Kickoff Meeting
2017 Health Benefit Plan Reporting In Maryland

November 30, 2016

11:00am – 1:00pm (EST)

MHCC MARYLAND HEALTH CARE COMMISSION

Agenda

Introduction

Theressa Lee, Director, Center for Quality Measurement and Reporting

HEDIS 2017

Presenter: Paul Mertel, HealthcareData Company, LLC

CAHPS® 2017

Presenter: Renee Henley, WBA Research

RELICC 2017

Presenter: John Miller, Mid-Atlantic Business Group on Health

HEDIS 2017

MHCC Reporting Audit Activities

Presenter: Paul Mertel

MHCC Project Partner:

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Agenda Items Discussed

- MHCC Reporting Requirements
- Changes to the General Guidelines and Timeline
- Changes in HEDIS Measures for 2017
- New Measures for HEDIS 2017
- Problem Areas from HEDIS 2016
- CAHPS Process for 2017
- Supplemental Data Approval Process for 2017
- Medical Record Review Validation Process for 2017
- Important Changes to the Roadmap
- Changes in the Audit Process and Requirements
- Important Changes in Audit Requirements for 2018

HEDIS 2017 Reporting Requirements

- Refer to QPRR published on October 1, 2016
- Remove CAT measure – retired with October Technical Update
- Retained January 31, 2016 for submission of Quality Profile
- Behavioral Health Assessment Tool and Quality Profile Template published on Sharefile and available for download with other administrative instructions. Submission date is April 14, 2017
- Instructions for Member Level File in QPRR

General Guidelines
Updates and Revisions

Hospice

- Exclude hospice members from all product lines (previously just Medicare)
- Remove hospice member before determining EP and drawing samples. Plan can exclude if found during MRRV as a valid data error but must replace from oversample)
- Must retain hospice members for health plan descriptive measures (e.g. RDM, EBS)

Dual Eligible Members: Members with both Commercial and Medicaid coverage should be reported in the Commercial HEDIS Report and excluded from the Medicaid HEDIS report.

Do not include denied claims in Overuse/Appropriateness measures (e.g. URI, LBP, DAE, etc. for numerator events – can be used for denominator)

General Guidelines
Updates and Revisions

Supplemental Data

- Separate category of member-reported supplemental data was removed and now is a subset of non-standard supplemental data
- Not permitted for measures without numerators (ex. FSP)
- Prior year validated historic hybrid medical record results files are reviewed as part of the Roadmap and not considered supplemental data anymore, documented in Section 7
- Data from certified eMeasure vendors are considered standard supplemental data and will need a Section 5 submitted in Roadmap. New Appendix 12 of Roadmap must also be submitted to plan by vendor and forwarded to the lead auditor.

General Guidelines
Updates and Revisions

Benefit and Continuous Enrollment

- Member must have required benefits during the continuous enrollment period to be included in the eligible population
- A gap in a benefit is considered a gap in continuous enrollment.
- Two gaps in a benefit at two separate times = not continuously enrolled
- Auditors will test this during queries and it is also part of measure certification testing performed by NCQA

Measure Changes for HEDIS 2017

WCC – Documentation specific to the acute chronic conditions does not meet criteria for nutrition or physical activity counseling. Some examples, if found in clinical record that are noncompliant:

- Member seen for stomach ache. Advice is follow a BRAT diet
- Members with acute knee pain evaluated for pain when exercising

CBP – Added note ”When confirming the dx of hypertension, the intent is to identify the date when the provider became aware of the HTN dx and documented it in the medical record (vs. the time the patient acquired hypertension)”

CDC – Added clarification for negative eye exam. Normal findings are OK if it is clear and patient had a dilated or retinal eye exam. Does not specifically need to state “No diabetic retinopathy”

Measure Changes for HEDIS 2017

LBP – Many changes to better identify members for whom low back pain and imaging studies are appropriate (physical therapy, added other exclusions, prolonged use of corticosteriods).

