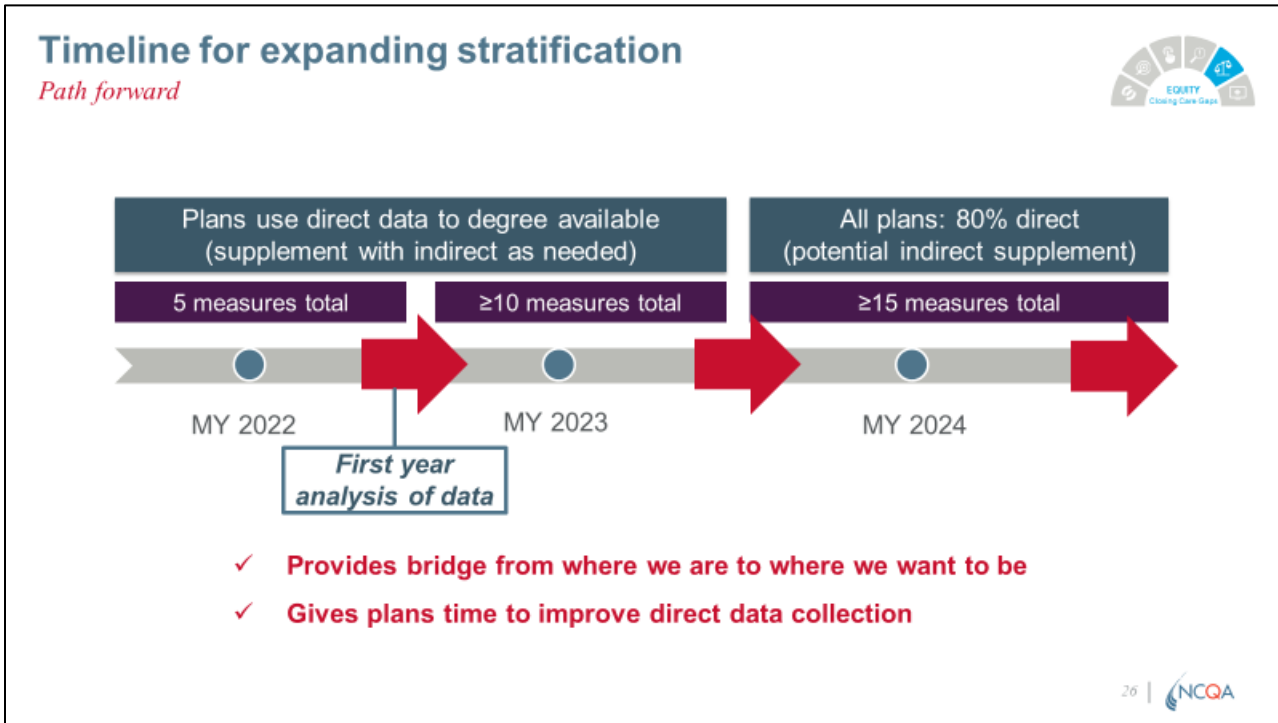
## Measures with Race and Ethnicity Stratification

*Measures selected for MY2022 stratification*



Measure	Product Lines	Domain
Colorectal Cancer Screening (COL; COL-E)	Commercial, Medicare	Effectiveness of Care
Controlling High Blood Pressure (CBP)	Commercial, Medicaid, Medicare	
Hemoglobin A1c Control for Patients With Diabetes (HBD)	Commercial, Medicaid, Medicare	
Prenatal and Postpartum Care (PPC)	Commercial, Medicaid	Access & Availability of Care
Child and Adolescent Well Care Visits (WCV)	Commercial, Medicaid	Utilization

So here's an example of what we mean by "Investigate." This is the start of race and ethnicity stratifications for five HEDIS [00:25:00] measures. These measures—Colorectal Cancer Screening, Controlling High Blood Pressure, Prenatal and Postpartum Care, and Child and Adolescent Well Care Visits are the first HEDIS measures to be stratified for measurement year 2022. These measures were selected from known existing disparities, and most used for reporting and accountability programs. Stratifying by race and ethnicity is our first step to transforming our approach to quality and accountability to center equity.



[00:25:30] I also want to take a moment to review our timeline for stratifying HEDIS measures. This is an area where public comment gave us a lot of input. A challenge health plans have voiced is the collection and completion of race and ethnicity data for their members. So what we're doing is that in the initial two years of stratifying HEDIS measures, we anticipate the use of direct and supplemented indirect [00:26:00] data for race and ethnicity. The first two years do not have the threshold requirements to give organizations more flexibility to work towards collecting complete, direct, self-reported race, ethnicity data.

And then, in year three, we will implement a minimum 80 percent threshold for complete self-reported race, ethnicity data. This threshold is achievable. Initiatives in California and Minnesota have been able to improve data progression to this level.

[00:26:30] To progressively incorporate stratification across HEDIS measures, we're adding additional measures in measurement year 2023 to a minimum of 10 measures to be stratified. An additional five measures in 2024 to a minimum of 15 measures. We could potentially have more measures, but our current target is a minimum of 15 HEDIS measures to be stratified by race and ethnicity by measurement year 2024.

Lastly, I just wanted to note that we'll [00:27:00] be conducting a first-year analysis of the initial five stratified measures in the summer of 2023 for data visibility, reliability, and variation. These analyses will help us make decisions for potential public reporting, with the earliest possible public reporting from measurement year 2023 or reporting year in the summer of 2024.

## Health Equity Accreditation: Coming October 5


*Scoring aligns with Health Plan Accreditation. Look for an announcement email next week.*




Organizational Readiness and Promoting DEI	Race/Ethnicity, Gender Identity, Sexual Orientation and Language Data Collection	Access and Availability of Language Services
Practitioner Network Responsiveness	Cultural and Linguistically Appropriate Services Programs	Reducing Health Care Disparities <i>(report stratified HEDIS measures)</i>

[00:27:30] As part of Illuminate, next week we will be announcing our new Health Equity Accreditation Program. You should be getting an email announcing this program. And health equity accreditation is based on health plan accreditation; the scoring will be similar. It includes six standards for health equity accreditation that emphasizes the needed structures and systems to improve the ability to collect and report on measures stratified by race and ethnicity. And [00:28:00] this will bring visibility and a way forward for healthcare systems to identify and eliminate disparities.

**Want more details on HEDIS and equity?**



**Registration:**  
[ncqa.org/qiseries](https://ncqa.org/qiseries)

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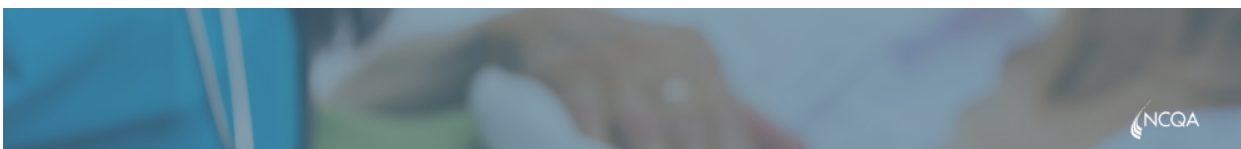
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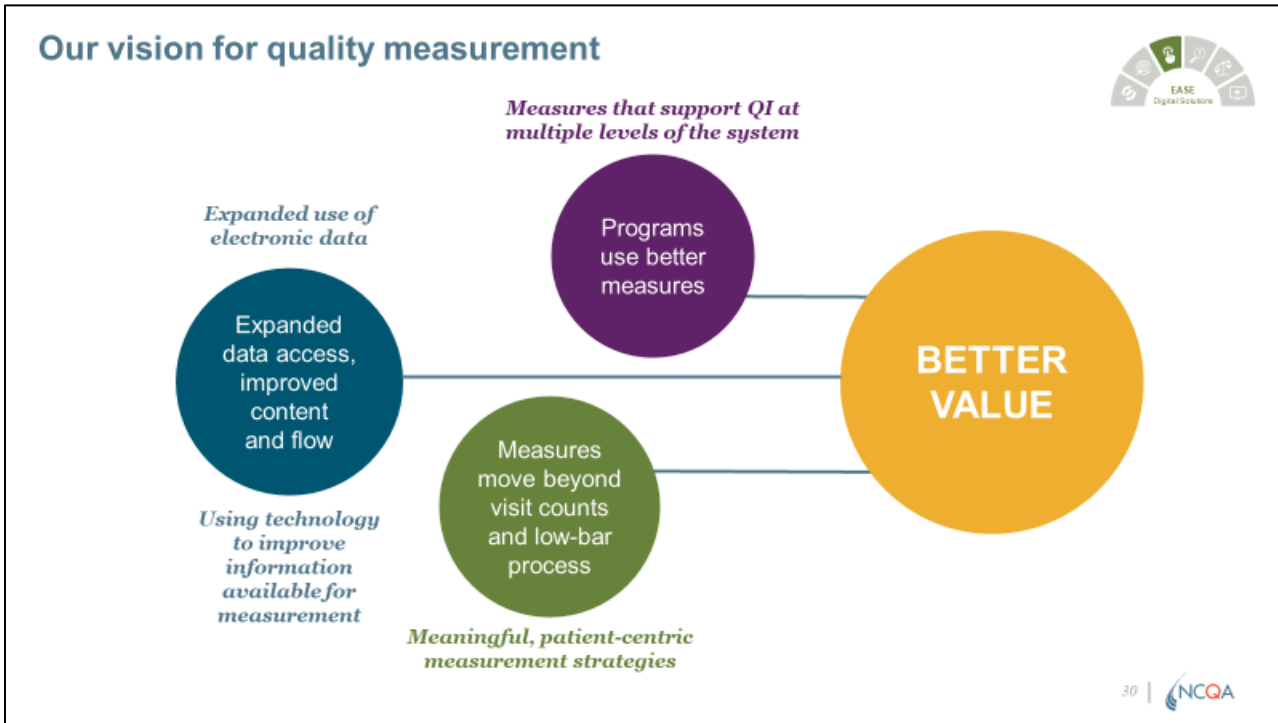
I also wanted to highlight a learning opportunity with our two research scientists leading the work on HEDIS for health equity. Doctors Rachel Harrington and Deidre Washington will be presenting on October 13th on some of our lessons learned so far, and future [00:28:30] directions for HEDIS and equity, including discussions of potential new measure concepts, data sources, and strategies. And I hope you'll consider viewing that Quality Innovation Series. They provide more information, and a great learning opportunity. Now, I'm going to turn the presentation over to Anne Smith for digital measures.



