Report:

Medicaid Managed Care Organization (MCO) – Qualified Entity (QE) Supplemental Data Exchange Project

Final Report: December 2021 – August 2023

Prepared for:

Jim Kirkwood
Director, Center for Health Data Innovation
Office of Quality and Patient Safety
Corning Tower, 19th Floor, Empire State Plaza, Albany, NY

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1 Introduction

There is significant interest among federal, state, and local partners to promote the use of electronic clinical data sources for quality measurement reporting. The electronic exchange of clinical information is vital to improving health care quality, safety, and patient outcomes.[1] Electronic clinical information allows for the secure transport of a patient's medical information in real time, improving the speed, quality, safety, coordination, and cost of patient care.

Increasing and standardizing the use of Electronic Clinical Data System (ECDS) reporting can play a significant role in advancing quality measurement. ECDS is a reporting standard for health plans that collect and submit quality measures for the national Healthcare Effectiveness Data and Information Set (HEDIS) program and New York State's (NYS) Quality Assurance Reporting Requirements (QARR). It sets forth data sources and the types of structured data acceptable to use for a measure. Electronic clinical data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.[2]

Currently, health plans produce quality measures using a combination of the administrative, hybrid, and ECDS methods. The hybrid method requires medical record review that is costly and time-consuming, and only uses a sample of the health plan's members. While health plans collect electronic clinical data to supplement their administrative data sources, they do not yet have a sufficient volume to fully transition to administrative or ECDS reporting methods, both of which would provide data on all measure-eligible health plan members as opposed to just a sample of those members.

To support quality measurement activities, stakeholders have turned their attention towards programs that optimize the exchange and use of electronic clinical data among health plans, data aggregators, and data contributors. The National Committee for Quality Assurance (NCQA) implemented the Data Aggregator Validation (DAV) program that "evaluates clinical data streams to help ensure that health plans, providers, government organizations and others can trust the accuracy of aggregated clinical data for use in HEDIS reporting and other quality programs."[3] Data aggregators that complete the DAV program produce and share standard supplemental data with partners in validated Continuity of Care Documents (CCDs). From March 2021 – August 2023, the New York State Department of Health

[1] Why is health information exchange important? | HealthIT.gov

[2] HEDIS Frequently Asked Questions - NCQA

[3] Data Aggregator Validation - NCQA

(NYSDOH) developed and implemented the Medicaid Managed Care Organization (MCO)-Qualified Entity (QE) Supplemental Data Exchange project ("MCO-QE project") which aimed to:

- Build capacity for MCOs and QEs that are establishing supplemental data[4] connections.
- Operationalize the NCQA DAV program by providing guidance to MCOs as they receive supplemental data from QEs for quality reporting programs, namely HEDIS and QARR.
- Monitor and advance MCOs' ability to receive timely and actionable data for care coordination efforts.

1.1 The MCO-QE Supplemental Data Exchange Project

The MCO-QE project was developed and informed using findings from the Health Plan Readiness Assessment (Readiness Assessment), an initiative to assist NYSDOH develop a baseline understanding of health plan capacity to adopt new technology relevant to quality measurement reporting.[5] Following the Readiness Assessment, NYSDOH engaged MCOs and QEs to understand their processes and challenges of establishing a connection to exchange supplemental data. Documenting organizations' practices will provide valuable insight into the resources necessary to successfully leverage electronic clinical data for quality measurement. Findings will inform guidance for health plans and QEs seeking to establish connections and exchange supplemental data for quality reporting.

Participating in the MCO-QE project was voluntary for both MCOs and QEs, and no funding was made available to the organizations. The MCO-QE project focused solely on documenting successful practices and lessons learned as MCOs and QEs worked to establish standard supplemental data connections. Any decisions involving payment and other contractual relationships between the MCO and QE were beyond the scope of this project and decided on and executed between the organizations themselves. The MCO-QE project also did not stipulate any exchange of payment between the MCO and QE but recognized that QEs may have their own requirements regarding the sharing of supplemental data with health plans. Furthermore, the Project Team did not provide any assistance to the QEs with requirements related to completing the NCQA DAV program.

The Project Team developed an Interim Report which documented the MCO-QE project's methodology, activities, findings, and challenges from March through November 2021.[6] This document, the MCO-QE

[4] Standard supplemental data is electronically generated files from providers that follow clear production policies and procedures; standard file layouts remain stable from year to year and are not required to be accompanied by proof-of-service documents; audit does not require primary source verification, unless requested by the auditor.
[5] For more information on the Health Plan Readiness Assessment, please see the Health Plan Readiness Assessment White Paper delivered to OQPS in March 2021.
[6] The Interim Report was delivered to OQPS in May 2022.

Supplemental Data Exchange Project Final Report, covers project findings, progress, and lessons learned from December 2021 through August 2023.

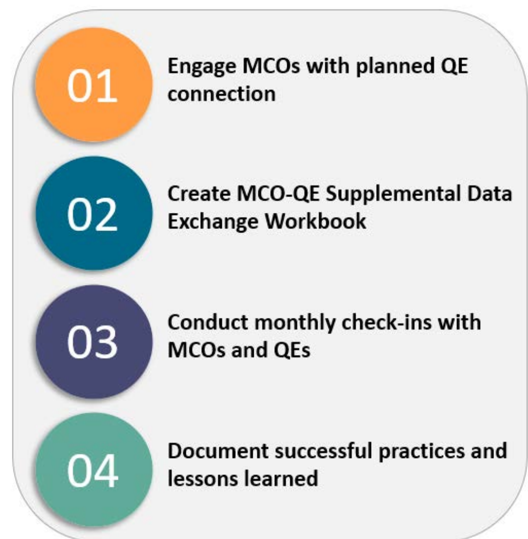
For the purposes of this report, “connecting” or a “connection” between an MCO and QE specifically relates to a connection established for the exchange of standard supplemental data, as opposed to other use cases.

2 Methodology

The Health Plan Readiness Assessment was distributed in November 2020 to the 13 MCOs in NYS with a Medicaid Line of Business serving the adult population at that time. Respondents answered questions related to their: 1) current and planned connectivity to the Statewide Health Information Network for New York (SHIN-NY) via QEs, 2) data-sharing processes, and 3) organizational capacity and needs related to establishing connections with QEs for quality measurement purposes. To participate in the MCO-QE Supplemental Data Exchange project, the Project Team conducted outreach to MCOs that indicated they were either planning or in the process of establishing a supplemental data connection with a QE.[7]

The process of establishing a MCO-QE connection for supplemental data exchange was divided into four phases with distinct goals, milestones, and business requirements. The Project Team consulted with internal technical experts, as well as health plans, QEs, and NYSDOH, to ensure that the business requirements and milestones were comprehensive and feasible. A MCO-QE Supplemental Data Exchange Workbook was created in Excel, with an accompanying SharePoint site, to help the Project Team and MCO-QE project participants navigate the supplemental data exchange connection process and document findings.

FIGURE 1. OVERVIEW OF MCO-QE PROJECT METHODOLOGY



Monthly check-ins were scheduled with the MCOs and QEs to review the business requirements and discuss the steps taken to prepare for and complete the actions necessary to establish a supplemental data connection.

[7] The Project Team is comprised of the following NYSTEC members in the Population Health – Data Insights Practice: Norain Siddiqui (Principal Consultant) and Kelly Pilkey (Consultant)

3 Project Activities: December 2021 – August 2023

This section describes the activities the Project Team completed between December 2021 and August 2023 to facilitate discussions between MCO-QE pairs, capture findings, and track the progress of establishing a supplemental data connection between the organizations.[8] The main project activities, described below, include facilitating monthly check-ins with MCO-QE pairs, documenting and tracking MCO-QE pair progress, and developing resource and guidance materials using lessons learned. The Project Team also completed additional initiatives related to understanding data exchange between MCOs and QEs: 1) Reviewed MCOs' Electronic Clinical Data Systems (ECDS) measure results for Measurement Years (MY) 2020 and 2021, and 2) Administered a survey to all MCOs in NYS to confirm what information they are sharing with QE(s).

3.1 Monthly Check-ins

The Project Team scheduled and facilitated monthly check-ins with each MCO and QE pair. Updates were approximately one hour in length and held via WebEx. The agenda for each monthly check-in included a review of the Business Requirements for the specific project phase, a discussion on what the challenges and successful practices were for the MCO and QE(s) as they complete(d) each requirement, and any outstanding items from the previous monthly check-in. Throughout the project's duration, the QEs participated in various NCQA DAV program cohorts; check-ins included a brief update from the QE(s) on their progress when applicable.[9] MCO and QE teams also had the opportunity to ask each other questions and discuss other relevant issues with the group.