PPC – Plans my now use EDD to identify 1st trimester for prenatal care and date of delivery for postpartum care. 2016 Specs were silent on this issue

HPV – measure was retired and integrated into IMA

IMA – Combo 2 added (includes HPV)

COL – added new testing procedures to reflect changes in technology (includes CT Colonography and FIT-DNA tests)

BCS – added back in diagnostic mammograms

PCR – Clarified that plans may not consolidate status into a single stay if the date of discharge and the 2nd admission are 2 or more calendar days apart

TLM - Clarified that plans should not double count any members, including dual-eligible members

New Measures for 2017

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Standardized Healthcare-Associated Infection Ratio (HAI)

Note: Required to be reported but results will not be publicly reported in MHCC quality reporting.

Problem Areas Experienced During HEDIS 2016

- OPM and CMS Required Measures Inadvertently Not Reported
- Confusion With Inclusion of On vs. Off Marketplace Enrollees
- CAHPS Vendors Required Early Submission of Sample Frames
- Late Recertification of Measures by Some Software Vendors
- Supplemental Data Impact Reports Not Available
- Confusion On New PLD for Medicaid and Commercial
- New Audit Requirements: Queries and IDSS Warnings
- Changes in Medical Record Validation Process

Problem Areas During HEDIS 2016

OPM and CMS Memos – Required Measures Not Reported

- 1st year measures traditionally not required by OPM or CMS
- IHU and EDU were required by OPM
- IHU, EDU, and HPC required by CMS
- Auditors do get list of required MA and PBP Required Submitters
- Problem:

  Auditors not informed as to which plans have FEHBP contracts
  No way to track if required measures are being reported

Take Away for HEDIS 2017:

- Keep auditor informed and reflect FEHB on Roadmap Appendix 1
- Provide auditor with as much background on plan and products as possible
- Pay attention to HEDIS 2017 OPM and CMS memo's
- IDSS may be programmed to highlight required measures for auditor. The HDC benchmarking tool will also be programmed for OPM, CMS, QHP and PBP required measures

Problem Areas During HEDIS 2016

Confusion With Inclusion of On vs. Off Marketplace Enrollees

- HEDIS 2015 Guidance was confusing and conflicting
- HEDIS 2016 – only "on exchange" members included in QHP reporting (guidance in September 2015 Technical Guidance Memo)
- Some plans did not update their enrollment extract programs and inadvertently included both off and on exchange enrollees
- Presence of "off" exchange members not caught in validation of EES survey
- Mistake impacted both CAHPS survey and Marketplace measures
- Mistake also not discovered by certified measures or CAHPS vendors

Take Away for HEDIS 2017:

- Auditors requesting guidance on how to identify "off marketplace" enrollees
- HDC will analyze EES for "off" marketplace enrollees – if found then file fails

Problem Areas During HEDIS 2016

CAHPS Vendors Demanded Early Submission of Sample Frames

- Some vendors requested validated sample frames by January 12, 2016
- Health Plans not prepared to provide enrollment data that early
- HOQ only opened on January 11, 2016
- Sample Frames must be validated for compliance with layout requirements and eligible membership in file benchmarked
- Validation takes 1-2 days and longer if mistake is found in sample frame
- "Plans should demand a later submission date when contracting with a CAHPS vendor

Take Away for HEDIS 2017:

- HOQ will now close on February 17, 2017
- Sample Frames must be provided to HDC by January 20, 2017

Problem Areas During HEDIS 2016

Late Recertification of Measures by Some Software Vendors

- Auditors accept recertification of measures vs. having to review code
- Requires plan to run measures again so the GUID matches latest version
- Requires auditor to revalidate measures and benchmark
- NCQA changing deadlines for certification and availability of XML files
- Impossible to predict any need for recertification

Take Away for HEDIS 2017:

- NCQA revised dates for software vendors
  - 12/15/2016 – hybrid, sampling and CAHPS/EES completion
  - 02/15/2017 – all remaining measures must be certified