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Anne Smith: Thank you, Sarah. I am going to give an update on our digital measure packages for this year. And [00:29:00] I'm going to do just a little bit of level setting before that to ensure that everybody kind of knows what we're talking about, but Brad's presentation is going to go into our digital solutions a little more than I will go into it.



So what is our goal here? Our goal is to reduce the burden of quality measurement in reporting, and we want to foster measurement across all levels of the healthcare system, [00:29:30] and we want to support high-value care and a learning health system. That is, we want to make sure the right data is there at the right time.

NCQA has been embarking on a mission to enhance quality measurement by building our specifications to use standardized, electronic clinical data that are captured and exchanged using standard formats and measure logic. We think that using these clinical data sources will allow us to have more, to [00:30:00] have measures that move beyond these accounts and process metrics, and instead, get to more meaningful, patient-specific measures.

As programs begin to adopt these measures, we are also striving for alignment of measurement across various programs and levels of accountability. And with implementation of better and more standardized measures, we hope to get to better accountability and healthcare quality at all levels of the healthcare system.

Like I said, [00:30:30] today I'm going to give you a little update on some of our technical pieces of work. And those provide us with a foundation to get us to the upper levels and help to achieve this vision.



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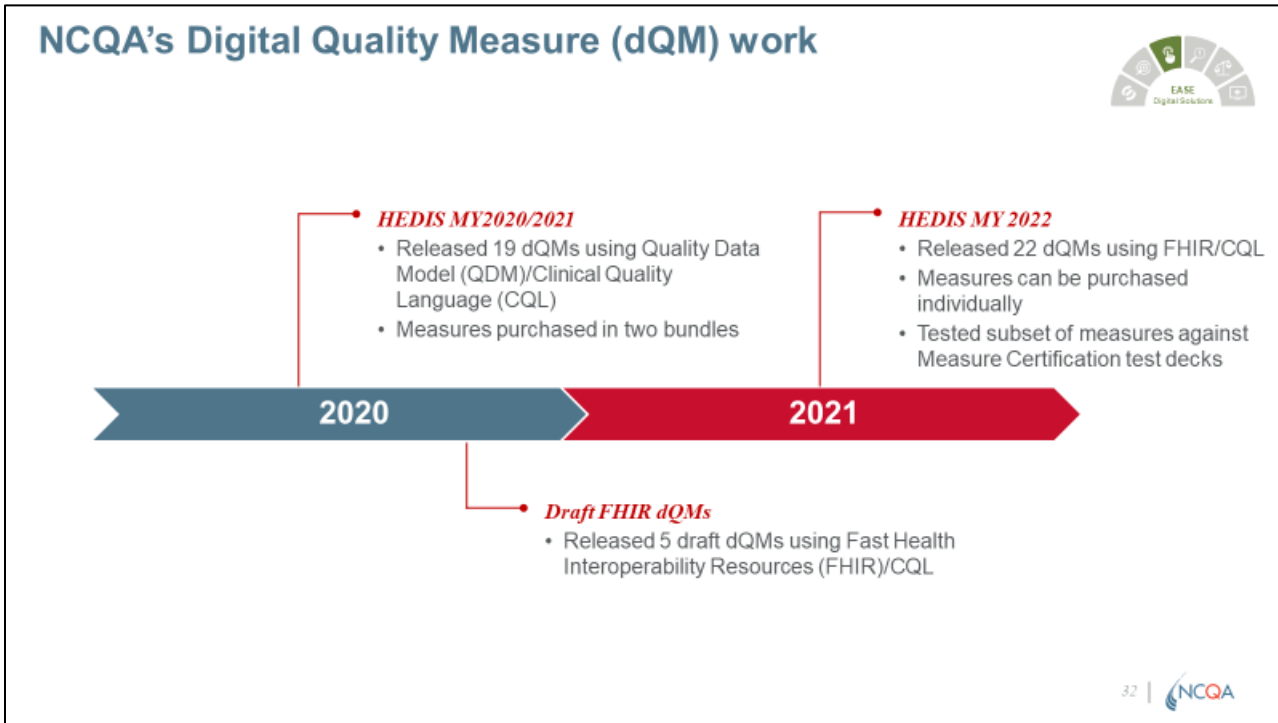
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So digital quality measures are really the foundation to move the ecosystem. By creating digital measures, we're able to leverage more data and to gain greater insights. We can use data that are created closer to the point of care, and we're also able [00:31:00] to base our measures on patient-specific care. If you look at something like breast cancer screening, right now, our measure is a two-year measure, which may not be the right level of care for all patients.

Using digital quality measures also allows us to align our measures with interoperability standards and value-based payment models. As we are able to align measures across different programs because we're following these standards, we're hoping [00:31:30] to decrease the measurement burden. We also want to decrease the measurement burden by having the measures flow from data generated by patient care, and not extra data that's captured by the clinician.

The results of this are more timely quality insights. Just as we are using data that is closer to the point of care, we want the insights gained from quality measures to affect the patient's care. Digital measures support the goals of value-based contracting. [00:32:00] Because digital measures that are re-used across programs help decrease the measurement burden, this will also help decrease the cost of measurement. This also helps us achieve alignment and transparency with other stakeholders.





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Our digital quality measure journey started a couple years ago when we released our digital quality measures in the Quality Data Model, or QDM, and CQL, Clinical Quality Language. At that time, you [00:32:30] could purchase the measures in two bundles.

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In 2020, we also released five draft measures in FHIR/CQL. FHIR is Fast Healthcare Interoperability Resources. And we wanted to signal a change to everyone. We wanted to signal that we were looking at using FHIR. FHIR provides a more robust data model for medical data.

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And in 2022, now, we have released all 22 [00:33:00] of our digital quality measures using FHIR/CQL, and we've changed the way that these are packaged. The measures can be purchased individually now. They no longer need to be purchased in bundles.

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And because we moved to a more standardized data model, we actually were able to do some additional testing on our measure packages before they were released. We tested a subset of the measures against our measure certification test decks prior to release.



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[00:33:30] So, as I said: Our digital measure packages for measurement year 2022 were released on September 10th. And as we made this conversion to FHIR, we definitely had some highlights and some challenges.

### Highlights and challenges



Highlights	Challenges
Measures are in FHIR/CQL	Adjusting to new data model
New data elements	Learning curve for new resources (e.g., claims)
Common logic organized into libraries	Understanding complicated logic/less human readable
Measure packages include value sets JSON files	Pace for digitalization of measures



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There were new data elements. And that's a highlight, because Quality Data Model did not cover all of the data elements that we needed to be able to program the HEDIS measures. So we

386 [00:34:00] welcomed this change to be able to add some data elements to the measures and be  
able to program more of the measures.

388 We also looked across our measures and looked at common logic, and we organized those into  
libraries. So where there's common logic, we now use common pieces of the programming to be  
able to re-use those. So everybody knows [00:34:30] they're all being calculated the same.

390 And lastly, in our measure packages, we included JSON files. Our value sets are now in JSON  
files in those measure packages. So for the 22 digital measures, you will see the value sets  
392 included in there in a machine readable form.

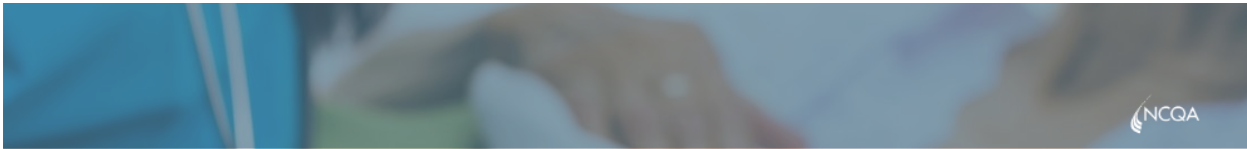
394 And we had a lot of challenges along the way. Like I said, there were new data elements. And  
that created a learning curve for us. As we looked at those new data elements and how they  
could be used in FHIR, [00:35:00] we particularly looked at the claims resource. Quality Data  
396 Model did not have any way to program in claims. But FHIR has a claims resource. And we  
looked at that and added that into our measures.