In December 2021, the Project Team asked each MCO-QE pair if the monthly meeting cadence should continue or if a different schedule is preferred. Due to the timeline for HEDIS reporting and related requirements, some pairs opted to meet less frequently. The Project Team continued to follow up and remain available for these participants via email and on an as-needed basis in between check-ins. For MCO-QE pairs that opted to maintain a monthly check-in cadence, schedules often necessitated shifting from calls to emails. When this occurred, MCO-QE pairs provided updates in writing.

[8] For project activities completed between March and November 2021, please refer to the MCO-QE Supplemental Data Exchange Interim Report, delivered to OQPS in May 2022.
[9] Directory: Data Aggregator Validation - NCQA

In February 2023, MCO-QE pairs were notified that the MCO-QE project would be winding down in August 2023 and that all subsequent updates until then would be conducted via email. Emails identifying outstanding business requirements specific to each MCO-QE pair were sent on a monthly basis to teams that were still actively working on setting up a supplemental data connection. After each check-in, the Project Team compiled meeting minutes with key takeaways, updated the project pair's MCO-QE Workbook with progress notes, and uploaded the MCO-QE Workbook to the external SharePoint site. A timeline of check-ins is available in Appendix A.

The final email check-in was sent to all six MCO-QE pairs in June 2023 and included a survey that asked for perspectives on lessons learned, successful practices, and any impact on HEDIS measures due to establishing supplemental data connections.

3.2 Data Quality Assessments

The Project Team developed separate tools for MCOs and QEs to assess the quality and evaluate the impact of receiving standard supplemental data from NCQA DAV-QEs on MCOs' quality measurement rates. The Data Quality Assessments were developed in an Excel workbook and tailored to either a MCO or QE.

In order for the Data Quality Assessments to be straightforward and feasible for organizations to complete in a timely manner, NYSDOH determined that the tool should focus on one Electronic Clinical Data Systems (ECDS) quality measure: Depression Screening and Follow-Up for Adolescents and Adults (DSF-E).[10,11] The DSF-E measure was chosen due to known issues related to the lack of completeness and conformance of DSF-E data elements. NYSDOH determined that focusing on the DSF-E measure in the Data Quality Assessments could help explain where specific gaps in data exist and what next steps could be taken to improve the overall quality of data for this measure.

The QE Data Quality Assessment assessed how much data is available for the DSF-E measure and how well that data conforms to coding standards. Participants were asked to fill in information on data element value sets, location in CCD, count of data elements present, coding standards, and count of data elements adhering to coding standards (conformance). The MCO Data Quality Assessment asked the MCO to document overall DSF-E measure results as well as supplemental data events specific to the data received from the QE(s) it is connected to. For example, the tool asked for number of hits for the DSF-E initial population, how many members were excluded by QE data sources, and number of hits for the DSF-E numerator and denominator, among other metrics.

[10] Depression Screening and Follow-Up for Adolescents and Adults - NCQA
[11] HEDIS Depression Measures Specified for Electronic Clinical Data - NCQA

Data Quality Assessments were finalized and approved by OQPS in December 2021, and shared with project participants in January 2022. Separate Data Quality Assessments were sent to each MCO and QE project participant. QEs connected to more than one MCO were asked to complete a Data Quality Assessment for each MCO they sent supplemental data to. Similarly, MCOs connected to more than one QE were asked to complete a Data Quality Assessment for each QE they received supplemental data from. The Project Team reminded participants that Data Quality Assessments would be kept private, not be shared with other organizations, and only be discussed with NYSDOH.

The Project Team was available to review the tool and answer any questions as needed. Calls and email conversations were held with several MCO and QE participants, as requested, to explain the tool and further clarify instructions.

3.3 Resource and Guidance Materials

In June 2021, the Project Team created several resource materials for MCO-QE pairs to guide them through the process of planning and implementing a supplemental data connection, including a MCO-QE Supplemental Data Exchange Workbook and SharePoint site with a Resource Library. In June 2023, based on NYSDOH and project participant feedback, the Project Team updated the MCO-QE Supplemental Data Exchange Workbook and created additional resources to serve as continuing guidance for organizations wanting to learn about supplemental data connections and/or implement supplemental data connections with QEs in the future.

The SharePoint site and Resource Library will be discontinued due to lack of engagement. See Section 5.2 for more details.

3.3.1 MCO-QE Supplemental Data Exchange Workbook

The original MCO-QE Supplemental Data Exchange Workbook (MCO-QE Workbook) was created by the Project Team in June 2021 with input from the six QEs and several health plans. The Excel document contained project materials for participants to guide them through the process of planning and implementing a supplemental data connection. Sections of the MCO-QE Workbook are briefly described below. For more details on the original MCO-QE Workbook, please refer to the Interim Report.[12]

- **Overview** – Introduction to the MCO-QE project.

[12] Delivered to OQPS in May 2022.

- **Suggested Timeline** – Suggested timeline for establishing a supplemental data connection between an MCO and QE. The connection process was divided into four main phases and a kick-off phase, each which contained milestones that organizations could use to track their progress.
- **Action Plan** – Contained the phases and milestones broken down into discrete tasks with a detailed description, assigned owner(s) responsible for completion, and space to document start/end dates and additional notes.
- **Business Requirements** – Provided specific requirements for each task identified in the Action Plan. The Project Team consulted with internal technical experts, as well as health plans and QEs, to ensure that the requirements were comprehensive.

As the MCO-QE project progressed and participant needs became more apparent, the Project Team consulted with NYSDOH and determined that the MCO-QE Workbook could be revised to be more useful to organizations seeking to establish supplemental data connections. The updated MCO-QE Workbook incorporates lessons learned throughout the project, as well as feedback from project participants as to what information is relevant. The document sections are described below and available in Appendix B.

- **Background**
- **Overview of Supplemental Data Exchange Process** – Outlines the main steps that occur when a health plan and QE establish a supplemental data connection. Steps may vary depending on individual organizations' processes and systems.
  - *Supplemental Data Exchange Flow* – Visio diagram.
  - *Supplemental Data Exchange Flow Roles* – Organization role in supplemental data exchange.
  - *Supplemental Data Exchange Flow Description* – Chart detailing the high-level steps shown in the Supplemental Data Exchange Flow Visio. Provides additional information where applicable.
- **Suggested Business Requirements** – Details specific, suggested, requirements for each phase of establishing a supplemental data connection: Secure Data Access, Development, Testing, and Production. Suggested business requirements in the updated MCO-QE Workbook remained largely the same as the original requirements, though many were consolidated for brevity. The updated business requirements also includes additional notes and lessons learned from project participants to serve as guidance.

3.3.2 Action Plan Overview

The Action Plan Overview is an infographic that outlines a high-level phased approach that MCOs and QEs may follow as they establish supplemental data connections. The one-pager is designed to be a

quick reference resource to help in the planning and implementation of supplemental data connections between MCOs and QEs. The Action Plan Overview is available in Appendix B.

3.3.3 Frequently Asked Questions and Terms Sheet

The Frequently Asked Questions (FAQ) and Terms Sheet compiles a list of frequently asked questions and issues that arose during the MCO-QE project, as well as a list of common terms and definitions. The resource is available in Appendix B.

3.4 Related Initiatives

The Project Team completed two additional initiatives, as requested by NYSDOH, related to understanding data exchange between MCOs and QEs.

3.4.1 Health Plan Electronic Clinical Data Systems (ECDS) Measure Rates for Measurement Years 2020 and 2021

Electronic Clinical Data Systems (ECDS) is a HEDIS reporting standard for health plans collecting and submitting quality measures to NCQA.[13] Since NYS health plans can leverage data from QEs for ECDS reporting, NYSDOH is interested in promoting the use of ECDS as a practical application of how MCO-QE connections can contribute to improving the quality of patient care.

ECDS Measurement Year 2020

As part of the effort to support supplemental data connections between MCOs and QEs, the Project Team reviewed and analyzed health plans' Electronic Clinical Data Systems (ECDS) results for Measurement Year (MY) 2020. They also reached out to MCOs to understand their experience with ECDS reporting. Using a dataset provided by NYSDOH, the Project Team calculated rates for four ECDS measures (Adult Immunization Status, Breast Cancer Screening, Depression Screening and Follow-Up for Adolescents and Adults, Prenatal Immunization Status) across the Commercial and Medicaid lines of business for seven health plans: Health Plan E, Health Plan F, Health Plan D, Health Plan A, Health Plan G Health, Health Plan C, and Health Plan B.

