Cognizant’s Value-based Healthcare and Quality and Improvement Capabilities

Tenth National Accountable Care Organization (ACO) Summit

Ninth Bundled Payment Summit

Fourth MACRA Summit

Washington, DC

June 17 – 19, 2019

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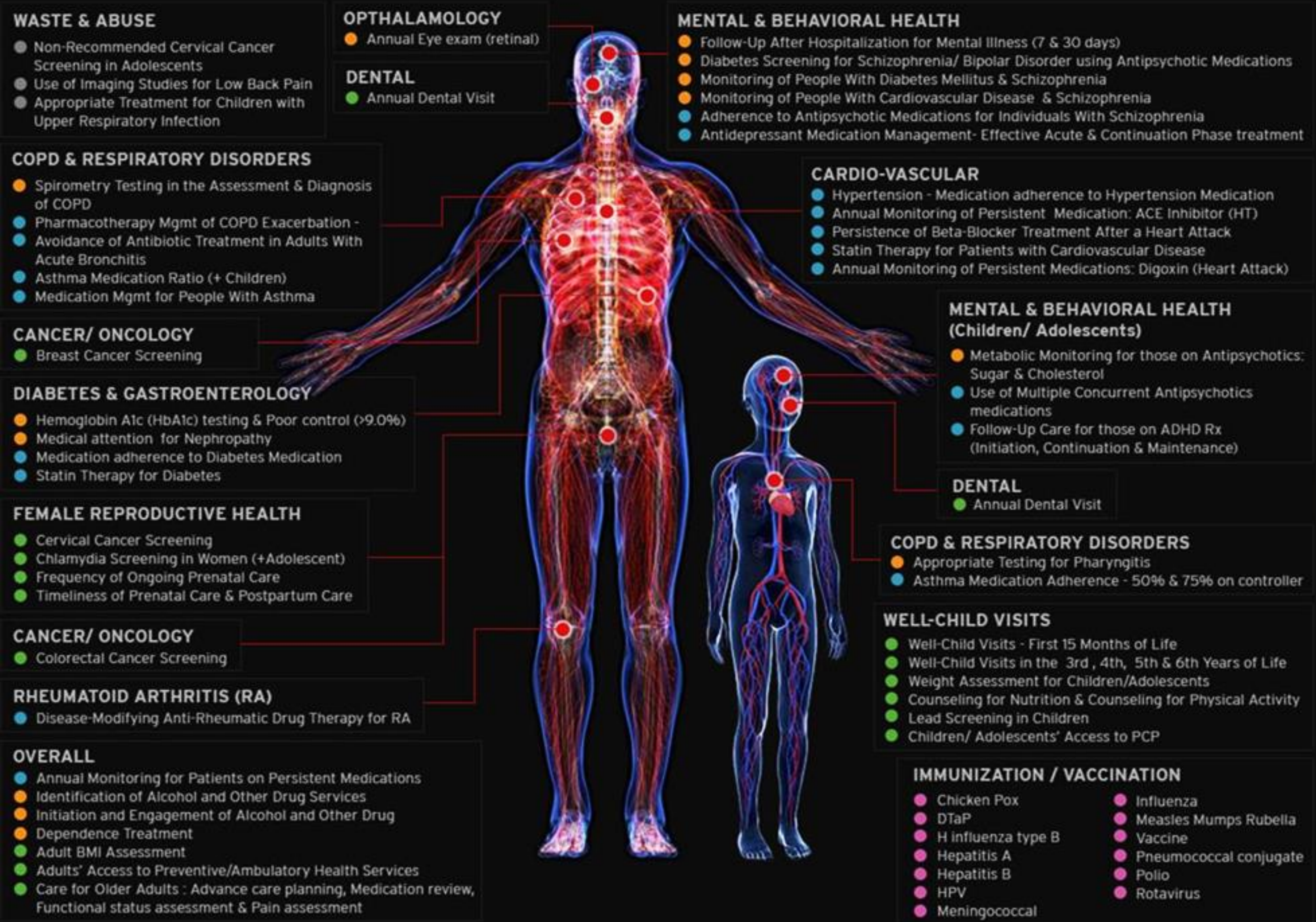


Holistic

Member approach to

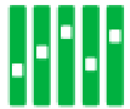
Clinical Quality

improvement

MACRA Quality Payment Program tracks: MIPS and Advanced APM

MIPS TRACK

Providers may earn positive payment adjustment based on **PERFORMANCE** or may be subject to **PENALTIES** for non-compliance


Advancing care information

Quality

Resource use

Clinical practice improvement activities

ADVANCED APM TRACK

Providers may earn 5% **INCENTIVES** for participating in an innovative model and bear more **FINANCIAL RISK** based on:

1. Care cost and patient outcomes
2. Quality measures comparable to MIPS
3. Certified EHR technology

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Who qualifies for what track?

MIPS

92%

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists (CRNA)

ADVANCED APM

8%

- **Practices**
- APM is a payment approach that applies to:
  - A care episode
  - A specific clinical condition or
  - Population
- Advanced APMS are subsets of APMs (CMS identified 7 – see Appendix)

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Pathways to MIPS and Advanced APM

MIPS TRACK

Report on over 271 measures via:

- Qualified Clinical Data Registry (QCDR)
- Certified EHR
- **Claims**
- CMS Web Interface
- CMS Certified CAHPS Vendor

ADVANCED APM TRACK

2 pathways to allow eligible clinicians to become QPs:

- Medicare option: available for all performance years; status achieved based on eligibility and participation in an AAPM within Medicare FFS
- **All Payer Combination Option**: available starting with performance year 2019; status achieved based on eligibility and a combination of participation in AAPM within Medicare FFS and **Other Payer AAPMs** (offered by other payers)

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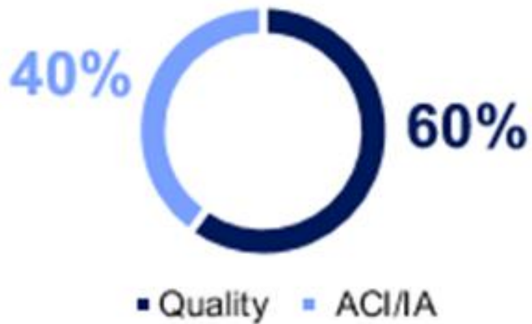
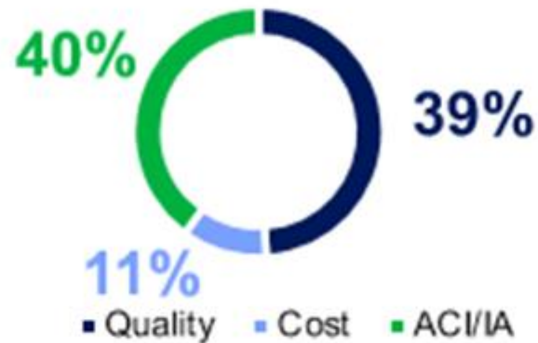
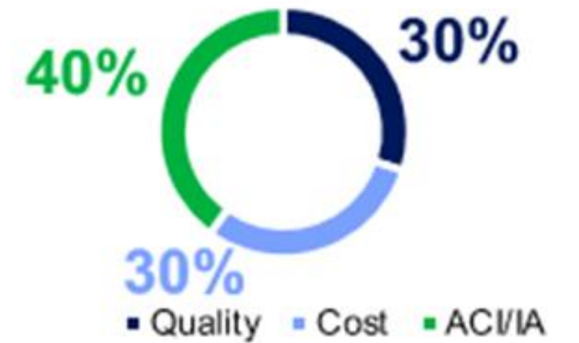
MIPS performance categories weights

Scoring formula → add all 4 category score x weights and multiply by 100







2017 – Reporting year
2018 – Evaluation year
2019 – Reimbursement year based on 2017 performance

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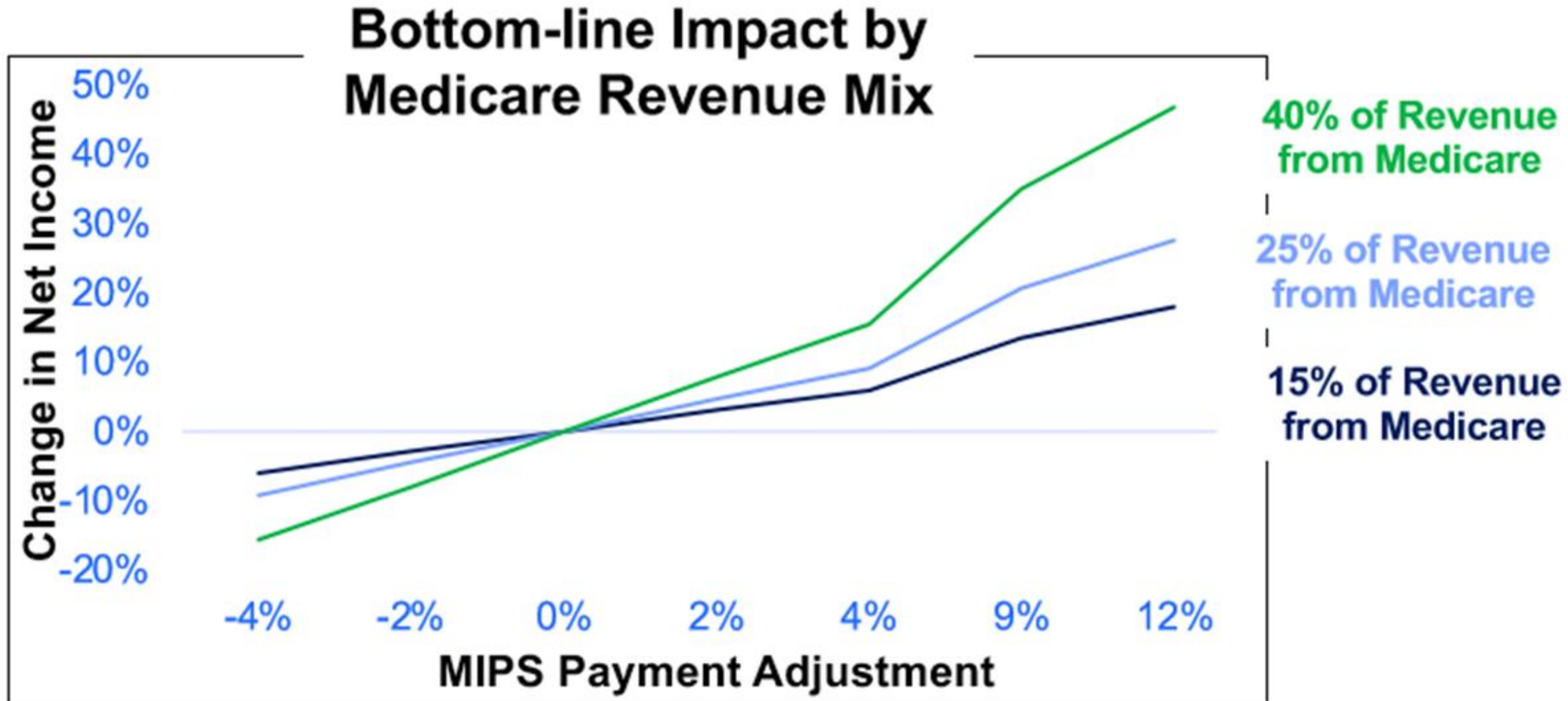
Organizations dependent on Medicare face greater risk