Problem Areas During HEDIS 2016

Supplemental Data Impact Reports Not Provided

- Roadmap is provided before any supplemental data is approved – impact report in Table 5.6, Section 5 is almost impossible to complete
- Final impact of supplemental data on measure generally determined when hybrid review is completed, MRRV is successful, IDSS is populated with final rates.
- Tables from IDSS can be of assistance
- Update Roadmap after loading xml files into IDSS

Take Away for HEDIS 2017:

- Attestation can be submitted pending receipt of impact report
- Auditors recommended template for impact report be adopted for all vendors
- Required for plans with internal programming code

Problem Areas During HEDIS 2016

Patient Level Detail File

- Required for Medicare only in prior years
- Expanded to Commercial and Medicaid submissions
- Different layout than Medicare
- PLD's not available until very late in the process
- Often IDSS and PLD did not match and slowed finalizing IDSS submissions

Take Away for HEDIS 2017:

- No change for Medicaid and Commercial PLD's
- CMS Requirements:
  - PLD must be complete, if measure missing = assigned 1 star
  - HICN number must be properly formatted. If missing HICN number could impact star ratings
  - New vendor for PLD – now Scope InfoTech, Inc.
  - Guidelines expected January 2017 (new portal address and practice data set must be submitted)

Problem Areas During HEDIS 2016

Queries Requested by Auditor

- NCQA added the requirement for auditors to do queries for HEDIS 2016
- Queries required in 6 Groups
- Group 3 Query had to be conducted on site
- On site queries were challenging for many plans (a few surprises)

Take Away for HEDIS 2017:

- For HEDIS 2017, auditor must complete 4 of the 6 queries available
- None required to be completed on site, but highly recommended
- Primary source verification (PSV) is required on at least 2 measures and 5 cases each measure with documentation provided to auditor
- Auditor must retain proof that PSV was performed (challenge if reviewed during onsite visit. Auditor must work with plan on getting print screens, scanned documents, etc.)
- Auditor must document why a particular query was selected

Problem Areas During HEDIS 2016

Auditor Review of IDSS Warnings

- IDSS produces warnings if data is incomplete or violates an expected relationship
  - Example hybrid rate should be higher than administrative rate
  - Final sample size should be bigger than minimum required sample size if oversample rate is greater than zero
- Auditors required to
  - Review Warnings and determine if they were a true concern
  - Follow up with client if necessary
  - Document findings in the audit work papers
- Process Takes Time – some plans did not anticipate this in their project planning

Take Away for HEDIS 2017:

- Same as 2017, but NCQA may increase warnings but only provided to auditor – will compare rates across years and within a "family" of health plans
- GUID validation will accommodate special circumstances (LSC/CIS)

Problem Areas During HEDIS 2016

Hierarchy of Data Types

- NCQA established rules around what counts if an event is found in different data sources
- General Hierarchy: 1. Administrative data from transaction systems. 2. Medical record data 3. Administrative data from supplemental data sources
- Special Hierarchy rule: If a measure requires data from multiple sources and they include both supplemental and medical record data the hit is counted as supplemental data. However, the medical record hit is still subject to MRRV

Take Away for HEDIS 2017:

- No change to policy
- Prior MRR results and claims look back (e.g. COL) = primary data
- EHR and electronic data files from e-certified vendors will be up for review as standard or primary (for 2018)

Problem Areas During HEDIS 2016

MRRV Timeline Changes

- NCQA revised the measure notification date from May 1 to May 16.
- On May 16 plans submit counts of medical record numerator positive members
- Auditors chose measures to be validated for each of the 6 NCQA categories
- Plans submit lists of numerator positive members and members excluded
- Auditors review charts and abstraction forms

Issues: Plans lost ability to carefully prepare the selected measures

- Significant increase in number of medical record validation failures
  - Second samples
  - Corrective Actions
  - Report Administrative Rate
  - Take a BR for biased rate
- Delays in finalizing rates in IDSS

Take Away for HEDIS 2017:

- No change in current policies and dates
- Date changes to May 15 to select measures