Analyses included measure rate calculation and comparison to the statewide average, as well as high and low performers. From January – March 2022, the Project Team scheduled and held calls with each of the seven health plan teams and NYSDOH to gain insight into successful practices and challenges with ECDS reporting. In preparation for these calls, the Project Team reviewed the MCOs' ECDS MY 2020

[13] HEDIS Electronic Clinical Data Systems (ECDS) Reporting - NCQA

results and discussed the below questions with MCOs to understand the challenges and useful practices related to ECDS reporting:

1. What processes changed when reporting data using the ECDS methodology vs. traditional methodologies?
2. What were some of the key challenges to reporting data for the measures required to be reported via ECDS?
3. How can key stakeholders (i.e., NCQA) assist your organizations through the adoption of ECDS reporting?
4. While reviewing results for measures reported using the ECDS method, plans with higher rates leveraged additional sources like HIEs (Health Information Exchange)/Registries and EHRs (Electronic Health Record). If your organization did not access data beyond administrative data sources, why not?

These discussions helped inform conversations between MCOs and QEs regarding the most effective data-sharing processes. Findings from the calls were compiled and shared with NYSDOH in March 2022.

ECDS Measurement Year 2021

Using the ECDS MY 2021 dataset provided by NYSDOH, the Project Team calculated and reviewed average statewide rates for Medicaid, Commercial and Special Needs Plans (SNP) lines of business across five ECDS measures: Breast Cancer Screening, Colorectal Cancer Screening, Adult Immunization Status, Prenatal Immunization Status, Depression Screening and Follow-Up for Adolescents and Adults, and Postpartum Depression Screening and Follow-Up.

Aggregate statewide results were analyzed to understand the:

- Statewide average for ECDS measures for commercial, Medicaid, and SNPs.
- Average data source contribution to each measure numerator across commercial, Medicaid, and SNPs.
- Commercial, Medicaid, and SNP plan high and low performers for each measure.
- Data source contribution to each measure numerator for the commercial, Medicaid, and SNP high and low performing plan.

Results were presented to a NYSDOH audience in April 2023. The Project Team also compared MY 2021 to MY 2020 results to understand statewide trends in measure rates and numerator data source usage for commercial and Medicaid lines of business. Findings were compiled and shared with NYSDOH in June 2023.

3.4.2 MCO-QE Data-Sharing Survey

In December 2022, NYSDOH sought to assess the scope of data sharing between MCOs and QEs in NYS for quality measurement purposes. Leveraging the connections made through the MCO-QE project, the MCO-QE Data Sharing Survey was shared with twelve NYS Medicaid MCOs via email and responses were collected from December 2022 through February 2023. The survey aimed to understand:

- Which MCOs have Participation Agreements with QEs, and
- What information is being shared between MCOs and QEs, specifically regarding demographic and claims data.

Findings were compiled and shared with NYSDOH in March 2023.

4 Findings

This section outlines the findings from the project kick-off through August 2023. It is inclusive of updates originally outlined in the Interim Report to show the full spectrum of findings in each project phase.

4.1 Phase 1: Secure Data Access

Phase 1 addresses the beginning stages of establishing connections for supplemental data exchange for project participants. The goal of this phase is to establish data-sharing agreements and ensure that the appropriate MCO and QE team members have access to secure sites to exchange information. Table 1 provides an overview of the statuses of data-sharing agreements between the MCO-QE pairs as of August 2023.

TABLE 1. STATUS OF MCO-QE DATA-SHARING AGREEMENTS

	Business Associate Agreement	Participation Agreement	Addendum to PA re: SHIN NY Policy	Statement of Work	Security Assessment
Health Plan D – QE 3	✓	✓	N/A	✓	✓
Health Plan A – QE 1	✓	✓	✓	✓	✓
Health Plan A – QE 2	✓	✓	✓	✓	✓
Health Plan C – QE 1	✓	✓	✓	✓	✓
Health Plan C – QE 2	✓	✓	✓	✓	✓
Health Plan B – QE 3	✓	✓	N/A	N/A	✓

4.1.1 Data-sharing agreements

Four main documents are required to be in place between an MCO and QE prior to supplemental data exchange: a Business Associate Agreement (BAA), Participation Agreement (PA), Statement of Work (SOW), and Security Assessment. The first three fall under the purview of the QE, while the Security Assessment is a health plan requirement. Five of the six MCO-QE pairs were already exchanging data for other use cases and had a BAA and PA in place. The MCO-QE pairs leveraged these existing documents for the MCO-QE project but required a separate SOW for the exchange of supplemental data.

The BAA describes the permitted and required uses of protected health information by organizations that have access to such data.[14,15] The PA outlines the responsibilities of each involved party and "ensures that participants comply with the data sharing policies and procedures." PAs can also "be amended and adapted as needed to reflect policy updates or changes in scope."[16] For example, the updated SHIN-NY Privacy and Security Policies and Procedures for Qualified Entities and their Participants broadens the circumstances in which QEs may disclose protected health information to payers without a patient's written consent.[17] To cover this update, QE 1 and QE 2 created addendums to their respective PAs with Health Plan C and Health Plan A while QE 3 plans to incorporate language into their SOW with Health Plan D.

The SOW defines the products or services to be supplied under a contract.[18] SOWs are often included as part of the PA and are specific to a business use case or project. As part of the SOW with QE 2, Health Plan A is including a Proof of Concept (POC) to ensure that they have the appropriate architecture and environment needed to support supplemental data exchange. Lastly, the Security Assessment is "intended to protect and secure electronic protected health information from a wide range of threats, including emergencies and system failures that may compromise the confidentiality, integrity, and availability of data."[19] The Security Assessment process is time and resource intensive and often takes longer than expected. MCOs require QEs to complete Security Assessments regardless of the QE's HITRUST Certification or other security measures in place.[20] Some health plans, including Health Plan A, require annual Security Assessments for their data contributors.

In January 2022, Health Plan B informed the Project Team that they would no longer pursue a supplemental data connection with QE 3, primarily due to the low number of data sources that QE 3 was able to validate through the NCQA DAV program. The Health Plan B team noted that they may reconsider this decision if QE 3 was able to validate additional data sources in future DAV cohorts. The Project Team received regular status updates from the MCO-QE pair on the status of this decision however, no further progress was made on the supplemental data connection between Health Plan B and QE 3. Additional details on this project pair are available in the following sections.

[14] Data Governance and Data Sharing Agreements for Community-Wide Health Information Exchange: Lessons from the Beacon Communities - PMC (nih.gov)
[15] Business Associate Contracts | HHS.gov
[16] Data Governance and Data Sharing Agreements for Community-Wide Health Information Exchange: Lessons from the Beacon Communities - PMC (nih.gov)
[17] v4.0 - Privacy and Security Policies with Appendices (ny.gov)
[18] Statement of Work - Delivering Successful Service Projects (pmi.org)
[19] Healthcare Information Security Assessment and Auditing (aha.org)
[20] For more information on the HITRUST Certification, see: HITRUST Alliance | Information Risk Management and Compliance

4.1.2 Transport and monitoring of electronic information

Each organization noted that they had specific teams responsible for the secure access, transport, and receipt of member rosters and supplemental data. Teams were generally comprised of technical and analytical specialists. All of the MCO-QE pairs use, or are planning to use, standard encryption processes for data in transit and at rest. Pairs are exchanging member rosters and supplemental data via a Secure File Transfer Protocol (SFTP), except for QE 3 who noted that they will likely share CCDs with Health Plan D via a virtual private network (VPN.)

FIGURE 2. FINDINGS FROM PHASE 1, SECURE DATA ACCESS

Data Sharing Agreements
Documents/processes required for supplemental data exchange include a Business Associate Agreement, Participation Agreement, Statement of Work, and Security Assessment.

Transport and Monitoring of Electronic Information
The majority of MCOs and QEs will exchange member rosters and supplemental data files via SFTP.

4.2 Phase 2: Development

The goal of this phase is to establish the requirements for sharing member rosters and supplemental data, including member roster file layouts, lookback periods for historical data, frequency of sharing data, and file alert and change management processes. Many of the items in this phase are determined by the MCO-QE pairs when developing the SOWs for sharing supplemental data. Table 2 provides a summary of MCO-QE pairs' statuses of the main Business Requirements in Phases 2, 3, and 4.

4.2.1 Member rosters

Although several MCOs were already sharing member rosters with QEs for other use cases, the MCOs noted that different rosters were required for supplemental data exchange. The process of determining members rosters for supplemental data exchange is typically a joint effort between the MCO and QE as the format should be readable by the QE.

For supplemental data, some MCOs shared their entire member list with the QE, while others filtered their full member roster based on a QE's region and/or needs. Health Plan A, for example, shared their full roster of 1.6 million members with QE 1 but filtered their membership by zip code to send a smaller roster of approximately 117,000 members to QE 2. This is due to the different internal processes between the QEs; QE 1 reviews the roster and sends information back only on members within their environment while QE 2 generates a CCD for every member included on a received roster. The member roster that Health Plan C shares with QE 1 and QE 2 is based on the member's county of residence, while Health Plan D has opted to share the same member roster with QE 3 for supplemental data as they do for ADT alerts.

