

Implementing a digital quality strategy

By Katie Devlin, DHSc, MS, CPHIMS and Jamison Gillitzer

The annual process of gathering, reporting, and submitting data for HEDIS® reporting has typically been thought of as a retrospective activity: health plans retrieve and abstract medical charts to demonstrate the quality of care they provided during the previous year, which is known as the measurement year (MY). By the time January 1 arrives, plans can no longer close care gaps, influence member actions, or perform provider outreach activities that would impact the current reporting year's measure scores— placing plans without a year-round strategy at a disadvantage.

To stay competitive, maintain and increase compliance, and drive the preventative

care impact desired, plans must shift from a retrospective approach to HEDIS data collection to building a structured and intelligent digital foundation for year-round quality. A sustainable, continuous approach for acquiring, ingesting, and normalizing codified data is vital to the success of a quality program.

The evolution of quality measures

For HEDIS, there are roughly 85 quality measures that are designed to allow clinical comparison across health plans. These measures are used for accreditation and in other programs such as state Medicaid assessments and Medicare Star Ratings. There are several different types of measures in the HEDIS measure set:

- **Administrative:** The bulk of measures fall into the administrative category. Administrative measures are calculated using claims, encounter, enrollment, and provider data.
- **Survey:** Survey measures, such as CAHPS®, and Qualified Health Plan (QHP) for the Exchange line of business, measure patient experience by conducting surveys. There are only a handful of survey measures today.
- **Hybrid:** Hybrid measures use claims data supplemented with manual retrieval and abstraction. These measures allow for medical record review to increase rates on a sampled portion of the measures population, since what they are measuring is not always or easily captured via claims data.

- **Digital/ ECDS:** Now, we have the future of quality measures, digital and Electronic Clinical Data Systems (ECDS) measures. ECDS measures are a subset of digital measures and rely on electronically gathered data to stratify measure results. The quantity of digital and ECDS measures increase each year as we march toward a digital future, while administrative and hybrid decline.

The evolving landscape of digital measure requirements imposed by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS) necessitates a strong, year-round digital strategy. Sourcing clinical data is a complex and sensitive process that begins with transformation. As more measure requirements become digital, sourcing clinical data will require a multi-faceted approach.

Here are practical steps that payers can take to become more data-centric while benefiting members, reducing costs, and improving quality of care.

Devising a digital strategy to improve quality of care

To help identify gaps in data and technology, plans should initially take an inventory of the data that is currently accessed, the

existing infrastructure, and which resources have knowledge of digital measurement. Subsequently, and in partnership with key stakeholders, health plans can design a roadmap for data acquisition, data normalization and mapping, and data enablement to align with strategic priorities.

NCQA has made clear that digital measurement is permanent and though the transition from hybrid to ECDS has been slow, it is accelerating. Additionally, sourcing digital clinical quality data was voted as a top strategic priority by Cotiviti's own Quality Product Advisory Board in 2022. In Measurement Year (MY) 2024 and MY 2025, several traditional HEDIS hybrid measures have been proposed to shift to digital or drop the hybrid component altogether, with colorectal cancer screening (COL), immunizations for adolescents (IMA), childhood immunization status (CIS), and cervical cancer screening (CCS) moving to ECDS-only reporting. These four measures account for around 30% of hybrid measures today. Transitioning these measures to digital should indicate that now is the time to devise a data strategy to maintain and improve rates in the digital future.

Next, an increasing number of plans have started to perform monthly, proactive data runs. Of note, more than 60% of Cotiviti-hosted

clients are performing data refreshes monthly. Frequent data updates allow you to track and trend key measure performance against goals, update member target lists to proactively close care gaps, obtain the latest data on provider performance, and perform proactive chart review to gather supplemental data.

Gathering supplemental data

The transition to digital measurement and the retirement of traditional hybrid measures such as COL is causing concern on how to boost and maintain rates. Furthermore, many plans do not feel they have access to the data they need to maintain their current rates in a fully digital state.

Cotiviti analyzed the average hybrid lift for clients—the difference in measure rate after hybrid chart review—and found that plans may be more prepared for the transition to ECDS than they realize, at least for the measures that have already been proposed or confirmed (Figure 1). The relative size of the bubble containing the measure indicates the average lift Cotiviti clients received after hybrid chart review was completed. Measures outlined in pink are confirmed or proposed for retirement or transition to ECDS reporting in MY 2024 and MY 2025. These measures saw the lowest hybrid lift and suggested that NCQA is following a “low-hanging fruit”

Average hybrid lift | Analysis

Measures outlined in pink are proposed and confirmed for MY2024 or MY2025 retirement or transition to ECDS reporting. These measures also happen to have some of the lowest hybrid lift.



Figure 1. Average hybrid lift for measures proposed or confirmed for retirement or transition to ECDS reporting versus other hybrid measures.

approach by first transitioning measures that will not be as impacted when chart review is removed. Interestingly, the recent release of MY 2024 HEDIS Volume 2 specifications indicated the eye exam for patients with diabetes (EED) measure will maintain its hybrid component even though it was previously proposed for retirement and see a relatively small hybrid lift. This is possibly related to feedback that NCQA received during its public comment period and the relevance of the measure in Star programs. Based on the data, we would not be surprised to see the lead screening in children (LSD) measure make the transition to ECDS in coming years due to its relatively low hybrid lift.

Some remaining measures such as WCC, BPD, and CBP will be difficult to transition to ECDS in the future without strong adoption of digital data sources or modifications to the measures themselves due to a high hybrid lift.

