The Future of Healthcare
Quality Improvement
QUALITY IMPROVEMENT OUTLINE

+ The Current Changing Landscape
+ Preparing for Changes in Clinical Measurement
+ Preparing for Changes in Accreditation and Regulatory
+ Preparing for Changes in Member Experience
The current Changing Landscape

“Quality means doing it right when no one is looking”

Henry Ford
Level I: Foundational = What we are going to do

Level II: Structural = How we are going to do it

Level III: Supportive = The rewards for doing it
THE WORLD OF QUALITY IS EVER CHANGING

**Accreditation & Regulatory**
- Nationally reported Medicare/Medicaid/Commercial Stars System
- Health Equity Accreditation
- New State Reporting Requirements

**Clinical Measure Performance**
- Digital measurement and certification
- Electronic Clinical Data Sets
- HIE, EMR, and Case Management Data Integrations
- New Pay for Performance Programs
- Removal of Hybrid Measures
- Telehealth Allowances
- Data aggregator certification

**Experience**
- New CAHPS requirements (HCBS, MACAHPS, CAHPS, HOS, ECHO)
- Increase Medicare Stars weightings
A COMPLEX SYSTEM

Health Management Associates

Copyright ©2020 Health Management Associates, Inc. All rights reserved. PROPRIETARY and CONFIDENTIAL
3 MAJOR RATING SYSTEMS

**CMS Medicare/SNP**
- CAHPS/HOS = 34%
- HEDIS = 19%
- Administrative = 18%
- Pharmacy = 16%
- Improvement = 13%

**NCQA Star Ratings**
- HEDIS = 85%
- CAHPS = 15%
- Accreditation = .5 Stars

**CMS Marketplace (QRS)**
- HEDIS = 75%
- CAHPS = 20%
- Pharmacy = 5%
Quality Data and Reporting

“All ECDS measures are Digital, but not all Digital measures are ECDS”

Dr. Michael Barr, EVP NCQA
CURRENT STATE

+ Administratively cumbersome and not efficient
+ Becomes more difficult with expansion
+ Time crunch to get charts and conduct reviews
+ Increasing FTE requirements to keep up with manual reviews and abstractions (as plans grow new staff needs to be added to keep up with volume)
+ Increased audit risk with more chart abstractions
+ Need for more relevant clinical data and information

*National strategy is to move in a direction that is more reliant on electronic clinical quality data, removal of sampling, and using new coding specifications to allow for less variation in results*
CURRENT DATA FOR QUALITY REPORTING

- Administrative
  - Claims
  - Pharmacy
  - Enrollment

- Standard Supplemental
  - Lab Data
  - State Registries

- Nonstandard Supplemental
  - Chart Review
  - Manual Information
  - Pseudo Claims
• Average health plan chases around 4-5k medical records per product per year
• Average mid size provider group 200-300 records per payer
• Multiple “Clinical Data Connections” to support data exchange
• Year-round medical record review and retrieval
• HEDIS Engines vary in complexity and performance
What is the future of Quality Measures?

The future of quality measurement involves an evolving approach to how we measure quality for billions of dollars in value-based payment. It relies on “Machine Readable” measure specifications, the removal of chart chasing, and a heavy reliance on clinical data completeness. It involves new and complex measures that blend traditional claims data with many other data sources.

+ **Digital Measure** = Digital measures are machine readable, leveraging standard coding language (CQL, FHIR) where a measure can be produced and purchased to run, rather than manually built and “certified”.

+ **ECDS** = An expansion of existing data sets to allow for more complete data as well as new and more complex measures build designs that leverage EMR, Care Management, HIE/Repository and Administrative data.

*Image Source NCQA 2021*
• Reliance on more clinical data sharing between health plans, providers and software vendors
• Increased reliance of “Data Aggregators” such as Health Information Exchanges (new DAV certification)
• Need to leverage more advanced clinical data such as assessment forms
• Ability to run your own “Certified HEDIS measure code”
ECDS MEASURE EXAMPLE

- Breast Cancer Screening
- Colorectal Cancer Screening
- Follow-up Care for Children Prescribed ADHD Medication
- Depression Screening and Follow-up for Adolescents and Children
- Utilization of the PHQ9 to Monitor Depression
- Depression Remission or Response for Adolescents and Adults
- Unhealthy Alcohol Use Screening and Follow-up
- Adult Immunization Status
- Prenatal Immunization Status
- Prenatal Depression Screening and Follow-up
- Post-Partum Depression Screening

