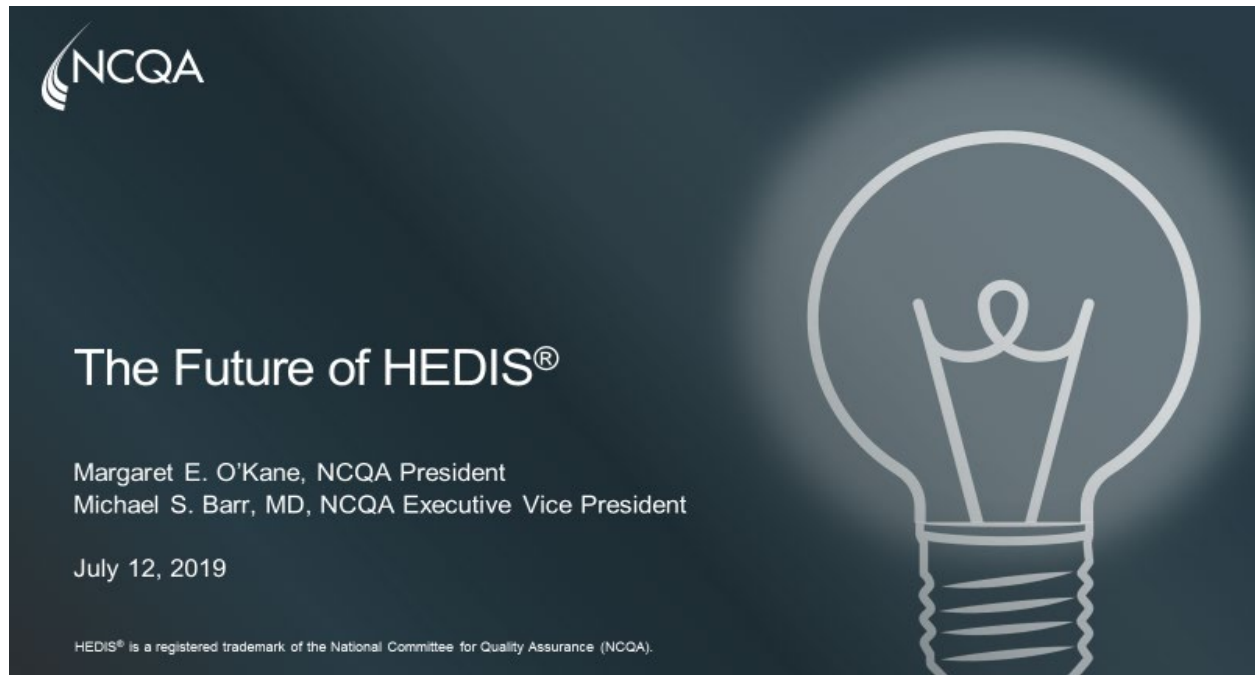


# Transcript: The Future of HEDIS

## July 12, 2019

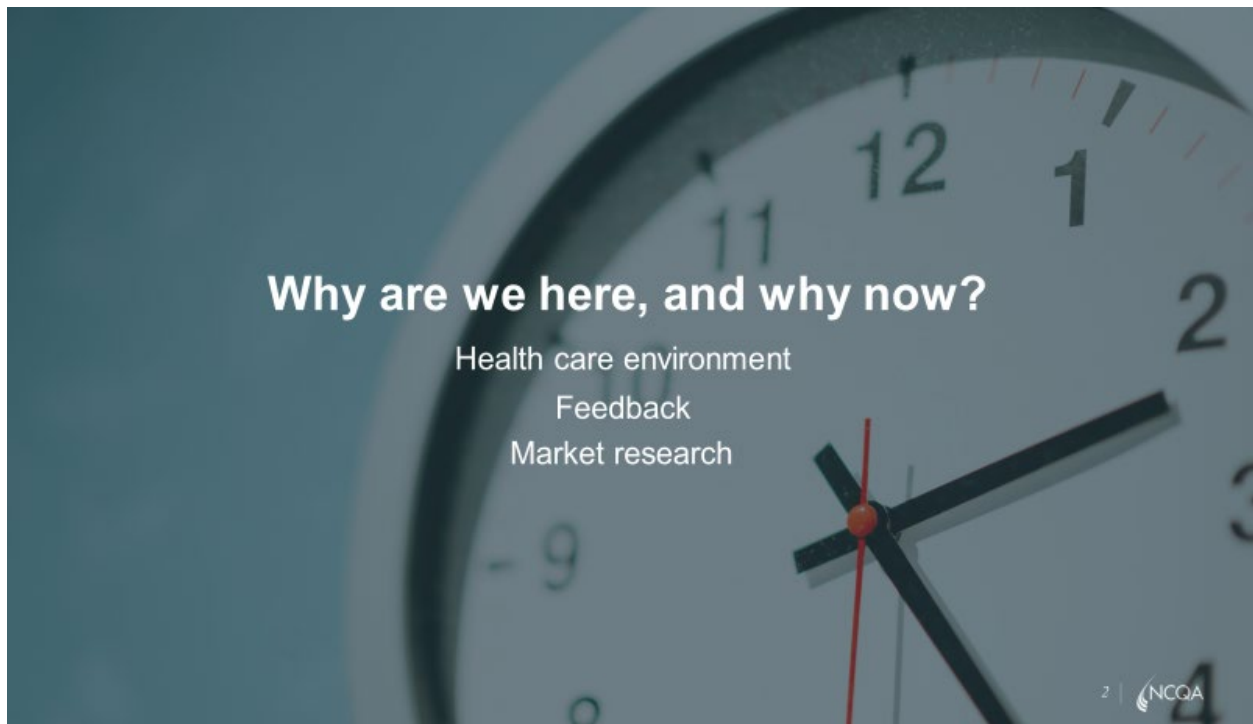


2 *Please note: This transcript has been lightly edited to facilitate reading spoken statements in writing.*

### 4 **Speakers**

6 Peggy O'Kane, NCQA President  
6 Michael Barr, NCQA EVP, Quality Management and Research Group  
6 Andy Reynolds, NCQA AVP, External Relations  
8 Ben Hamlin, NCQA Lead Research Scientist  
8 Mary Barton, VP, Performance Measurement  
10 Sepheen Byron, NCQA AVP, Performance Measurement  
10 Suzanne Porter, NCQA Director, Measure Validation  
12 Patrick Dahill, NCQA AVP, Policy

14 Peggy O'Kane: I want to welcome the many people who are on the WebEx and thank you for  
16 taking the time on a Friday afternoon in July to walk through this presentation  
16 with us. We've been talking to many of you in smaller groups for over a year now  
18 as we've been trying to cross the future of performance measurement at NCQA.  
18 So, why are we doing this [00:00:30], and why now?



- 20 Peggy O’Kane: I don’t need to tell you that the health care environment is changing rapidly.  
22 There are many issues and we’ll talk more about those, but to name a few, we have more accountable entities, there’s more data out there and lots of questions, and we also have issues with the current environment of inefficiency.
- 24 Peggy O’Kane: We’ve gotten feedback from a number of you [00:01:00]. We’ve done market  
26 research. We’ve had a market researcher—a third-party—who’s talked to a number of plans, IT companies that are engaged with you, auditors and so forth.  
28 We start this with some understanding of what you’re thinking, but really I think this is the first time we’ve tried to communicate it to a broad audience. Thank you [00:01:30] for engaging with us.

## NCQA Measurement Goal

Relevant measures that emphasize effective, efficient care with minimum burden

- ▶ **Why** **Better data** present new opportunities  
**Burden** threatens measurement's utility, viability
- ▶ **What** Measures that **matter to patients, payers and government**  
Measures that speak to **outcomes** and **social risk**
- ▶ **How** Capitalize on **electronic data** generated as a by-product of care  
Build measures from **standardized** components

3 | NCQA

Peggy O’Kane: Our measurement goals are, as always, to have relevant measures that emphasize effective and efficient care with minimum burden. Why are we changing the way we’re doing it? Well, our data present new opportunities. Now, I have to immediately give you the caveat that although the better data are out there, sometimes it’s very hard to get at it. We are well [00:02:00] aware of the limitations of the current data environment and the current care delivery environment.

Second, burden threatens measurement’s utility and viability. Every day, we think about beleaguered practitioners who are calculating performance measures in different ways for different audiences. We understand that it threatens the future of [00:02:30] performance measurement to have this much inefficiency in the environment.

Peggy O’Kane: So, we want measures that matter to patients, payers and government. They may not all have the same interests, but they all need to be engaged. And we need measures that speak to outcomes and to social risk—which we’ve learned, in the last few years, really drives a lot of those outcomes. How are [00:03:00] we going to do that?

Peggy O’Kane: We’re going to capitalize on electronic data that’s generated as a byproduct of care. A byproduct of care is quite different from, “I do the care now and I calculate the performance measures later.” This is kind of a futuristic statement, but it is very clearly where we want to get to, and we know you all want to get there, too. And we want to build measures from standardized components. We have many “standard [00:03:30] setters” out there and NCQA is going to speak

54 the lingua franca of the data world. This is obviously a tall order, for us and for everybody who works with data.

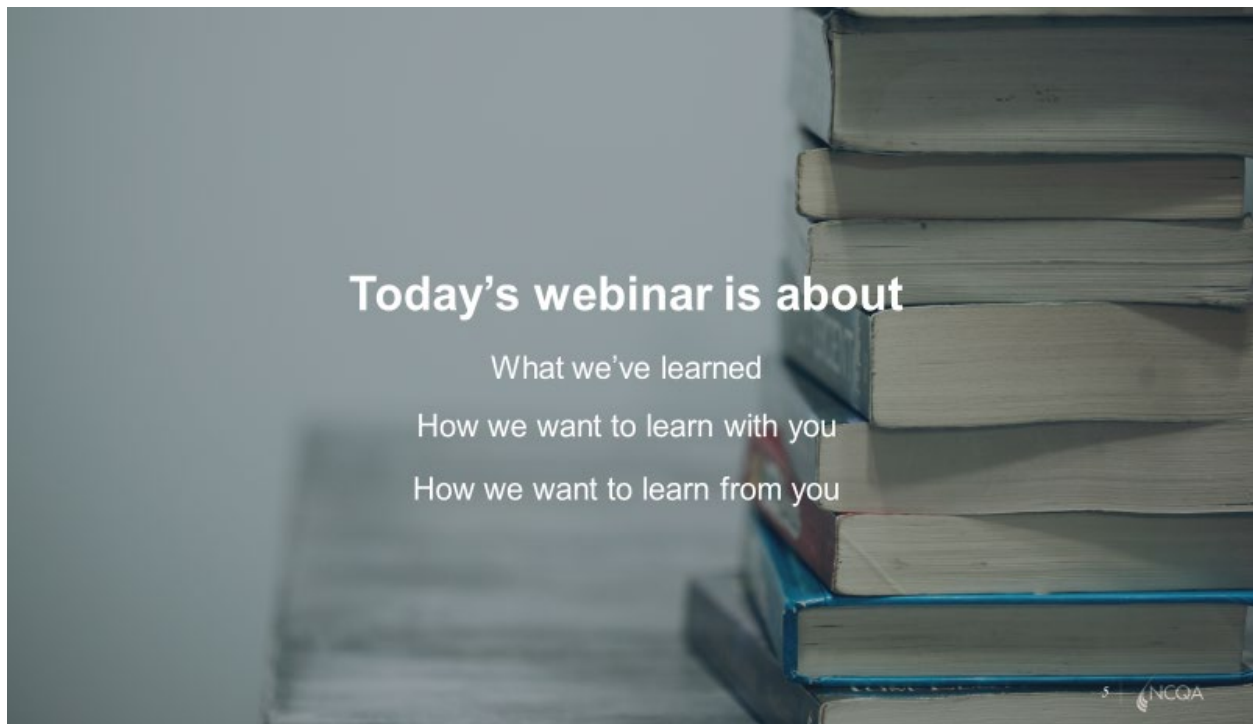
56 Peggy O'Kane: To recap, we want to improve the utility and efficiency of data and we want to maintain the integrity of measures [00:04:00] throughout the system.