4.2.2 Supplemental data file layout

All three QEs that participated in the MCO-QE project had data streams validated through the NCQA DAV program during the project duration. As a result, the QEs indicated that their supplemental data CCD formats and layouts will align with NCQA's Output Data Integrity (ODI) standards and adhere to the CCD Implementation Guide (IG)[21] for generating CCDs, per the most current DAV program requirements.[22] At the time of the project's conclusion, all three participating QEs have validated data streams through December 2023.[23]

4.2.3 Lookback period for historical data

There is considerable variation among the MCOs on preferred lookback periods for historical data on members. Health Plan C originally indicated that they preferred not to receive any historical data on members due to the data obtained through their acquisition of YourCare Health Plan in Western New York; ultimately, however, they opted to receive two years of data on their members from QE 1 and one year from QE 2. Health Plan A asked QE 2 to limit historical data to two years due to concerns over the file size of CCDs containing longer lookback periods, though they noted the need for additional historical data on members to align with certain HEDIS measure specifications.

QE 3 is supplying Health Plan D with all the data they have on a member. For example, if a member has three or eight years of data available, QE 3 will provide those records to Health Plan D. Prior to deciding not to move forward with QE 3, Health Plan B had indicated they would like 10 years' worth of longitudinal data on members to adequately cover HEDIS measure specifications.

[21] Health-Plan-DAV-Information_Oct2022_FINAL.pdf (ncqa.org)
[22] Data Aggregator Validation - NCQA
[23] Directory: Data Aggregator Validation - NCQA

4.2.4 Data frequency

The exchange of supplemental data between the QE and MCO is part of the business arrangement between the two organizations. QEs often have various service offerings related to the frequency and method of data shared with health plans. QE 3, for example, offers multiple services that differ based on the number of members that information is being shared on, in addition to how often data is being delivered (i.e., daily updates vs. continuous information).[24] While the Project Team recognized that QEs have their own requirements regarding the cost of sharing supplemental data with health plans, any decisions involving payment between the MCO and QE were beyond the scope of this project.

The frequency at which supplemental data is shared between QEs and MCOs is also dependent on how often MCOs are able to share member rosters with QEs, as well as their ability to manage the volume of data received at this rate. Health Plan D initially requested a monthly exchange of data from QE 3 to align with their other clinical quality initiatives; the final determination of exchange cadence is unknown as the project teams were still working on this arrangement at the project's conclusion. Health Plan C initially requested an annual exchange of supplemental data to align with HEDIS reporting, but then noted that a monthly exchange would be more efficient and convenient with both QE 1 and QE 2.

Health Plan A and QE 2 decided on a weekly cadence for supplemental data exchange. Initially, this arrangement posed an issue as Health Plan A' membership file is updated monthly. The project teams were able to devise a solution wherein the membership file that Health Plan A shares with QE 2 will be repeated each week, until the next monthly restatement. In effect, QE 2 would be receiving a membership file each week with which to generate CCDs from.

4.2.5 Monitoring, alerts, and change management processes

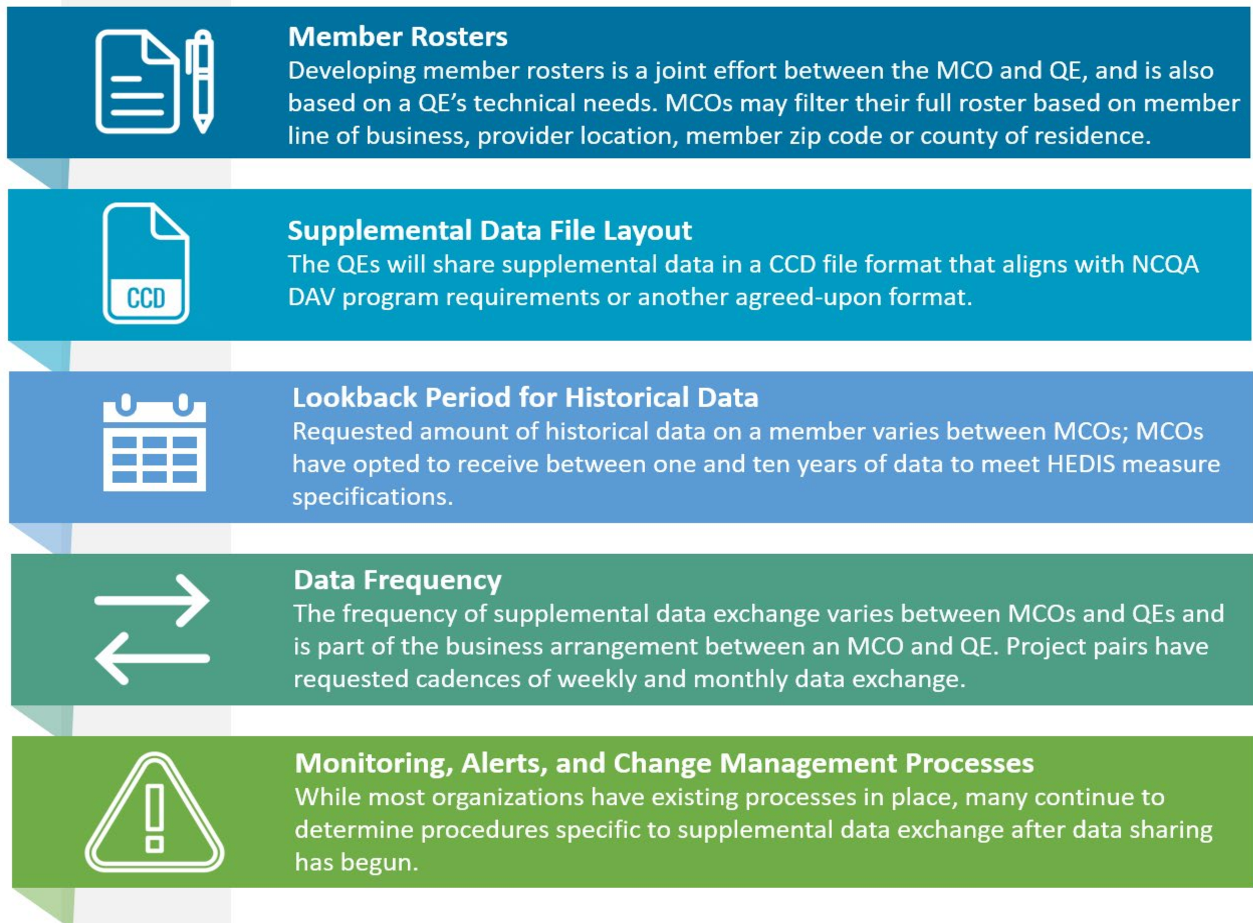
Most organizations reported having formal, internal procedures in place to manage process changes but noted that additional steps specific to supplemental data exchange may be implemented at a later date. Monitoring requirements when exchanging data files, however, are not consistent across MCOs and QEs. For example, some organizations are only alerted when files are sent incorrectly while others have notifications in place when files are both sent or received incorrectly. Some organizations automated the notification process, however, manual support was required to remediate file issues.

MCOs connecting to more than one QE indicated they would prefer to align the monitoring, alerts and change management process for consistency, as was the case for Health Plan C and Health Plan A who were both establishing connections with QE 2 and QE 1.

[24] QE 3 Services - QE 3

While the project participants noted the need for data exchange monitoring and alerts, it was not a high priority for teams. Many organizations continued to fine tune this process after beginning data exchange and were not able to confirm protocols related to monitoring and alert procedures specific to member roster/supplemental data exchange by the project's conclusion.

FIGURE 3. FINDINGS FROM PHASE 2, DEVELOPMENT



4.3 Phase 3: Testing

The goal of this phase is for the MCO to receive supplemental data files from the QE(s) and prepare the data for integration into their HEDIS software. In Phase 3, the QE and MCO test their processes and

infrastructure to ensure that both environments are ready for supplemental data exchange. Table 2 provides a summary of MCO-QE pairs' statuses of the main Business Requirements in Phases 2, 3, and 4.

4.3.1 Test member rosters and sample CCDs

Prior to moving into the Production Phase, MCOs may share a sample, or test, member roster with the QE for the QE to use to generate and return sample CCDs to the health plan. While some MCOs chose to share a test roster based on a subset of members, many MCOs ended up sharing examples of what their actual member rosters would look like for full supplemental data exchange. The initial roster shared from Health Plan A to QE 1, for example, contained their full membership of 1.6 million people. Health Plan D, on the other hand, initially shared a test roster containing 1,000 members with QE 3, followed by a roster containing 84,000 members when full production began.

