Medicaid Managed Care Organization

Value-Based Purchasing Activities Report

Final Report

Calendar Year 2004

Submitted by:
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HealthChoice and Acute Care Administration
Division of HealthChoice Management and Quality Assurance

Calendar Year 2004 Value-Based Purchasing Activities

National Value-Based Purchasing Activities

Private and public purchasers of health care have increasingly promoted value-based purchasing strategies to improve health care quality. Value-based purchasing improves quality by awarding business and incentives to contractors based on their performance along a range of dimensions. Virtually all large Fortune 500 companies report collecting some information about health plan quality, and approximately 30 state Medicaid agencies collect information about enrollee's satisfaction with care.[1]

Value-based purchasing initiatives are supported by multiple national organizations. For example, the National Health Care Purchasing Institute (NHCPI) has worked to improve health care quality by advancing the purchasing practices of major corporations, government agencies, and public employers. NHCPI's work has been incorporated into The Leapfrog Group, a collaborative of 160 public and private health care purchasers working to improve health care quality and to save lives by recognizing improvements in health care quality, patient safety, and customer value with preferential use and intensified market reinforcements. The Center for Health Care Strategies' State Purchasing Programs works with state Medicaid and SCHIP agencies to develop, pilot, and implement value-based purchasing strategies.

The Maryland Department of Health and Mental Hygiene (DHMH) began working with the Center for Health Care Strategies in 1999 to develop a value-based purchasing initiative for HealthChoice, Maryland's Medicaid managed care program. Maryland is at the forefront of states' adoption of this type of quality strategy. Other early adopters of value-based purchasing initiatives for Medicaid managed care programs include Massachusetts, Rhode Island, and Wisconsin.

Maryland HealthChoice Goals

The goal of Maryland's purchasing strategy is to achieve better enrollee health through improved managed care organization (MCO) performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care, increased access, and administrative efficiency. Maryland's purchasing strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. In addition, the state's strategy meets the

[1]Vittorio, M., Goldfarb, N. I., Carter, C., & Nash, D. B. (2003). *Value-based purchasing: A review of the literature.* Retrieved June 2, 2003, from The Commonwealth Fund Web site: http://www.cmwf.org

requirements of the Federal Balanced Budget Act of 1997. See Appendix II for more information on compliance with federal law and regulations.

2004 Performance Measures

DHMH solicited input from stakeholders including MCOs, the Medicaid Advisory Committee, the Special Needs Children Advisory Committee, and Local Health Officers in selecting the performance measures for 2004. The measures address three dimensions of plan performance.

- Access to Care: The ability of patients to get needed services in a timely manner.
- Quality of Care: The ability of services to promote desired outcomes.
- Administration: Structure of the health care delivery system that enables delivery of services.

DHMH selected measures that are (1) relevant to the core populations served by HealthChoice, including children, pregnant women, special needs children, disabled adults, and adults with chronic conditions; (2) relevant to the State of Maryland's priority areas for improvement, such as dental services and lead screening; (3) evidence based, to ensure that delivery of the service is known to improve health outcomes; (4) measurable with available data; (5) comparable to the performance measures of other state and commercial plans, to provide for benchmarking; (6) consistent with the way in which the Centers for Medicare & Medicaid Services is developing a national set of performance measures for Medicaid MCOs; and (7) possible for MCOs to affect so that they can be held accountable.

Performance targets for the measures were set in several ways, depending on the data source and other factors. For those measures based on the Health Plan Employer Data and Information Set (HEDIS®), targets were set from national Medicaid HEDIS benchmarks (90th percentile based on 2001 data for incentives) and Maryland's average HEDIS scores (95% of the Maryland average based on 2001 data for disincentives). A set of performance measures designed to provide information for comparison of health plan performance, HEDIS is a nationally accepted system used by employers, government agencies, consumers, health plans, and others. For measures based on encounter data, targets were set from Maryland's scores (105% of the best performer in Maryland based on 2001 data for incentives and 95% of the Maryland average based on 2001 data for disincentives). Other targets were set according to regulatory requirements, legislative mandates, and commercial standards.

Table 1 shows the 2004 measures and their targets. More information on data sources and target rationale is included in Appendix III.