398 And in our implementation guide, you will notice some highlights about the claims resource, how  
we used it to be able to map data to it. We were able to program some of our more complicated  
400 logic. Makes the measures [00:35:30] a little less human readable, but it also is a more complete  
programming of the measures.

402 And now we're looking forward at the pace at which we will digitalize measures. We are  
404 considering stakeholder feedback, the type of measure, outcome versus process, to start putting  
together a plan as to how fast we can digitalize measures for the future. And now, I am going to  
turn it over to Brad to talk about our digital solutions.

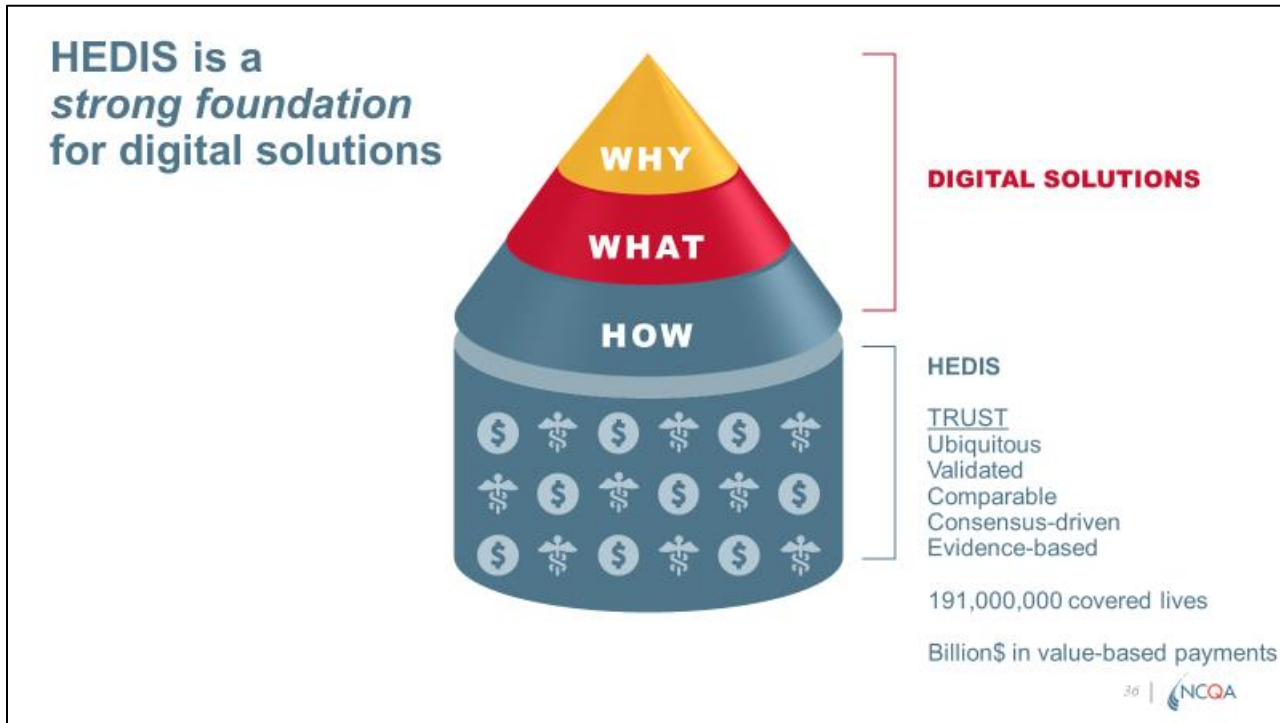


## Digital Solutions: Building beyond health plan quality reporting

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408 Brad Ryan: [00:36:00] Thank you so much. I'm going to speak today about digital solutions, but in the context  
of enabling some of the things that we've been talking about for the future of HEDIS. As some of  
you will know if you've been following our other presentations, that NCQA has a digital solutions

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roadmap that's a [00:36:30] little broader. But since our focus today is on HEDIS, we're going to talk about digital solutions enabling the direction we want to take HEDIS as a measurement system.



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So importantly, we're thinking of digital as an enabler of a lot of the same strategies, the foundations upon which HEDIS has been built. And HEDIS itself has some foundational [00:37:00] components that we expect to be both present and really important to our digital future.

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Number one: Trust. And there's a bunch of things that contribute to the trust that the HEDIS measurement system has evolved to provide between parties. Number one: It is evidence-based. There's scientific evidence. There is expert [00:37:30] input, and there are consensus mechanisms that are pretty robust and allow for lots of voices to be heard, and lots of considerations in the process of creating and maintaining the HEDIS measures that help create a foundation of trust when they are delivered.

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Then, there's the administration of the system. There's the validation and certification of both the data and the [00:38:00] implementations that go on in the data collection and measure execution.

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And because of those things, HEDIS has become nearly ubiquitous. In other words, nearly a universal measurement system, particularly when it comes to the use of measures in value-based contracts and in the program structures between parties where they're looking to drive towards common, aligned [00:38:30] goals.

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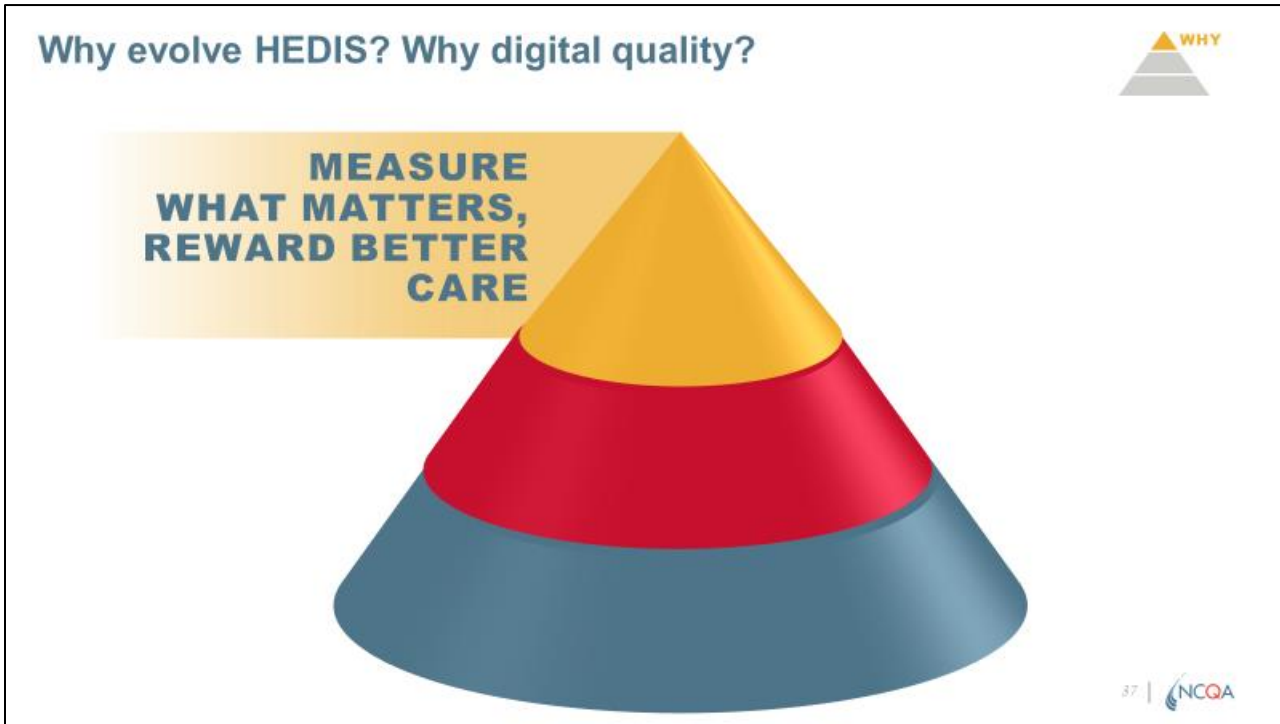
And that HEDIS foundation and the trust that all those components build up to create are where it will give us the opportunity to take advantage of some of what digital capabilities enable in the future. So I'm going to talk today about how our digital strategy helps take HEDIS to the next level.

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First: Talking about why [00:39:00] we think it's so important to get to all digital. We've talked about some of that already in this discussion, exactly what digital enables us to do with the

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measurement system that is valuable and different beyond what we have done traditionally, and then a little bit about how digital enables that.