58



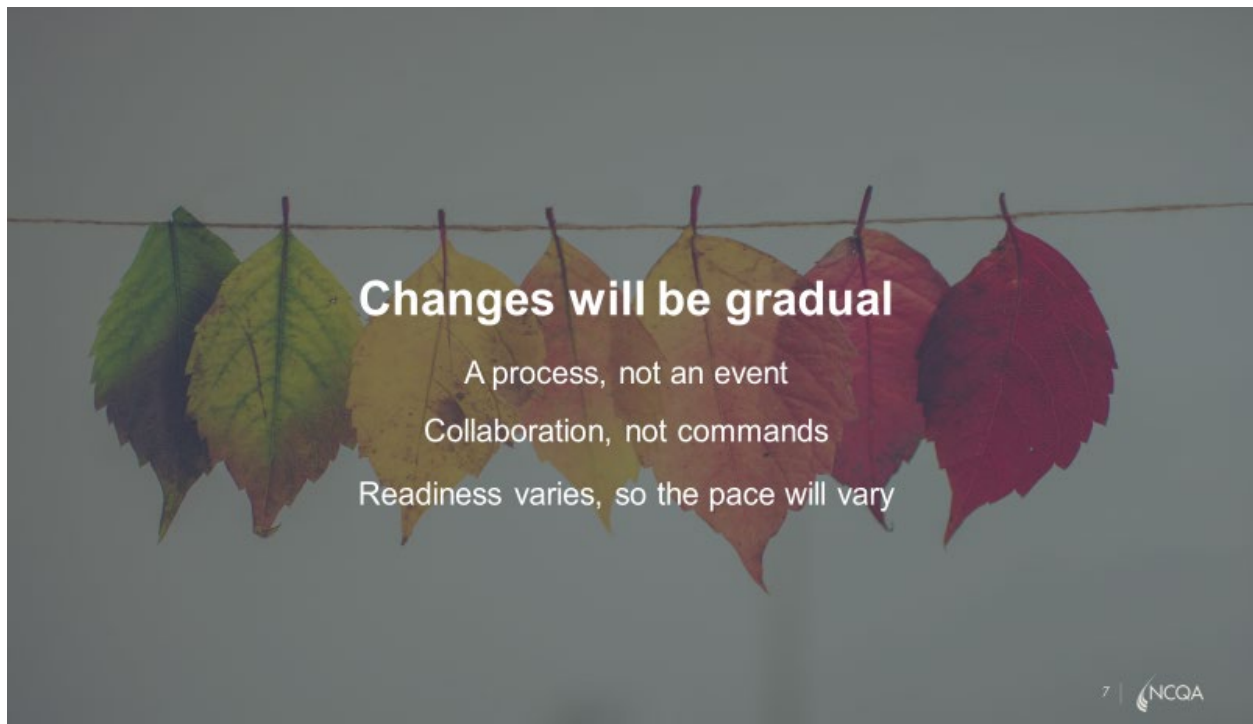
60 This is really important, especially as we are in a value-based environment where  
62 people are often paid for achieving certain levels of performance, and as we get to a prepaid health care environment, claims data will become less available.

64 What we're going to talk about today is what we've learned, how we want to learn [00:04:30] with you and how we want to learn from you.



66 We have no illusions that we have all the answers. I think collectively, we and the  
68 other people on this call, and others who aren't here today, are going to be  
70 blazing a trail—with all the uncertainty that comes with trailblazing. We thank you  
for your cooperation and for your feedback and [00:05:00] for all the things that  
have helped us keep this this movement on track for these many years.

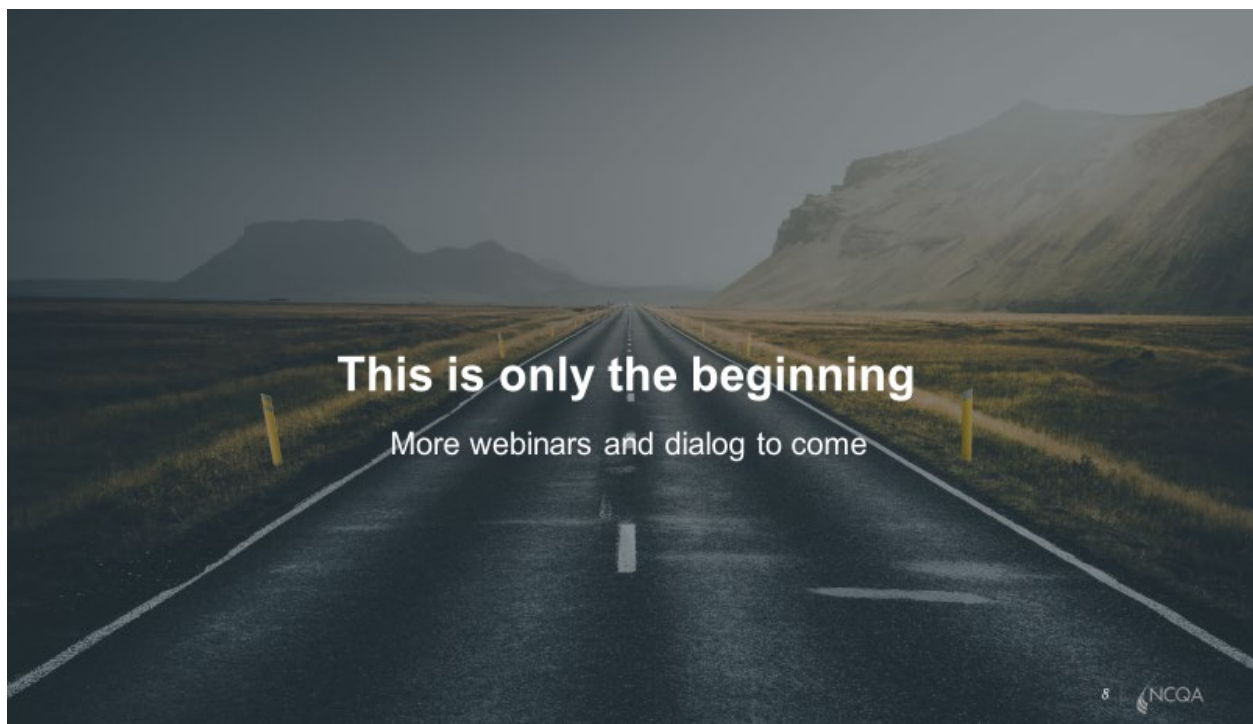
72 Peggy O'Kane: I also want to reassure you that changes will be gradual. Change is a process,  
not an event. It involves collaboration, not commands from NCQA. Readiness  
74 varies, markets vary. We're aware of all the variation on the ground, so the pace  
necessarily [00:05:30] has to vary.



76

The other point I want to make is this is only the beginning and we will be working very hard to be in dialogue with you through webinars and other mechanisms that Michael will talk about.

78




80 With that, I want to turn it over to Dr. Michael Barr, NCQA's Executive Vice President. Thank you, Michael.



Michael S. Barr, MD  
NCQA Executive Vice President

82



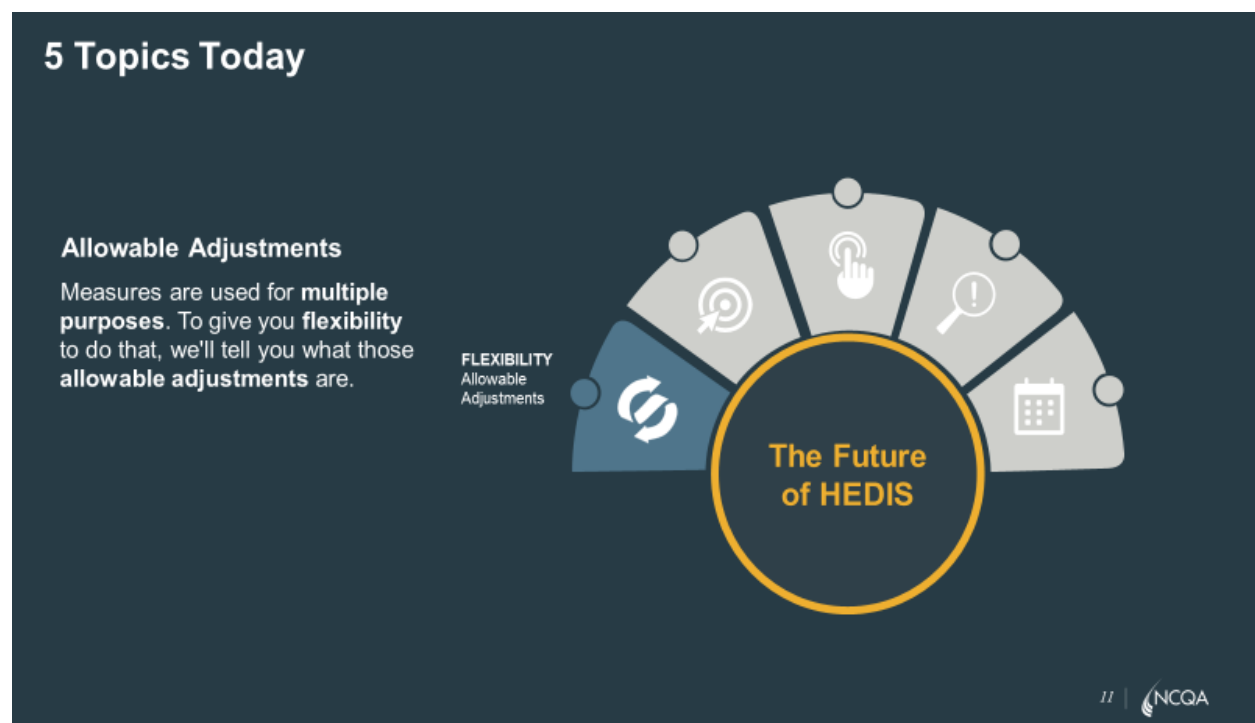
84 Michael Barr: Thank you, Peggy. And because I know all of you are interested, I want to make sure you are aware that all the slides and the recording of this webinar will [00:06:00] be made available next week.

86 There are five topics that I want to cover today. All five are what you might call  
88 the "HEDIS infrastructure" or how HEDIS works. They are not about the content  
90 of the measures or about what HEDIS evaluates. All the topics of the webinars  
and conversations Peggy O'Kane mentioned will happen later. I'm going to go  
through them quickly and come back to each one with more detail.