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Table 1. 2004 Value-Based Purchasing Performance Measures

Performance Measure	Data Source	2004 Target
Well-Child Visits for Children Ages 3 through 6: % of children ages 3–6 (enrolled 320 or more days) receiving at least one well-child visit during the year, consistent with American Academy of Pediatrics and EPSDT recommended number of visits	HEDIS	Incentive: >68% Neutral: 61%–68% Disincentive: <61%
Dental Services for Children Ages 4 through 20:* % of children ages 4–20 (enrolled 320 or more days) receiving at least one dental service during the year	Encounter Data	Incentive: >60% Neutral: 40%–60% Disincentive: <40%
Ambulatory Care Services for SSI Adults: % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the year	Encounter Data	Incentive: >86% Neutral: 72%–86% Disincentive: <72%
Ambulatory Care Services for SSI Children: % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the year	Encounter Data	Incentive: >77% Neutral: 63%–77% Disincentive: <63%
Timeliness of Prenatal Care: % of pregnant women (enrolled 43 days prior to delivery through 56 days after delivery) who receive a prenatal visit during the first trimester or within 42 days of enrollment	HEDIS	Incentive: >89% Neutral: 72%–89% Disincentive: <72%
Cervical Cancer Screening for Women Ages 21–64: % of women ages 21–64 (continuously enrolled during reporting year) receiving at least one PAP test during the last 3 years, consistent with U.S. Preventive Services Task Force recommendations	HEDIS	Incentive: >77% Neutral: 47%–77% Disincentive: <47%
Lead Screenings for Children Ages 12–23 Months: % of children ages 12–23 months (enrolled 90 or more days) who receive lead test during the year	Encounter Data and Lead Registry Data	Incentive: >53% Neutral: 41%–53% Disincentive: <41%
Eye Exams for Diabetics: % of diabetics (continuously enrolled during reporting year) receiving dilated funduscopic eye exam during the year, consistent with American Diabetes Association recommendations	HEDIS	Incentive: >64% Neutral: 42%–64% Disincentive: <42%
Childhood Immunization Status: % of children who turned 2 years old during the measurement year who were continuously enrolled for 12 months immediately preceding their second birthday and who had 4 DtaP/DT, 3 IPV, 1 MMR, 3 H influenza type B, 3 hepatitis B, and 1 chicken pox vaccine (VZV) by the time period specified and by the child's second birthday (aka: Combo 2)	HEDIS	Incentive: >68% Neutral: 50%–68% Disincentive: <50%

Performance Measure	Data Source	2004 Target
Practitioner Turnover: % of primary care physicians affiliated with the MCO as of December 31 of the year prior to the measurement year who were not affiliated with the MCO as of December 31 of the measurement year	HEDIS	N/A
Claims Timeliness:** % of claims paid/denied by MCO within 30 days of receipt	HEDIS	N/A

* Dental incentive target is a legislative mandate.
** National Committee for Quality Assurance (NCQA) has made the decision not to publicly report any audited results for this measure. DHMH has elected to remove all MCO-specific audited rates from this report until additional instructions and guidelines are published by NCQA.

In 2003, two measures, practitioner turnover and childhood immunization status, were added for a total of eleven measures. Performance thresholds for the Practitioner Turnover and Claims Timeliness measures were eliminated for reporting year 2005. In future years, other measures may be added to the set of nine or may be rotated with measures in the set. The flexibility of this strategy provides the opportunity to change measures based on evolving priorities and health care needs.

2004 Results

The 2004 performance results were validated by DHMH's External Quality Review Organization (EQRO) contractor, Delmarva Foundation for Medical Care, Inc. (Delmarva), and DHMH's contracted HEDIS Compliance Audit™ firm, HealthcareData.com, LLC. The contractors determined whether the measures were calculated correctly and validated the accuracy of the performance scores. All measures were calculated in a manner that does not introduce bias, allowing the results to be used for public reporting and sanctioning. See Appendix III for more information on the validation process and results.

In calendar year (CY) 2004, there were seven HealthChoice MCOs:

- AMERIGROUP Maryland, Inc. (AGM),
- Diamond Plan (DIA),
- Helix Family Choice, Inc. (HFC),
- Jai Medical Systems, Inc. (JMS),
- Maryland Physicians Care (MPC),
- Priority Partners (PPMCO), and
- UnitedHealthcare (UHC).

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DIA began providing managed care services to HealthChoice enrollees in September 2003. Given that many of the performance measures require member populations that are enrolled for a certain length of time, or that an MCO have sufficient numbers of members for each measure, DIA did not meet the technical requirements for comparable performance measures. Thus, DIA is not included in this report. It is anticipated that as its population increases and membership is enrolled for longer continuous periods, DIA will be able to report all of the performance measures.

For the majority of the measures, the MCOs scored either within the neutral or incentive ranges. The results are summarized in Table 2.