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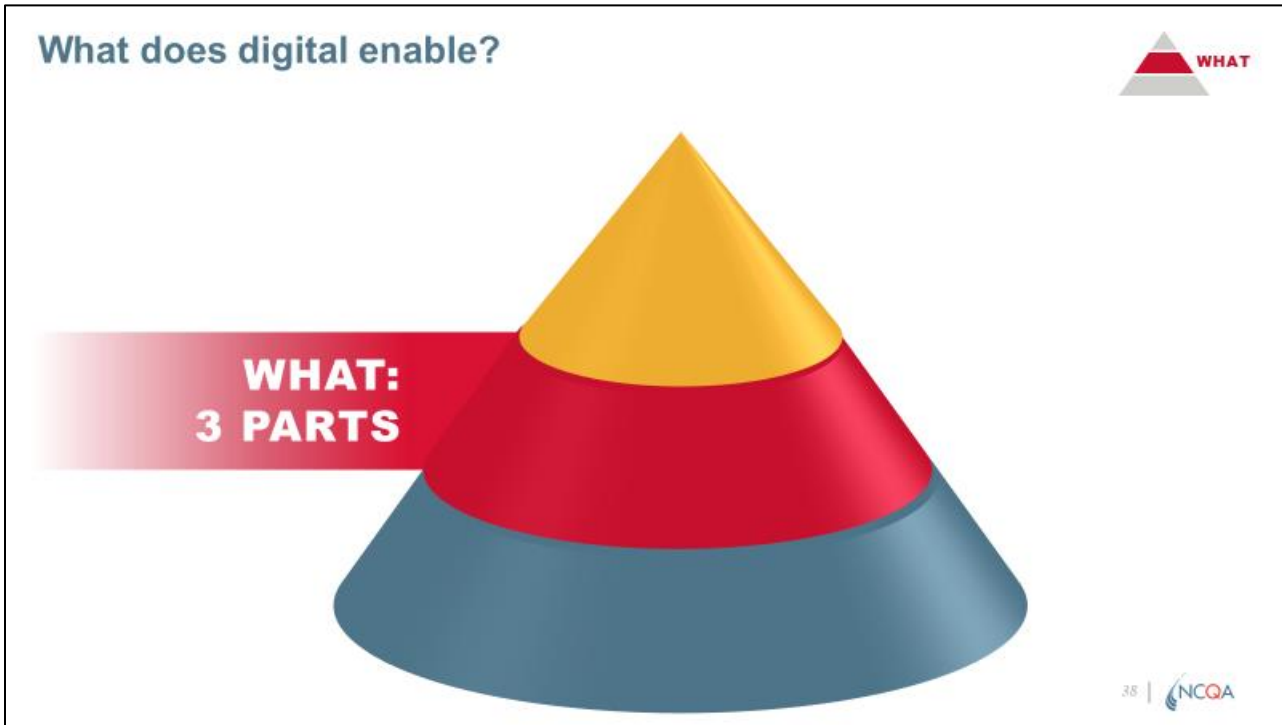
If you don't remember anything else from today, [00:39:30] please remember that we're seeking to evolve HEDIS and get to digital. Not digital for digital's sake, but because it delivers on the mission that we, our industry partners, and most of you have been committed to since the early days with our company and HEDIS, which is to help enable better quality care and better value for care. And so [00:40:00] this whole strategy is aimed towards doing a better job of measuring what matters and enabling reward for better care.

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### What does digital enable?



**WHAT:  
3 PARTS**

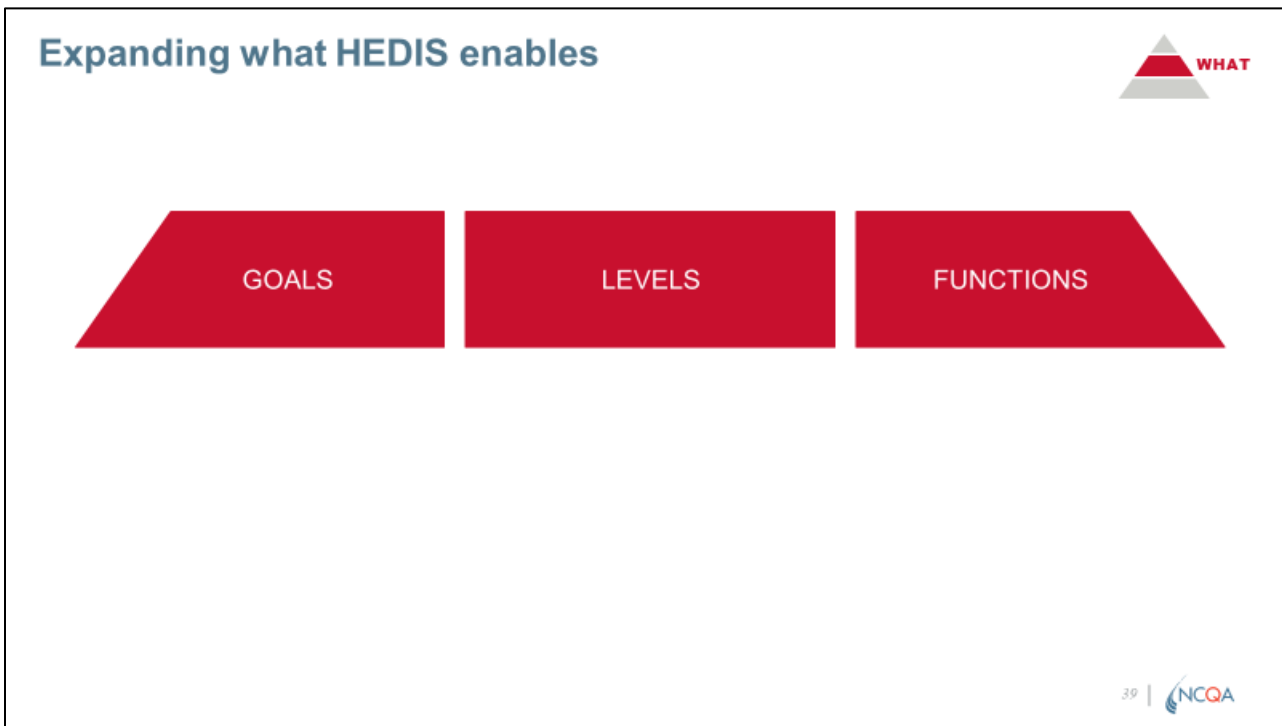
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Exactly what we're seeking to accomplish by evolving HEDIS comes down to three dimensions upon which we can expand what HEDIS has traditionally been able to provide.

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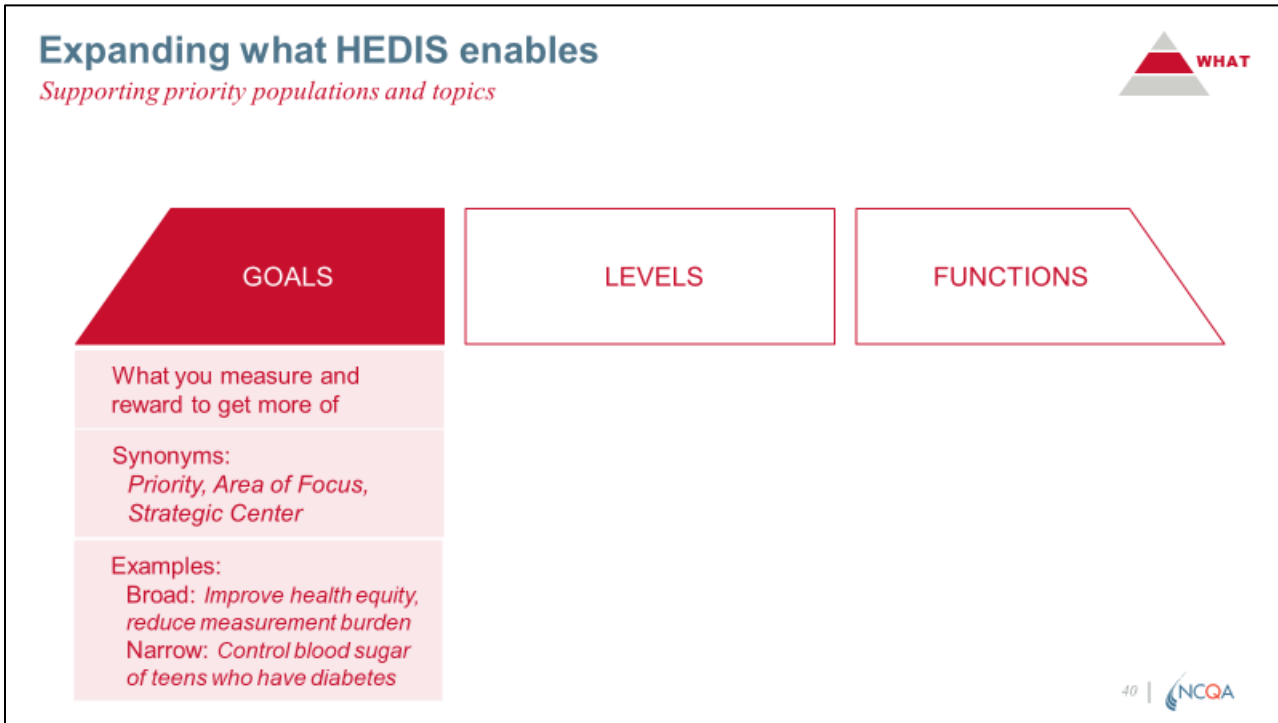
### Expanding what HEDIS enables



**GOALS**      **LEVELS**      **FUNCTIONS**

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The first dimension here [00:40:30] is the goals. These might be program goals or focus areas, but this is really just what we want to measure and what we want to get more of out of our healthcare system, whether that's priority populations or topics.