92 Michael Barr: [00:06:30] Allowable adjustments are associated with new flexibility.



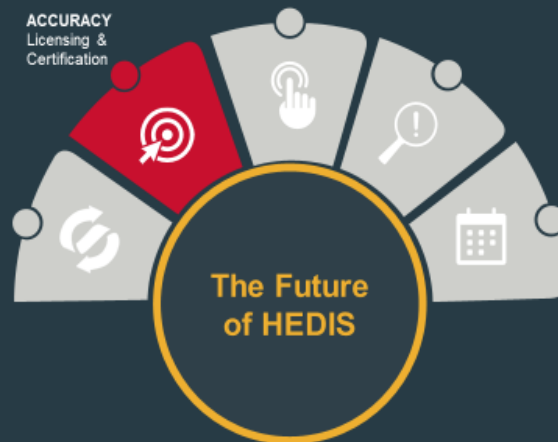
94 Michael Barr: Licensing and certification provide the accuracy we need.



## 5 Topics Today

### Licensing and Certification

Then, we'll make sure uses of our measures are **accurate** and **reflect the quality** of the care you provide.



12 | NCQA

- 96 Michael Barr: Digital measures help reduce implementation time, human errors and non-standardization.

## 5 Topics Today

### Digital Measures

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



13 | NCQA

Michael Barr: Electronic clinical data systems, or ECDS, help generate new insights about quality and are later generated as care is delivered.

100



102 Michael Barr: A schedule change will give you access to HEDIS specifications [00:07:00] much earlier in the life cycle.

104 For each of the five topics, I will cover the “what,” the “so what” and the “now what.” The “what” in each case answers the question of “what’s the vision” or “what’s the big idea?” The so what answers the questions that are always on people’s minds, “why should I care? What’s in it for me?” The “now what” is about next steps. Here’s what I [00:07:30] suggest you can do next.

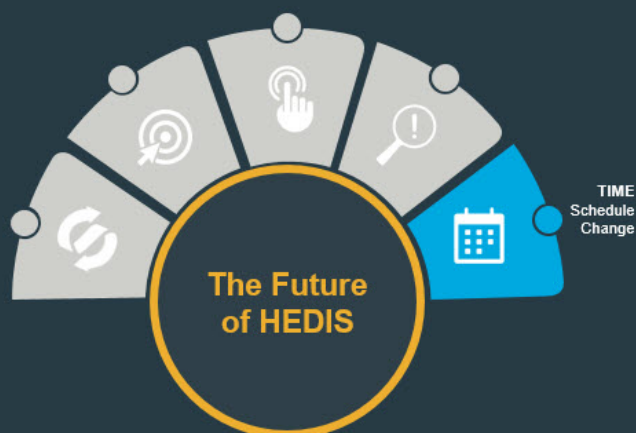
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108

## 5 Topics Today

### Schedule Change

And we'll do all of this **earlier** to give you more **time** each year.



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## What?

*"What's the vision?"*

## So What?

*"Why should I care?"*

## Now What?

*"What's my next step?"*

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110

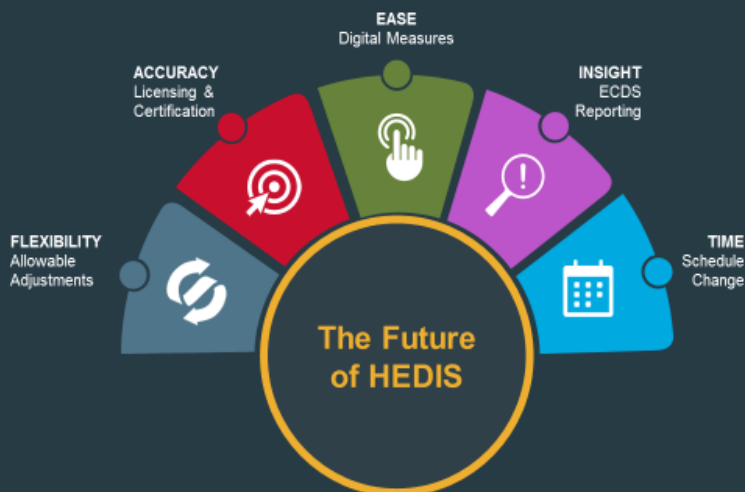
Michael Barr:

112

Let's get into more detail about the future of HEDIS: more flexibility, accuracy, greater ease, insight and time.

## 5 Topics Today

Now let's get into the details...



17 | NCQA

114 Michael Barr: Here's the "what" for allowable adjustments.

## Allowable Adjustments

*What? "What's the vision?"*



Adjust measures

Keep clinical intent

Use HEDIS at different  
levels of system

18 | NCQA

116

We introduced allowable adjustments a year ago when we released HEDIS 2019. Now that people use our measures for multiple purposes, they don't always maintain the integrity of the measures; therefore, we developed allowable adjustments to help you adjust measures [00:08:00] without changing the clinical intent. Allowable adjustments are also how you can use HEDIS at different levels of the health care system and for purposes other than health care... health plan reporting.

## Allowable Adjustments

*What? "What's the vision?"*



*Examples: Adjustments applicable to most measures.*

Product lines

Enrollment criteria

Measurement period

Required benefit

Population subsets  
(groups, conditions)

Michael Barr: Here are examples of allowable adjustments. You can filter results by product lines, turn off enrollment criteria and focus on a population subset; for example, a narrower age range or demographic within the original measure specification.

## Allowable Adjustments

*What? "What's the vision?"*



*Examples: Adjustments that are not allowable.*

Numerators

Changes to value sets

20 | NCQA

128

Michael Barr:

[00:08:30] Here are examples of what we do not consider allowable adjustments, such as changes to the numerator logic or changes to value sets, because these changes may modify the measures' clinical validity and therefore are not permitted.

130

132

## Allowable Adjustments

*So What? "Why should I care?"*



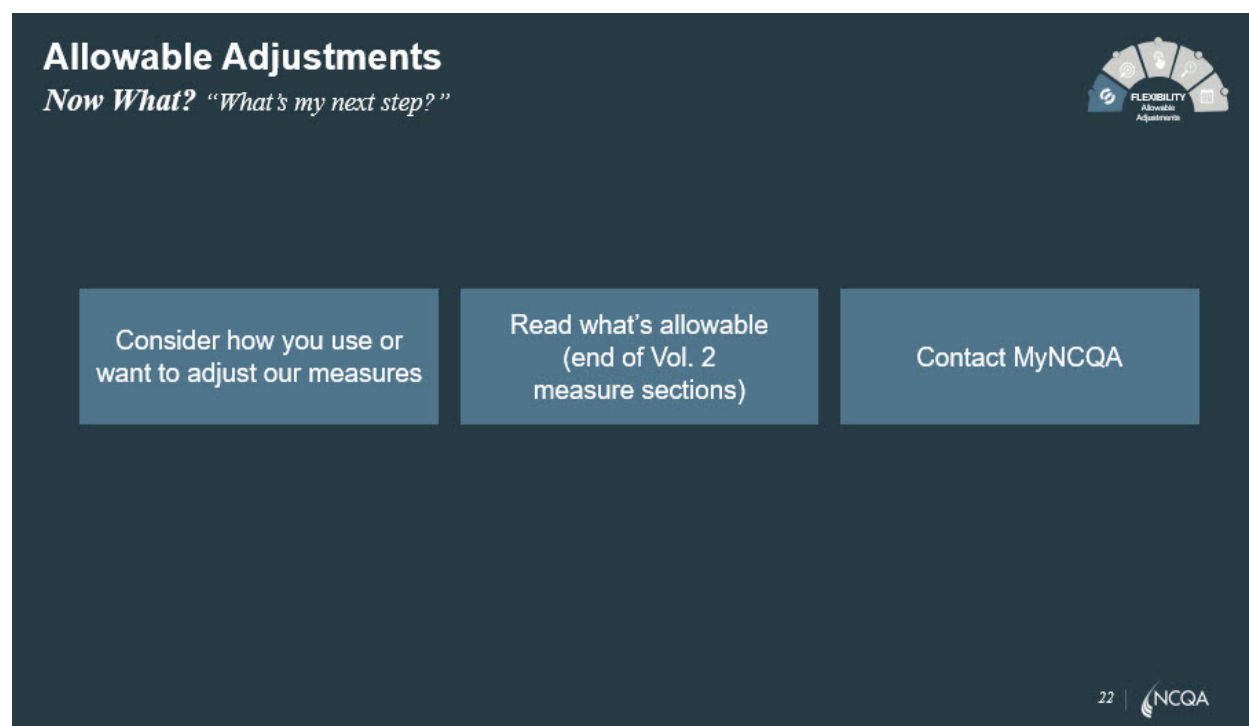
Customize *correctly*

Study gaps in care

Reduce burden

21 | NCQA

134 Michael Barr: "So what"; why should anybody care? Allowable adjustments help you use  
136 measures correctly, while adhering to the underlying clinical guideline for that  
138 given space. All of our adjustments give you the freedom to use HEDIS  
140 measures [00:09:00] within delivery systems to guide clinical interventions and  
142 close gaps in care. We think this will help reduce the burden of measure  
collection and reporting by explicitly defining allowable adjustments. NCQA  
hopes to deliver the variation you currently see in the measures and align core  
clinical concepts and definitions across practices, networks and health plans. In  
other words, everyone will be assessed on the same clinical concepts derived  
from the same evidence base.



**Allowable Adjustments**  
*Now What? "What's my next step?"*

Consider how you use or want to adjust our measures

Read what's allowable  
(end of Vol. 2  
measure sections)

Contact MyNCQA

22 | NCQA

144

146 Michael Barr: [00:09:30] What's the next step? Think about how you use our measures or  
148 might want to adjust them. We encourage you to read details about allowable  
150 adjustments or at the end of the measures section in HEDIS 2020 line 2, which  
152 we released on July 1. You can also contact us at My.NCQA with questions. The  
same time allowable adjustments expanded uses of HEDIS at different levels of  
the health care system, we need to ensure that the use of the measures is  
appropriate and [00:10:00] the results produced are accurate, by expanding our  
licensing and measure certification packages.



## Licensing & Certification

*What? "What's the vision?"*



All HEDIS users need  
a license agreement

Commercial services based on  
HEDIS also need certification

- 154 Michael Barr: HEDIS is NCQA's intellectual property and using HEDIS measure specifications  
156 requires a license agreement with NCQA, which is used internally for quality  
158 improvement within your health plan or delivery system. We count that as  
160 noncommercial use. The standard license agreement will instruct you on the  
162 NCQA store. If you are a health plan that uses [00:10:30] internal software to  
164 record HEDIS, your plan software must be certified by NCQA or you must  
contract with a certified software vendor no later than 2021, with HEDIS reporting  
in 2022. Any software used to calculate or report HEDIS measures or rates must  
have a separate HEDIS license and be certified by NCQA. To put it another way,  
if you self-service a software that uses HEDIS measures, you must first receive  
NCQA measure [00:11:00] certification to demonstrate that how it will use our  
measures meets our standards.

## Licensing & Certification

*So What? "Why should I care?"*



Accuracy, reliability

Trust in value-based  
payments

Apples-to-apples  
comparability

24 | NCQA

166

Michael Barr:

168

170

172

“So what?” The point in licensing and certifications is to help you ensure HEDIS results are accurate, reliable and can be used for all the purposes you intend—most importantly in improving clinical care. Our priorities confirming the measure calculations are based on accurate measure specifications. Measure accuracy should be a priority because value-based payment models use quality [00:11:30] measure results that direct fully into dollars and payments. It’s vital that all parties trust the underlying calculations.