CAHPS HEDIS 2017

Commercial and QHP

CAHPS & EES Process

- Make sure surveys are annotated in the HOQ
- If using internal code to generate sample frame – submit 10-15 days before survey vendor deadline
- Check sample frame before submitting to HDC
  - ensure members are not duplicated
  - make sure required variables are present
- Download Data Collection Form (DCF) from Audit Information Packet (AIP) documents and complete
- Submit DCF and sample frames at least 10 days before survey vendor deadline (validation and benchmarking take 4-6 days)
- If using a vendor with certified CAHPS/EES measures, you must also upload a record or log showing the GUID numbers used to create the sample frames (HDC must validate these numbers against master list from NCQA)

CAHPS & EES Process (continued)

- HDC validates every required data element in sample frames. Mandatory fields must be complete and formatted correctly or sample frame will fail
- If submitting an EES for a QHP plan, it is critical that all required fields are completed and the Variant ID is available – used to ensure no “off market” members are included.
- HDC must benchmark the number of members in the sample frame against NCQA provided benchmarks. Errant numbers will be flagged and approval not given until resolved. QHP benchmarks will be provided. Plans submitting CAHPS later than 1/23/17 must be reported to NCQA.
- Once approved, HDC will send approval email AND will submit a zipped and encrypted copy of the sample frame to the client. Vendor will not accept unless file is zipped and encrypted. New for 2017 – cannot combine products in one zipped file. Each product gets a separate zipped file.
- Health Plan is responsible for submitted zipped and encrypted sample frame files to their survey vendor
- HDC marks “Supports Reporting” in the HOQ for each survey that is validated

Supplemental Data Approval Process

HEDIS 2017

Supplemental Data Approval

- Each standard and nonstandard supplemental database must have a separate Section 5. If using multiple laboratories, but files are the same, then one Section 5 is okay but list all lab vendors
- Auditor approval can start as early as December 1, 2016. If nonstandard, data entry into database must stop when submitted for approval.
- Once approved, standard databases can be used at any time and can be "added to" during the reporting process (e.g., lab results).
- Once approved, nonstandard databases are frozen for HEDIS 2017.
- Data entry into a nonstandard database must stop on March 1, 2017 and the database validated and approved by March 31, 2017.
- Auditor selects a random sample from each nonstandard database.
- Plan must provide proof of service for each member in the random sample.
- Supplement data only used for numerator compliance or exclusions – not for denominator identification

Supplemental Data Random Sample Sizes

Nonstandard supplemental data

Events in File	Minimum Sample Size
0-400	16 events
401-999	5%
≥1,000	50 events

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Supplemental Data Approval

- Key items to remember:
  - Nonstandard database must capture data elements required by the measure. If measure has a hybrid option, then the hybrid requirements must be captured (e.g. date of service, results (as applicable). Data elements must be in proof of service that is provided.
  - Pay attention to measure requirements for timing (e.g., BMI calculated by end of measurement year)
  - Auditor must decide if database is standard or nonstandard. Hence, the main reason why Section 5 is provided. Make sure it is completed properly and completely.
  - Prior year medical record results or claims data extract (e.g., for COL measure) are documented in Section 7 now and a Section 5 is no longer required. Considered as primary data for reporting.

Supplemental Data Approval

Changes for HEDIS 2017:

- Only the auditor can make the decision if a supplemental data source is standard or nonstandard.
    - If previously categorized as nonstandard but now categorized as standard, the complete justification must be provided by auditor in their working papers on why the change to standard designation.
- If standard data from an eMeasure vendor, the auditor must:
    - Receive a completed eMeasure vendor section of the Roadmap and confirm the supplemental data files being used contain only data for certified measures. Auditor must also receive a final certification report for the vendor
    - If uncertified measures, then nonstandard data validation processes must be followed
    - If provider type is required for nonstandard data, auditor must verify that appropriate staff are collecting this information.