Prenatal Depression Screening and Follow-up

- Use claims/enrollment to identify initial population (Traditional Administrative Data)
- Uses results of Screening data from Care Management Systems to find hits (CM, HIE, EMR)
**Breast Cancer Screening: (BCS and BCS-E)**

- **Traditional**
  Breast Cancer Screening is a traditional measure that has been part of standard HEDIS for 15+ years

- **ECDS**
  Breast Cancer Screening is an ECDS measure since it leverages new expanded data sets for capture from HIE, EMR, and Care Management Systems

- **Digital**
  Breast Cancer Screening is a digital measure that can be produced using FHIR-QI Core which relies on a new language CQL for productions
FUTURE QUALITY REPORTING

Structured Data

Administrative
- Claims
- Pharmacy
- Enrollment

EMR
- EPIC
- Cerner
- All Scripts

Care Management
- Virtual Health
- Cognizant
- Livongo

HIE
- Health Information Exchanges
- State Registries

Unstructured

Natural Language Processing
- EMR Information
- Chart Notes
- Assessment Forms
**DIGITAL AND ECDS MEASUREMENT CATALYSTS**

*As Digital/ECDS measures become more widely adopted and required several major strains will be placed on the system*

**Regulators/States/Federal Agencies:** States will work to embed new requirements around digital quality and ECDS measures to take advantage of initiatives to improve quality scores and promote interoperability and outcomes (2025 CMS Digital Strategy for Stars)

**Health Plans:** Health Plans will need to work across multiple clinical data systems and provider groups to embed data sharing arrangements for clinical data assets while simultaneously rethinking their quality data models to account for new measures

**Providers:** Providers will need to set-up data sharing arrangements through either an HIE or directly with a payer to transfer clinical data files that will affect their value-based payments and gated to more advanced risk arrangements

**Health Information Exchanges:** HIEs who are certified have a large potential catalyst to support VBP arrangements between health plans and providers and serve as a link to data sharing agreements

**Vendors:** Vendors will need to understand how these new programs work in order take advantage of new certification programs from NCQA and to help plans and providers assist in this transition
PLANNING FOR THE FUTURE

Develop a path of “Steppingstone”

**Work Stream 1 External:** Develop network support functions for structured and unstructured data that can be used to enhance value-based arrangements and maximize quality scores.

**Work Stream 2 Internal:** Review internal data structures and use care management information to maximize scores on new more complex measures and operationalize Interoperability rules.

- Care Management System
  - Structured Data
    - HIE EMR
  - Unstructured Data
    - NLP

- Digitally Enabled HEDIS Engine
  - Data Analysis KPIs
  - Data Source Tracing
REAL LIFE SCENARIO

A Large 120,000 covered beneficiary lives Medicare advantage plan is planning its 2022-2023 strategic Medicare Stars initiatives with a large provider group with 10k Medicare patients. With the upcoming changes to Colorectal becoming an ECDS only metric, there is concern as to how to build new value-based arrangements. The plan and providers get an average lift of 8%-10% during medical record retrieval, but the new specifications now require that the entire eligible population be reported. How do we solve for this?

Inefficient:

+ Health plan starts manually reviewing upwards of 60,000 medical records a year for evidence of a closed gap in care since there is no more sample for the colorectal measures, which involves reviewing notes and abstraction processes
+ Health plan requires providers to send individual supplemental data feeds and/or manually upload records to a secure portal for thousands of members to support their value-based targets and boosts scores at the end of the year due to data inefficiency
+ Providers comb their EMR to submit thousands of medical record images for abstraction and reporting across all its payers
+ Provider sets-up 10-11 data sharing arrangements to support its payers across its Medicare contracts all with different data specifications

Efficient:

+ Health plan partners with the provider to develop a VBP arrangement to join a local DAV certified HIE that they are connected to. The HIE patterns as a data aggregator to support the health plan and provider in clinical data sharing and assists both entities in data completeness and reliability, saving hundreds of hours of manual work and staffing resources/costs for both entities
+ Providers in joining an HIE can now direct payors to their data partner to get all the information they need for quality reporting of colorectal cancer screening, there is only a need to maintain one central data feed and support through
+ Through the same built data feeds, the plan partners with a new NLP group to maximize the review of unstructured notes data that can be used to do measures “clean-up” on the initial 8% of data that is missing without needing to conduct a “year-round review”
Changes in Accreditation and Regulatory
**CHANGES IN HEALTH EQUITY REQUIREMENTS**