Table 2. Performance Summary

Performance Measure	2004 Target	MCO					
		AGM	HFC	JMS	MPC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)					
Well-child visits for children ages 3–6	Incentive: >68% Neutral: 61%–68% Disincentive: <61%	78.8% (I)	75.3% (I)	79.1% (I)	67.8% (N)	70.8% (I)	68.4% (I)
Dental services for children ages 4–20	Incentive: >60% Neutral: 40%–60% Disincentive: <40%	38.4% (D)	46.8% (N)	33.3% (D)	44.4% (N)	48.0% (N)	44.4% (N)
Ambulatory care services for SSI adults	Incentive: >86% Neutral: 72%–86% Disincentive: <72%	74.8% (N)	80.9% (N)	82.4% (N)	80.7% (N)	81.0% (N)	79.7% (N)
Ambulatory care services for SSI children	Incentive: >77% Neutral: 63%–77% Disincentive: <63%	68.0% (N)	76.3% (N)	61.0% (D)	72.8% (N)	70.6% (N)	67.4% (N)
Timeliness of prenatal care	Incentive: >89% Neutral: 72%–89% Disincentive: <72%	93.9% (I)	90.3% (I)	82.7% (N)	86.0% (N)	81.5% (N)	87.1% (N)
Cervical cancer screening for women ages 21–64	Incentive: >77% Neutral: 47%–77% Disincentive: <47%	64.5% (N)	62.8% (N)	60.1% (N)	62.8% (N)	69.1% (N)	53.5% (N)
Lead screenings for children ages 12–23 months	Incentive: >53% Neutral: 41%–53% Disincentive: <41%	50.8% (N)	54.0% (I)	48.4% (N)	50.7% (N)	51.6% (N)	43.1% (N)
Eye exams for diabetics	Incentive: >64% Neutral: 42%–64% Disincentive: <42%	50.3% (N)	38.9% (D)	62.5% (N)	41.1% (D)	40.4% (D)	50.1% (N)
Childhood immunization status—Combo 2	Incentive: >68% Neutral: 50%–68% Disincentive: <50%	80.1% (I)	73.1% (I)	75.8% (I)	66.1% (N)	75.7% (I)	65.2% (N)
Practitioner turnover	N/A	6.8%	9.2%	6.5%	2.6%	1.5%	9.4%
Claims Timeliness	N/A	Although all 6 HealthChoice MCOs were able to report this measure, NCQA has elected to remove all MCO-specific audited rates. (See ** following table 1.)					

2004 Sanctions

Financial sanctions were assessed for Value-Based Purchasing measures where performance was below minimum compliance targets. The Incentive Fund Pool was re-directed to fund MedBank through fiscal year 2006; financial incentives for performance over the incentive targets will not be available in fiscal year 2005. An incentive methodology was applied to allow plans to offset sanctions or disincentives.

The methodology for assessing sanctions is the same for all applicable measures except for the dental measure. The dental sanctions differ from the other measures: the targets are legislatively set and the MCOs received an infusion of funds to fully cover their costs under the capitation rates. Sanctions for all measures except for dental are assessed by calculating the number of percentage points below the disincentive target, multiplied by the MCO's per 1,000 enrollment level (based on the MCO's average total enrollment in CY 2004), multiplied by a defined dollar amount. The dollar amount increases as the score moves further below the target. The sanctioning amount ranges are shown in Table 3.

Table 3. 2004 Disincentive Dollar Amounts

Points Below Performance Sanctioning Target	Sanction Amount
1 to 10 points	$50 per point multiplied by the MCO's per 1,000 enrollment level
11 to 20 points	$100 per point multiplied by the MCO's per 1,000 enrollment level
21 points and below	$150 per point multiplied by the MCO's per 1,000 enrollment level

The incentive amounts applied to offset any disincentives are shown in Table 4.

Table 4. 2004 Incentive Offset Amounts

Points Above Performance Incentive Target	Amount Applied To Offset Any Disincentives
1 to 10 points	$100 per point multiplied by the MCO's per 1,000 enrollment level
11 to 20 points	$200 per point multiplied by the MCO's per 1,000 enrollment level
21 points and above	$300 per point multiplied by the MCO's per 1,000 enrollment level

For both sanctions and incentives, the increase in dollar amount applies only to those points within the corresponding ranges. For example, if an MCO's performance is 22 points below the sanctioning target, DHMH will apply a $50 sanction amount to each of the first 10 points; a $100 sanction amount to each of

the second 10 points; and a $150 sanction amount to each of the last 2 points. Any sanctions will be withheld from MCOs' future capitation payments.

For the dental performance measure, sanctions are assessed by calculating the number of percentage points below the 40% target utilization rate, multiplied by the MCO's per 1,000 enrollment level for the population of interest (i.e., children age 4 through 20 enrolled for 320 or more days as of December 31 of the measurement year), multiplied by $500.

The MCOs' incentive and sanction amounts for 2004 performance are shown in Table 5. Sanction amounts are shown in parenthesis.