Organizations with a greater share of revenue from Medicare face disproportionate gains and losses depending on performance under MIPS



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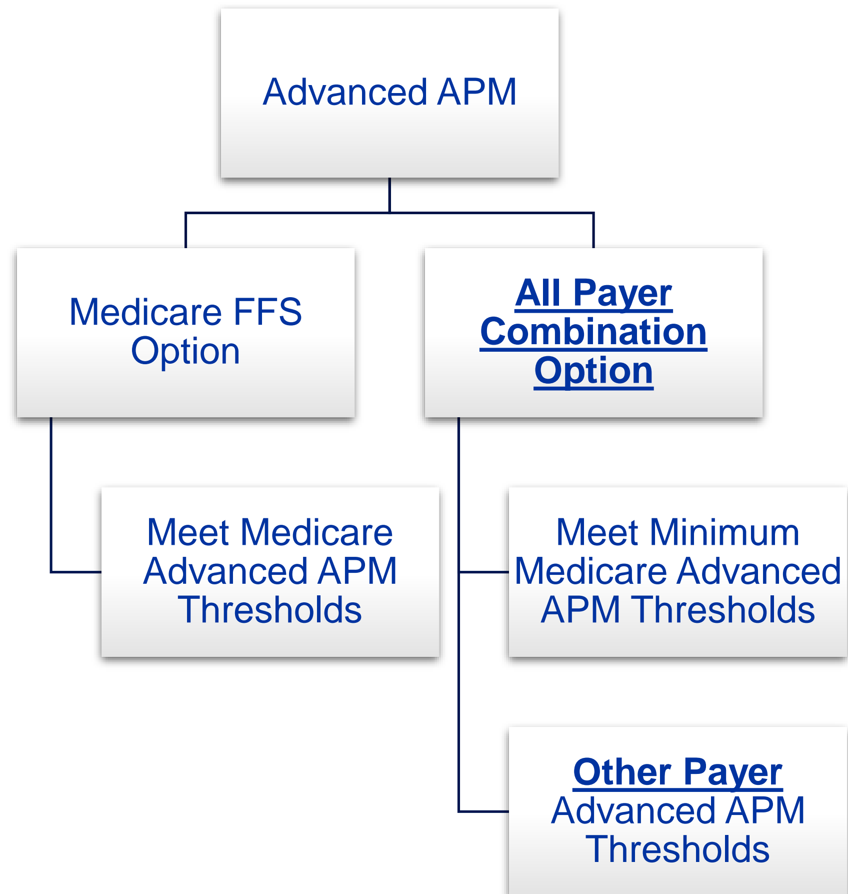
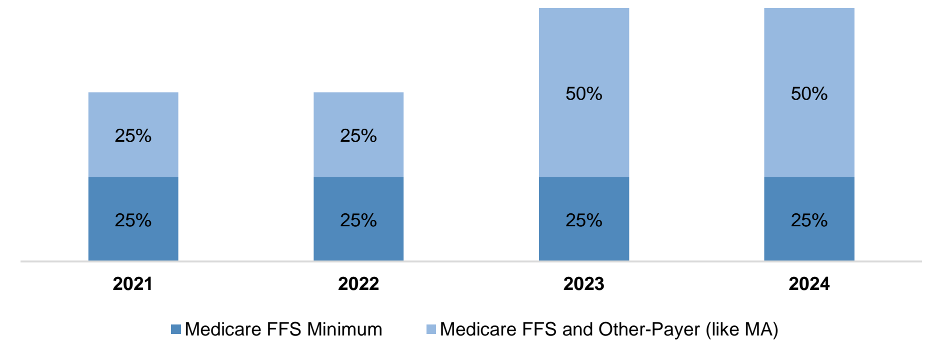
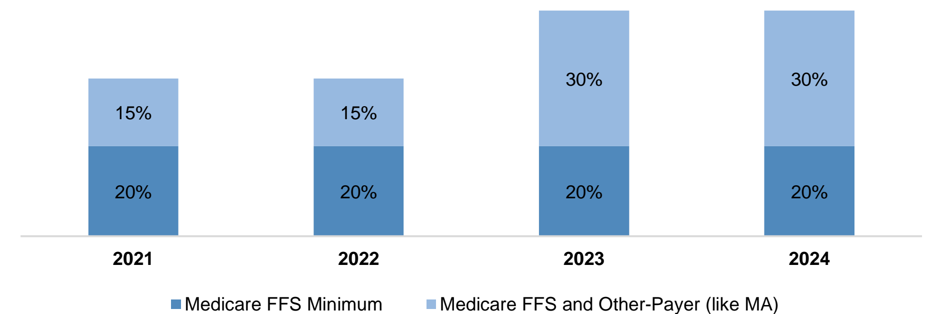
Advanced APM → All Payer Combination Option

All Payer Combination Option, takes into account the clinician's participation in Advanced APMs both with Medicare (FFS) and Other payers (like Medicare Advantage and Commercial)



All Payer Combination Option Thresholds





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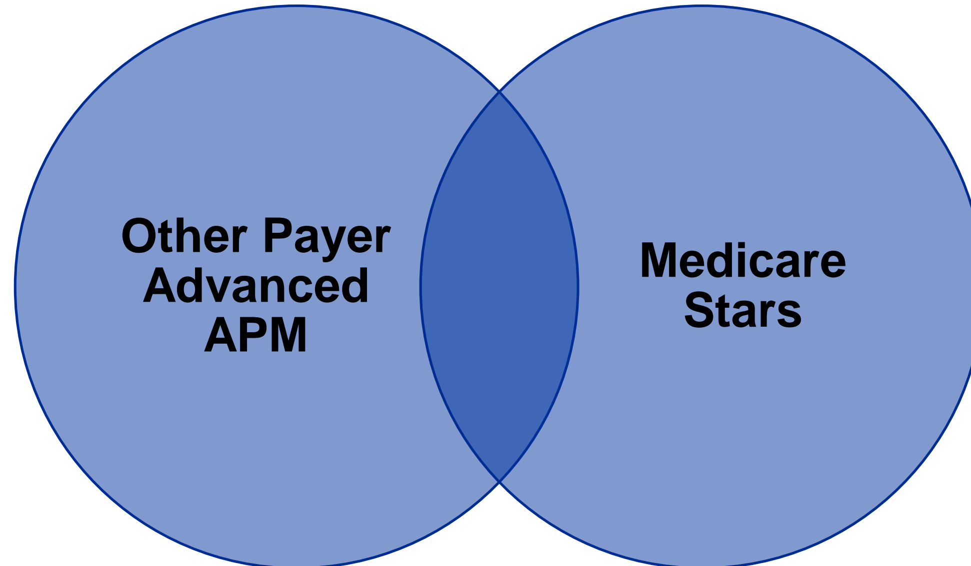
Intersection and Synergy of Other Payer Advanced APM and Medicare Stars program



Quality measures: Overlapping measures between Stars, MSSP and MIPS

Financial risk: Risk-based contracts to improve Star measures that also qualify for Advanced APM

Use of CEHRT: FHIR and Interoperability to share clinical information

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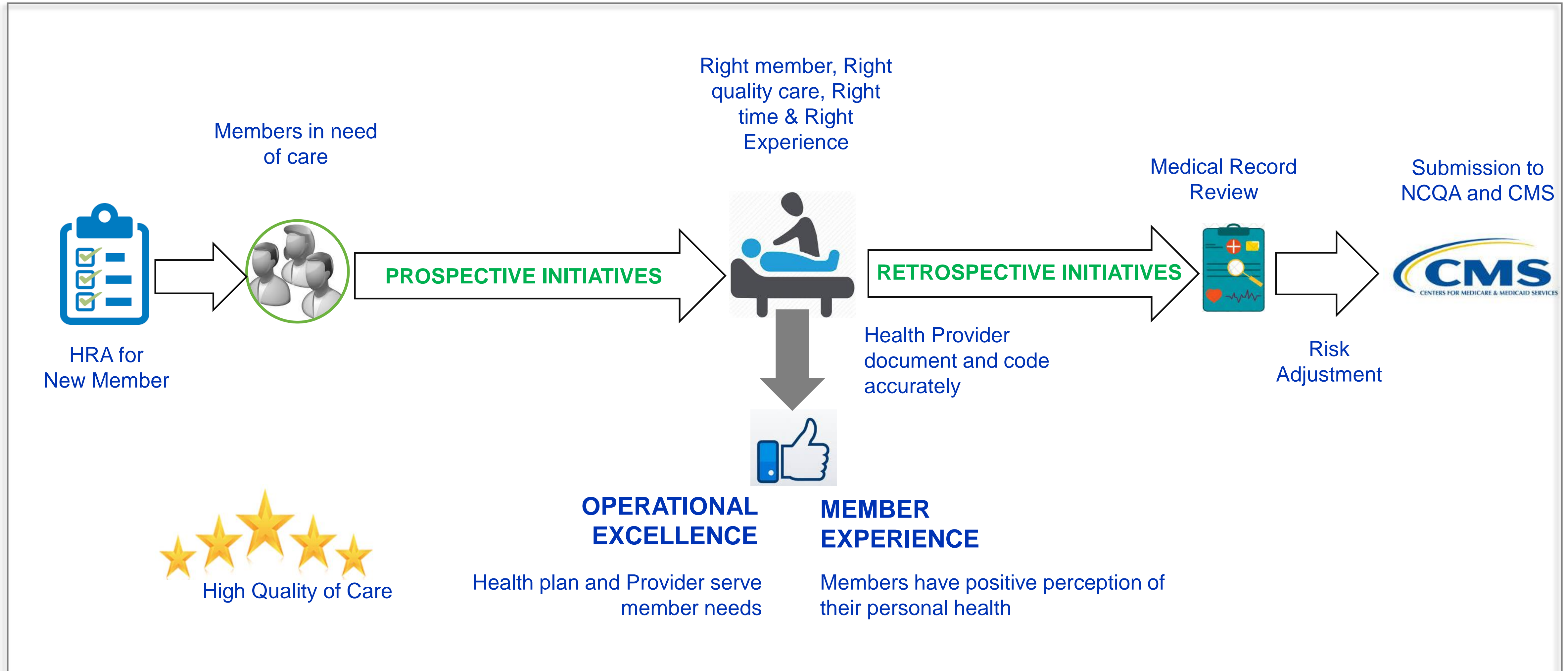
Success requires performance across the Value chain