Medical Record Review Validation Process HEDIS 2017

MRRV – Key Dates

- Convenience Sample must be submitted no later than April 14, 2017. Criteria for plan to be exempted by auditor from convenience sample strengthened. Plan may still request a convenience sample.
- Convenience sample typically around 10 charts – 2 charts per measure.
- Summary MRR hybrid totals submitted to auditor on May 15, 2017 or earlier if abstraction has been completed – must use Hybrid Input File Form found in AIP
- Auditor selects measures and notifies plan by May 19, 2017. Plan then sends detail member-level lists to HDC for random selection
- Plan provides selected charts to HDC for review by May 26, 2017
- Plan notified of MRRV results starting on May 31, 2017 or earlier

Note: IDSS must be locked by plan no later than June 8, 2017. Consider this date in relationship to MRR project, above requirements and a projected stop date.

MRRV – Key Components

- All MRR documentation is transmitted via secure Sharefile. No email or bonded carrier shipment of documents is permitted due to PHI
- Hybrid Input File Form found in AIP must be used to record total numerator events (admin and hybrid) for each hybrid sample – no exceptions
- Member level files of hybrid compliant members transmitted via Sharefile using health plan hybrid selection template found in AIP. Random sample returned same way.
- Plan provides selected charts to HDC for review by May 26, 2017. Make sure you provide both abstraction form and copy of clinical record . Highlight applicable area in clinical record, if possible (speeds up process significantly).
- Plan notified of MRRV results starting on May 31, 2017 or earlier

MRRV – Revisions

- If a “critical” error if found in the random sample, the critical error must be corrected, removed from reporting, or added back to the sample if they are not approved exclusions.
- If one error is found, the auditor must select a new random sample of 16 members. If the second sample is free from errors, the measure and group pass. However, the auditor must confirm the error found in the first sample was removed or corrected.
- If the rate of unconfirmed hypertension cases (CBP) is high, the auditor must perform a review of 16 cases to ensure the organization is not removing the wrong members.
- New for 2017 – auditor must validate training materials used by plan in training abstractors.

Roadmap Revisions
And Requirements
HEDIS 2017

Roadmap Revisions

- Section 6 deleted with retirement of CAT measure
- Added requirement for plan to notify auditor of any additional reporting requirements (state, OPM, CMS, Marketplace)
- All changes and additions were highlighted in red font
- Added requirement for plan to provide oversight reports where services are outsourced to a third party vendor – included with Roadmap
- Additional questions and tables added to Section 5 to more fully explain data collection and oversight to both internal collection (plan staff collect) and external collection processes (vendor provides data)
- Appendix 12 added – Audit Roadmap for Data Received from Organizations Calculating eMeasures. Note: this is completed by the eMeasure vendor(s) and not by the plan. Auditor must receive one from each eMeasure vendor contracted by the plan.

Timeline Changes

HEDIS 2017

Reporting Timeline Changes

HEDIS AUDIT TIMELINE	
Task	**NCQA Deadline**
Organization contracts with an NCQA Licensed Organization.	December 1
Validating supplemental data may begin only if all supplemental data collection is complete and all Roadmap documentation is submitted to the auditor.	December 1
Onsite visits begin. *Onsites are not to be held before the start of the reporting year.*	After January 2
Organization submits the completed current year's Roadmap to the auditor. **The auditor must receive the Roadmap by January 31 or at least two weeks prior to the site visit, whichever date is earlier.*	January 16–31*
Auditor completes the survey sample frame validation.	January 31
Auditor selects a core set of noncertified measures for code review.	February 13
Measure certification deadline. NCQA sends final certification reports to auditors.	February 15
Organization submits completed source code for auditor review (for noncertified measures).	March 1
Organization completes and stops all nonstandard and member-reported supplemental data collection and entry. *No exceptions! Failure to meet this deadline could result in inability to use supplemental data to report rates.*	March 1
Auditor finalizes approval of *all* supplemental data. PSV for nonstandard supplemental data must not occur prior to March 1 unless the organization has finished all supplemental data processes, collection and entry. *No exceptions!*	March 31
Onsite visits completed.	April 28
Preliminary rate review is completed. *NCQA encourages preliminary rate review to take place earlier in the audit process.*	May 1
Organization completes the medical record abstraction process for all measures; sends final numerator-compliant counts for all measures and exclusions for MRRV. *No exceptions! Failure to meet this deadline could result in inability to use medical record data to report rates.*	May 15
Auditor picks a measure from each measure group and all exclusions, selects 16 records from each for MRRV review, and informs the plan of the selections.	May 19
Organization sends selected records to the auditor for validation.	May 26
Auditor begins communicating MRRV results, including the MRRV corrective actions, with the organization.	May 31
Organization completes all corrective actions and follow-up requests and submits the plan-locked commercial, Marketplace, Medicaid and Medicare submissions and patient-level detail files to auditor.	June 8
Auditor reviews all IDSS warnings, performs final rate review, compares PLD file to summary data, ensures that the MRR numerator counts entered in IDSS match the lists submitted on May 15 and measure identifiers match vendor's final certification report.	June 15