By the end of the MCO-QE project, all project pairs had shared either a sample member roster, sample CCDs, or both to prepare for supplemental data exchange. The sample CCDs allow the MCO to review and provide feedback on the data, in addition to helping ensure that they have the architecture in place to properly ingest, read and use the data shared by QEs. QEs produce both longitudinal and incremental CCDs. Longitudinal CCDs, or historical CCDs, incorporate all of a patient's data within a defined lookback period whereas incremental CCDs contain episodic updates that occur after the initial longitudinal CCD has been created by the QE and shared with the health plan. Although Health Plan B chose not to pursue a connection with QE 3, as explained in Section 4.1.1, the QE 3 team did prepare and upload ten sample CCDs to an SFTP that was never accessed by Health Plan B.

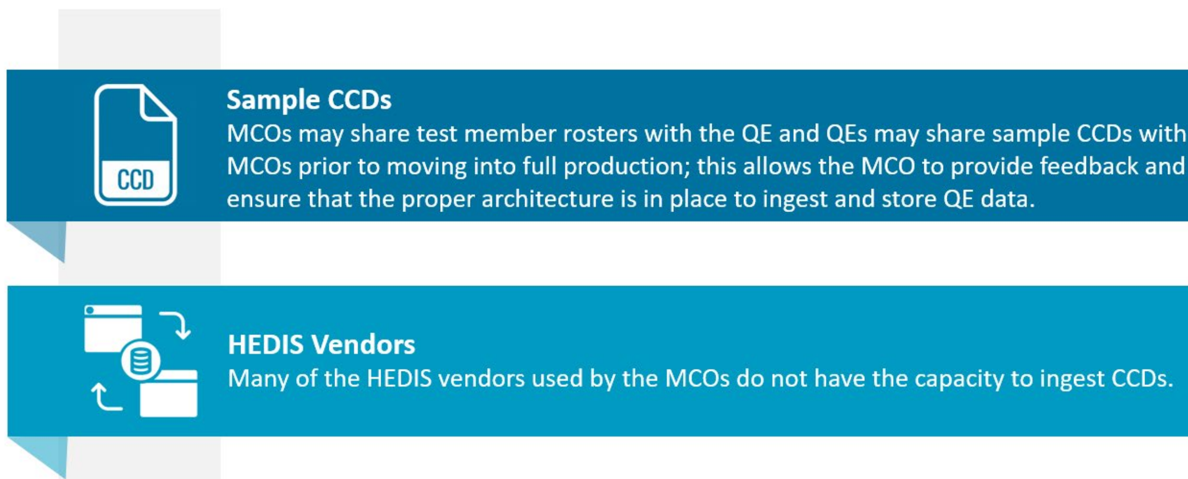
Health Plan A completed a POC with QE 2 to ensure that their environment is ready for supplemental data exchange. As part of this process, Health Plan A focused on a small number of electronic clinical measures to support a use case for HEDIS data sharing. QE 2 generated and shared 9,300 historical CCDs, followed by 1,200 incremental CCDs, on a sample of members to support this project. This allowed Health Plan A to ingest and parse a subset of the data in the CCDs relevant to HEDIS measures.

QE 2 generates a "placeholder CCD" on members that are not found in their system. Placeholder CCDs include basic member information (e.g., name, address, ID, etc.) but no clinical information; this is done so QE 2 has a record of the member in their system should the member have clinical data come through in the future. In some instances, Health Plan A found that they received incremental CCDs with clinical data on members that they originally received placeholder CCDs on. QE 2 and Health Plan A concluded that this may have been due to the manner in which the initial member roster was sorted and sampled. Overall, this process yielded positive results for the organizations and QE 2 was able to find clinical data in their system on approximately 88% of the members on the roster shared by Health Plan A. The POC was completed in May 2022.

4.3.2 HEDIS vendors

Health plans often work with third party vendors for accurate HEDIS measure calculation, reporting, and other regulatory and contracting purposes. Vendors that offer these services use measure calculation and reporting software that has been assessed and certified by NCQA.[25] Some HEDIS vendors may not have the capacity to ingest CCDs. As a result, the MCOs must determine how to appropriately use the data in CCDs per NCQA guidelines on the permissible use and transformation of standard supplemental data received from NCQA DAV-QEs[26]. This was a commonly discussed issue between the MCO-QE pairs and often required a collaborative solution between the MCO, QE, and HEDIS vendor in terms of documentation, file mapping, and overall process flow.

FIGURE 4. FINDINGS FROM PHASE 3, TESTING



4.4 Phase 4: Production

The Production Phase is the final phase in the MCO-QE Supplemental Data Exchange project, in which MCOs and QEs actively exchange member rosters and standard supplemental data on an ongoing, established cadence. The goal of this phase is for the MCOs to integrate the standard supplemental data received from QEs into their HEDIS software for use in HEDIS reporting. To date, four project pairs are in full production (Health Plan D-QE 3, Health Plan C-QE 1, Health Plan C-QE 2, Health Plan A-QE 2), one pair is still in process toward achieving full production (Health Plan A-QE 1), while one MCO (Health Plan B) has opted to obtain supplemental data using a different model and not establish a connection with the QE (QE 3) as originally intended at the start of the MCO-QE project.

[25] Health Plans: How to Choose A Vendor - NCQA
[26] Health-Plan-DAV-Information_Oct2022_FINAL.pdf (ncqa.org)

Health Plan D and QE 3 have begun the process of exchanging member rosters and CCDs while continuing to work on determining a cadence for ongoing data exchange. A target date to use QE 3 data for HEDIS measurement and reporting was not identified by the project's close in August 2023.

Health Plan C entered full production with QE 2 in July 2022 and with QE 1 in February 2023. The MCO has been exchanging information with both QEs on a monthly basis and intends to use the QEs' data for HEDIS MY 2022. Health Plan C is performing internal data validation to ensure that the mapping from CCDs to their HEDIS software extract layout is sound and captures all QE data being submitted. Health Plan C additionally noted incremental gains in five measure rates, which have been attributed to data shared by QE 1. See section 4.5.5 for details.

Health Plan A and QE 2 began full production in February 2023 and indicated plans to use supplemental data for HEDIS MY 2022. Health Plan A and QE 1 finalized a SOW for supplemental data exchange in late July 2023. QE 1 noted that data exchange was expected to happen within six to eight weeks after signing the SOW and Health Plan A indicated they planned to leverage the data for HEDIS MY 2023.

As explained in Section 4.1.1, Health Plan B ultimately opted not to pursue a supplemental data connection with QE 3. Instead, in January 2023, Health Plan B began working with QE 2 as a "pass-through submitter" to obtain ambulatory, supplemental data from multiple QEs. In this model, QE 2 would serve as a centralized repository to collect relevant data from other QEs before sending it to Health Plan B, thus serving as a single source data feed for the MCO. In March 2023, Health Plan B informed the Project Team that it was in receipt of HEDIS MY 2022 CCDs from QE 2, Bronx RHIO, Hixny, and QE 1 through this new model. QE 3 and Rochester RHIO elected not to participate in the arrangement.

TABLE 2. CURRENT STATE OF PROJECT PARTICIPANTS ACROSS PHASES 2-4

	Member Roster	Sample CCDs	Lookback Period	Data Frequency	Production Status	Projected HEDIS MY Use
Health Plan D – QE 3	Shared test roster w/1,000 members + Medicaid LOB roster	Shared 100 CCDs	Varies by available member data	Monthly	Full production*	TBD

	w/84,000 members					
Health Plan A – QE 1**	Shared full roster of 1.6 million members	Shared 363 CCDs	TBD as of August 2023	TBD as of August 2023 (weekly or monthly)	In process as of August 2023	MY 2023
Health Plan A – QE 2	Shared roster of ~117,000 members based on zip code	Shared 10,500 CCDs	Two years***	Weekly	Full production	MY 2022
Health Plan C – QE 1	Shared roster of ~35,000 members based on county of residence	Shared 200 CCDs	Two years	Monthly	Full production	MY 2022
Health Plan C – QE 2	Shared roster of ~35,440 members based on county of residence	Shared samples of small, medium and large CCDs	One year	Monthly	Full production	MY 2022

*Updated provided by QE 3, not confirmed by Health Plan D as of August 2023
**Signed SOW in July 2023; Finalizing other business requirements as project ended in August 2023
***Additional data will be supplied as requested to align with HEDIS measure specifications

4.5 Additional Project Findings

4.5.1 Data Quality Assessments

Data Quality Assessments were sent to project participants in January 2022. As described in Section 3.2, Data Quality Assessments focused on the Depression Screening and Follow-up (DSF-E) measure only in order for the tool to be feasible for organizations to complete in a timely manner. MCOs and QEs were encouraged to complete the tool as soon as they were sending/receiving supplemental data to/from their respective connection(s). Since supplemental data exchange is dependent on the organizations completing and executing a SOW and Security Assessment specific to the supplemental data use case, each MCO-QE pair was on a different timeline of establishing a connection and being able to complete the Data Quality Assessment. As a result, the Project Team received completed Data Quality Assessments from project participants at different points throughout 2022.