174 Michael Barr:

176

By earning measure certification, as organizations know the information systems calculating HEDIS results, have passed the industry’s most rigorous assessment. This also means that everyone in value-based contracting can have confidence in “apples to apples” comparability of different organizations’ HEDIS results.

## Licensing & Certification

*Now What? "What's my next step?"*



How do you use HEDIS?

Commercial Users:  
MyNCQA> Ask a Question>Orders>  
Custom License Agreement

25 | NCQA

Michael Barr:

[00:12:00] "Now what?" Consider how you use HEDIS. If you use HEDIS for internal quality improvement noncommercial use, a license you get from the store when you buy Volume 2 is all you need. If you use is anything other than that, go to My.NCQA and look for the custom license agreement link under ask a question and orders. NCQA staff will be happy to work with you on an agreement for licensing and certification.

## Digital Measures

*What? "What's the vision?"*



Digitalized versions of  
existing measures that use  
traditional reporting

Measures written as  
computer code  
(machine-readable)

Download measures directly

- 186 Michael Barr: Moving on to digital measures, what's [00:12:30] the vision? What do we mean  
188 when we say "digital" measures? Right now, I'm talking about digitalized versions  
190 of existing HEDIS measures that many plans currently report the traditional way.  
In a few minutes, I'll talk about [ECDS 00:12:44] measures, which are also digital  
but reported differently.
- 192 Michael Barr: In October, NCQA will release eight HEDIS 2020 digital measures for traditional  
194 reporting. These will be machine readable and downloadable from the NCQA  
store, and we plan to release [00:13:00] more measures in digital format for  
traditional reporting each year.

## Digital Measures

*So What? "Why should I care?"*



Easier transfer of measures  
into your IT system

Reduce interpretation,  
recoding, human error

Standardize to ease use  
across care continuum

27 | NCQA

- 196 Michael Barr: Digitalization means NCQA writes measures as computer codes, so you don't  
198 have to. It eases the need for you to read, interpret and re-code measures. That  
200 means you avoid human error and non-standardization. Our digital measures  
202 follow industry standards, so HEDIS is easier to implement across the continuum  
of care. That consistency means providers measure themselves using the same  
clinical [00:13:30] constructs that they do when they report HEDIS results to  
health plans.
- 204 Michael Barr: For those watching today who are more technology oriented, you'll be interested  
206 to know that we currently use the quality data model. CQL or clinical quality  
language is the logic that ties together elements inside the data model. We are  
also exploring additional industry standards to ensure our measures remain  
aligned with others in the quality measurement field.

## Digital Measures

*Now What? "What's my next step?"*



Visit the NCQA Store to see  
digital measures

See announcement in late July  
re: measures available in October

28 | NCQA

Michael Barr: You can [00:14:00] see descriptions of the digital measures in our store. Look for an announcement at the end of this presentation about the specific digital measures we intend to release in October. You can pre-order them now.

## ECDS Reporting

*What? "What's the vision?"*



A type of digital measure

Report clinical data according  
to data source

29 | NCQA

Michael Barr: Moving on to ECDS: ECDS brings all the efficiencies of digital measures I spoke about a few minutes ago, and we are into clinical quality measurement toward greater use of electronic clinical data. ECDS measures encourage use of clinical information [00:14:30] from many sources, not just electronic health records, because we anticipate more clinical data will become available. We believe ECDS is the future of clinical measurement, and combining claims data with data from EHRs, health information exchanges and other electronic sources can provide more complete results and better insight into the quality of care being delivered to individuals and groups.

## ECDS Reporting

*So What? "Why should I care?"*



Leverages more and better data  
into greater insight

Fosters patient-centered care

Michael Barr: For example, the current breast cancer screening measure specifies an age range as exclusions [00:15:00] but does not account for risk profiles or patient preferences very well. An ECDS measure could include all the logic of clinical diagrams. We can ensure with one measure that women get the screening appropriate to their unique clinical conditions, needs and preferences. Medicine is moving toward more customized clinical guidelines and our view of the future is for measurement to reflect that.

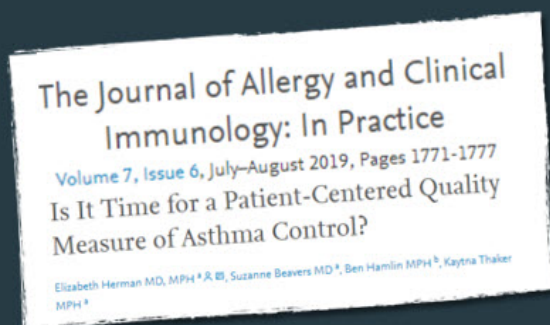


## ECDS Reporting

*So What? "Why should I care?"*



*ECDS helps make care patient-centered*



*"NCQA has developed the HEDIS **ECDS** program, a first step toward providing a **more complete picture of patient experience** of care and the quality of care received. Coordination across technical, clinical, and patient groups and better coordination across EHR vendors can help when developing an asthma control quality measure using complex clinical data and patient inputs."*

31 | NCQA

Michael Barr:

ECDS [00:15:30] is electronic clinical data systems. Ben Hamlin, one of the architects of our ECDS strategy is a co-author of this recent article in the *Journal of Allergy and Clinical Immunology* that makes a case for ECDS as a way to measure asthma control. We recommend the article to you.

## ECDS Reporting

*Now What? "What's my next step?"*



Order ECDS measures for  
download on July 15

Report ECDS measures

Join Digital Measurement Community  
([ncqa.org/dmc](https://ncqa.org/dmc))

Share experiences about  
ECDS reporting

32 | NCQA

- 236 Michael Barr: We know that several health plans already have connections to electronic health  
238 records, use data aggregators or health information exchanges, immunization  
[00:16:00] registries and case management systems to support traditional HEDIS  
240 reporting. That's going to help you as we segue into ECDS reporting. We also  
242 know many plans are trying to build these connections but may only be able to  
244 access data from parts of their network. That is why we are collaborating with  
246 plans to understand their experiences with ECDS and one of the reasons ECDS  
248 measures are voluntary. We invite you to report the 11 ECDS measures for  
voluntary reporting that we announced July 1 [00:16:30] and that will be available  
for download on July 15. Among those 11 are 3 existing measures to which we  
added ECDS reporting—Breast Cancer Screening, Colorectal Cancer Screening  
and Follow Up for Children Prescribed ADHD Medication. Also, we are  
particularly interested in having health plans report these measures through both  
traditional and ECDS methodologies, to help inform our ECDS strategy.
- 250 Michael Barr: We also urge [00:17:00] you to join our Digital Measurement Community—a  
252 forum where you can share ideas and best practices about using clinical data  
and quality measurement. We'll also announce future opportunities for you to  
254 engage with NCQA, such as through pilots. [00:17:13] or learning collaboratives.  
You can register for the digital measurement community at the URL on the  
screen, [NCQA.org/dmc](https://www.ncqa.org/dmc).

## Schedule Change

*What? "What's the vision?"*

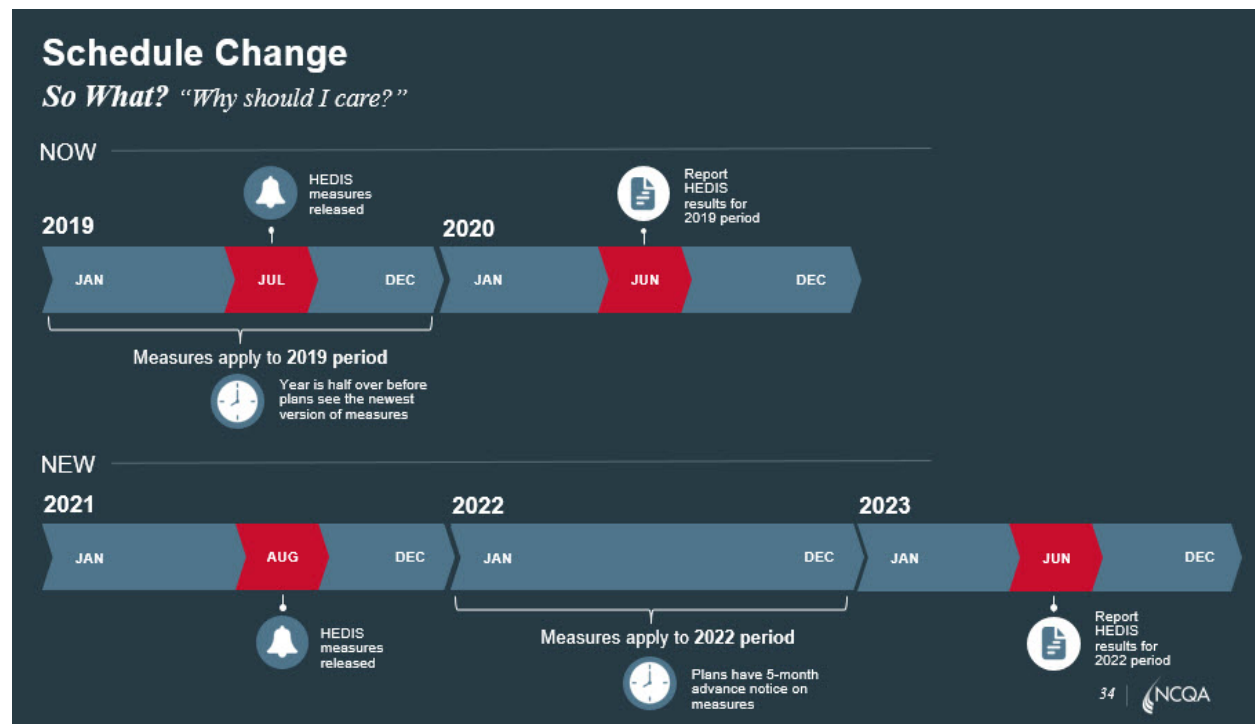


Current: 6-month lag  
(Jan-Dec measures = July notice)

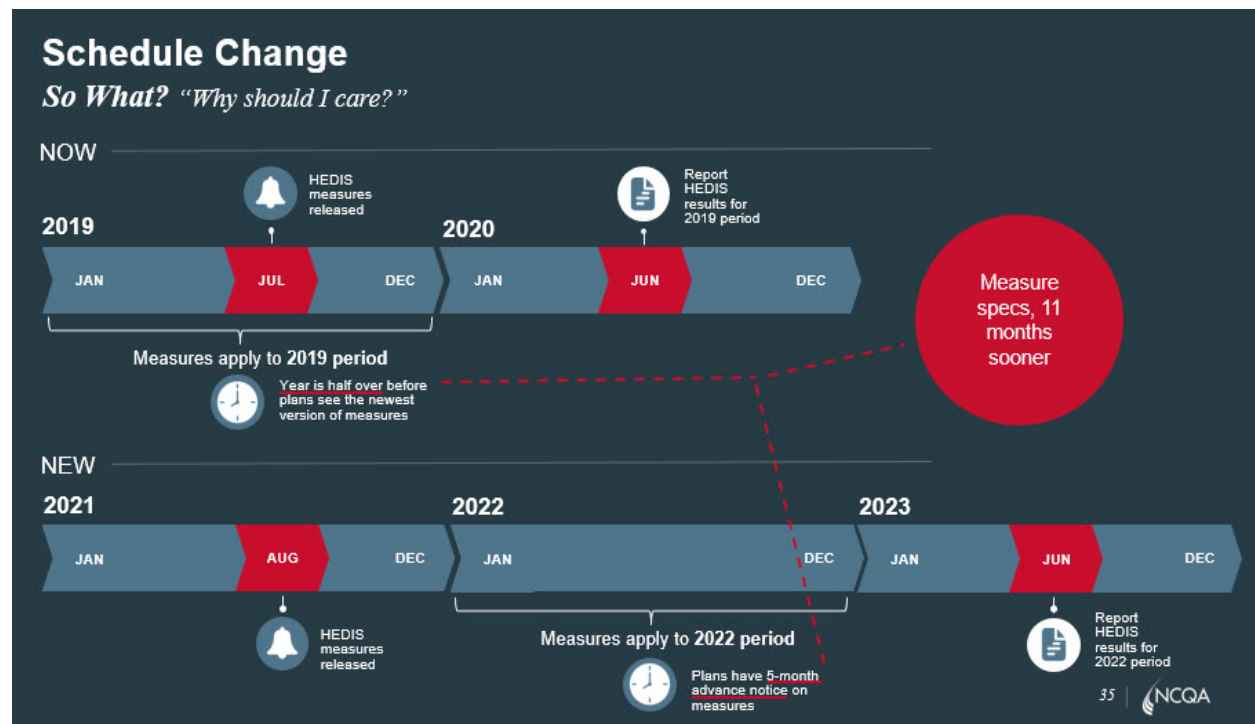
Future: 5-month head start  
(Jan-Dec measures = *prior* Aug notice)

- 256 Michael Barr: And now the last topic, a change to the HEDIS schedule. What's the big idea?  
258 [00:17:30] We are changing when we specify measures that apply to a  
measurement period. Let me show you what I mean.