Summary of Important Changes and Audit Requirements

HEDIS 2017

Changes and Audit Requirements To Remember

- HOQ opens January 9, 2017 and closes February 17, 2017
- CAHPS/EES has to be completed by January 23, 2017
- Nonstandard supplemental data entry stops on March 1, 2107 and database must be approved by March 31, 2017
- Queries reduced to 4 but auditor must do PSV for 2 measures and 5 records for each measure
- Auditor must now justify any rate change of 5% or more – if not evident, then plan will be asked to comment on the change
- Audit of MRR process now includes a review of the training materials and the testing in addition to the abstraction tools
- Tier 4 validations performed at NCQA and results provided to auditor – compares rates across multiple years and family of plans/products, as applicable

Changes and Audit Requirements To Remember

- MRR must hybrid abstraction by May 15, 2017
- Preliminary rates must be completed by May 1, 2017 (no exceptions) and loaded into IDSS for auditor review
- Health plan lock on IDSS due by June 8, 2017 (no exceptions)
- Validated sample frames must be zipped/encrypted individually
- Enhanced validations performed on all sample frames (HEDIS/EES)
- Enhanced validations performed on Medicare PLD – all measures are reported and HCIN numbers are populated and correct length

Audit and Reporting Requirements

HEDIS 2018

HEDIS 2018

- Requirement for a Maryland only residents IDSS submission is rescinded
- MHCC will accept plan-wide IDSS submission submitted to NCQA
- Plans responsible for providing their own audit firm
- If not using HDC as audit organization, plan must provide HDC with the zipped consolidated download from the IDSS (contains required data files for analysis).
- Zipped consolidated file submitted by June 17, 2018
- HDC will continue to provide analysis, reporting and trending of HEDIS measures for quality reporting

Questions and Comments?

CAHPS® 2017

Consumer Assessment of Healthcare Providers and Systems

Presenter: Renee Henley

MHCC Project Partner:

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wba RESEARCH

CAHPS® – Summary of Changes for 2017

- NCQA updated sampling methodology
  - New deduplication method to be used before systematic sampling

Summary of CAHPS® 2017

- **CAHPS® 5.0H Adult - Commercial Survey**
- **Global Ratings Questions include:**
  - All Health Care
  - Personal Doctor
  - Specialist Seen Most Often
  - Health Plan
- **Composite Scores include:**
  - Claims Processing
  - Customer Service
  - Getting Care Quickly
  - Getting Needed Care
  - How Well Doctors Communicate
  - Shared Decision Making
  - Plan Information on Costs
- **Item-Specific Question Summary Rates include:**
  - Health Promotion and Education
  - Coordination of Care

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CAHPS® Sample Size

- **Sample Size:**

	Adult
Required Sample Size	1,100
Oversampling Rate	10%
Final Sample Size	1,210

- **At the Plan's cost, each Plan has the option to increase the over-sampling rate in addition to the 10% executed by MHCC**