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In some cases, I think it's helpful to think of measures as the business KPIs when your business is delivering and managing healthcare. And so that might be, [00:41:00] in different scenarios, the priorities or the areas of focus, like I said, program goals. But they might be broad, like improving health equity. They might be more narrow, like specific populations at risk such as younger Type 1 diabetics.

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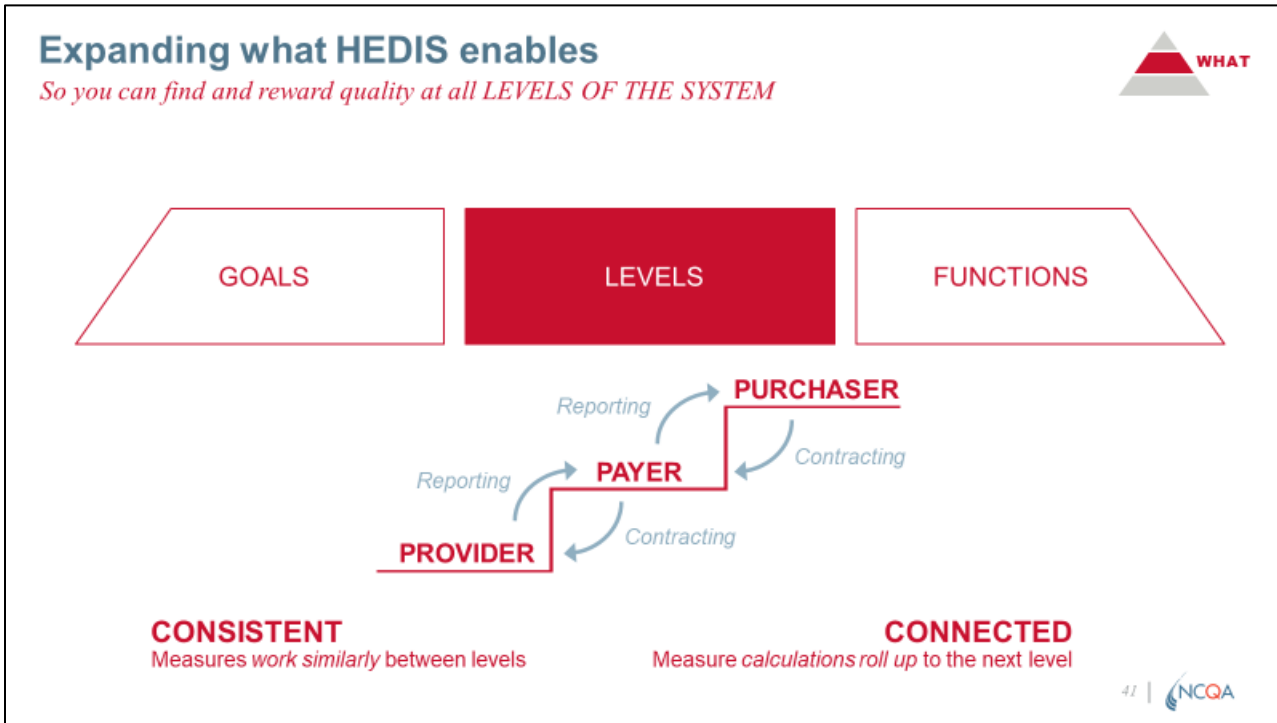
But this sort of dimension of HEDIS is somewhat aligned with the way that we have traditionally evolved HEDIS. We have always [00:41:30] taken an active look at the measurement set and said, "What are the priorities, and the priority populations, and the priority focus areas, the things we want to measure? And how do we evolve to cover those areas more and more?"

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This will continue to be one of the key dimensions to help enable the programs and incentives that we all want to reward, but with a digital first approach, it'll let us both attack some of the new areas and improve the way [00:42:00] that we deliver the product within those areas. And that's related to the next two dimensions that I'll talk about, one being levels.

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So if you just think in really oversimplified terms about the key stakeholder groups in healthcare that care about quality, there are multiple levels of accountability and levels of aggregation for quality across the [00:42:30] purchasers of healthcare and health insurance, payers or administrators of health benefits, and the providers, and the care delivery networks that provide the care. HEDIS was created and focused for most of its existence on the relationship from the payer, the health insurance level, the population level, [00:43:00] and the purchaser.

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And most of what HEDIS has supported is the reporting use case. In other words, the retrospective look at, "Did we or did we not perform on the measures that we agreed to report the payer level to some purchaser or other outside comparator of performance at the health plan level?"

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Over time, that has led into HEDIS being built [00:43:30] into a lot of contracts. Whether it is a reporting only, or an incentive-based contract, or a value-based, or an at-risk contract, almost all of the value-based contracts that I've ever seen... and many of our stakeholders confirm... include, if not are completely based on, HEDIS measures. And that's a big reason for the universal and the ubiquitous nature of HEDIS that we've talked about. It's because of the trust factor that HEDIS [00:44:00] is often trusted to support this relationship.

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What was alluded to earlier with things like allowable adjustments was the acknowledgement that because of some of the qualities of HEDIS that we've already talked about, HEDIS has been used at other levels of accountability and other levels of application. Namely, for value-based and incentive-based rewards at the provider level, whether that be at the delivery system level, or [00:44:30] an accountable care organization, or the individual provider. This is flowing down, and pushing HEDIS, and the measurement system, and the measurement framework, into places that it wasn't necessarily designed for.

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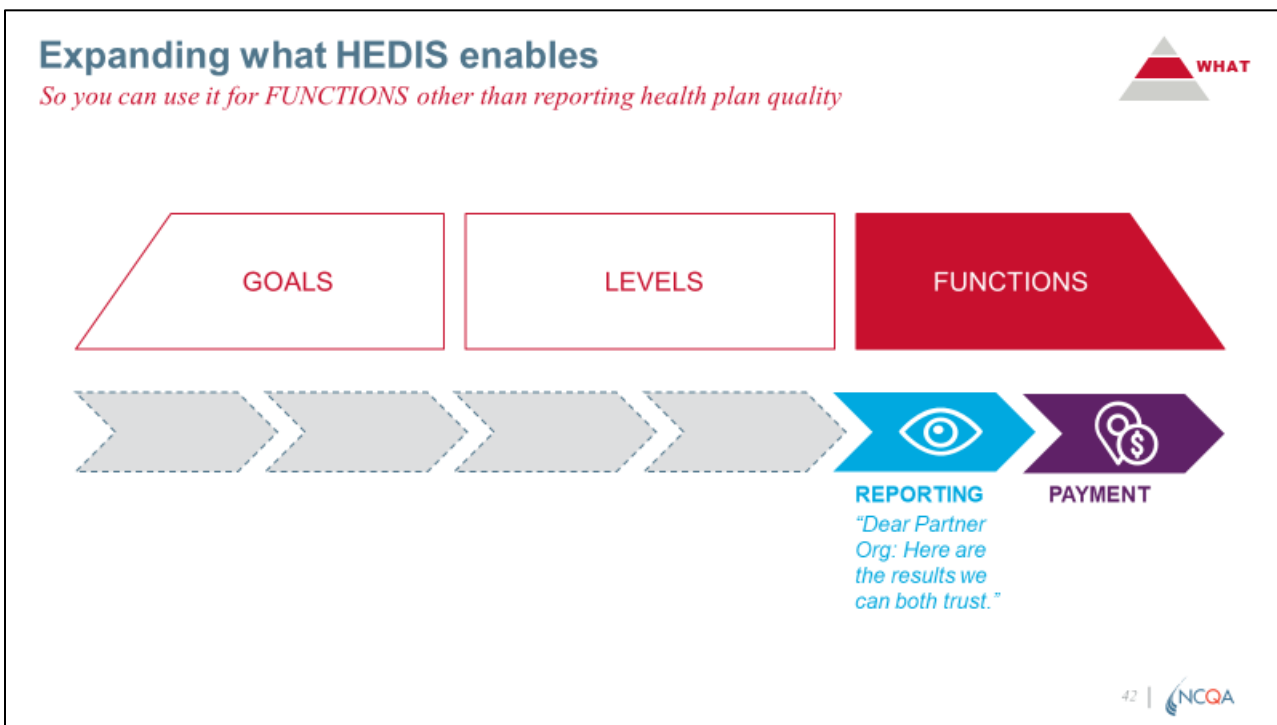
So we've made some moves to try to support that better, like allowable adjustments. But we think that there's a whole lot more that we could do to be proactive in supporting multiple levels of both reporting [00:45:00] and contract. And when we talk about supporting those other levels, many of



494 you who are expert in measure... many of you probably are more expert than I am... will look at  
 496 something like this and say, "Oh, well, HEDIS is the plan level measure. And there's provider  
 498 measures for the provider side."