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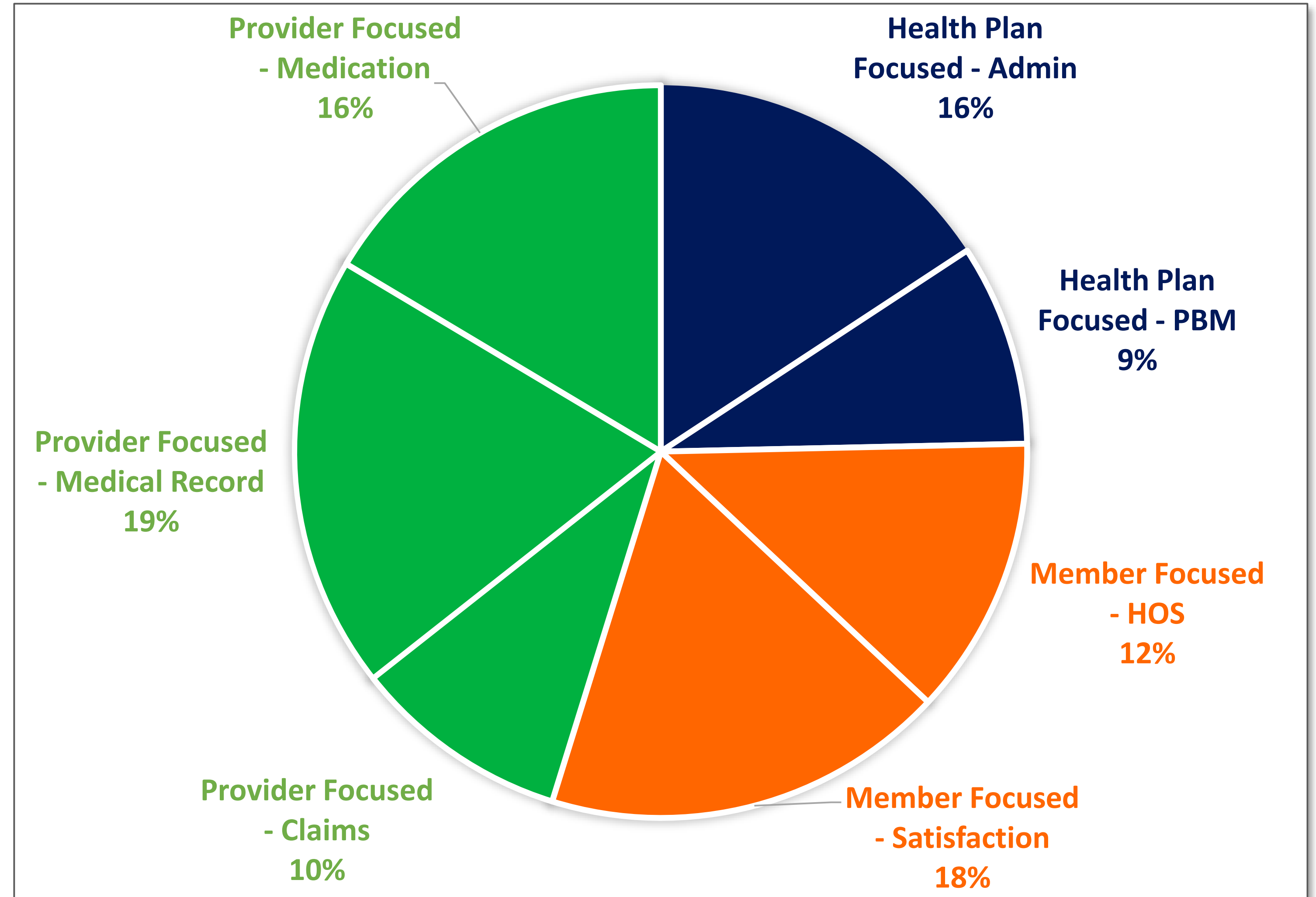
What is being measured by CMS Stars?

- Clinical Quality - 45%
- Health Plan Operations - 25%
- Member Satisfaction and Perceptions of Health - 30%



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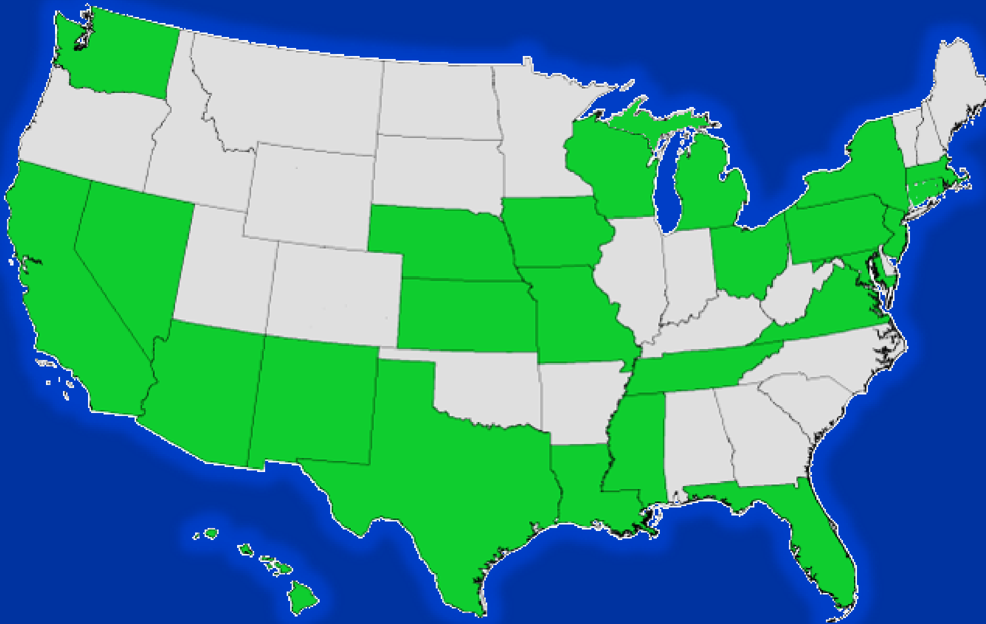
Cognizant's Quality Improvement Solution Footprint

Quality and Star Rating improvement achieved through Partner-Centric Planning covering 15+ Million Total Lives across 25 States and Medicaid, Medicare & Commercial Line of Business



9 Years of Successful NCQA Certification **25 States Growing Foot Print**	**11 Mn Medicaid Lives One of the largest Medicaid quality reporting vendors**
268,000 Providers Touched	**1000+ Measures Medicaid in a Box**
258,000+ Medical Record Chases	**10,000 Provider Incentive Reports**

Outcomes Delivered

- **$24 Mn+** Enabled MA & Medicaid Plan to earn incentive
- **4.5 CMS Star Rating**
- **10+** Quality Improvement Case Studies

Recognized by Research Analysts

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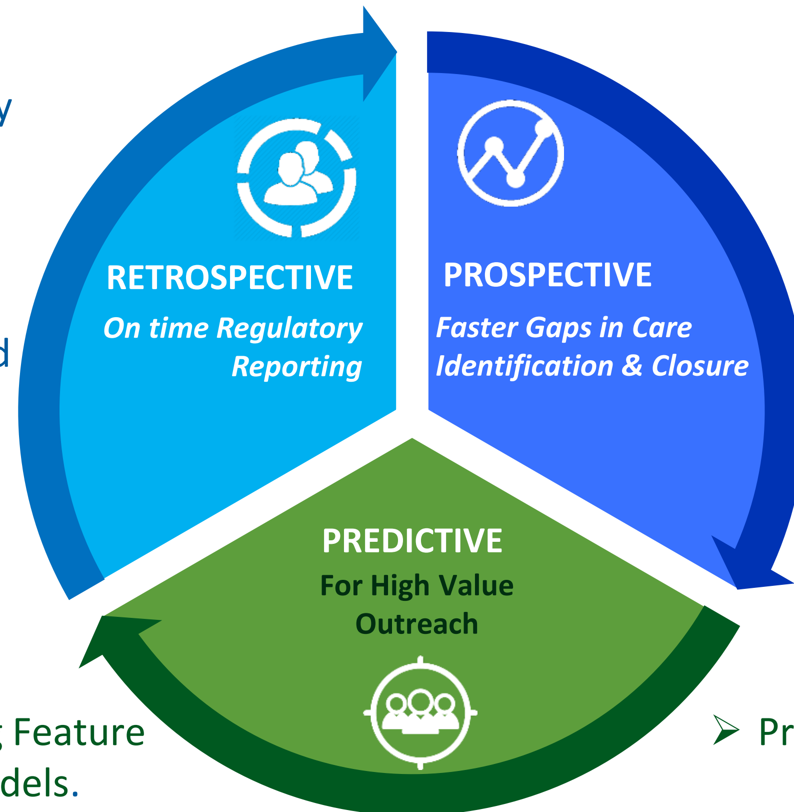
Quality Management Solution