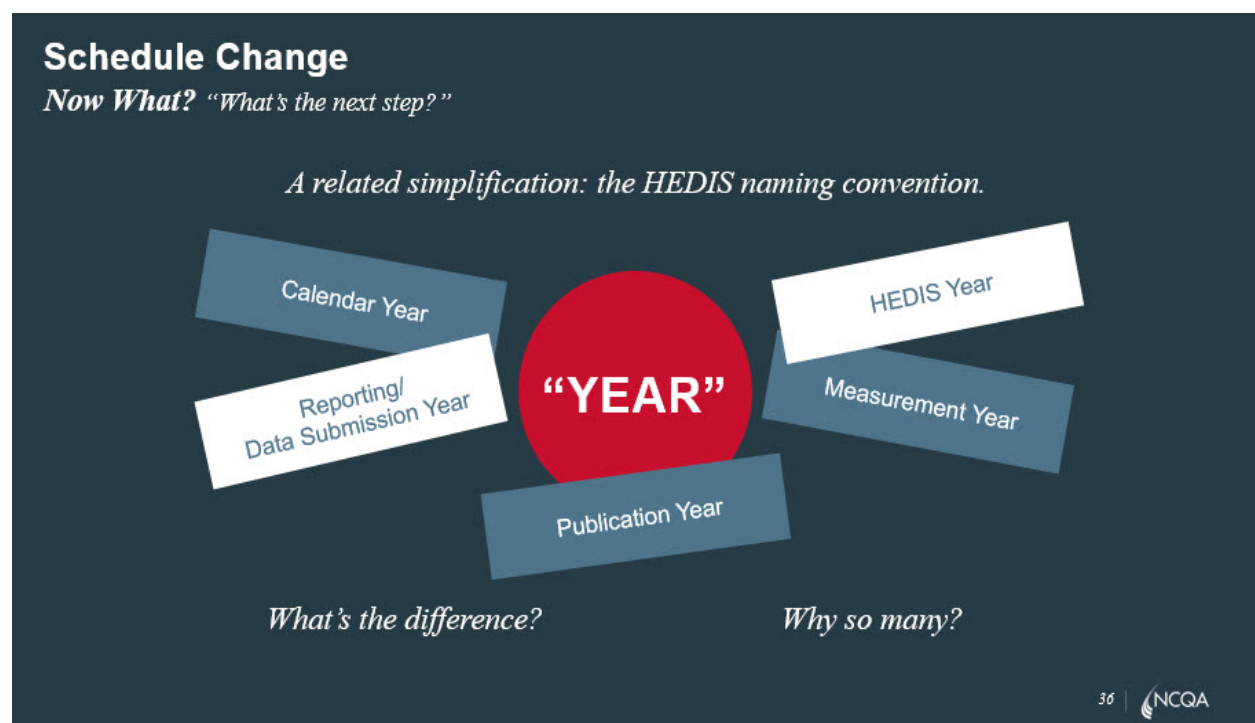
260



- 262 Michael Barr: Our traditional schedule is to release measure specs with HEDIS Volume 2,
- 264 halfway through the year, at which time specs are to be used. For example, the
- 266 measures released in July 2019 apply to services for this entire calendar year, January 1–December 31, 2019. [00:18:00] The measurement year is half over before plans know what they're expected to report. This 6-month flag has been a feature of the HEDIS cycle for decades. We think we can do better.
- 268 Michael Barr: Now I'll explain why, and how. On August 1, 2021, we will release measures, but
- 270 these measures will apply to services in 2022. Health plans will have a 5-month
- 272 lead time on what the measures will be. Note that we are not changing the [00:18:30] HEDIS submission deadlines. Reporting the data will still happen in June of the year after the measurement year, as it always has.



- 274 Michael Barr: Why does this matter? The shift in our schedule will bring you certainty about measure specs sooner—11 months sooner. We think that the HEDIS community
- 276 will be happy to have this early clarity. We know that having a 5-month head start every year will help you plan ahead, improve care and close quality gaps.



Michael Barr: [00:19:00] We also know that the word “year” can mean at least five things in connection with HEDIS. So, while we’re shifting the HEDIS schedule, we’re also going to simplify the naming convention starting in calendar year 2020. The HEDIS naming year will be named based on the measurement year.

## Schedule Change

*Now What? “What’s the next step?”*

*Transition Year: Two HEDIS editions coming July 1, 2020.*

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

37 | NCQA

Michael Barr: This table shows how various parts of the annual HEDIS cycle will evolve. There’s a lot of information on one slide and we know it will appeal to auditors and others who have specific roles [00:19:30] in the HEDIS process. When you download these slides from a web server or watch the recording, here is the most important date that affects everyone who’s watching. On July 1, 2020, we will publish measures that will apply to measurement years 2020 and 2021. This will be the transition year.

## In Summary



38 | NCQA

## 5 Topics Today

### Allowable Adjustments

Measures are used for **multiple purposes**. To give you **flexibility** to do that, we'll tell you what those **allowable adjustments** are.

FLEXIBILITY  
Allowable  
Adjustments



39 | NCQA

292

Michael Barr:

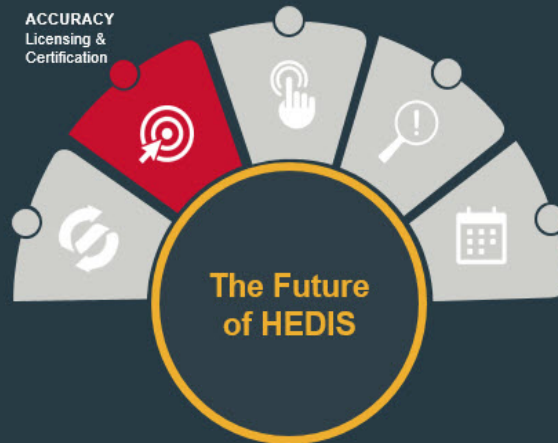
To sum up, allowable adjustments are associated with new flexibility. [00:20:00]



## 5 Topics Today

### Licensing and Certification

Then, we'll make sure uses of our measures are **accurate** and **reflect the quality** of the care you provide.



40 | NCQA

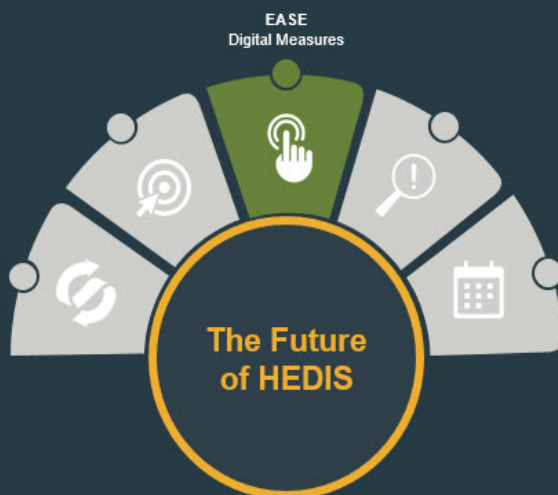
294

296 Michael Barr: Licensing and certification provides the accuracy needed.

## 5 Topics Today

### Digital Measures

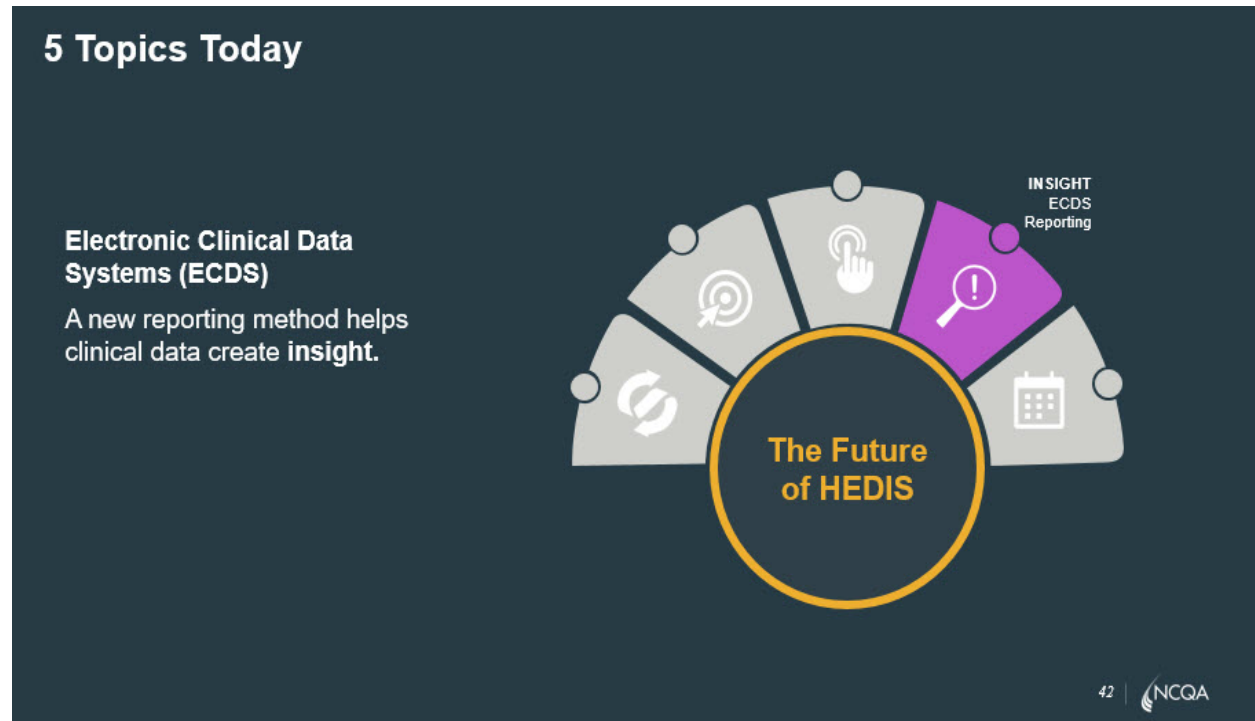
We'll start giving you measures in a **digital format** that's **easier** to work with.