496 But one of the challenges here is that those two are sometimes related, sometimes not, but often  
 498 not directly connected. And we [00:45:30] think there's a huge opportunity in aligning across the  
 500 levels some consistency, such that the measure of frameworks and the measure of concepts  
 502 really work similarly between levels and reinforce one another, and that they can be more  
 504 connected. Meaning that, whether directly or indirectly, the measure, the data, and some of the  
 506 calculations can roll up [00:46:00] and be used across levels where you're not thinking about  
 508 clinical data for provider measures and claims data for payer measures.

504 And you heard a lot earlier in this discussion about things like ECDS, where we've already been  
 506 testing the waters with these measures that are more agnostic of the data source or inclusive of  
 508 multiple data sources and could conceivably be built to support these multiple levels and deliver  
 510 on some of this consistency [00:46:30] and connectedness across levels. So that's a key second  
 dimension of focus for us that is a little bit different from what we've focused on in the past where  
 we've been more... I would say passive or reactive with allowable adjustments, meaning it's a  
 policy enhancement to try to be an enabler to use HEDIS at other levels. But we want to be more  
 proactive and invest in evolving the system to support [00:47:00] some of these other levels.

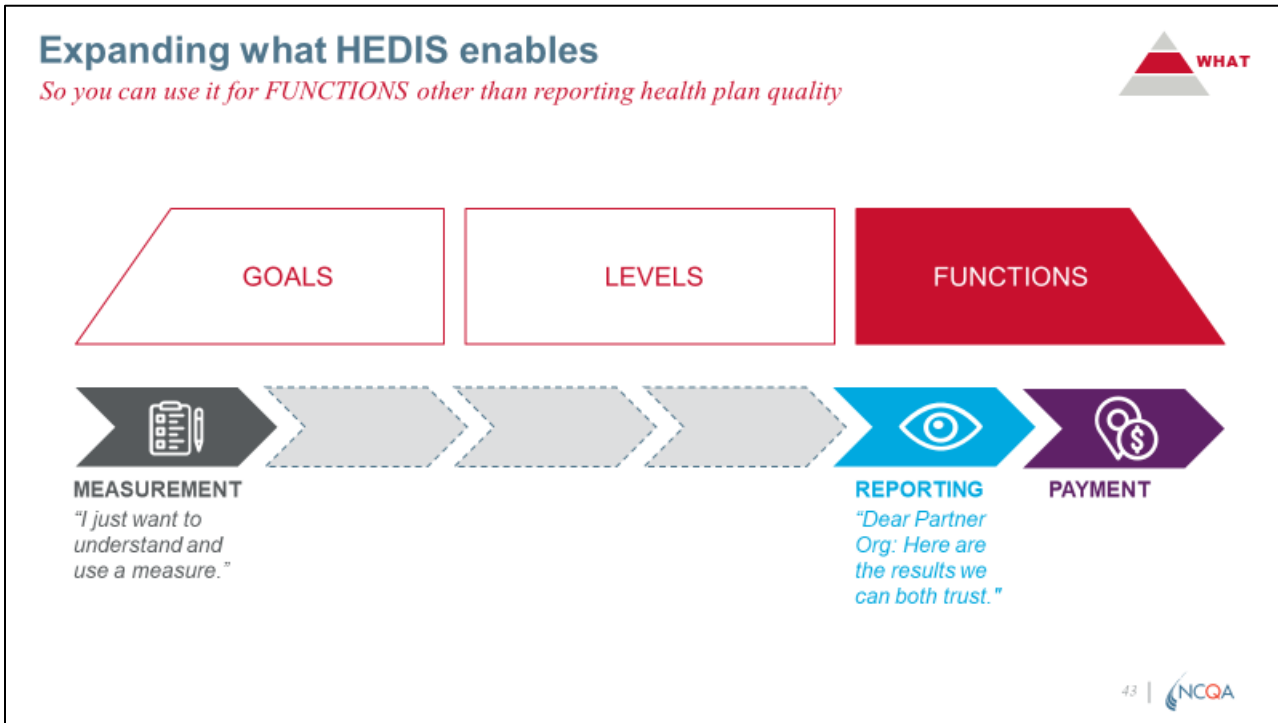


512 The last dimension I want to talk about are functions, or applications, or use cases in quality. I just  
 514 mentioned that, for much of its history, HEDIS has really focused on the reporting use case.  
 516 Meaning the retrospective, end of the period view of, "Did we perform the way we wanted  
 [00:47:30] to against this measure?" You could think of it in HEDIS terms as, "Here are the results  
 that we can both trust for how we did, a report card."

518 And in a lot of cases, that's indirectly, today, already been connected to payment, things like stars  
 and many other payment mechanisms that are connected to that end of year reporting, and  
 sometimes benchmarks. But we believe, and we've heard from our [00:48:00] stakeholders, that

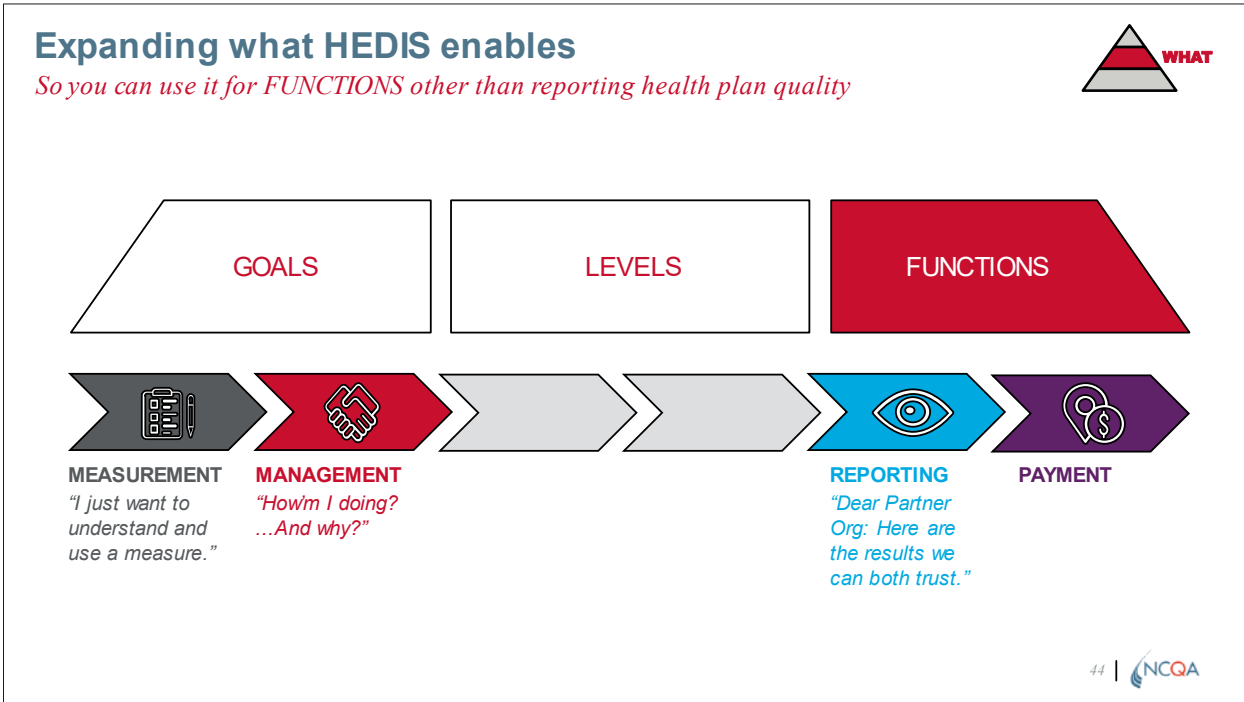
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there are a lot of other things that organizations, whether they're health plans, or vendors that are supporting them, or delivery systems and providers, and the vendors that support them, there are many other use cases and functions that these organizations are trying to support.