Table 3 shows the status of Data Quality Assessments received/not received from project participants. Findings are further explained below.

TABLE 3. STATUS OF DATA QUALITY ASSESSMENTS

Organization	Status of Data Quality Assessment	Details
QE 1	✓	Completed for DSF-E data that will be sent to Health Plan A once SOW and Security Assessment are complete
QE 1	✓	Completed for DSF-E data that will be sent to Health Plan C once SOW and Security Assessment are complete
QE 2	✓	Completed for DSF-E data sent to Health Plan A
QE 2	✓	Completed for DSF-E data sent to Health Plan C
QE 3	X	Did not complete for DSF-E data that would be sent to Health Plan B; In January 2022, Health Plan B decided not to move forward with establishing a supplemental data connection with QE 3
QE 3	X	Did not complete for DSF-E data that will be sent to Health Plan D once SOW and Security Assessment are complete
Health Plan A	✓	Completed for DSF-E data received from QE 2
Health Plan A	X	Unable to complete for DSF-E data received from QE 1 since supplemental data exchange was not taking place
Health Plan C	X	Unable to complete for DSF-E data received from QE 1 since supplemental data exchange was not taking place
Health Plan C	✓*	*See explanation below re: DSF-E data received from QE 2
Health Plan B	X	Did not complete for DSF-E data received from QE 3; In January 2022, Health Plan B decided not to move forward with establishing a supplemental data connection with QE 3
Health Plan D	X	Unable to complete for DSF-E data received from QE 3 since supplemental data exchange was not taking place

✓ Received
X Not received

The Project Team received two Data Quality Assessments from QE 1, two from QE 2, and one from Health Plan A. It is important to note that even though QE 1 did not have SOWs in place for supplemental data exchange in 2022, they were able to complete the Data Quality Assessments for Health Plan C and Health Plan A based on the data they would eventually send to the MCOs once agreements were executed. Health Plan C and Health Plan A, in contrast, were not able to complete Data Quality Assessments for data received from QE 1, since no supplemental data was being shared with them at the time.

Although Health Plan C was receiving supplemental data from QE 2, they opted not to complete a Data Quality Assessment as they were not seeing an impact on the DSF-E measure from QE 2 data. Health Plan C shared that they did not have any numerator hits for the DSF-E measure; while denominator

numbers were present, Health Plan C noted that none of the denominator hits were triggered by QE 2 sources.

QE 3 did not complete Data Quality Assessments for either Health Plan D or Health Plan B as the timelines for establishing a SOW for supplemental data exchange were delayed or stopped, respectively. Consequently, since no supplemental data was being received from QE 3, Health Plan D and Health Plan B were also unable to complete Data Quality Assessments on their end.

QE 2 expressed some hesitation around completing the Data Quality Assessment on the DSF-E measure, noting that QEs were already aware of the lack of complete data on the measure. Prior to completing the Data Quality Assessments, QE 2 knew that they did not receive the specific data elements needed for the DSF-E measure from their provider connections and were concerned that completing the tool may not be a worthwhile use of time.

The Project Team noted a significant number of discrepancies among the completed Data Quality Assessments and feedback received from QE 2, Health Plan A, and Health Plan C. The DSF-E numbers and information shared from QE 2 regarding the data sent to Health Plan A did not correspond to the Data Quality Assessment that Health Plan A completed on the data received from QE 2. Similarly, while QE 2 completed a Data Quality Assessment on DSF-E data sent to Health Plan C, Health Plan C noted that they did not receive any data from QE 2 that affected their DSF-E measure rates. Furthermore, since Health Plan A and Health Plan C were not able to complete Data Quality Assessments on QE 1 data, the Project Team was unable to draw any conclusions using the Data Quality Assessments received from QE 1.

Upon sharing these findings with NYSDOH in November 2022, it was determined that the Project Team would not conduct additional follow up with MCO-QE pairs regarding the Data Quality Assessments as there was not enough data available to conduct valuable analysis. The discrepancies in information would be noted as part of the larger project's findings with the understanding that significant work is needed to understand where the gaps in DSF-E data element completeness and conformance exist, and how data quality for this measure can be improved by working with MCOs, QEs, and QEs' provider networks.

4.5.2 Project Timeline

When preparing the project's timeline, the Project Team assumed that the MCO-QE pairs would work through the phases of establishing a supplemental data connection in a linear manner. After understanding organizations' processes during the monthly check-ins, the Project Team realized that the phases, as originally determined, have significant overlap. MCOs and QEs often simultaneously work on

business requirements spanning more than one phase. Correspondingly, the amount of time needed to complete each phase varied between MCO-QE pairs. For example, Health Plan C and Health Plan A both planned supplemental data connections with both QE 2 and QE 1. Health Plan C and QE 2 began full production in July 2022, approximately six months before Health Plan A and QE 2 entered full production in February 2023. Similarly, Health Plan C and QE 1 were in full production by April 2023, while Health Plan A and QE 1 had just executed the SOW in July 2023 and were still working toward full production at the conclusion of the project in August 2023.

4.5.3 Available Resources across MCOs and QEs

There is a great deal of variation among MCOs and QEs in terms of infrastructure and resources, impacting the way in which organizations participate in the project. Health Plan A, QE 1, and QE 2 were involved in collaborative efforts to establish connections before the project began. Not only were team members already familiar with one another during the MCO-QE project monthly check-ins, but the organizations could also ensure that the correct representatives (e.g., technical expert, HEDIS project manager, etc.) were on the call to speak to the agenda items. As a result, monthly check-ins with these organizations were highly collaborative resulting in productive and useful discussion.

4.5.4 Connecting to QEs

Advantages of connecting to an NCQA DAV-QE include a decreased burden on health plans during the HEDIS audit process as “data streams validated by NCQA can be used as standard supplemental data in HEDIS reporting, eliminating the need for primary source verification (PSV)”, a time- and resource-intensive process. MCOs will also be able to know which specific EHRs and providers are included in a QEs validated data stream, allowing some insight into the member data they may expect to receive from the QE.

Many of the MCOs however, including those that chose not to participate in the MCO-QE project, expressed concerns about connecting to a QE that include:

- Uncertainty around the quality of data received from QEs.
- The time, resources, and cost needed to establish a supplemental data connection with a QE.
- The lack of information on the return on investment when connecting to a QE, especially when already receiving standard supplemental data from EHRs and other data aggregators.

Several MCOs also noted their preference to establish one connection directly to the SHIN-NY instead of managing multiple connections to various QEs. MCOs with a greater coverage area (e.g., national health plans) likely need to connect to more than one QE to receive data on their entire membership. Having to

conduct multiple Security Assessments and oversee varying connection and process requirements across QEs is a time and resource-intensive endeavor for MCOs.

Health Plan A, QE 1, and QE 2 are an example of how MCOs and QEs can proactively work together to reduce the burden of establishing a supplemental data connection. As mentioned, the organizations regularly met prior to the start of the MCO-QE project to discuss how they could align requirements of establishing a supplemental data connection between an MCO and QE. The connection process between Health Plan A and QE 2 is being viewed as a template for the steps that Health Plan A and QE 1 will take as they further establish their supplemental data connection.

Additionally, the Project Team did not take potential alternative models for setting up supplemental data connections into account. Late in the MCO-QE project, Health Plan B informed the Project Team that they would not complete a one-to-one data connection with QE 3, instead choosing to use a centralized “pass-through submitter” model as described in Section 4.1.1.

4.5.5 MCO-QE Project Closeout Survey

In June 2023, as part of the conclusion of the MCO-QE project, participants were asked to provide their perspectives on lessons learned when establishing a supplemental data connection. MCOs were also asked to share any impact to HEDIS measure results since establishing a supplemental data connection. A full list of survey questions is included in Appendix C.

Three of the seven project participants responded to the survey: Health Plan B, QE 2, and QE 1. While the return rate was lower than anticipated, the one MCO and two QEs that did respond provided the project team with valuable feedback on the MCO-QE project and their experiences with establishing a supplemental data connection.

With respect to lessons learned and the value add of participating in the MCO-QE Supplemental Data Exchange project, QE 1 and QE 2 noted that they have moved toward adopting standard operating procedures and agreements to facilitate future data connections. They also noted that hearing about the processes of other organizations was helpful. Having the NYSTEC Project Team facilitate regular check-ins to assist the teams through the connection process was much appreciated.