- Increased use of SDoH, Health Equity and Health Disparities in Medicaid Procurement cycle
  - 6 Managed care procurements in 2021 had significant points linked to quality work tied to health equity and social determinant based work
  - 3 States now require stratification by Race/Language/Ethnicity of quality data with links to performance dollars
  - 9 States require or encourage Multicultural Health Accreditation that will need to switch to Health Equity

- Data on SDOH, Health Equity and Multicultural and widely variable market by market with large data gaps across the board
Developing a model around Health Equity: what do we mean?

Health Disparities
- Race
- Language
- Ethnicity
- Health Literacy

Social Determinants
- Housing
- Food Insecurity
- Area Deprivation Index
- Transportation

Gender and Inclusion (SOGI)
- Sexual Orientation
- Gender Identify

Care Inclusive of Everyone
Remove Disparities
Influence Social Factors
MULTICULTURAL HEALTH CARE VS HEALTH EQUITY

+ 76 Health Plans across the United States are currently Multicultural Accredited that will need to go through Equity Accreditation
+ MHC program will phase out in favor of a far more advanced program called “Health Equity” and “Health Equity Plus”

Accreditation and Health Equity

Distinction in Multicultural Health Care (MHC) will become Health Equity Accreditation (HEA), with an additional evaluation option, Health Equity Accreditation Plus, starting with the July 2022 surveys.

Two levels of Health Equity Accreditation programs provide a comprehensive framework that organizations can use to elevate and measure health equity goals, deliver culturally and linguistically appropriate services and reduce disparities.

Health Equity Accreditation is a contract differentiator substantiating a higher level of commitment to the health equity journey.

- Health Equity Accreditation incorporates MHC’s existing standards and raises the bar to a higher degree of equity.
- Health Equity Accreditation Plus includes an evaluation option that includes the core HEA requirements and “Plus” standards focused on social determinants of health (SDOH).

See more about the change from Multicultural Healthcare Certification to Health Equity Accreditation.
Several states are starting to adopt and require plans to at minimum stratify and report HEDIS rates by race, language and ethnicity.

Some states are going further and adding this to value-based care programs.

834 enrollment files and state data is widely inaccurate in this area, and is a crucial component in RFPs to address inequities in a State.

Future requirements move beyond R/E/L and into more difficult SOGI, Z-Code, and other SDoH data.
WHY DOES IT MATTER TO HEALTH PLANS AND PROVIDERS

+ Health Plans and providers have “Scraped the Barrel” on what can be done via traditional programs such as
  + Member Incentive Programs
  + Call Campaigns
  + Provider Value Based Programs
  + Care Management Outreach

+ Increased competition with RFPs and business growth within the Medicaid Space. Aspects of Health Equity are now core in many if not all Medicaid Managed Care Procurements. States what answers as to what plans will do and want OUTCOMES of what has happened

+ Engaged members have higher CAHPS scores and engages services needed for critical preventative services

+ New measures and systems will start to emerge that de-emphasize claims data and move into more assessment and demographic based information that plans will need to learn how to leverage and excel at

+ New value-based targets programs will begin to emerge for providers and health plans in both Medicare, Medicaid, and CMMI models focused on disparities data collection, reporting, and outcomes
Member Experience
WHY NOW?

+ Member Experience for Medicare Stars will make up >33% of the total scoring by 2023
+ Member experience starting to enter more Medicaid Value based programs
+ Pharmacy influenced measures will touch roughly 33% of the total score by 2024 (Part D, statins, adherence, improvement, etc.)
+ Most plans invest 80% of their time in to HEDIS and the rest into other measures (operations and CAHPS), this will need to reverse course and force new methodological shifts

### 2022 Star Rating

<table>
<thead>
<tr>
<th>Domain</th>
<th>Score</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS</td>
<td>65</td>
<td>16.67%</td>
</tr>
<tr>
<td>CAHPS</td>
<td>75</td>
<td>19.23%</td>
</tr>
<tr>
<td>HOS</td>
<td>45</td>
<td>11.54%</td>
</tr>
<tr>
<td>CMS</td>
<td>90</td>
<td>23.08%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>65</td>
<td>16.67%</td>
</tr>
<tr>
<td>Improvement</td>
<td>50</td>
<td>12.82%</td>
</tr>
</tbody>
</table>