41 | NCQA



298 Michael Barr: Digital measures help reduce implementation time, human errors and non-standardization.



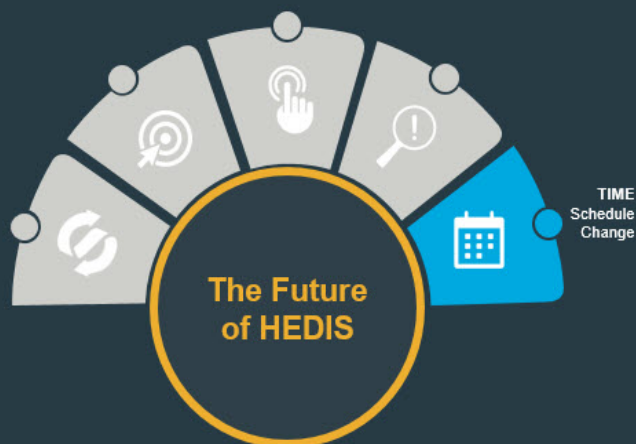
300

302 Michael Barr: Electronic clinical data systems help generate new insights about quality from data generated as care is provided.

## 5 Topics Today

### Schedule Change

And we'll do all of this **earlier** to give you more **time** each year.



43 | NCQA

304 Michael Barr: And the schedule change will give you access to HEDIS specifications much earlier in the cycle.

**This is only the beginning**

More webinars and dialog to come

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306

308

Michael Barr:

[00:20:30] This is only the beginning, as Peggy O’Kane said; there are more webinars and dialogue to come.

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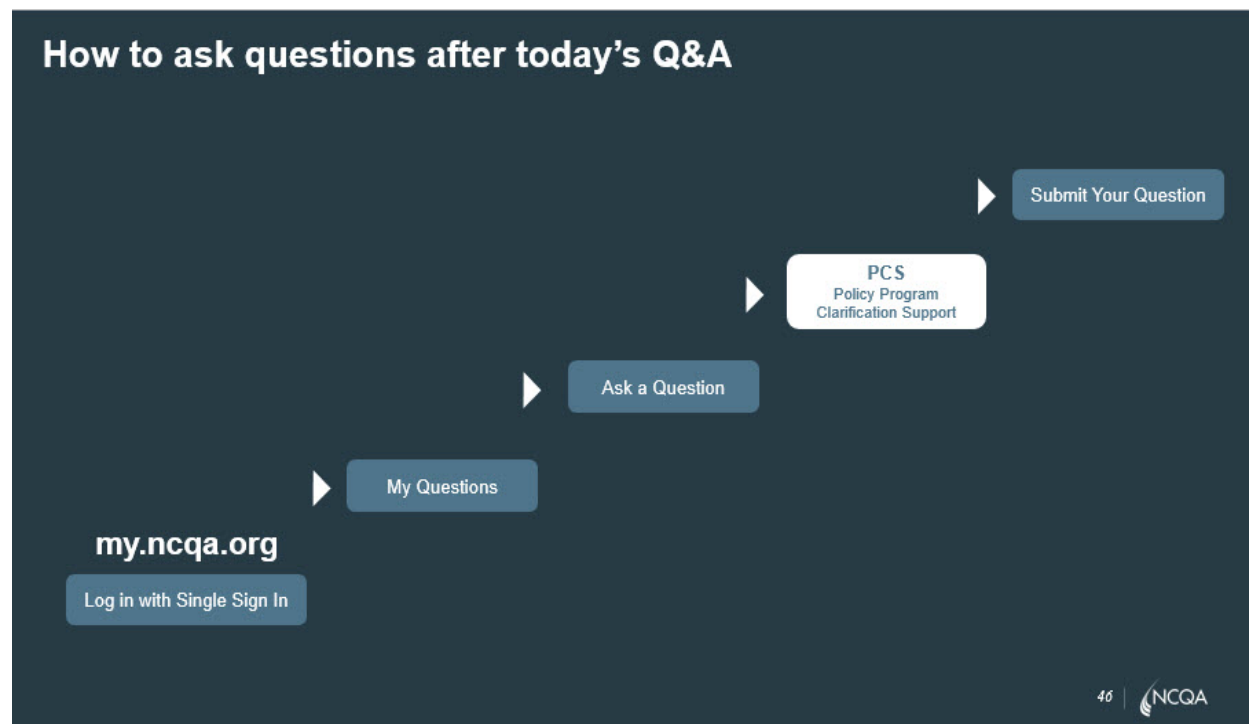


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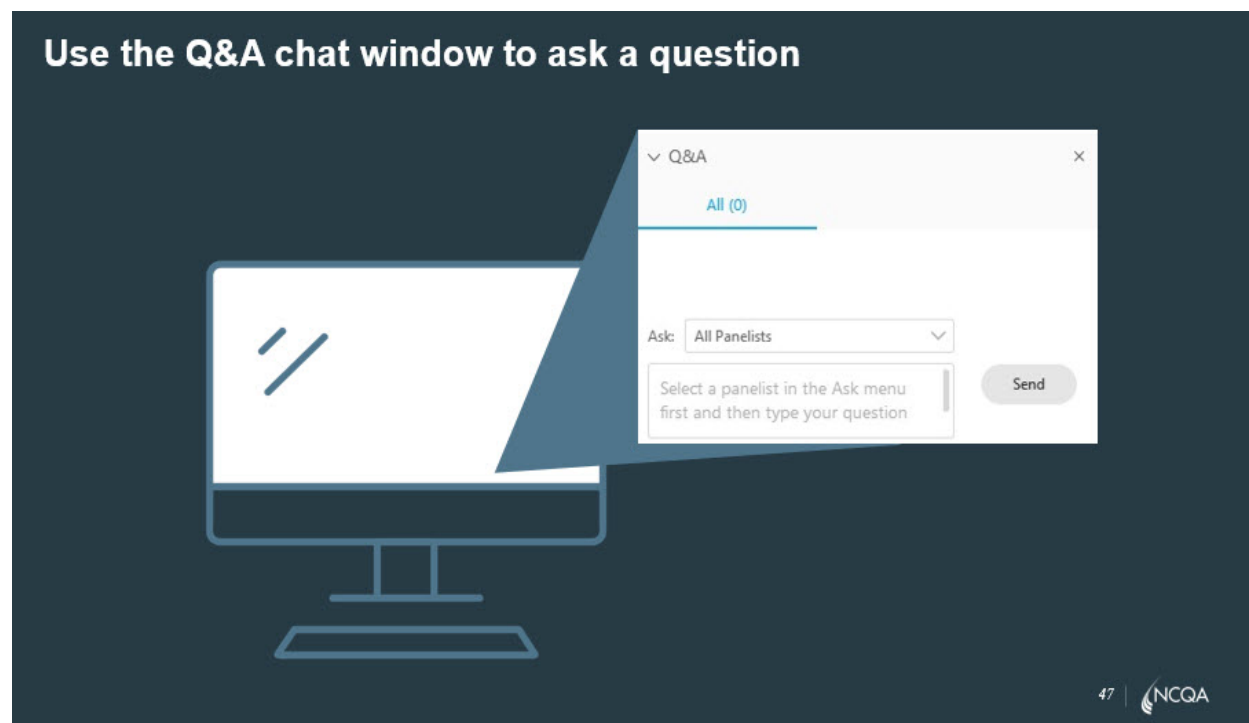
Michael Barr:

One of the nearest opportunities is our Health Care Quality Congress, which will be in Dallas in October. We encourage you to join us there; we look forward to meeting you.

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314 Michael Barr: And, to ask questions after today's session, you can log into My.NCQA, go to my  
316 questions, ask a question, go to the policy program clarification support  
[00:21:00] system and submit your question.



318 Michael Barr: If you haven't done so now during this presentation, we encourage you to submit some questions to the chat box on your WebEx screen.

320 Michael Barr: And with that, I'll turn it over to Andy Reynolds, who's going to moderate the Q&A.

322 Andy Reynolds: We have several questions. The first one is, "What is the relationship between these five topics and are they dependent on each other?"

324 Peggy O'Kane: I think that they are all part of the [00:21:30] movement of HEDIS toward a more digitalized implementation and so they are related, to some extent; they're part of a strategy. In that sense they are dependent on each other.

326

328 Michael Barr: They also help—we hope they help—make use of HEDIS measures closer to clinical care, more available, easy to implement, easy to understand, and leverage data that many of you are generating if you're in delivery system or collecting through health plan data [00:22:00] aggregators and so on—enhancing the value of the data and the bridges to data that are already being built to support clinical care.

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334 Andy Reynolds: "Can you say more about the relationship between digital measures and ECDS measures?"

336 Michael Barr: [crosstalk 00:22:20] to Ben Hamlin, the author of the article that I flashed on the screen.

338 Ben Hamlin: As Michael mentioned earlier in the slide deck, ECDS [00:22:30] are digital measures because they do take advantage of all the aspects that digital measurement can provide us. The difference is that a digital measure expressed through our traditional reporting methods is essentially an exact representation of what you might see on paper, so the use of a quality data model in the CQL language is essentially intended to replace the process of publishing a paper measures specification and then having [00:23:00] external clients translate and code that specification to produce the quality measure report for HEDIS.

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346 Ben Hamlin: Again, they are both very similar; however, the digital measures that Michael first mentioned in this presentation are essentially just a digital representation of the traditional paper-based measures. ECDS is a new reporting method that changes how [00:23:30] you submit measure results. We want to encourage use of clinical data and we have different rules and guidelines for those types of measures. Much of the data in the ECDS domain is packaged beyond what's available in administrative claims, whereas traditional measures rely much more on claims.

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354 Andy Reynolds: "How does your [00:24:00] approach align with the CMS use of the ECQMs for regulatory reporting, such as for [MIFS 00:24:05] and CDC Plus?"

356 Ben Hamlin: We intentionally made a decision to use the same standard; the MIFS measures use the quality data model as well as well as the CQL—the clinical quality language—so despite that, there are still differences in the measures, because the MIFS measures are reported at a practice level or provider level, whereas

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360 HEDIS are still at the population level for payers, [00:24:30]. But now they are  
362 speaking the same language, using the same data dictionary and the same logic  
model where there are commonalities between the measures. Theoretically, a  
vendor that can produce a MIFS measure would also be able to support HEDIS  
measures because they're speaking the same language.

364 Andy Reynolds: "What's going to happen to HEDIS hybrid measures?"

366 Mary Barton: [00:25:00] Our vision for the long term is that the use of these alternative sources  
368 of data would obviate the need for paper chart review. We realize that that day is  
not tomorrow, and we're really hard at work trying to figure out at the right  
pathway from today to that future—so we are interested in your thoughts, as well  
as the thoughts of many others we [00:25:30] have talked with so far.

370 Michael Barr: Do you want to say anything about the relative difference between the three  
372 measures that we've specified the ECDS reporting; one of which, I believe, has a  
hybrid corollary and we're trying to see how it works without a hybrid method.  
[crosstalk 00:25:51] [Byron 00:25:51].