When asked about barriers to establishing a supplemental data connection, survey respondents acknowledged difficulties with the varying abilities of MCOs and HEDIS vendors to consume and use data in a CCD format (See Section 4.3.2 for more details). Additional barriers identified included the cost of data collection and the unknown return on investment of receiving supplemental data; respondents did state that this barrier could diminish over time as the practice of using supplemental data matures

and gains are realized. QE 1 also noted that expanding the use case for supplemental data beyond HEDIS and QARR reporting would allow MCOs to gain additional value by increasing potential avenues for their investment in establishing a supplemental data connection. In terms of impacts to HEDIS measure results, Health Plan C noted incremental gains from the data they received from QE 1 for the following HEDIS measures:

- Hemoglobin A1c Control for Patients With Diabetes
- Kidney Health Evaluation for Patients With Diabetes
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Metabolic Monitoring for Children and Adolescents on Antipsychotics

Overall, feedback from the survey indicated that taking part in the MCO-QE Supplemental Data Exchange project was a valuable experience, with participants stating that they appreciated the Project Team's support and guidance over the years.

FIGURE 5. ADDITIONAL PROJECT FINDINGS

Data Quality Assessment
Additional work is needed to understand gaps in completeness and conformance to increase data quality for the DSF-E measure.

Project Timeline
The phases of establishing a supplemental data connection have significant overlap and are not as linear as the Project Team initially assumed.

Available Resources Across MCOs and QEs
There is a great deal of variation in infrastructure and resources among MCOs and QEs, impacting the way in which organizations participate in the project.

Connecting to QEs
MCOs expressed concern with QEs' data quality, the cost and time required to connect to a QE, and overall return on investment.

Project Closeout Survey
Project teams stated participation in the project was a valuable experience that led them toward adopting standard operating procedures and agreements to facilitate future data connections.

5 Limitations and Challenges

The Project Team encountered several challenges with the project design and methodology, described below. The limitations and challenges present opportunities for a revised and more tailored approach to providing support for MCOs and QEs in the future.

5.1 Sample Size

There are 13 Medicaid MCOs that operate in NYS.[27] The Project Team engaged the 10 MCOs that were either planning or in the process of establishing a supplemental data connection to a NYS QE.[28] Of the six health plans that initially agreed to participate, two MCOs failed to continue responding to the Project Team's communications. As a result, the Project Team was only able to work with four of the ten eligible MCOs, which were planning connections to three of the six QEs in NYS. While the Project Team was able to hold productive conversations with each MCO-QE pair and gain valuable insight into the supplemental data connection process, the findings may not be as comprehensive as if all 10 MCOs and six QEs were project participants.

FIGURE 6. LIMITATIONS AND CHALLENGES

5.2 Participant Engagement

The Project Team found that the MCO-QE SharePoint site, created for MCO project participants, was largely underutilized. The site was developed as a resource for MCOs to access project-related materials in one place, including each MCO's updated Action Plan, Business Requirements, and meeting minutes. While the Project Team regularly uploaded meeting minutes and MCO-QE Workbooks to the SharePoint site, additional efforts could have been made to remind participants to visit and check the site regularly. Due to the sensitive nature of some of the information shared, the SharePoint site was only accessible to approved users. The additional steps needed to verify participants' emails, titles, and organizations may have posed a barrier to access. Moving forward, NYSDOH may opt to keep high-level supplemental

[27] Managed Care Organization (MCO) Directory by Plan (ny.gov)

[28] As reported in the Health Plan Readiness Assessment (November 2020).

data connection resources, including the documents described in Section 3.3, on another website (e.g., NYSDOH Health Information Technology-Enabled Quality Measurement site) for convenient access.[29]

An additional challenge related to participant engagement was the change in Health Plan B's approach to working with QEs. In January 2023, as discussed in Section 4, Health Plan B began working with QE 2 as a centralized, "pass-through submitter" for supplemental data wherein QE 2 would collect relevant supplemental data from other QEs before sending it to Health Plan B. This approach, while interesting, was new for both NYSDOH and the Project Team. Given that the MCO-QE project was already slated to end by mid-2023, there was not enough time to work with Health Plan B and QE 2 in this new capacity to understand the planning and implementation process for such a supplemental data connection agreement and process flow.

5.3 Data Quality Assessments

As discussed in Section 4.5, the Data Quality Assessments were fairly challenging for project participants to complete.

Timeline

The Data Quality Assessments were shared in January 2022. While the Project Team did not have a specific deadline for completion, it was requested that organizations fill out the tool as soon as they were able to. This ask ran concurrent with HEDIS reporting deadlines, meaning that many organizations were not able to allocate resources to the Data Quality Assessment until much later in the year. The Project Team received Data Quality Assessments between May and October 2022.

Focus on the DSF-E Measure

Upon discussing the Data Quality Assessments with the MCOs and QEs, another major concern with the tool was its focus on the DSF-E measure. As mentioned, the DSF-E measure was already known to have completeness and conformance issues with various data elements; organizations were somewhat hesitant to allocate time and resources to filling out the tool when they could predict that results may not be the most helpful to identifying areas of improvement. If NYSDOH were to pursue a similar initiative in the future to understand the impact of QE data on health plan measure rates, it may be worthwhile to work with MCOs and QEs to choose a quality measure that organizations are more comfortable with.

[29] HIT-Enabled QM (ny.gov)

Delayed SOWs between MCOs and QEs

QE 1 was able to complete Data Quality Assessments on DSF-E data that would eventually be sent to Health Plan A and Health Plan C. However, since the SOWs for supplemental data exchange between QE 1 – Health Plan A and QE 1 – Health Plan C are/were still ongoing, no supplemental data was being sent from the QE to the MCOs. While the MCOs had data from sample CCDs shared from QE 1, they concluded that it was not a significant enough volume, or large enough relevant sample size, to complete the Data Quality Assessments.

5.4 Updated SHIN-NY Privacy and Security Policies and Procedures for QEs

As mentioned in the Findings section, the SHIN-NY Privacy and Security Policies and Procedures for Qualified Entities and their Participants establishes a "set of privacy and security rules that govern the exchange of information via the SHIN-NY."[30] The document states that QEs do not need a patient's consent to disclose data to a health plan for the purpose of calculating the performance of HEDIS or QARR measures.[31]

The level of familiarity with the current SHIN-NY policy varied amongst MCO and QE participants. Some organizations requested additional details on the consent requirement, in addition to clarification on the allowable quality measurement use cases the updated policy applied to (i.e., case management). While this uncertainty may not have directly delayed SOWs between the MCOs and QEs, it was a much-discussed topic during many of the early monthly check-ins.

5.5 NCQA DAV Program Timeline

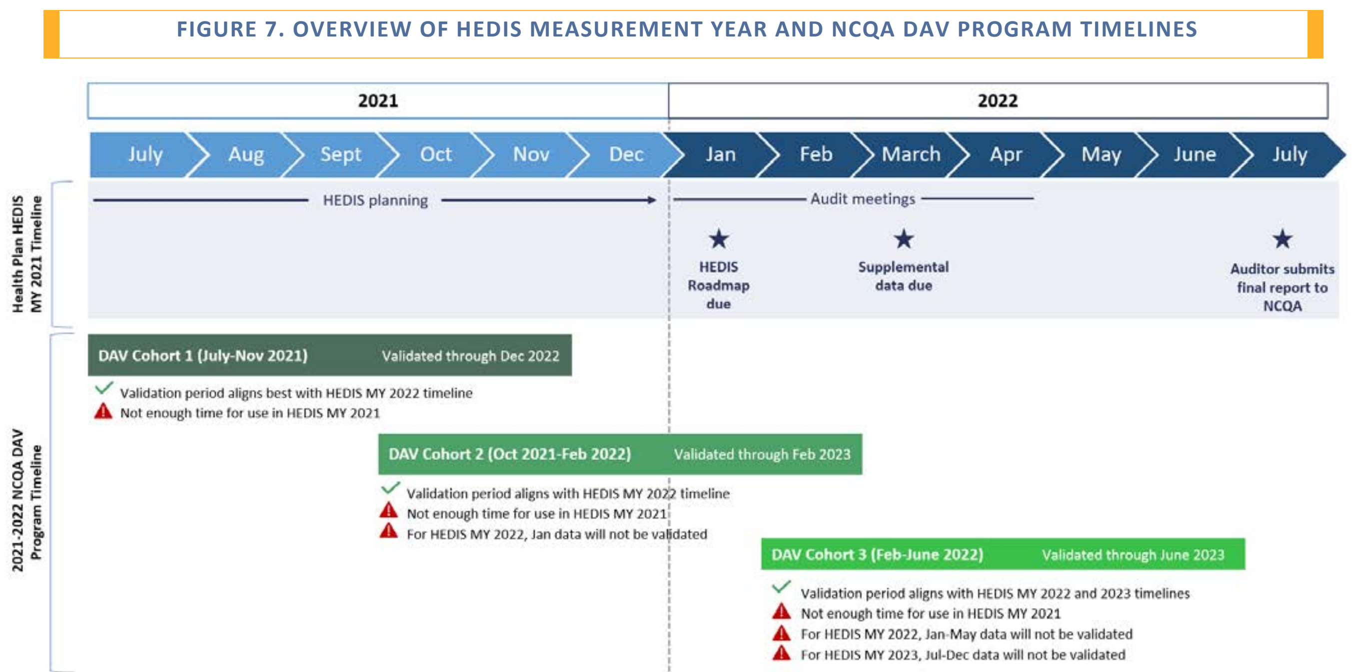
QE 1, QE 2, and QE 3 all participated in the NCQA DAV program and are currently validated through 2023.[32] While the QEs' participation in the program was known, the Project Team did not anticipate how the program's timeline would affect progress between MCOs and QEs.