### 2023 Star Rating

<table>
<thead>
<tr>
<th>Domain</th>
<th>Score</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS</td>
<td>65</td>
<td>15.12%</td>
</tr>
<tr>
<td>CAHPS</td>
<td>145</td>
<td>33.72%</td>
</tr>
<tr>
<td>HOS</td>
<td>15</td>
<td>3.49%</td>
</tr>
<tr>
<td>CMS</td>
<td>90</td>
<td>20.93%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>65</td>
<td>15.12%</td>
</tr>
<tr>
<td>Improvement</td>
<td>50</td>
<td>11.63%</td>
</tr>
</tbody>
</table>

11/3/2021
IMPACT OF STAR PROGRAM CHANGES

- Changes are significant and will likely disadvantage several health plans including those who currently have a 4-star rating.

- Changes could negatively impact Part C premium for added benefits and eligibility to receive additional rebate dollars.

- Changes could have a negative impact to margins and market share.

- Need to have an increased focus on the higher rated patient experience and access measures because a strategy that ignores these in favor of lower weighted measures will no longer work in a plan’s favor.

- Need a data driven and strategic approach to address and resolve barriers to care that lead to poor measure performance, including social determinants of health (SDOH) and access to providers and pharmacies in order to realize year over year CAHPS performance improvement.
Improvement requires a strategic and data driven approach to CAHPS initiatives to create incremental year over year changes in the performance of these measures. Creating a CAHPS game plan is critical to the success of improving the experience of care for patients and members.
CAHPS improvement strategy

CAHPS is **NOT** HEDIS and does **NOT** lend itself to a “4th quarter push” it requires a 365 day yearly strategy.

- **Member 365 Day Experience**
  - 1) Requires ongoing support, engagement, access and interventions aligned internally and externally at the START of the year for each new and existing person.
  - 2) Working with members on benefit understanding, provider satisfaction, network access/adequacy, care management and support.
  - 3) Assisting with complex needs and members who have not had appointments yes, reviewing data on appeals, complaints and grievance. Leveraging a Medicare concierge team.
  - 4) A 4th quarter push works well for small incremental improvements (1-2%) on select measures during a specific window, such as flu vaccines.

- **Member Experience**
- **4th Quarter**
MEMBER LISTENING POST
PLANNING FOR CAHPS IMPROVEMENT

CAHPS data today is NOT actionable, improvement requires the same discipline that many of invested into data initiatives around clinical, pharmacy and operational performance

1. Make CAHPS Data Action, develop an on-going process of collecting data based off encounters
2. Develop feedback loops from all areas that touch the members perception/experience of care
3. Create data sets down to the regional and provider level
4. Embed experience metrics as part of both internal and external organization goals (pharmacy satisfaction, member services satisfaction, provider/network Satisfaction
5. Develop a performance and reimbursement model that starts to incent for experience of care
6. Create a “Member Experience Workplan” and workbook like a QI strategic plan, aimed and engaging and supporting members
7. Start on day 1, CAHPS requires a 365-day strategy. Plans and providers worried about experience scores need incremental year over year improvement
Final Thoughts
FINAL THOUGHTS

Health Plans Will Need To:
+ Develop EMR and HIE data sharing arrangements with providers and vendors alike
+ Solve for unstructured information from medical records and within care management notes
+ Use more disparate data sources from SDoH and enrollment
+ Blend quality data increasingly with our data sources
+ Embed new value-based arrangements that incent for experience of care and clinical data capture
+ Look for new technologies and vendors to remain competitive

Provider Will Need to:
+ Prepare for increased data needs from health plans to support value-based contracting
+ Centralize their data analysis and submission process to streamline
+ Develop experience KPIs to solve for member experience needs
+ Identify partners to help streamline contracting, VBP, Risk, and Quality operations

Vendors will Need To:
+ Understand the core provider and health plan QI business drivers for Medicare and Medicaid performance revenue
+ Review their current core software systems and offerings to ensure they adjust to new pressures for increased performance
+ Develop individual market strategies respective of different quality arrangements/requirements
+ Review how their data and systems could impact health plan and provider incentive dollars.