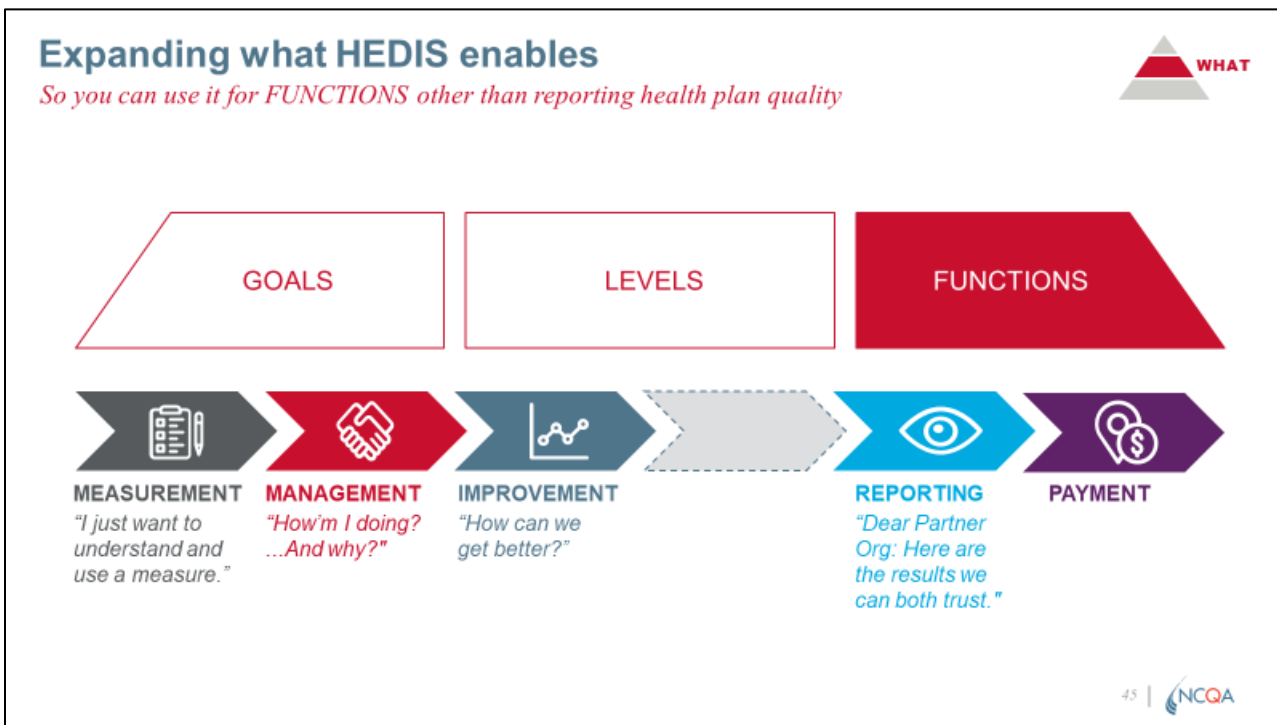
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And again, allowable adjustments has gone some way in helping expose us to what these use cases are. But we want to take an approach through digital [00:48:30] that helps us be more proactive in supporting them. Just wanting to understand and implement a measure: "What's in it? How would I do? Which patients is it selecting and not selecting? What are the guidelines that are applied within the measure?"



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Performance management: Understanding, in an ongoing way, "How am I doing? What's driving my performance?"



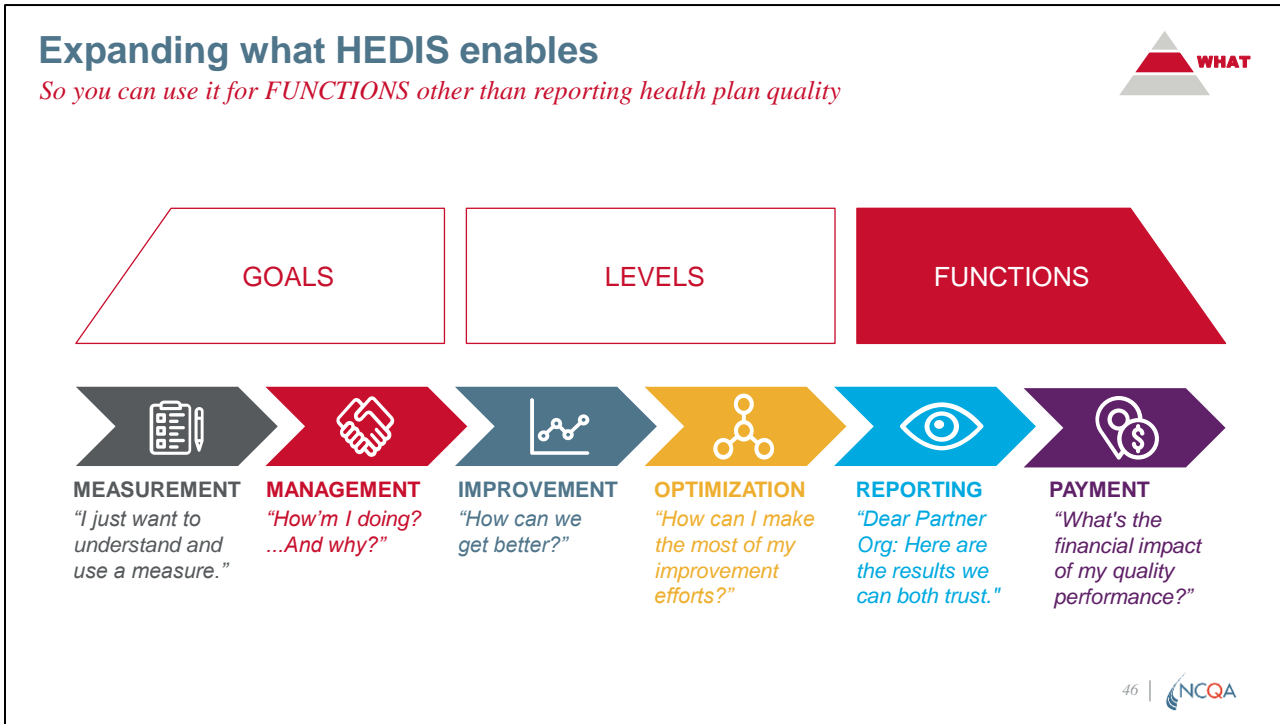
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Looking [00:49:00] along the way to support the operations behind performance improvement. A lot of talk about point of care. So the whole concept of care gaps in HEDIS has a... even the name "care gaps" implies a retrospective kind of flavor to it. We want to start thinking more

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proactively about identifying and taking action [00:49:30] at the time when a patient, or a care provider, or a care planner is engaged with their health.



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And then optimization at an organizational level: Organizations want to invest in quality improvement as a part of their score card. How can they make the most of those improvement efforts across the measures and the contracts that we have? And that ties it all back to the idea of: [00:50:00] We know that HEDIS is embedded in many payment programs. How do we design a product that more readily and proactively supports embedding it in those financial arrangements and enables more visibility into the impact of quality improvement, and quality performance on financial improvement and financial performance?

Here's more on how digital works

**DIGITAL:  
2 PARTS**

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[00:50:30] So again, there's a lot of themes that are going to be very familiar but taking this time to try to explain the way we're thinking about and the dimensions of expanding HEDIS. And then the way that digital is going to help us get there is something that we're going to talk a lot more about in future sessions as we get more and more into the digital product offerings. And it does go beyond what we've done to date.

Here's more on how digital works

Digital CONTENT	Digital DELIVERY
What and how to measure	How you ingest, implement and interact with measures and content
New and different measures based on new and different data sources	<i>Eventually:</i> Digital measures as software components (think: Spotify!)
<i>Example:</i> Tracking diabetes control through home monitoring	<i>Example:</i> FHIR/CQL measures that are configurable and API-enabled

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554 So what you heard already is that we've published FHIR/CQL [00:51:00] versions of HEDIS  
measures. That's a step. That's a necessary but insufficient step to get to all the things that I've  
just described.

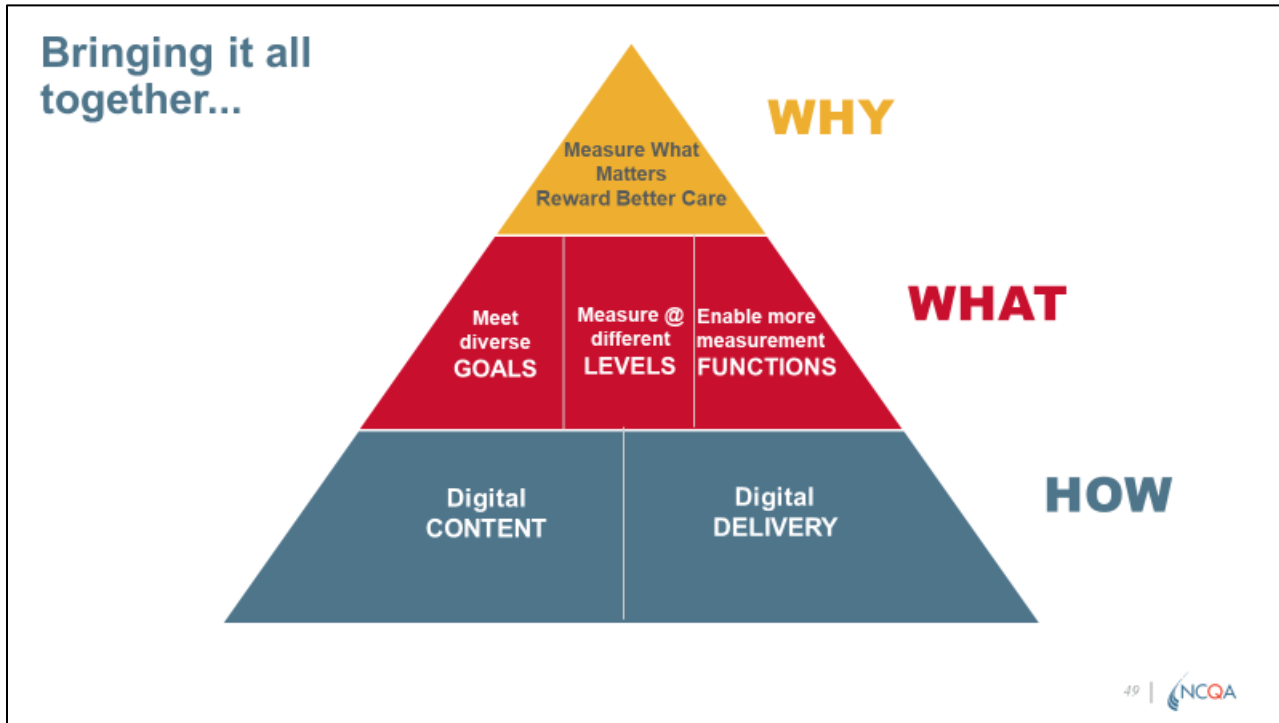
556 The things that we just talked about require evolving the content, the measures themselves,  
558 through digital, but also new measures. But the content, meaning what we measure and how we  
measure it, we think there's a big opportunity to not just create new measures in new areas, but  
560 to replace [00:51:30] measures that are good concepts. In other words, things that we want to  
measure and that should be priorities, but where we've got sub-optimal measures that were  
562 created in a different situation with only, say, administrative data in mind and certain constraints.  
We think there's a big opportunity to think about new measures, and new and different data  
sources.