374 Mary Barton: As you saw from the release we have just put out, we have three measures that  
376 get [00:26:00] reported traditionally in HEDIS—the breast cancer screening,  
colorectal cancer screening and ADHD measures that Michael mentioned earlier.  
378 Those will be reported in the traditional way, but we have also added the  
electronic clinical data systems reporting method to those measures, so for  
380 health plans that can voluntarily report that way, we might look to see if there are  
differences in the reporting and really understand how the data are flowing into  
382 HEDIS and work various ways. [00:26:30] We are keeping the hybrid measure  
reporting for those. Colorectal cancer screening is a hybrid measure, but we  
384 would like to see how the measures reported in ECDS format may or may not  
change the results that we see.

386 Andy Reynolds: "Will vendors be required to use the digital measure packages for 2020 or in the  
future?"

388 Peggy O'Kane: At no time—at least in our current envisioning [00:27:00]—will anyone be  
required to use the digital measures. This is an opportunity for folks who want to  
decrease effort on their side and to increase consistency on their side.

390 Michael Barr: I think the question is probably very specific to the digitalized versions of existing  
392 HEDIS measures, because the ECDS measures are currently only available in  
the digital measure format, downloadable [00:27:30] through the store. Correct?  
394 Right? As I mentioned earlier, we're going to continue to produce digitalized  
versions of our existing HEDIS portfolio measures for traditional reporting. Plans  
396 will still have—and vendors will still have—the opportunity to use Volume 2, the  
current method of programming them yourselves. We just think that using the  
398 digital measures will be easier, more accurate, less prone to error [00:28:00] and  
hopefully, will cut down on the costs associated with implementing those  
measures.

400 Ben Hamlin And the similar fits are there for the ECDS measures, for those who want to  
report those ECDS measures, the same downloadable format, digital version.

402 Andy Reynolds: "You mentioned HEDIS 2020 and HEDIS 2021 versions will be published on July  
404 1, 2020. Can we assume there will be two years that have the same specifications?"

406 Patrick Dahill: [00:28:30] Yes, that is the intent, and we'll have a similar process where we'll measure technical updates after that publication. The two years would be the same.

408 Andy Reynolds: "Building the infrastructure for digital and ECDS measures is going to require a  
410 significant investment. How can we know that the requirements will not change, therefore making the work obsolete?"

412 Peggy O'Kane: We will be communicating [00:29:00] with you. We will be running pilots with  
414 volunteers who are interested in doing that. This is one of the trickier questions, I think, because it is an environment that's in rapid change and all I can say is that  
416 we will be in close contact with you, we will be following what's going on in the environment. We will be trying to project out the need for future changes and we'll do our best to make this an efficient process.

418 Mary Barton: [00:29:30] I just want to add to what Peggy just said, that the idea of sharing  
420 clinical data and making it available across the various entities that are responsible for patient outcomes, is going to be never wrong and is likely to unveil other fits that we don't even imagine yet.

422 Michael Barr: And potentially types of measures we can't currently [00:30:00] conceive of  
424 because of the lack of available data. But we're hoping that this is sort of a push and somewhat of a cool strategy where we shed some guidance, work with you to make sure we don't go too far ahead, but also help set some of the  
426 expectations for measurement and show and demonstrate how we can do better measures that are more clinically relevant and drive better care.

428 Ben Hamlin: And part of our choice to use these standards is to ensure that our measures  
430 [00:30:30] are again using those data definitions that are available that are being used to share clinical information, are used by a number of different clients for this. So again, it is unlikely that the measures will suddenly flip to a new ... a  
432 whole new standard unless the entire health care system flips to a whole new standard. So again this- this choice of now specifying HEDIS using international  
434 standard definitions and international standard models is to really align better with the, with the current data measurement practices that are being used in health care now. And so, [00:31:00] um ...

436 Andy Reynolds: Can the ECDS measures be reported through manual source code? In other words, without using machine reading?

438 Ben Hamlin: We anticipate right now that most of our digital measures are not able to be  
440 directly consumed based on the newness of the standards, we're using to express them. They are certainly still a very good template for creating your own manual source code, because the code is generated from NCQA [00:31:30]. So  
442 again, you can use those digital specifications. You can even use the XML or JSON files to help facilitate your own manual source code; however, you have to



444 be very careful because the measures will be certified using the digital measures  
so alterations will be picked up through our certification process.

446 Andy Reynolds: "Is there any effort to make one set of measures that are used by both CMS and  
private [00:32:00] payers, instead of having "similar" set of measures?"

448 Peggy O'Kane: We've been talking about this for a long time. We really would love to get to this  
450 point. We believe that much of the pain that people are experiencing with  
measurement in the delivery system is a result of this. Our whole goal is to create  
452 standards across different audiences, so we welcome the opportunity to work  
with those who would like to move that forward.

454 Andy Reynolds: [00:32:30] "Did I hear correctly that health plans that generate HEDIS results are  
required to go through measure certification in place of the CHCA review of  
measure result production?"

456 Suzanne Porter: That's correct. Michael said that starting in 2021, for 2022 reporting,  
458 organizations that write their own source code either need to contract with a  
certified vendor or come through our certification process.

460 Andy Reynolds: "What [00:33:00] are NCQA's plans to encourage plans to start reporting ECDS  
measures?"

462 Sepheen Byron: As Peggy says, it's something we would hope to move toward in the future. We  
464 are providing many technical resources, we are creating a digital measurement  
community, [00:33:30] we are also doing learning collaboratives. What I think  
466 we're trying to learn together are ways to improve health information exchange  
and really think through success stories and disseminate them widely, so that  
468 other plans may learn from the success stories of others and really get those tips  
on how to establish data connections, so everyone has more information about  
the patient, because we think [00:34:00] that a fuller data picture of the patient's  
health leads to better outcomes eventually.

470 Andy Reynolds: "We collaborate on the point that was made about electronic data being a  
472 byproduct of care and what's the point that there's an opportunity for real time  
evaluation?"

474 Michael Barr: I'll start and I'll ask others to chime in. I think the first part of that is, we are trying  
476 to move away from asking clinicians and clinical teams and others to do  
additional work to generate data for measurement. In other words, trying  
[00:34:30] to leverage what's being generated—the data when you take care of  
478 somebody, there's a lot of data being generated. Use that data for measurement,  
not add additional checkboxes to workflows and work streams that are actually  
quite burdensome and get in the way of delivering care.

480 Mary Barton: I think that the beauty of doing that is when you know what our measure  
482 sequence looks like, [00:35:00] you can then use that in your own quality  
improvement, whether you want to do it weekly or monthly (laughs). And then at  
484 the end of the year, or whatever, that's fine with us. We want to promote, we  
want to be in lock-step, encouraging quality improvement on the ground.

486 Michael Barr: We specify typically at the health plan level, but as you heard earlier, we allow  
488 adjustments based upon the HEDIS volume [00:35:30]; for example, enrollment  
490 criteria. If you want to use the HEDIS measure of quality improvement, make it a  
492 more real-time type of quality effort in your health systems. The clinical content,  
the clinical specifications, will be the same as the HEDIS measure because you  
can't change those. And then, ultimately when we roll it out, your HEDIS plan  
reporting should be positively affected by using the same clinical content and  
standards when you're assessing the care in more real time.

494 Ben Hamlin: [00:36:00] I think we ought to think of this in terms of that the technology exists to  
496 examine the existing data that is being currently documented. There's some  
498 wonderful technical applications out there and I think our interests are trying to  
500 align the quality measurement world with the HIQ world in terms of how we  
502 express our measures. Currently we use CQL to express our measures. That  
504 same logic is used for clinical decision support system. Essentially, we can now  
take evidence-based [00:36:30] care, using a quality measure as the rule, to  
inform a decision-support tool—that's how seamless integration of quality  
measures and decisions can actually work together. If the idea is compatibility in  
moving measurement much closer toward the existing data and applications that  
are being used in health care, we can now understand how the quality measures  
apply to support care, as opposed to assessing it after the fact.

506 Andy Reynolds: [00:37:00] "We understand that measures must be certified. Please confirm  
when, or if, digital measures will ever be mandatory."

Peggy O'Kane: ECDS, I think, is what we're talking about, right?

508 Ben Hamlin: We're anticipating to take our first couple years of ECDS reporting experience  
510 through the approval process, to have these measures available for public  
512 reporting programs and for other consideration for things [00:37:30] like  
514 Accreditation and rankings. Right now, they're in pilot status, which means we  
516 cannot release the results that we've received so far. We need to do a very  
thorough analysis that we do for all our data measures before they're released  
for public use, but we anticipate, based on the submissions that we've received  
this year, that we may be able to get several of these measures into that domain,  
which will then inform how we can move forward with getting involved in other  
programs like rankings and Accreditation, and so on and so forth.

518 Ben Hamlin: They have to achieve that [00:38:00] first critical step. And so I think as we  
520 introduce more ECDS measures and are able to get enough people reporting  
522 them, so we have adequate data to ensure that they're actually doing what  
524 they're intending to do, they meet our criteria for scientific exemptability, validity  
and reliability that we've always maintained in HEDIS, that we will see more of  
them. I don't think we're ever going to turn off the paper measure or paper  
measure concept the minute we have an ECDS measure. There's a long latency  
period between these two, to make sure that the measures meet our standards  
[00:38:30] for quality.

Andy Reynolds: "What do these topics mean for the future of supplemental data?"

528 Ben Hamlin: I'm not sure (laughs). The ECDS domain was designed around the fact of current  
rules or our current use of supplemental data. We designed it to try and get

530 improvements on this data because there was an increasing amount of  
532 supplemental data being used to supplement claims-based rates. We understood  
534 this is what was [00:39:00] giving us the confidence that this clinical data was  
536 available to plans and that they were interested in using it to help inform health  
538 care quality. We have attempted to design a protocol and a program that will  
allow us to no longer consider this volume of clinical data and information as  
supplemental to something that is more standard and like a claims-based rate, if  
you will. We're trying to make the data equivalent and that it has value,  
regardless of its initial source. [00:39:30] As long as it's being managed  
appropriately.

540 Ben Hamlin: And so I think eventually, we will have to think about—as soon as we have  
542 enough ECDS measures and public reporting domain and we're able to use them  
544 for programs—think about the continued use of supplemental data for traditional  
546 HEDIS measures and what that means to us, and whether the burden is worth  
548 having parallel programs where you have supplemental data for traditional  
measures and ECDS for ECDS measures. That's a lot of work for a very similar  
data source and there's a huge burden [00:40:00] for audit and for everything  
else that goes along with that, so we really have to try to think efficiency and the  
burden reduction and where we can make progress in those domains.

550 Michael Barr: Ben Hamlin, can I just expound on one thing you said at the end sort of similar  
data sources?

552 Michael Barr: Because I think sometimes [HCS 00:40:15] people think its completely different  
554 data. But can you draw the parallels between the expectation of the four sources  
of data or buckets we use in ECDS and what data may already be collected for  
traditional reporting?

556 Ben Hamlin: Supplemental data [00:40:30] tend to take the form of multiple databases, but  
558 they tend to be things like EMRs, case management systems, some internal  
registries from the plans. But the fact is, much of the clinical data is stored in  
those from the point of transaction, and therefore, we can just make the measure  
specify the direct access to that clinical data. It really is the same data source, it  
560 just has to fall within the categorical, [00:41:00] quality validations use of EMR  
562 data vs. use of case management data vs. use of claims data, whereas now it's  
564 all under the umbrella “supplemental.” The rules are toward the entire bucket of  
multiple data sources, as opposed to data types, as opposed to the ECDS,  
where we try and put them into categories so we can run validation rules by data  
type that allows up to incorporate more data in.