ClaimSphere™ QaaS On Time Regulatory Reporting	StarServ™ Quality Improvement Analytics	Clinical+ Payer-Provider Convergence Platform

- ✓ E2E HEDIS vendor offering Regulatory Reporting as a Service
- ✓ Extensive Quality Measure Library
- ✓ Unified Claims & Clinical data processing engine, with an Integrated Data Quality Engine



- ✓ Population Health Registry with Provider Scorecard and support for various Value-based programs
- ✓ Star Quality Improvement Analytics and Cohort Explorer features
- ✓ TriZetto Core Engine Integration

- ➢ Data Science Workbench Including Feature Engineering and Predictive Models.
- ➢ Predict Member Adherence to Evidence based Clinical Guidelines

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Quality Reporting & Star Improvement Solution Footprint

Cognizant TriZetto® ClaimSphere® QaaS

HEDIS® REPORTING & STATE MEDICAID LIBRARY

- Gaps in Care Analytical engine with Extensive Member profiling features
- Faster turn around time with daily processing of Quality measures
- Integrated Data Quality Engine to uncover data gaps
- TriZetto Core Engine Integration - FACETS & QNXT

Cognizant TriZetto® StarSERV®

STAR & QUALITY IMPROVEMENT ANALYTICS

- STAR Rating Performance Insights across measures and data sources
- What-if Modelling to develop a comprehensive Star improvement strategy
- Improve member experience by offering Next Best Action insights

Cognizant TriZetto® ClaimSphere® Clinical+

QUALITY REGISTRY FOR PROVIDERS

- Gap closure engine - NCQA certified platform enables Bi-Direction data exchange between Payers and Provider in Near real time
- Enable Providers to track MIPS and HEDIS® measure performance
- Detailed Patient level insights at point of care

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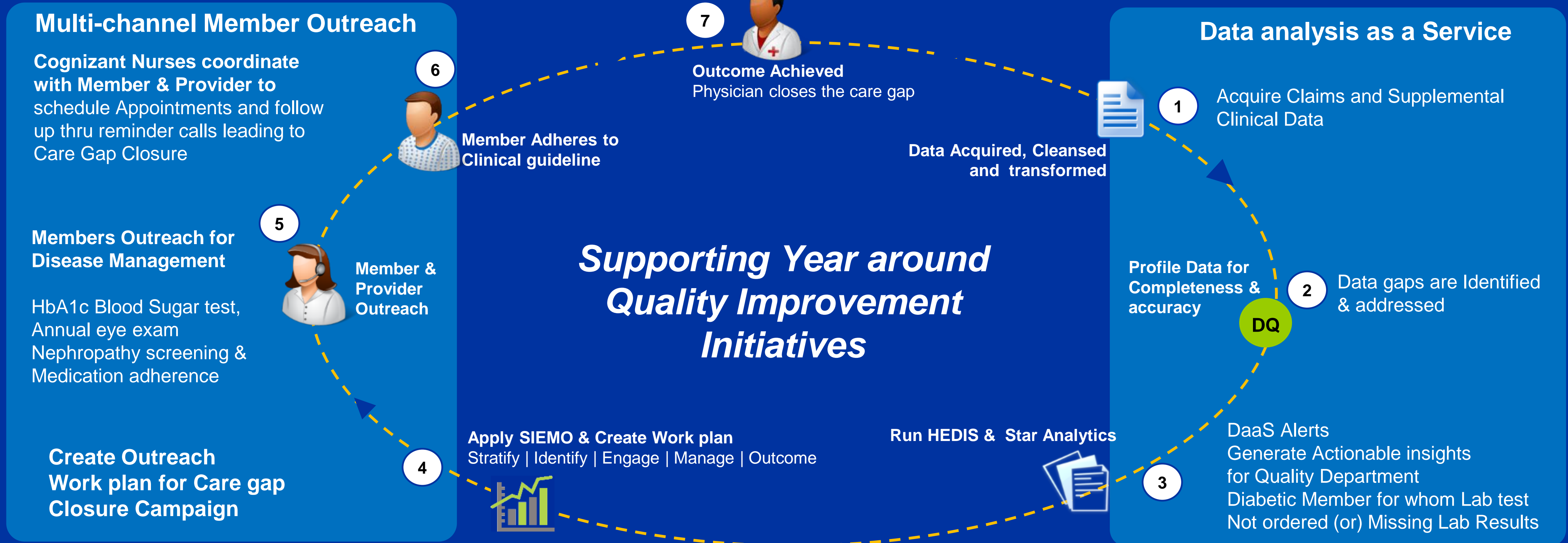
QaaS Prospective Quality Improvement



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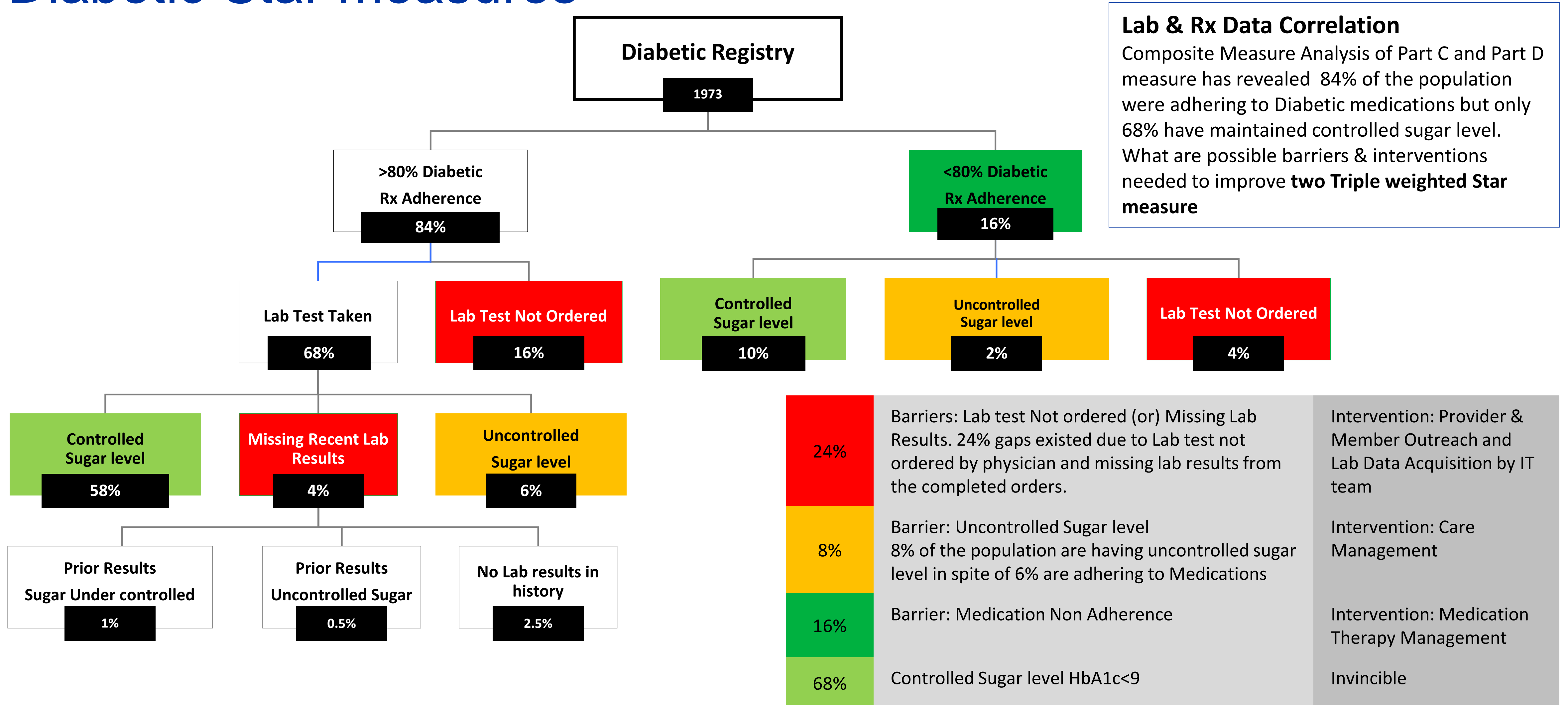
Cohort segmentation: Composite analysis of two triple weighted Diabetic Star measures



Lab & Rx Data Correlation

Composite Measure Analysis of Part C and Part D measure has revealed 84% of the population were adhering to Diabetic medications but only 68% have maintained controlled sugar level. What are possible barriers & interventions needed to improve **two Triple weighted Star measure**

24%	Barriers: Lab test Not ordered (or) Missing Lab Results. 24% gaps existed due to Lab test not ordered by physician and missing lab results from the completed orders.	Intervention: Provider & Member Outreach and Lab Data Acquisition by IT team
8%	Barrier: Uncontrolled Sugar level 8% of the population are having uncontrolled sugar level in spite of 6% are adhering to Medications	Intervention: Care Management
16%	Barrier: Medication Non Adherence	Intervention: Medication Therapy Management
68%	Controlled Sugar level HbA1c<9	Invincible

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Barrier Assessment

DATA COMPLETENESS

BARRIER	REMEDY
Missing Encounter, Vision & Lab Results	Supplemental Data Collection
Disparity in Pharmacy Data between CMS & Health Plan	Reconcile data. Perform member level analysis
Late arriving Member enrollment records and and Missing Member Contact Info.	Data Governance and Establish SLAs with Stakeholder. Outreach Teams procuring correct info
Hospital Readmission Data Lag & Missing Medication History Data	Prior Authorization/ ADT to enable better monitoring of readmissions. Supplemental Data Collection - Prospective Chart retrieval
Missing Provider credentials and Specialty mapping	Uncover Provider data gaps relevant HEDIS/Star measures and fix the gap
New Members Data Gaps	Conduct HRA. Retrieve prior medical records from IPAs

PROVIDER & CONTRACTING

BARRIER	REMEDY
Incorrect Coding	Handbook - *University*
Missing lab data	Relook IPA contract with lab vendors
Missing Big picture	Monthly IPA scorecards with member list
Lack of incentive	PCP incentive. Risk sharing contracts with IPAs

BENEFIT DESIGN

BARRIER	REMEDY
LIS members not taking meds	Copay and Donut hole
High cost of meds:	Generic substitutes
Unable to Pay Rx	Copay for Drugs