564 And this is [00:52:00] evidenced in all the things that we've been trying to do with ECDS and  
some of the measures that are trying to take advantage of clinical data to date. But we think  
566 there's a whole lot more on that journey to take advantage of more and different data sources.

568 The part that people often don't think about is beyond the content, the measure itself, but how we  
deliver the product [00:52:30] to the market, which gets to some of the things around improving  
the speed, reducing the redundant effort in development and testing, reducing redundant  
570 infrastructure. But it also gets to enabling more of those use cases by making something that is  
more configurable, and modular, and behaves more like software than like a static description or  
572 a piece of code.

574 And so when we think [00:53:00] about the future of digital measures, we think it's beyond  
publishing the FHIR CQL code that we're publishing today. It more looks like software  
component, just like you might think about evolutions in other markets where maps that came in  
576 atlases then turned into a Google Maps API that you can embed right in your website and  
leverage. Or things like Spotify [00:53:30] that are more consumer oriented, where we've gone  
578 from publishing and licensing and purchasing a single copy of something to really subscribing to  
platforms of software that you can mix, and match, and change, and configure without affecting  
580 the integrity or the intellectual property that's associated.

582 And so when you think about the future for the [00:54:00] way we deliver these measures, we  
align with what we've heard in some recent CMS communication with their definition, which is a  
digital measure looking less like source code and more like an executable piece of software that  
584 is API enabled—a component, if you will; a piece of software. And that's where we're spending a  
lot of our time and effort, because that unlocks a lot of the configurability [00:54:30] and flexibility  
586 that we talked about in the upper part or the middle part of the triangle here.



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So that's a quick trip through the why, what, and the how of the HEDIS transition journey, if you will, towards digital, and the way that we're thinking about it. And this is obviously a journey that started a couple of years ago and won't be over any time soon. But we think we're in a [00:55:00] critical sort of point to really take advantage of some of what digital has to offer in unlocking some of these capabilities.

I will finish there. And I know... I think it's Andy. I'll turn it to you for questions.

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Andy Reynolds:

I'll jump in. I hope I've been spotlighted so that you can hear me. Thank you, Brad. Thank you to our other presenters. [00:55:30] I'll ask our presenters to stick around. We're coming up at the top of the hour, but if you have time, we do have some questions. I will invite Anne and Sarah, our presenters, all to please turn your cameras on if you have not already.

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Let me point out a couple of things. First, that recording of Brad was for HUG, which stands for the HEDIS Users Group. That's a special group of expert users of HEDIS, people who are very interested in HEDIS. They get special access, [00:56:00] early access, to leaders like Brad. If joining the HUG is something you might be interested in, we'll pass along a link to that.

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Also, let me point out that our colleagues in our education would want you to know that webinars have been great during the pandemic. However, many people crave in-person interaction. And we're getting back into that in a big way 13 months from now. Our new Health Innovation Summit will be in Washington, D.C., October 31st [00:56:30] into the first few days of November 2022. So mark your calendars. Claim your budgets. We're getting back into in-person instruction much bigger than we've had before.

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Why don't we jump to questions? Sarah, I think this one will be best for you. One of our viewers observes that, "We know that utilization of care fell. For example, even though performance on childhood immunization improved, this was likely on a significantly smaller [00:57:00] base of children eligible for the measure." Can you comment on that, Sarah? What are your thoughts about that significantly smaller base in the measure?



614 Sarah Shih: Yes, we've been asked that question about the denominator composition for several of the  
616 measures. So we see no change or potential increase as well as the decreases. And because of  
the way we get our data, we cannot disaggregate or know about who's in that denominated  
population.

618 But the denominators did not decrease over time, compared [00:57:30] from 2020 measurement  
year from 2019, for the most part. So we would appreciate your observations on this piece  
because we don't have the visibility specifically around that denominator. Thank you.

620 Andy Reynolds: Thank you, Sarah. Brad, or maybe Anne, you might want to tackle this one. A viewer asks, "We,  
622 as a health plan, purchased digital measures. The question is: What software is needed to run or  
test the CQL code? Can NCQA provide an implementation [00:58:00] guide?" Brad or Anne, your  
thoughts on that, please?

624 Brad Ryan: Happy to try to address that one. Even at the end of the presentation I gave, you heard me  
626 reference both the content that's evolving for digital measures and the delivery mechanism. So  
the reference, the question is about the CQL measure specification, which really is the content.

628 To [00:58:30] answer that question: It does require some infrastructure, like a CQL execution  
630 engine. There are some HL7 FHIR standard implementation guides, and NCQA does have some  
resources in our digital measure community and elsewhere along with the measures that can  
help with that implementation. But over time, we are seeking to provide products that include both  
the code, the content, and some of the tooling [00:59:00] and software that's required to use it.

632 I think the question was asked anonymously, but if you would like to reach out, we are actively  
634 looking for partners for helping us pilot and define what that product is going to look like. We're  
sort of in development, so I'd be interested to hear from organizations that are interested in  
implementing those digital measures within your infrastructures.

636 Andy Reynolds: [00:59:30] Thank you, Brad. Oh, go ahead.

638 Anne Smith: I'm just going to throw in there, Andy, too, that if in those digital measure packages you go to the  
end of what is called the Implementation Guide, you will find some links that will help you as well.

Andy Reynolds: Thank you, Anne. Implementation Guide: Good tip.

640 Sarah, let's bounce back to you. A viewer notes that, "COVID vaccines are having a huge  
642 negative impact on completing breast cancer screening mammograms. [01:00:00] What do you  
recommend for health plans if they're not able to help members get their mammograms done in  
2021?"

644 Sarah Shih: So measurement wise, I apologize, but I don't think there's much we can do differently. But I  
646 think, from a public health perspective, and trying to make sure that your members receive  
messaging that breast cancer screenings are important, think about maybe messaging around  
648 the safety if they have safety concerns, or potentially [01:00:30] prioritizing populations in which  
prevention is really important.

650 But in terms of measurement: Do the best you can. I suspect, if you're seeing decreases or  
652 inability for your members getting mammograms, others will be experiencing similar. But we will  
be monitoring closely if there are regional differences or differences across those that are able to  
report. So thank you for that question.



654 Andy Reynolds: Thank you, Sarah. [01:01:00] I am intrigued by a question that a viewer asked very early in the  
656 session, and it has to do with the connection... or any predictions about the connection... between  
real-time analytics and predictive medicine. So that's a big picture item. Peggy, Brad, do you  
have any thoughts about how what we've talked about today connects to real-time care, and how  
that connects to predictive medicine?

658 Peggy O'Kane: I'm not sure [01:01:30] what's meant by "predictive medicine." You know? I'm just not sure what  
660 term of art that is. There are contexts for predictions in medicine, but I think what we're talking  
about is having at the point of care the information you need, and even in the future, having  
guideline driven suggestions. I mean, that happens today, but really not in many contexts.

662 So people are trying [01:02:00] to deliver care without having the information they need right in  
664 front of them. So we're talking about a context where they would have it right in front of them. And  
Brad, please, why don't you add some color to that if you want to?

666 Brad Ryan: Yeah. I think the notion of using a measure in a care gap to provide something that's, quote,  
"real-time," or near real-time is almost a misnomer. Right? It implies that there was already  
something that should have happened.

668 [01:02:30] We would like to get more proactive about identifying the actions that need to take  
670 place in providing some of that guidance. And it really should go hand-in-hand with the measure.  
Right? The measures are based on guidelines. The guidelines should be something that can be  
672 implemented and or predicted at the time when a patient or their provider is engaged with that  
patient's care. And so that's the type of content that we imagine extending as we [01:03:00] think  
674 about moving HEDIS closer to the clinical concepts, closer to clinical data, and closer to the point  
of care.

676 Andy Reynolds: Got it. Thank you. I see we're about five minutes over time. I suggest we wrap up now. Again,  
thank you to our speakers for being with us. Thank you to our audience. Thank you for joining.

678 Peggy O'Kane: And thank you all for coming. Thank you. And thank you to all the presenters. A nice job, thank  
you.