566 Much of the supplemental data is not allowed for HEDIS. That's a huge burden  
568 on the auditors to make those determinations [00:41:30] in the field. We're trying  
to reduce that and allow them to have a more standardized fashion of using this  
data and for more parts of the HEDIS measure.

570 Andy Reynolds: “I get that digital reporting is the future. However, it will be hard in my  
572 organization to switch to digital reporting. So how does that work in to burden  
reduction? Are you going to be reducing the number of measures?”

574 Peggy O'Kane: Well, I can say that we have already reduced the number of measures because  
[00:42:00] we have retired, I think, five measures this year and two last year. So,

576 we are certainly on a path to curate the data set of measures to focus on things  
578 that are important, not only for clinical care and where there are gaps in quality,  
580 but also to focus on what's important to patients. And as we move that forward,  
582 we are hoping to have more relevant data about patients' outcomes, which is,  
again, part [00:42:30] of the push toward electronic data. Because no lab test  
that will tell you if a patient can walk down the steps outside their front door, so  
as we go through this, we are certainly looking to remove measures that no  
longer meet our standards for either quality improvement or feasibility of  
reporting.

584 Andy Reynolds: [00:43:00] "In the interest of driving data collection as a byproduct of data  
generated, is there any collaboration with EHR vendors?"

586 Ben Hamlin: Yes, a lot (laughs). Increasingly in our measure development project and  
588 development of ECDS rule of domain overall, we've been working with both  
590 vendors and with registries, we've been working with the plan, as well, to  
592 understand the feasibility of not only accessing the data, but the presence of data  
594 in the different data sets. [00:43:30] How much of it is native and inaccessible?  
How much of it is actually being collected as standardized right at the point of  
care? And really to vet EHR vendors and those other platforms that support  
population health management—the only ones who really have information;  
they've been very willing to work with us, which has been fantastic.

Andy Reynolds: "Will all measures be digital or just the subset?"

596 Michael Barr: I think our aim is to take appropriate measures from the current [00:44:00]  
598 portfolio, taking into account what Dr. Barton said earlier about measures being  
retired and so on, but take a subset of those and over time and digitalize them  
600 over the next few years. Some might not get into digital form because A) it might  
602 be too difficult to specify them as they're written or B) we might feel like they're  
going to be updated in the future or retired. At the same time, we're going to build  
ECDS measures based upon interest, available funding and [00:44:30] what the  
market does in terms of—

604 Peggy O'Kane: And ability to use them.

606 Michael Barr: And ability to use them—how people respond. That's part of the test [00:44:36]  
608 mentioned earlier where those three measures are in both worlds, traditional as  
610 well as ECDS, and we really would love health plans to report both ways to help  
inform the very question that was just asked. What kind of measures should we  
produce in that format, over what piece, and then what are the expectations of  
health plans in the market?

612 Andy Reynolds: "What is NCQA's position on the FHIR data model? [00:45:00] Do you plan to  
provide measures used in FHIR instead of or in addition to the QDM?"

614 Ben Hamlin: We are both watching FHIR development and we're also very involved in FHIR  
616 development. We're working with our external stakeholders to help us  
understand when FHIR will be ready to be deployed for quality measurement. It  
is almost there and I think that will be an option for us that we're very much going  
to consider in the future, because again, [00:45:30], FHIR enables not only our

618 ability to specify quality measure in a very discrete way, it also enables sharing of  
620 information identified by gaps when a quality measure is run—so it's a step  
beyond just running an assessment of a health measure.

622 Ben Hamlin: We're hopeful that this is going to create another opportunity for us to continue to  
624 improve quality measurement and [00:46:00] sharing of information across  
626 networks of health care. It shows a lot of promise. It's not to a stage where it's  
ready for primetime deployment at the NCQA national quality reporting level yet,  
but we're very involved in both the development and the advancement for the  
possibly future of quality standard.

628 Andy Reynolds: "As far as what will be required, do you see ECDS being required before digital  
recording or vice versa?"

630 Ben Hamlin: [00:46:30] You have the option of using a paper specification or the digital  
632 measure specification. We're trying to offer a choice in terms of how to report  
634 traditional HEDIS measures. Since the ECDS measures are only digital, they  
636 only have one way to report. If we're able to get them into the public reporting  
638 sphere, they will be optional for reporting, but they'll be available for use in  
640 accordance with the program. [00:47:00] There's an open question of whether  
we're going to only produce digital measures and no longer produce paper  
specifications, but the presence of a digital measure, again, does not mean that  
the paper version's going to disappear overnight. There will always be a choice  
for health plans, as long as we continue to have a measure in the program, we'll  
be very cautious and conservative about retiring the traditional paper versions of  
measures.

642 Michael Barr: [00:47:30] Don't the digital measure bundles include a human readable format  
within the bundle?

644 Ben Hamlin: They do. It is different from the paper version, however; it's more of a reference  
646 document. It does not provide the same level of information that the paper  
648 specifications do, because most of that heavy lifting of a measure calculation is in  
650 the executable digital measure part. So, the human readable version is a great  
652 reference for the quality folks and for CMIOs and other physicians or [00:48:00]  
clinicians who want to understand the measure—its intent and what it's  
addressing. But again, the value of digital measurement is it allows you to do a  
lot of the prior work that is required by humans to be automated, and automated  
in a very consistent, standardized fashion. You can really focus on the clinical  
components and clinical care.

654 Peggy O'Kane: What I hear behind that question is maybe some anxiety about, [00:48:30] am I  
656 going to be forced to report ECDS or am I going to be left behind? And I think  
658 what we're trying to say to you is, we're well aware of the difficulties of getting to  
660 ECDS and that we are going to work with you and we are not going to have  
people be abandoned because there are limitations in their data environment. It's  
[00:49:00] a little bit of a scary proposition to think about trying to support all  
these different platforms, but we can't see any other way to move forward except  
to go through this messy period. But you have our commitment that we will work  
with you and we will not move faster than you are able to move.

662 Ben Hamlin: And I'd like to remind folks that we will have the digital measurement community  
664 available [00:49:30] for people, regardless of your ability or your interest in  
reporting ECDS or digital measures. I would encourage you to join that  
666 community because that's going to be where we share a lot of the information,  
best practices shortcuts, tips, techniques for doing digital measures, and we're  
668 hoping it's going to be an interactive forum that will allow you to not only share  
information with your peers, but also get the latest and greatest messages that  
670 we're able to identify as we continue to work with other people in this space. So  
again, NCQA.org/dmc to [00:50:00] get on that mailing list for when we have that  
community up and running.

672 Andy Reynolds: "How, if at all, do digital measures support scalability?"

674 Ben Hamlin: They do and in an interesting way. Again, the consistency of the specifications  
and the way we're constructing these digital measures allows us to harmonize  
676 the different measure versions and specifications to create components of  
measures. We now think of these now [00:50:30] as the core clinical measures  
678 that can be scalable from the practice level all the way up to the payer level, and  
there shouldn't be any difference in that core component of a measure: The  
680 clinical evidence-based logic that informs whether quality of care is being  
delivered. But the add on, or the attributes to that core clinical point, is where the  
682 attribution components come in, where the reporting requirements come in.  
Those are very flexible and they're going to probably remain flexible, and you've  
684 got a lot of choice in terms of the things you can do as you bring allowable  
adjustments. There are options that will [00:51:00] allow people to customize  
686 measures, but still maintain the integrity of that core measured component that  
has been developed, tested and found to be reliable.

688 Ben Hamlin: It's not really a matter of whether you can develop one measurement and scale it  
across the system; it's a matter of whether you can take all the versions of the  
690 measures that are at every level of the system and consolidate them into a  
common algorithm that can then be customized at the front end or the back end,  
692 depending on how you wish to use that information that's generated by that core  
component.

Andy Reynolds: "How will IDSS [00:51:30] evolve for digital measure reporting?"

694 Suzanne Porter: The measures are going to stay the same. Yes, doctors are still going to collect  
the data. The robustness of the measures is how measure results are produced.  
696 We do have a redesign project going on, and there's some information on our  
website about the timeline for that. [00:52:00] In terms of changing data elements  
698 and themes to be more consistent and easier to understand, we can set up that  
information and a link to where that information is found. But otherwise, digital  
700 measures should not impact IDSS reporting.

Andy Reynolds: "What does NCQA think of the FHIR data model and do you plan to use it?"

702 Ben Hamlin: Love it and hope to use it very soon.

Michael Barr: Well that was so short and we [crosstalk 00:52:30]



704 Michael Barr: are waiting for more.

706 Ben Hamlin: [00:52:30] FHIR is very interesting. It is very new, it shows a lot of promise, but it  
708 has yet to be tested. So, we're paying very close attention to it. I think it shows a  
great potential for improving quality measurement and advancing it very rapidly.  
But again, it's still untested for the environment where it can function, so we're  
proceeding with cautious [00:53:00] interest.

710 Andy Reynolds: I believe this is our last question, all we have time for today. "In the analysis of  
712 ECDS measures, how does NCQA take into account the ECDS data currently  
are received from select plans? Not all plans can do that kind of data."

714 Ben Hamlin: I want to reiterate a common myth that ECDS claims are no longer valid.  
716 Administrative data is one of the core four component data types [00:53:30] that  
you're reporting for ECDS. So, if a plan has ECDS available in administrative  
718 data for all the measured components, we generate a measure rate from that.  
They don't need to chase additional data. Measures are reported by data type,  
720 so we have a way to create, essentially, data profiles for each plan submission  
for each measure, to understand what kind of data types plans are accessing for  
722 each individual measure report. And we hope to be able to use that information  
to help understand [00:54:00] where plans are with their data, especially in the  
clinical data access and other external data access. But also, to track progress  
724 over time over multiple submissions. As I said earlier, it's unanalyzed right now,  
but we think we have an adequate number of submissions this year to be able to  
726 do a lot of that analysis and to get these measures into the public reporting  
space.

728 Ben Hamlin: It is still less than a normal HEDIS [00:54:30] submission, but every year more  
and more plans are reporting ECDS measures, and that is a very positive  
indicator for us, that soon this will be the norm.

730 Andy Reynolds: There is one last question about how will NCQA get back to people who have  
submitted questions we haven't had time for today.

732 Peggy O'Kane: Or questions you might think of.

Andy Reynolds: Exactly.

734 Peggy O'Kane: As you're reflecting on this.

736 Andy Reynolds: [00:55:00] All of our regular channels are open to you. We want your feedback.  
The progression or series of clicks that you see here is what we recommend  
most.

738 Andy Reynolds: And as always, we welcome to hear from you in any way or however you want to  
740 get in touch with us. But certainly, PCS through My.NCQA is a great option that  
will help us route your question to the right person as quickly as we can.



742 Peggy O’Kane: I want to thank all of you who [00:55:30] stayed with us. I know we’re presenting  
744 you with a lot of complicated information. It will take a while to digest it. We are  
746 eager to hear from you. We’re eager to get your feedback. We’ll be telling you  
748 about other opportunities to work with us—this is a big deal, and we don’t  
750 underestimate it, so thank you, to those who really want to work with us. For  
those of you that are feeling worried about this, we just want to reassure you  
[00:56:00] we’re not going to pull the rug out from under you. We’re going to work  
with you. So, thank you again for being with us and we look forward to the future  
that we’re creating together.