SYSTEMS

BARRIER	REMEDY
Inability to segment & identify high ROI cohorts	Comprehensive Data analysis and **Measure Benchmarking to deliver actionable insights** at Measure, Member & Provider Level
Stakeholders lack ONE view	Implementation of Star Dashboard
Up to date patient info	Implement Patient registry for high impact cohorts

MEMBER CARE

BARRIER	REMEDY
Multiple Steps in Mammogram Tests Geographical access issue in mammo-gram Screening	Facilitating Mammograms Pre-Authorizations through Outreach. Set up of Mobile mammogram centers for easy accessibility
Reluctance for Cancer Screening	Overcome member reluctance by sending/ receiving FOBT kits
Non adherence to Time-Sensitive Tests	Proactive scheduling of Osteo BDT scans
New Members	Conduct HRA. Retrieve prior medical records from IPAs

MEMBER COMMUNICATION

BARRIER	REMEDY
Call fatigue	Reduce call to <10mins. Spread member outbound throughout the year. > Meds mid year. > Prevention early in year
Multiple outreach	Remove members touched by IPA calls from outreach
Wrong timing	Avoid holidays and seasons

MEMBER BEHAVIOR

BARRIER	REMEDY
Members with Minimal PCP/OP visits	Schedule In home assessments for such members
Member perception that their symptoms can be controlled without treatment	Member education programs
Low motivation at member level	Member rewards/ gift cards

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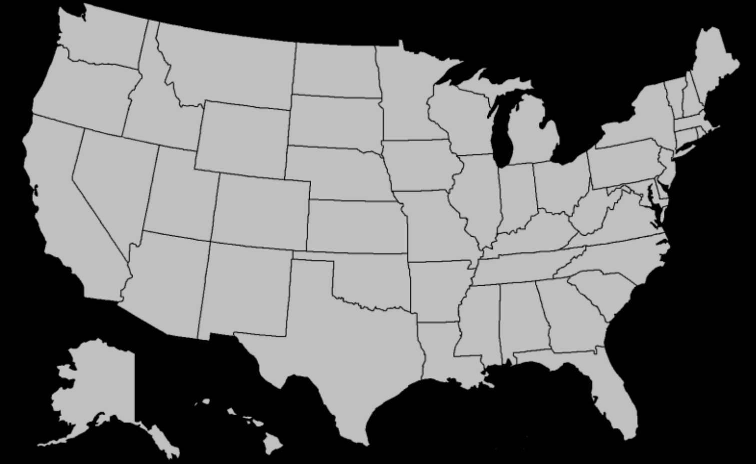
Enabling 'Micro-segment' Intelligence for National Campaign

'Gaps in Care' scored and segmented through Predictive Analytics

- Prioritized Member List on Predictive Scores
- Flexible Levers for Segmentation
- Micro-Segment Propensity Score for Success
- Campaign feedback Analysis and Re-prioritization

National Campaign

" 5-8% Rate Improvement by Targeting less than 20% of Population"



Outcomes as Realized by comparing Predicted and Actuals for State of NM # 170K Lives

Breast Cancer Screening (BCS)
Uncovered 266 Lives with potential of 6% Rate Improvement

Eligible Population 4740 Lives
Target Segments 890 Lives
Microsegment 266 Lives

Cervical Cancer Screening (CCS)
Uncovered 947 Lives with potential of 5% Rate Improvement

Eligible Population 17477 Lives
Target Segments 3374 Lives
Microsegment 947 Lives

Patients on Persistent medications (MPM)
Uncovered 39 Lives with potential of 5% Rate Improvement

Eligible Population 526 Lives
Target Segments 110 Lives
Microsegment 39 Lives

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DaaS - Data Analysis as a Service for Quality Rate Improvements

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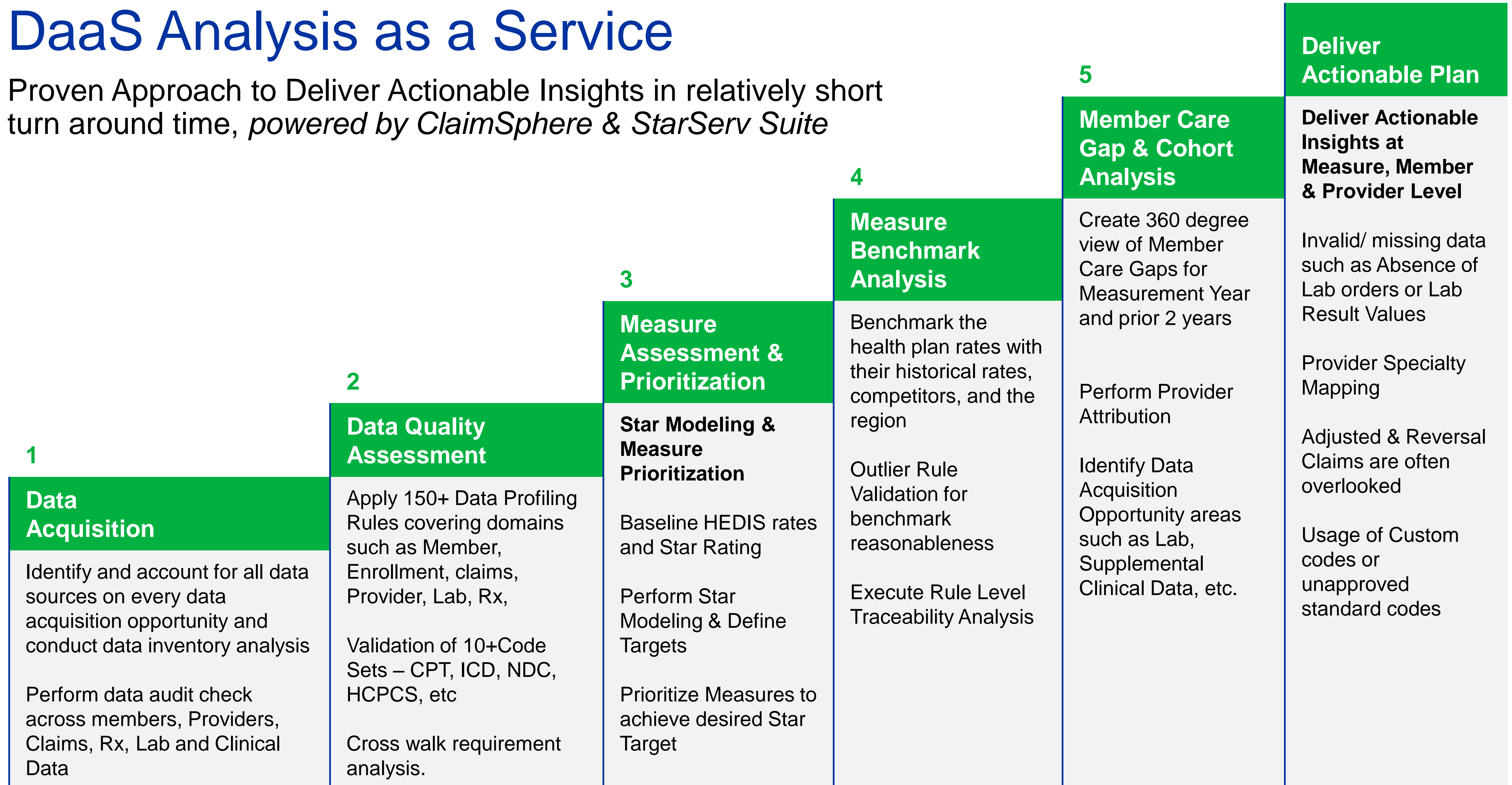
DaaS Analysis as a Service

Proven Approach to Deliver Actionable Insights in relatively short turn around time, *powered by ClaimSphere & StarServ Suite*



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Data Analysis as a Service for Enhanced Rate Improvements

Capabilities

- Analytical competency – DaaS SMEs who are familiar with both Star and HEDIS program along with technical know-hows to analyze data to identify actionable insights
- Domain leadership - Consultants who are well versed in Quality of care and Value based healthcare can converse with client's business leaders like Star czars and Chief medical officers

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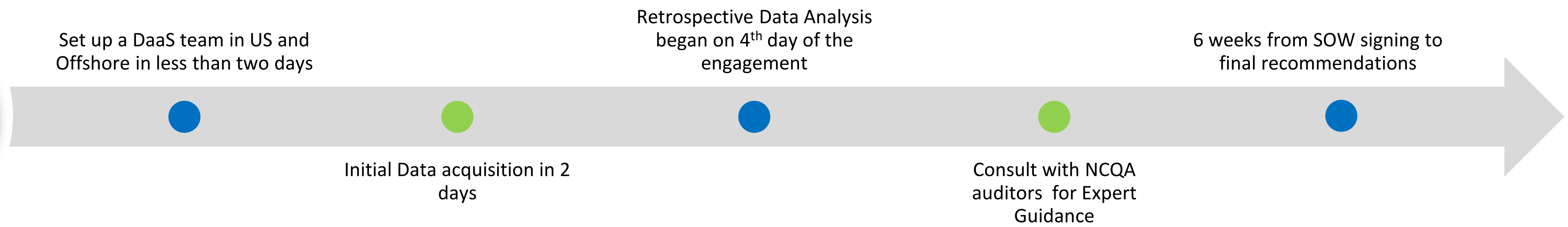

Key Differentiator

- DaaS Program delivered Actionable insights in daily increments
- Customer was able to act on the findings and it enabled them to Create Quality Improvement Program
- Demonstrated Operational Excellence with well-established Communication process & Governance structure

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ClaimSphere® DaaS Alert – Prenatal and Postpartum Care

ClaimSphere® DaaS Alerts

Insight #3 **Potential 10% Point Impact By Verifying Practitioner Type**

Prenatal and Postpartum Care (PPC)

6% potential improvement in rate for Timeliness of Prenatal Care for Administrative Data Reporting

- **1,449** patients non-complaint for PPC1 (Timeliness of Prenatal Care) have the relevant qualifying events for Prenatal Care but with practitioner type is NOT OB/GYN
- Leading to rate increase from **68% to 74%**

10% point improvement in rate for Hybrid Data Reporting

- **39** of these non-compliant patients are also included in the Hybrid sample frame
- Leading to rate increase from **71% to 81%**