Key Dates - CAHPS® 2017

Action	Completion
If desired, Plans forward supplemental questions to WBA Research	December 2nd
WBA Research receives MHCC logo, signature for mailing pieces, letterhead, etc.	December 16th
Plans send written notification to WBA Research regarding additional over-sample	December 20th
Plans submit CAHPS® Data Collection Form to HDC	Early January
WBA Research submits survey materials to MHCC and NCQA for approval	Early-Mid January
Start HOQ completion for CAHPS® Sample Frame (add any new HEDIS® auditor)	January 12th
HDC completes review, validates HOQ, and notifies Plan via email	January 20th
Plans send audited sample frame files that are securely zipped and encrypted to WBA Research (with forwarded email from HDC)	January 23rd

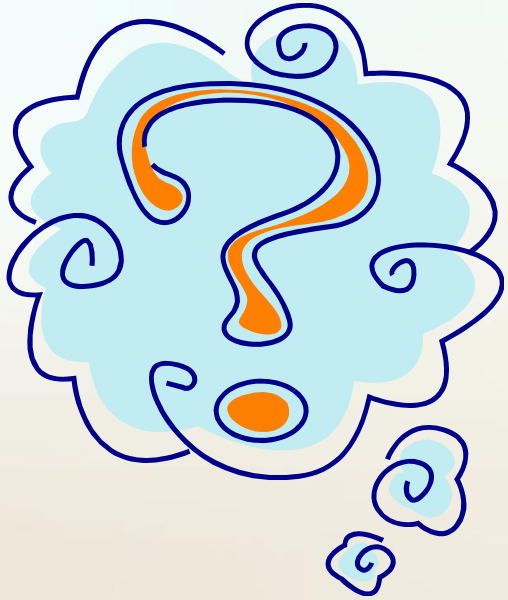
wba RESEARCH

Key Dates - CAHPS® 2017

Action	Completion
WBA Research mails 1st questionnaire with cover letter	Week of February 27th
WBA Research mails 1st reminder postcard	Week of March 6th
WBA Research processes returned mail	ongoing
WBA Research mails 2nd questionnaire with cover letter	Week of April 3rd
WBA Research mails 2nd reminder postcard	Week of April 10th
WBA Research appends telephone numbers to sample files	Week of April 17th
WBA Research conducts Computer Assisted Telephone Interviews (CATI)	April 24th – May 14th
WBA Research will process member-level data files and submit to NCQA	May 15th – 25th
NCQA makes survey results, validated member-level data files and summary-level data files available	June 1st
Plans review survey results from NCQA and submit signed Attestation of Accuracy	By June 15th
WBA Research conducts final analysis and issues report	August

wba RESEARCH

Questions and/or Comments?



RELICC 2017
Race/Ethnicity, Language, Interpreters, and Cultural Competency

Presenter: John Miller

MHCC Project Partner:

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MidAtlantic Business Group on Health

Background – Maryland RELICC Assessment

Maryland RELICC (race/ethnicity, language, interpreters, and cultural competency) Assessment:

- A custom designed quality and performance assessment tool for use by the State of Maryland which focuses on addressing disparities issues
- Customized by the MidAtlantic Business Group on Health (MABGH), with support from the National Alliance of Healthcare Purchaser Coalitions (National Alliance) (formerly the National Business Coalition on Health)
- Based primarily on related questions from the leading, national, evidence-based RFI tool, eValue8TM
- All of the carriers in Maryland have previously participated in eValue8 in some region
- MHCC sought feedback from key stakeholders, including Maryland's health benefit plans, in the design and implementation of the RELICC Assessment

Basis – Maryland RELICC Assessment

- **Purchaser voice/Evidence-based**
  - RELICC integrates a combination of purchaser expectations and evidence-based performance measures that have been demonstrated to drive improvements and increase the overall value for purchasers and consumers
- **Expert contributors**
  - Questions developed in partnership with purchasers, plans and other leaders in value-based purchasing: Catalyst for Payment Reform (CPR), Pharmacy Quality Alliance, and Health Care Incentives Improvement Institute (HCI3)
  - The National Committee on Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC) and other federal, state and academic centers have provided assistance
  - Every effort made to align with the programs/perspective of these entities
- **Advisory councils**
  - Business/health coalitions, individual purchasers, and health benefit plans comment and advise on questions