As described in the Findings section, MCOs and QEs often require a new SOW for the exchange of supplemental data. Aside from Health Plan A and QE 2 which already had a SOW for supplemental data exchange in place, all the MCO and QE pairs opted to delay the development of a SOW until the QE(s) successfully completed the first cohort of the DAV program, which ran from July to November 2021. The DAV program timeline for the first cohort of participants was also challenging due to the HEDIS timeline

[30] SHIN-NY Governance | New York eHealth Collaborative (nyehealth.org)
[31] v4.0 - Privacy and Security Policies with Appendices (ny.gov)
[32] Directory: Data Aggregator Validation - NCQA

that health plans must adhere to. For HEDIS MY 2021, health plans had to complete all supplemental data submission by early 2022, which required them to identify supplemental data sources that they will be using for HEDIS reporting once the previous measurement year ended. For organizations that did not begin the process of exchanging supplemental data until after the QEs received NCQA DAV certification in November 2021, it was not feasible for the health plans to test, use, and submit the data received from QEs by early 2022 for the HEDIS 2021 measurement year. NCQA has since moved to offering the DAV program on a bi-annual basis in January and July.[33] As of 2023, all six NYS QEs have completed the NCQA DAV program, possibly helping to make future MCO-QE supplemental data connections easier and more standard.[34]

FIGURE 7. OVERVIEW OF HEDIS MEASUREMENT YEAR AND NCQA DAV PROGRAM TIMELINES



5.6 Processing of Validated CCDs from NCQA DAV-QEs

The validated output of the NCQA DAV program is a CCD and many health plans use HEDIS vendors for quality measurement that are unable to easily ingest CCDs. As a result, health plans may need to transform the standard supplemental data they receive from NCQA DAV-QEs in CCDs into a format that is accepted by their HEDIS vendors.

[33] FAQs - NCQA updated
[34] Directory: Data Aggregator Validation - NCQA

MCO and QE participants were unclear if the transformation of a validated CCD is allowable and if doing so would deem the data as non-standard, thus requiring Primary Source Verification. The Project Team received clarification on this issue from NYSDOH in October 2021 and confirmed that the processing of validated CCDs was permissible if certain conditions were met, per the NCQA DAV program Manual.[35] Since purchasing the NCQA DAV program Manual is not required for health plans, it is possible that some MCO-QE project participants were not aware of this language.

[35] NCQA > 2023 Data Aggregator Validation Program Manual (epub)

6 Conclusion

At the conclusion of the project, each of the MCO-QE Supplement Data Exchange project teams (with the exception of Health Plan B-QE 3) had executed a SOW for supplemental data exchange and were either in full production, or in the final stages of working towards full production. Health Plan C and Health Plan A both intended to use QE data for HEDIS reporting. While the processes and discrete business requirements that each project team followed were similar, the order, pace, and manner in which the organizations moved toward the goal of setting up a supplemental data connection varied greatly.

Documenting the MCO-QE project pairs' successful practices, challenges, and lessons learned provides valuable insight into the process of establishing a supplemental data connection. These findings will aid NYSDOH in supporting and developing new opportunities to best support stakeholders and help inform policies and practices for sharing electronic clinical data that align with NYS' evolving quality measurement landscape.

Appendix A: Timeline of Engagement

Month	Call
March 2021	Held calls with the following health plans to review the MCO-QE Workbook and receive feedback: • Health Plan A • Health Plan G Health
April 2021	Held calls with the following QEs to review the MCO-QE Workbook and receive feedback: • QE 2 • Rochester RHIO • Bronx RHIO • QE 1
May 2021	Held initial calls with the following health plans to introduce MCO-QE project: • Health Plan D • Health Plan B
June 2021	Held initial calls with the following health plans to introduce MCO-QE project: • MVP • Health Plan A • Health Plan C Held initial call with the following MCO-QE pair to discuss project in more detail and review MCO-QE Workbook: • Health Plan B-QE 3
July 2021	Held initial calls with the following MCO-QE pairs to discuss project in more detail and review MCO-QE Workbook: • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 • Health Plan A-QE 1-QE 2 Facilitated monthly check-in calls with the following MCO-QE pairs to review Business Requirements for Phase 1 – Secure Data Access: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2

August 2021	Facilitated monthly check-in calls with the following MCO-QE pairs to review Business Requirements for Phase 2 – Development: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in with the following MCO-QE pair to review Business Requirements for Phase 1 – Secure Data Access: • Health Plan A-QE 1-QE 2
September 2021	Facilitated third monthly check-in calls with the following MCO-QE pairs to review Business Requirements for Phase 3 – Testing: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in calls with the following MCO-QE pair to review Business Requirements for Phase 2 – Development: • Health Plan A-QE 1-QE 2
October 2021	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in calls with the following MCO-QE pair to review business requirements for Phase 3 – Testing: • Health Plan A-QE 1-QE 2
November 2021	Facilitated monthly check-in with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 • Health Plan A-QE 1-QE 2

December 2021	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 • Health Plan A-QE 1-QE 2
January 2022	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 Reviewed the 2020 ECDS Measurement Results in lieu of a monthly check-in: • Health Plan A-QE 1-QE 2
February 2022	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan A-QE 1-QE 2 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in emails with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3
March 2022	Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-QE 2 • Health Plan A-QE 1-QE 2

April 2022	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan A-QE 1-QE 2 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3
May 2022	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan A-QE 1-QE 2 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3
June 2022	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan A-QE 1-QE 2 • Health Plan C-QE 1-QE 2 Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3

<table>
<tr><td>July 2022</td><td>Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process:
• Health Plan A-QE 1-QE 2
• Health Plan C-QE 1-QE 2

Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process:
• Health Plan B-QE 3
• Health Plan D-QE 3</td></tr>
<tr><td>August 2022</td><td>Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process:
• Health Plan C-QE 1-QE 2

monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process:
• Health Plan B-QE 3
• Health Plan D-QE 3
• Health Plan A-QE 1-QE 2</td></tr>
<tr><td>September 2022</td><td>Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process:
• Health Plan B-QE 3
• Health Plan D-QE 3

Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process:
• Health Plan A-QE 1-QE 2
• Health Plan C-QE 1
• Health Plan A-QE 1-QE 2

Note: Health Plan C-QE 2 began full production in August 2022 and were moved to a quarterly check-in cadence.</td></tr>
</table>

October 2022	Facilitated monthly check-in calls with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan A-QE 1 Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan A-QE 1-QE 2
November 2022	Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1-HeL • Health Plan A-QE 1-QE 2
December 2022	Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1 • Health Plan A-QE 1-QE 2
January 2023	Facilitated monthly check-in via email with the following MCO-QE pairs to review out-standing items from Business Requirements for Phases 1-3 and receive updates on the supplemental data connection process: • Health Plan B-QE 3 • Health Plan D-QE 3 • Health Plan C-QE 1 • Health Plan A-QE 1-QE 2
February-June 2023	Project teams were notified that the project would begin winding down and that all future monthly updates would be conducted via email with all project pairs.

Appendix B: MCO-QE Supplemental Data Exchange Project Resources

Action Plan Resource.pdf

MCO-QE Project FAQ.pdf

MCO-QE Project Terms.pdf

MCO-QE Supplemental Data

Appendix C: MCO-QE Supplemental Data Exchange Project Close-Out Survey Questions

Questions to assess MCO-QE Supplemental Data Exchange project participants' final perspectives:

1. For MCO Participants, please share any measure impact(s) since establishing a supplemental data feed with a NCQA DAV-validated QE(s).

2. Please share any lessons learned and/or successful practices that your organization will use when establishing supplemental data connections in the future.

3. What did you find to be most valuable as a participant in the MCO-QE project?

4. What is the biggest barrier your organization encountered when establishing a supplemental data connection?

5. Do you have any additional suggestions on how the NYSDOH and/or other stakeholders can support health plans and QEs in establishing a supplemental data connection

Phone: (888) 969-7832
Email: nystec@nystec.com
Website: www.nystec.com

ROME
99 Otis Street, 2nd Floor
Rome, NY 13441

ALBANY
540 Broadway, 3rd Floor
Albany, NY 12207

NEW YORK CITY
27 West 24th St., Suite 901
New York, NY 10010