Alert Date	Admin Data Refresh Date	Measure Priority
02/25/2019	02/12/2019	Medi-Cal Auto-Assignment Measure

Measure Snapshot for MediCal Reporting Population

	2019 Hy DR	2019 Hy NR_Admin	2019 Hy NR_MR	2019 Hy %	HEDIS 2018 IDSS (Hy)	2019 Admin DR	2019 Admin NR	2019 Admin %
PPC1	405	289	0	71.6%	82.22%	22,619	15,286	68%
PPC2	405	209	0	51.6%	56.54%	22,619	11,874	52%

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ClaimSphere® DaaS Alert – Controlling Blood Pressure

ClaimSphere® DaaS Alerts

Insight #2 **Physician Awareness To Increase Use of CPT Category II Codes**

Controlling Blood Pressure (CBP)

For The First Time NCQA is Allowing Admin Data Numerator Events for CBP

- **76%** (90,155) of patients identified with Hypertension who had an Outpatient Visit, don't have a CPT Category II code associated with Blood pressure
- Opportunity to reduce Medical record retrieval for up to **74%** (303) of CBP sample patients via admin hits

Improved usage of CPT II codes leads to:

1. Fewer Medical record request for
2. Better performance in
3. Lesser reminders to patients for screenings

Alert Date	Admin Data Refresh Date	Measure Priority
02/22/2019	02/12/2019	Medi-Cal Auto-Assignment Measure

Measure Snapshot for MediCal Reporting Population

	2019 Hy DR	2019 Hy NR_Admin	2019 Hy NR_MR	2019 Hy %	HEDIS 2018 IDSS (Hy)	2019 Admin DR	2019 Admin NR	2019 Admin %
CBP	411	58	-	14.11%	65.03%	118,254	19,922	16.8%

CPT Category II Codes

Current Procedural Terminology (CPT) Category II codes were developed by the American Medical Association (AMA) as a supplemental performance tracking set of procedural codes in addition to the Category I and III.

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ClaimSphere® DaaS Alert – Well Child Visits

ClaimSphere® DaaS Alerts

Insight #1 **Opportunity for 2% point improvement to W34 Hybrid Rate**

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Analysis of W34 Hybrid Sample Frame for HEDIS 2019

- Administrative Rate of W34 = 64.91%
- Denominator = 149,136
- Members w/ Well-Care event but Missing Provider Info= 2,071
- Hybrid sample frame size = 321
- Numerator compliant using administrative data = 205
- Hybrid Rate (using admin data) = 63.86%
- Admin Non-Compliant Members (potential chases) = 116
- Members w/ Well-Care event but Missing Provider Info = 7
- Lab Flag = 0 and PCP Flag = 0
- Lab Flag = 1 and PCP Flag = 0
- Lab Flag = 1 and PCP Flag = 1

Benefits

Potential rate increase to 66.04% (from 63.86%)

Reduced medical record retrieval operations

Alert Date	Admin Data Refresh Date	Measure Priority
02/13/2019	01/18/2019	Medi-Cal Auto-Assignment Measure

W34 Measure Snapshot for Medi_Cal Reporting Population

	2019 Hy DR	2019 Hy NR_Admin	2019 Hy NR_MR	2019 Hy %	HEDIS 2018 IDSS	2019 Admin DR	2019 Admin NR	2019 Admin %
W34	321	205	-	63.86%	74.65%	149,136	96,181	64.91%

NCQA HEDIS 2019 Specification

"At least one well-child visit (Well-Care event) with a PCP during the measurement year. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child"

Lab Flag should be = 0 | PCP Flag should be = 1

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ClaimSphere® DaaS Alert – Osteoporosis Management in Women

4 Star rating at risk for Osteoporosis Management in Women ☹

Ⓣ Numerator event time sensitive measure

For the measure C13 - Osteoporosis Management in Women who had a Fracture, as of 23rd September (today) only **19 of 60** non-compliant members (open care opportunities) are within the 180 days' time window from the date when they suffered a fracture.

OMW is a time sensitive measure and treatment provided after 180 days will not make a member compliant.

Out of the remaining 41 there are 7 members whose 180 days window ends in August and September and there is a possibility that they would have received the service and it's not available with us due to claims lag.

For 3 out of 19 members the window closes in **next 10 days** which may be too close to the date for Cognizant CER outreach.

We would suggest that they are immediately communicated to schedule a bone mineral density (BMD) test or a prescription for osteoporosis treatment drug be triggered.

Member	Target date	IPA	Action	Note
1	26th September	[illegible]	☐	
2	28th September	[illegible]	☐	
3	3rd October	[illegible]	☐	

It would be great if you can reply to this email and mark the Check box X after these members have been contacted. This would allow us to flag these members in StarSERV.

The performance of some of the bigger IPAs are listed below

- All [illegible]re: 6 of 6 open opportunities have crossed the 180 day window as of today
- A[illegible] re: 5 of 7 open opportunities have crossed the 180 day window as of today
- SA: 6 of 10 open opportunities have crossed the 180 day window as of today
- [illegible]ni: 4 of 6 open opportunities have crossed the 180 day window as of today

Current Star ★

Achievable Target ★★★★

Data Run 26th August

2016 Preview Cut points

Star	Cut point	Additional compliant members
★	< 20%	-
★★	≥ 20% to < 32%	6
★★★	≥ 32% to < 51%	14
★★★★	≥ 51% to < 75%	27
★★★★★	≥ 75%	43

Trending

Run date	Denominator (Total care opportunities)	Numerator (Closed care opportunities)	Rate	Star
08/26	68	8	11.76%	①
08/04	61	7	11.45%	①

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ClaimSphere® DaaS Alert – Medication Adherence

Aggressive Outreach for Medication Adherence "Hopeful" Registry

Ⓣ Time sensitive measure Ⓒ Denominator event count sensitive measure

100% conversion of the hopeful registry can enable [illegible] to achieve 5 Star for all 3 PDC measures as per the 2016 cut-points.

The PBM report (data thru' 10/31) was used to generate the list of members for focused outreach of the medication adherence measures.

Members with a single fill were removed for this analysis as they will not qualify for adherence measures

- Diabetes – 61 members
- RAS – 16 members
- Statins – 3 members

The members in the hopeful registry should be of high priority for the Outreach programs.

Diabetes

60.00%
40.00%
20.00%
0.00%
Impossibles Invincibles Hopefuls-<30 Hopefuls-30-60

RAS

40.00%
20.00%
0.00%
Impossibles Invincibles Hopefuls-<30 Hopefuls-30-60

Statins

3000
2000
1000
0

Invincibles – List of members who will be compliant without any further refills
Hopefuls-<30 – List of member who need less than 30 days of refill for compliance
Hopefuls-30-60% - List of members who need 31-60 days of refill for compliance
Impossibles – List of members who need more than 60 days of refill for compliance

Current Star	Medication Adherence for Diabetes Medications	4
	Medication Adherence for Hypertension (RAS)	3
	Medication Adherence for Cholesterol (Statins)	3
Target	Medication Adherence for Diabetes Medications	5
	Medication Adherence for Hypertension (RAS)	5
	Medication Adherence for Cholesterol (Statins)	5

2016 Cut points

Measure	Star	Cut point
Medication Adherence for Diabetes Medications	★	< 60%
	★★	≥ 60% to < 69%
	★★★	≥ 69% to < 75%
	★★★★	≥ 75% to < 82%
	★★★★★	≥ 82%
Medication Adherence for Hypertension (RAS)	★	< 58%
	★★	≥ 58% to < 73%
	★★★	≥ 73% to < 77%
	★★★★	≥ 77% to < 81%
	★★★★★	≥ 81%
Medication Adherence for Cholesterol (Statins)	★	< 50%
	★★	≥ 50% to < 61%
	★★★	≥ 61% to < 73%
	★★★★	≥ 73% to < 79%
	★★★★★	≥ 79%

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Case Studies and Outcome Delivered

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Quality Improvement Case Studies across Value Stream

Case Study 1 — Helped a MA plan to attain 4.5 Stars and realize **$16 Million** additional payment from CMS for **7,000 lives**

Case Study 2 — Cognizant's E2E Quality Improvement services helped a MA plan boost its Star ratings from **3.0 to 4.5**

Case Study 3 — **Sustained High Quality 4.5 Star ratings** for a Provider sponsored plan across MA Stars and NCQA Accreditation

Case Study 4 — **Integrated Risk and Quality Coding** for capturing diagnosis for CMS Risk Adjustment and to close Star/ HEDIS Gaps in care

Case Study 5 — Achieving **"Commendable" Accreditation status** for largest publicly-operated health plan in the West coast

Case Study 6 — **40% improvement** in NCQA Accreditation points for a **Large Blues Plan**

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Case Study - Attaining 5 STARS Rating for Clinical Measures in 120 days Using a Payer-Provider Convergence Platform

Clinical Data Acquisition & Management | **Payer-Provider Convergence** | **Double Digit Rate Improvement**

Opportunity

- **Complex network of providers** – PCP, Specialty, Hospitals, Lab etc.
- Increased investments and Challenges in **Aligning Physician Groups** with CMS Star Improvement Goals
- **Claims data quality issues** such as coding errors, claims data lags, historical information, etc.

Solution

- Bi-Directional Provider Registry for Year round supplemental data collection
- Taps into the inherent competitive nature of providers via a Peer performance scorecard

Business Outcomes

- First time **4.5 Star** rating in 2019 Stars
- $250-300/Member **Eligibility for Federal Funding**
- **45%** Overall Increase in Gaps Closures
- Approval for all HEDIS 2018 **Supplemental Databases**
- Newly introduced **Transitions in Care** measure. 81% vis-à-vis 38% for 90th percentile benchmark for Med Rec.

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Helped a MA plan to attain 4.5 Stars and realize $16 Million additional payment from CMS

The Customer

A Florida based MA plan offering boutique concierge-level services across three counties, and utilizing a narrow network of quality providers engaged via risk-based arrangements.

Cognizant has been supporting their NCQA HEDIS® reporting since 2013 and they are also a Cognizant TMG client.