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RELICC Requirement

- **The 2017 Quality and Performance Reporting Requirements (QPRR)**
  - Requires health benefit plans participating in the Health Benefit Plan Quality and Performance Evaluation System to utilize the RELICC tool for enhanced reporting to MHCC
  - With a successful 2013 pilot, RELICC information reported this year is scheduled for public release in the 2017 Health Benefit Plan Quality and Performance Report

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RELICC Description

2017 Maryland RELICC Assessment consists of:

- 8 Administrative Questions
  - Health benefit plan product information
  - Contact and organization information including tax status
  - Enrollment information (Maryland membership in each of the products)
- 13 RELICC-related Questions
  - 9 questions on racial, cultural and language competency
  - 4 questions on racial, cultural and language use
- Plus an opportunity for plans to provide additional information on how the plan ensures that culturally competent health care is provided
- As well as an Attestation of Accuracy that is signed by the designated health benefit plan representative

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RELICC Notes

- **Auto-populate**
  - Plans who have responded previously to eValue8TM and/or RELICC have the ability to select as a “default” their scored response from prior year
- **HMO/PPO in same template**
  - The PPO question always follows the HMO question. Plans providing responses for both HMO and PPO product lines should select both the HMO and PPO boxes in 1.1.5 to activate the questions

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RELICC Administration

- **Access and support**
  - The process and directions documents including mapping document and scoring guide
  - ProposalTech technical support with online training
  - Additional Q&A through ProposalTech secure platform and during teleconferences
- **Submission should reflect Maryland reporting entities**
  - Regional answers should be Maryland specific

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Key Dates – Maryland RELICC Assessment

Action	Completion
RELICC Guidelines document distributed to plans prior to Kickoff Meeting	November 29, 2016
ProposalTech Training Upon Request	Early-Mid-Dec 2016
Kickoff Meeting	November 30, 2016
RELICC Release	Dec 5, 2016
Questions to ProposalTech Submitted in Writing	Dec 5, 2016 - Mar 3, 2017
RELICC Response Due with signed Attestation of Accuracy	Mar 17, 2017
Evaluation and Scoring of Responses (Plans may receive follow up questions)	Mar 20 - Mid-Apr, 2017
Plan response to follow up	Apr 26, 2017
Administrative Reports (preliminary reports issued from contractor to MHCC)	May 12-Early Jun, 2017
Site Visits (or web-based conference option)	Mid – late Jun 2017

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Contact Information for RELICC Users

- **ProposalTech**
  - **truth@proposaltech.com**

- **National Alliance of Healthcare Purchaser Coalitions**
  - Foong-Khwan **Siew:fsiew@nationalalliancehealth.org**

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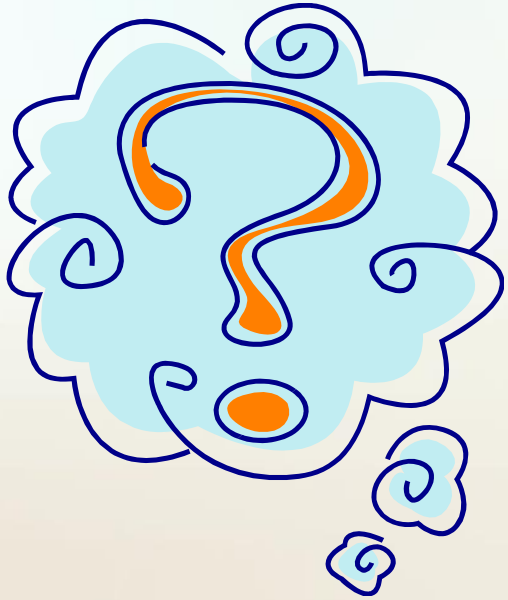
Questions and/or Comments?



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