Traditional supplemental sources like labs and immunization registries already have high adoption. Instead, plans should focus energy on digital supplemental data gathering and year-round chart review. Year-round insights can gauge measure performance, influence care gap closure, and positively influence provider behavior. With any year-round project, it is important to prioritize the measures and target membership that will

likely yield meaningful results. Prospective HEDIS measurement and reporting is a critical activity for continuous improvement of performance during the transition to digital measures.

Choosing data partners

The NCQA Data Aggregator Validation (DAV) program validates electronic clinical data streams that are queried for HEDIS measures. It ensures that supplemental data integrity is maintained and reduces the audit burden for plans by eliminating the need for additional primary source verification (PSV) of the data. When implementing a digital quality strategy, payers should prioritize working with a DAV-certified vendor. However, it is critical to understand that not all data streams may be DAV-validated. For example, a health information exchange (HIE) may have 1,000 participants (i.e., health systems or providers) that contribute data. However, each participant in the HIE must go through the DAV certification process. Due to the rigorous requirements, many HIEs have opted to take a phased approach to validating numerous participants. Therefore, it is possible that not all sources of data have gone through the DAV validation process at the time they are queried. That said, adoption is growing. NCQA recently indicated that an estimated 45% of MY 2022 submissions used some amount of DAV data.

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-NCQA

For network and vendor partners, health plans should analyze their market relative to the organizations that are currently sharing data with the partner for payment and operations exchange purposes.

National networks have long supported treatment, payment, and healthcare operations (TPO) use cases. However, participants are currently only mandated to respond to treatment and individual access requests. Data availability across all payer use cases is expected to improve with the adoption of the Trusted Exchange Framework and Common Agreement (TEFCA), which establishes a single “on-ramp” for healthcare stakeholders to participate in nationwide data exchange, for a variety of exchange purposes. These include TPO, public health, individual access, and government benefits determination.

TEFCA uses a brokered approach to data sharing and requires that qualified health information networks (QHINs) respond to treatment and individual access requests—at least for now.. Eventually, all participants will be required to respond to queries for all exchange purposes, including those received from health plans or their business associates. A mandate for QHINs to respond to payment and healthcare operations exchange purposes is anticipated next year. This will be an impactful milestone for payers looking to acquire records electronically.

While TEFCA offers much promise, it still does not mean that all data will be DAV-validated. With this in mind, it is important to talk to whatever health care organization, network, or vendor you may be considering and ask for a list of who is actively contributing data, and for which use cases. For example, some HIEs may support HEDIS data sharing, but not risk adjustment, or may require separate contracting to enable data flow.

Here are a few concrete concerns to consider when contracting with a vendor:

1. Analyze your market and volume relative to the partner.

- Ask for a list of organizations that are currently participating in payment and operations exchange purposes.

2. Be aware of minimums and licensing fees.

- Do not commit to a specific number of records retrieved since this depends on the data partner’s ability to accurately match patients.
- If you must negotiate minimums, consider committing to a specific number of members requested to estimate what you can reasonably ask for based on your market assessment.

Leverage data across projects and encourage new data partnerships to reduce volume, perform year-round chart reviews, and identify whether your member population is receiving optimal care. Prioritize, monitor, and improve measures that require quick action and use chart data to monitor administrative measures (like follow-up visits) as well as hybrid measures. If visits do not happen in a timely manner, conduct outreach to members to close gaps or identify providers who require education on the measures. Begin devising a strategy that starts by aligning on goals and identifies the strengths and weaknesses within your organizational technology and data acquisition systems.

Laying the foundation for digital measurement success

Start simple by asking what data is readily available, which tools you possess to gather the data, and which measures propose a high value. Evaluate the current state of your organization's technology to set reasonable goals for the future that align across the organization. Focus your energy on year-round efforts such as supplemental retrieval and abstraction, as well as digital supplemental data gathering. Build a solid foundation with room to adapt and grow as measures continue to digitize during this journey.

The evolving landscape of HEDIS requires a sophisticated program to understand the complexity of quality compliance. Implement a year-round measurement and reporting system with Cotiviti's Quality Intelligence solution. Reduce abrasion with minimal disruption to providers and their staff and achieve the highest number of compliant components possible within any reporting timeframe.

[Read the Quality Intelligence fact sheet](#)

Prepare for upcoming changes with these steps

- Take a pulse check on your readiness for digital measurement
- Devise a roadmap for data acquisition, data cleansing and mapping, and data storage
- Perform monthly proactive data runs
- Focus energy on digital supplemental data gathering and year-round chart review
- Prioritize working with a DAV-certified vendor
- Talk to any network and vendor partners about who is contributing data for your use cases

Already looking to get started?

Contact our experts today to learn about how Cotiviti can help.

[Start the conversation with Cotiviti](#)

About the authors



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Katie is responsible for creating an enterprise-wide health data exchange strategy to address our client's unique business needs, while reducing provider abrasion, maintaining regulatory compliance, and optimizing value. She oversees all initiatives related to digital health data acquisition, ingestion, storage, and normalization, including the expansion of Cotiviti's electronic health data networks and strategic partnerships.



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Jamison supports Cotiviti's Quality and Stars solution suite. His primary responsibilities include the delivery of quality solutions to ensure they meet clients' needs in support of HEDIS, AMP, and other quality reporting initiatives. He also works to develop and enhance our capabilities to support evolving quality requirements.

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