The Context

To grow their business and successfully compete with the strong market presence of large health plans the plan needed to raise its Star ratings from 3.5 to 4+ and improve HEDIS® measures.
Key challenges were:

- Enhancing clinical data acquisition and management
- Aligning Physician groups with CMS Star Improvement goals

The Solution

- Cognizant collaborated with the MA plan to develop a **Bi-directional Care Gap Registry** module to extend the functionality of ClaimSphere
- Supported client to run a **120 Days CMS Star Measure Rate Improvement** program, focusing on Preventive and Chronic care measures

1 Provider Incentive Program & Scorecard

Delivering actionable quality metrics and P4P reporting at the point of care

Impact of **$16 M** additional premium & rebate from CMS for attaining 4.5 Stars

2 Prospective Care Gap Closure

Across 10+ HEDIS measures including the newly introduced TRC – Med Rec

45% increase in care gap closure

3 Supplemental Data Acquisition

Year-round with providers uploading medical records as gap closure evidence. Successful **NCQA audit & PSV**

Dramatic reduction in Medical record review at year end

TRC: Transitions of care - Medication Reconciliation Post-Discharge
PSV: Primary Source Verification by NCQA auditors

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Cognizant's E2E Quality Improvement services helped a MA plan boost its Star ratings from 3.0 to 4.5

The Customer

A California based Mid-sized MA plan offering a coordinated continuum of care and serving Seniors, Duals and Low income subsidy population in & around Los Angeles county.

The Context

***"We absolutely have to be at 4 Stars to continue to live in and 4.5 Stars to thrive in this market"* – CIO**

The plan has been consistently rated below 4 Stars, with $8 - 10 Million annual impact to the topline in terms of lost Quality Bonus Payment and Rebates

Key challenges were:
- Premium pricing of HEDIS vendor for prospective analytics for a Mid-sized plan
- Star CoE team had bandwidth issues to support multiple ad hoc analytics requests

The Solution

- Cognizant conducted an initial data assessment and then deployed its **StarSERV®** platform for Star and HEDIS analytics
- Star analytics and weekly **member target list** pushed to **OnVida** Omni-channel engagement platform for member outreach by **10+ nurses**

Pathway to 4 Stars using SIEMO Framework

1 Member-Provider-Measure Analytics

PPVA to support provider incentive program; Micro-segmentation like time sensitive Dexa scans; Outreach prioritization & effectiveness analytics

2 Omni-channel Member Engagement

Call scripting and routing, Care gap closure (mammogram, FOBT, HbA1c test, Bone density etc) and Medication refill reminder program

3 Data Inventory and Profiling

Data acquisition opportunities like missing Eye and A1c test data; exclusions for BCS using prior year medical records

4 Cognizant Program Management – Multi vendor environment

SIEMO: Stratify Identify Engage Manage Outcome measured
PPVA: Practice Pattern Variation Analytics

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Sustained High Quality Star ratings for a Provider sponsored plan across MA Stars and NCQA Accreditation

The Customer

A Provider sponsored health plan with 800,000+ enrollees across Medicare, Medicaid and Commercial in Michigan.
Highly rated plan including 4.5 Star rated MA contracts and an existing TriZetto® Facets® client.

The Context

HEDIS measures, specifically gaps in care analytics are a core aspect of maintaining high quality rating across Stars and NCQA.

In additional they had a PCP Incentive Program covering all LOBs to improve patient care.

The plan wanted to transition from incumbent HEDIS vendor due to various reasons including lack of support for analytics and NCQA audit.

The Solution

- Cognizant implemented TriZetto® ClaimSphere® for **HEDIS regulatory reporting and Hybrid MRR**
- Premium Service bureau support and **Facets data mapping best practices** lead to implementation completed **6 weeks** ahead of schedule

1 Hybrid Rate Improvt. and MR Analytics

Analysis of 4 levers/ KPIs – Chart retrieval completion, Error events & records, Missing events and Yield rate.

20,000+ chases

2 MiHIN Integration for Supplemental Data

Standard supplemental data from Michigan Health Information Network including vitals, meds and laboratory test/ results

Positive impact on rates of clinical measures like HbA1c

3 PCP Incentive Program Reports

An integrated program focused on patient-centered care.
27 measures including 15 HEDIS/ Star measures

10,000 PCPs

MR: Medical Record

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Case Study 4

Integrated Risk and Quality Coding for capturing diagnosis for CMS Risk Adjustment and to close Star/ HEDIS Gaps in care

The Customer

A worldwide health services organization offering medical, dental, disability, life and accident insurance.

The Context

Cognizant was in a large BPaaS engagement with the customer where Medicare Advantage Risk Adjustment and Quality Coding Services was a part of the solution scope.

Integrated Risk and Quality coding enables better operational efficiencies, improved clinical documentation and coding, leading to faster care gap closure and reduced provider abrasion, which has a direct impact on Star Rating and Revenue.

The Solution

Cognizant delivered an As-a-Service model leveraging:

- **Risk Adjustment Manager** (RAM) platform that enables identification and collection of risk adjustment data to accurately assess the Member's Risk score and maximize revenue accuracy
- **ClaimSphere® Clinical+** Platform that enables clinical data acquisition to help close the Gaps in Care thereby improving quality scores and STAR ratings for higher quality bonus payouts

Member HRA initiated by plan → Physician completes HRA → Completed HRA shared via secure network → Cognizant's clinical coding team captures Diagnosis and Gaps in care closure details → Clinical data shared with plan in standard format for CMS reporting

25,000 HRA forms/ charts abstracted per month

60,000 Care gaps processed per month

99.9% average audit percentage for Clinical data acquisition.
RADV and NCQA PSV audits.

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Achieving “Commendable” Accreditation status for largest publicly-operated health plan in the West coast

The Customer

A California based local public agency providing health insurance to low-income individuals with 2+ Million Medi-Cal and MMP enrollees. They are also a Cognizant TriZetto® QNXT client.

The Context

California DHCS has mandated set of incentive measures including MPL, Quality Withhold measures for capitation payment, and AA measures to automatically assign Medicaid beneficiaries when they fail to chose a plan.

Key challenges with incumbent HEDIS vendor were:
- 20% of HEDIS measure rates dropped in 2017
- Inability to support monthly HEDIS rate regeneration and benchmarking to drive improvement in incentive measures
- 2+ weeks for data refresh
- Lack of analytics support

The Solution

- Cognizant implemented TriZetto® ClaimSphere® and Clinical+ for **HEDIS regulatory reporting, Hybrid MRR and Supplemental data acquisition**
- **Service Bureau Support** with dedicated HEDIS SMEs for measure rate improvement analytics

1 Focused Strategy for Rate Improvement

15 Ad hoc measure diagnosis using QBuilder and Cohort tool; non-compliant members, claims and event details shared post rate refresh

75% of measures had a rate improvement of 5% or more.

2 NCQA Accreditation Scoring

To benchmark NCQA Accreditation measures with national & regional percentiles and prior/ year rates

Commendable NCQA accreditation status in first year. Prior year was Accredited status.

3 Gaps in Care Reports for Providers

On various grouping such as LOB & PPG. Reports are shared on monthly basis via email or provider portal to view care gaps.

10,000 providers covered

MMP: Medicare-Medicaid Plan
MPL: Minimum Performance Levels
AA: Auto-Assignment

MR: Medical Record

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Case Study 6

40% improvement in NCQA Accreditation points for a Large Blues Plan

The Customer

A East Coast based not-for-profit health insurer serving 3+ Million individuals and groups across three states, including one of the largest Federal Employees Health Benefits Program enrollments,

The Context

The plan wanted to transition from the incumbent HEDIS vendor and the key requirements were:

- Integrated quality reporting and improvement platform
- HEDIS Engine Migration for producing higher Quality rates across 65 Admin and 10 Hybrid measures.

The Solution

- Cognizant implemented TriZetto® ClaimSphere® for **HEDIS regulatory reporting and Hybrid MRR**
- Client specific **MRR Sample Swap logic** programs accurately sampled unique members across major & sub-set of populations

Optimized Performance and Hardware Config 1

MRR chases out **3 weeks** earlier with improved chase processing rules

1 Million members processed in <24 hours

IDSS Across 18 Reporting Populations 2

40% increase in NCQA accreditation points

Commendable NCQA accreditation status from Accredited status.

PCMH Reporting for PCP Incentive 3

Including Prospective reporting instance for proactive care gap closure

2-3X Faster Provider & Member Outreach through timely actionable insights

PCMH: Patient Centered Medical Home

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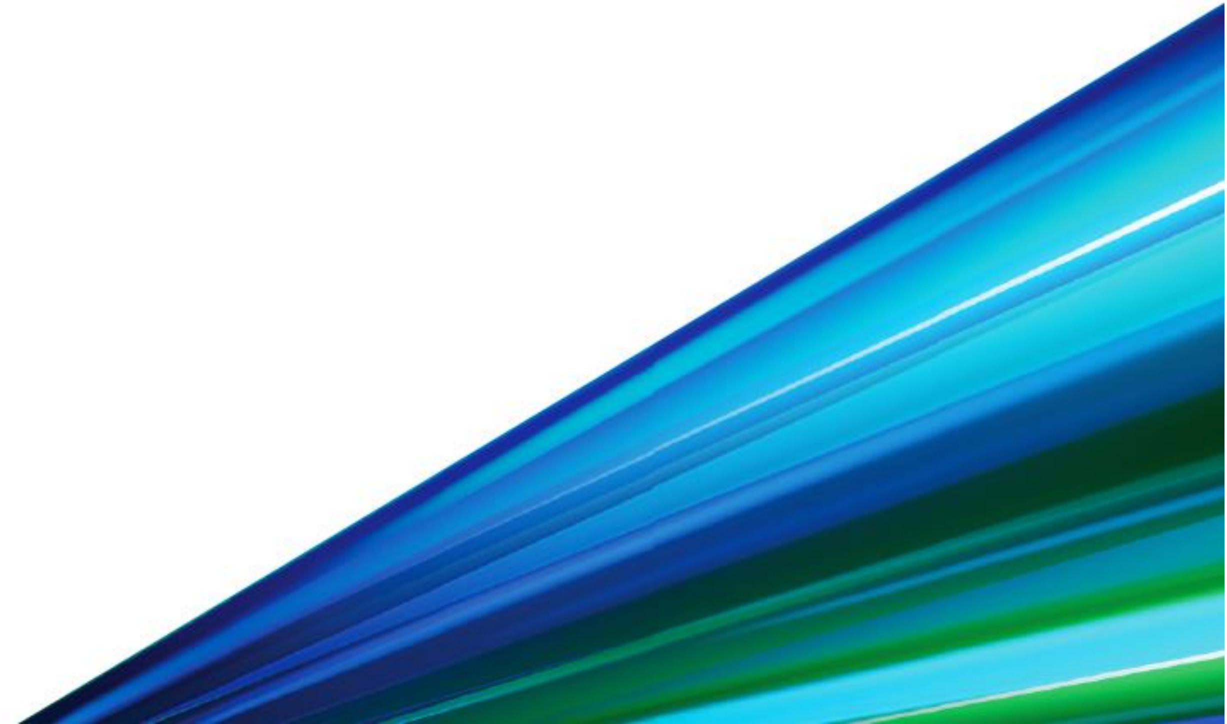
Thank You

Dr Vishnu Mohan



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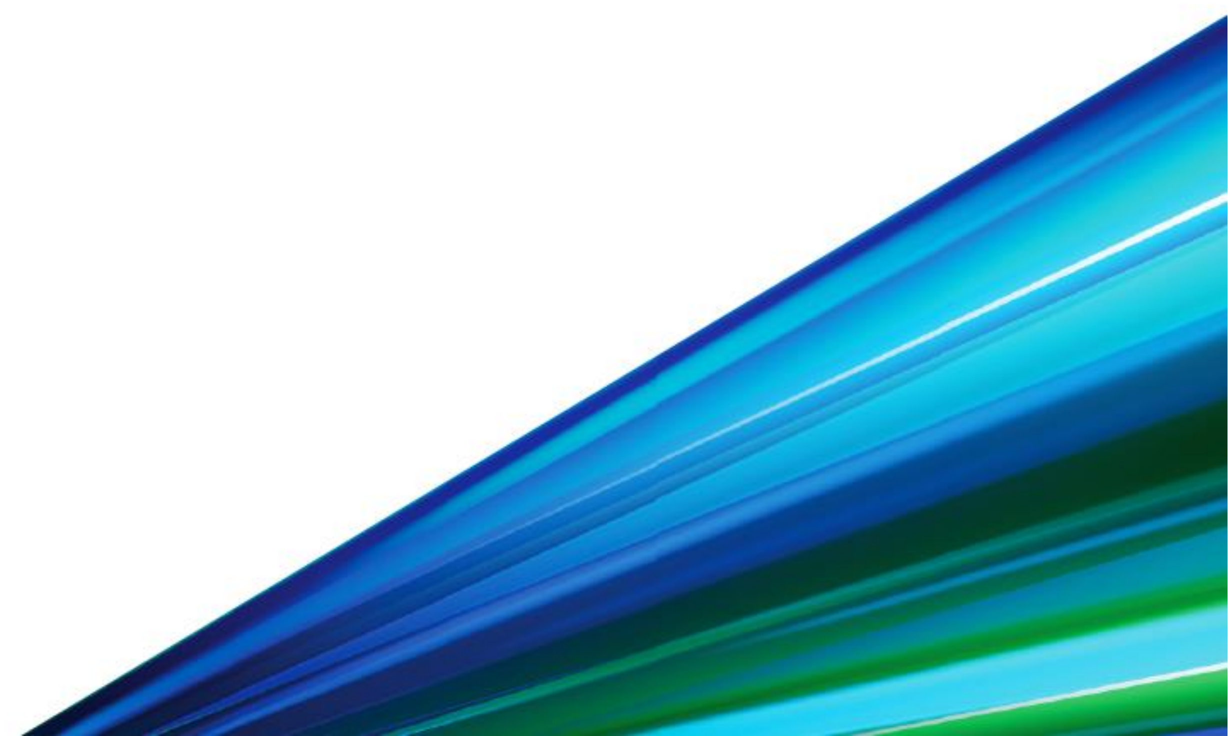

Future of Quality Reporting

Trend 1: Digitization of Quality Measure Specification (eCQM)

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Quality Measure Evolution

HEDIS® Measure Evolution

HEDIS® Administrative Measures	**HEDIS®** Hybrid Measures	**HEDIS®** Administrative measures	**HEDIS® ECDS Measures**	**eMeasure** Digital Measure Specification
Traditional HEDIS measures treats Claims as Standard data and EHR data formats as Supplemental data	Hybrid Measures using Clinical data gathered thru Manual (or) Automated Chart Retrieval	Clinical data often converted to "pseudo claims" and undergoes Auditor scrutiny	ECDS measures treats Clinical data as Standard data	Digital measures use CQL based specifications to work off of Claims and Clinical data

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Digital Measure Framework

What data to look for in patients medical record?	How to calculate the results of data to measure care?	What is the structure of the measure?
Data Model	**Expression Logic**	**Structure**
QDM Quality Data Model	**CQL** Clinical Quality Language FHIR Compatible	**HQMF** Metadata, Denominator, Numerator, Exclusion

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Digital Measure (eCQM)

eCQM Title	Breast Cancer Screening		
eCQM Identifier (Measure Authoring Tool)	125	eCQM Version number	7.2.000
NQF Number	2372	GUID	19783c1b-4fd1-46c1-8a96-a2f192b97ee0
Measurement Period	January 1, 20XX through December 31, 20XX		
Measure Steward	National Committee for Quality Assurance		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	National Quality Forum		
Description	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer		

Population Criteria

Initial Population

```
exists ( ["Patient Characteristic Sex": "Female"] )
    and exists ["Patient Characteristic Birthdate"] BirthDate
        where Global."CalendarAgeInYearsAt"(BirthDate.birthDatetime, start of "Measurement Period")in Interval[51, 74 )
            and exists AdultOutpatientEncounters."Qualifying Encounters"
```

Denominator

```
"Initial Population"
```

Denominator Exclusions

```
Hospice."Has Hospice"
    or ( Count("Unilateral Mastectomy Procedure")= 2 )
    or ( exists "Right Mastectomy"
            and exists "Left Mastectomy"
    )
    or exists "History Bilateral Mastectomy"
    or exists "Bilateral Mastectomy Procedure"
```

Numerator

```
exists ( ["Diagnostic Study, Performed": "Mammography"] Mammogram
        where ( Mammogram.relevantPeriod ends 27 months or less before day of end "Measurer
)
```


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                  - <a:s r="70">
```


Human Readable

Measure Header and Background

Human Readable

Measure Logic

An equation that relates information and calculates a measure result

Machine Readable

Measure Logic

“a machine can parse the content into sections and perform calculations”

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Future of Quality Reporting

Trend 2: Clinical data exchange standards

Industry collaboration to apply interoperability standards like FHIR and CCD to support Value-based Care Programs

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About the Da Vinci Project

Use Cases on Quality Measures

Data Exchange for Quality Measures	Coverage Requirements Discovery	Documentation Templates and Coverage Rules	eHealth Record Exchange: CDeX
eHealth Record Exchange: PDeX	Prior Authorization Support	Gaps in Care & Information	Risk Based Contract Member Identification
Alerts: ADT Notifications – TRC, ER	Performing Lab Reporting	Chronic Illness Documentation for Risk Adjustment	Patient Care Transparency

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DaVinci Use Case

To succeed in population health and **value-based care, gaps in care** and must be addressed efficiently and in a timely manner.

Gaps in Care Information: **Disparities in claims vs. clinical information** which makes it difficult to asses if best practices are being followed:

Bi-directional, real-time, FHIR-based communication that **reconciles payer information with clinical EHR** data to ensure best practices are followed, improve outcomes, and exchange information to reduce expense and disruption to provider workflows.

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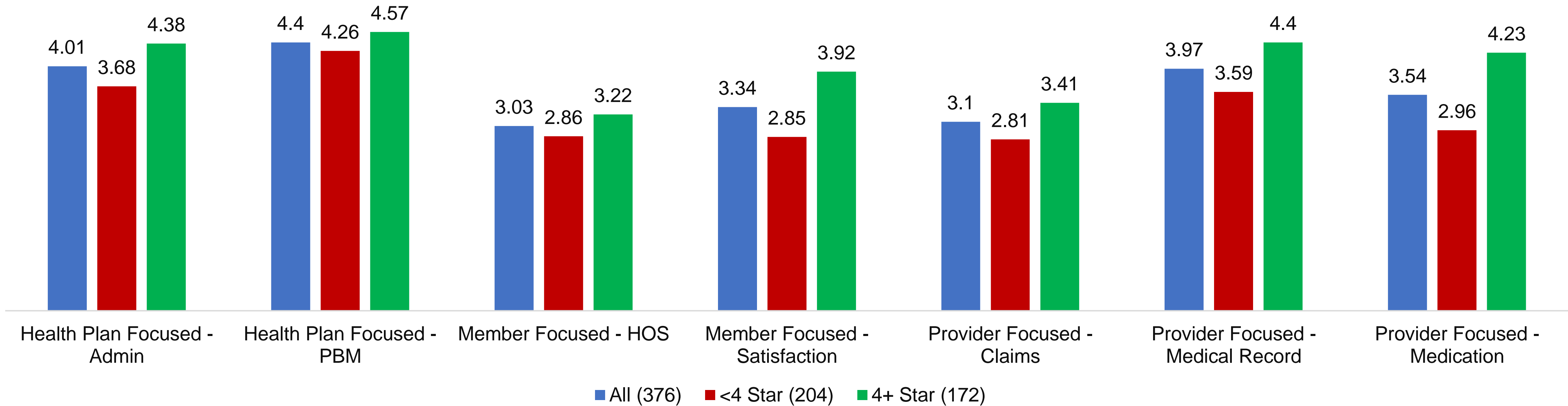
Benchmark Analysis by Measure Classification for 2019 Star Ratings



Measure Classification I	All (376)	<4 Star (204)	4+ Star (172)
Health Plan Focused - Admin	4.01	3.68	4.38
Health Plan Focused - PBM	4.4	4.26	4.57
Member Focused - HOS	3.03	2.86	3.22
Member Focused - Satisfaction	3.34	2.85	3.92
Provider Focused - Claims	3.1	2.81	3.41
Provider Focused - Medical Record	3.97	3.59	4.4
Provider Focused - Medication	3.54	2.96	4.23

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