Table 5. 2004 MCO Incentive/Sanction Amounts

Performance Measure	MCO					
	AGM	HFC	JMS	MPC	PPMCO	UHC
Well-child visits for children ages 3–6	$149,640	$14,600	$8,540	$0	$33,320	$4,360
Dental services for children ages 4–20	($55,200)	$0	($6,700)	$0	$0	$0
Ambulatory care services for SSI adults	$0	$0	$0	$0	$0	$0
Ambulatory care services for SSI children	$0	$0	($700)	$0	$0	$0
Timeliness of prenatal care	$63,210	$2,600	$0	$0	$0	$0
Cervical cancer screening for women ages 21–64	$0	$0	$0	$0	$0	$0
Lead screenings for children ages 12–23 months	$0	$2,000	$0	$0	$0	$0
Eye exams for diabetics	$0	($3,100)	$0	($4,005)	($9,520)	$0
Childhood immunization status—Combo 2	$183,180	$10,200	$5,460	$0	$91,630	$0
Total Incentive/ Sanction Amount	**$340,830**	**$26,300**	**$6,600**	**($4,005)**	**$115,430**	**$4,360**

Conclusion

The HealthChoice Value-Based Purchasing quality strategy has multiple strengths. It emphasizes continuous quality improvement and evidence-based medicine, making it consistent with trends in the larger health care market. The strategy increases the comparability of Maryland's performance to that of other states, enabling the sharing of best practices. In addition, performance evaluation based on administrative and encounter data rather than on the review of a small sample of medical records means that the quality indicators are representative of more enrollees.

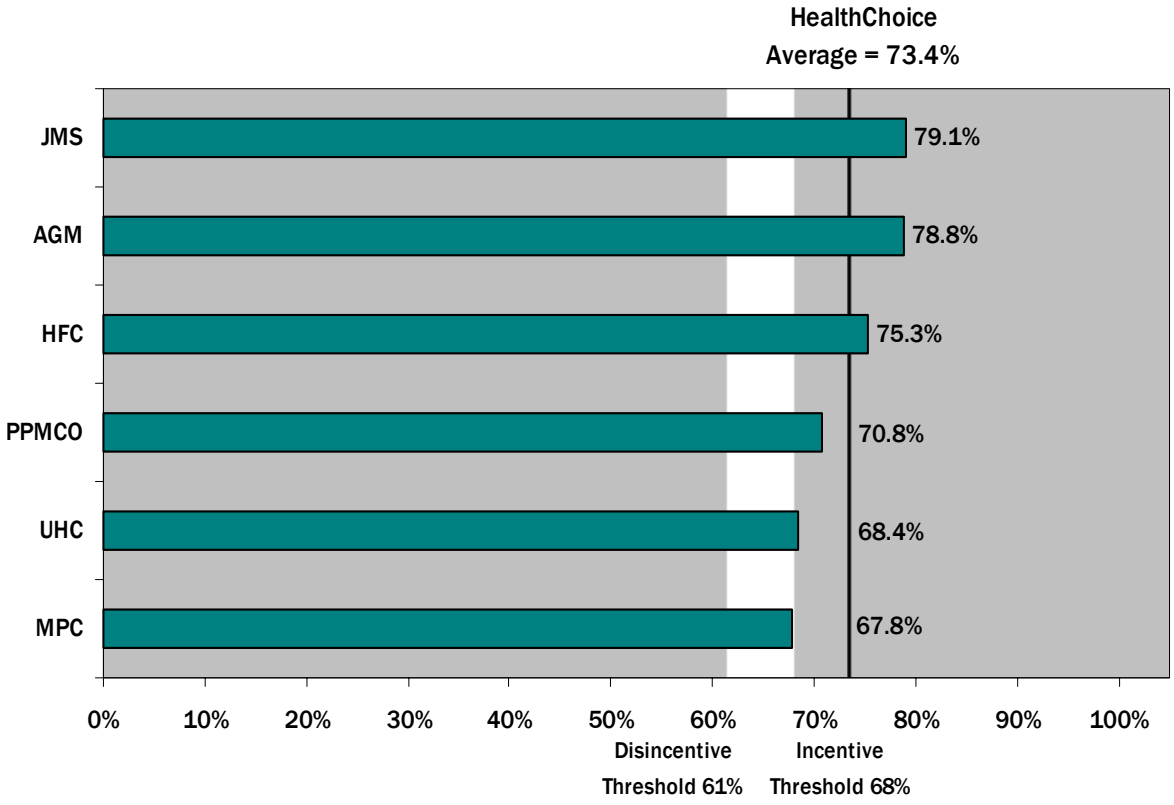
In future years, more measures may be added or measures may be rotated. This flexibility allows DHMH and participating MCOs to better meet changing health needs. If budgetary pressures continue and prevent DHMH from offering monetary incentives, DHMH will continue to explore other methods of providing incentives, such as offsetting disincentives and reducing administrative burdens.

Appendix I

MCO Performance By Individual Performance Measures

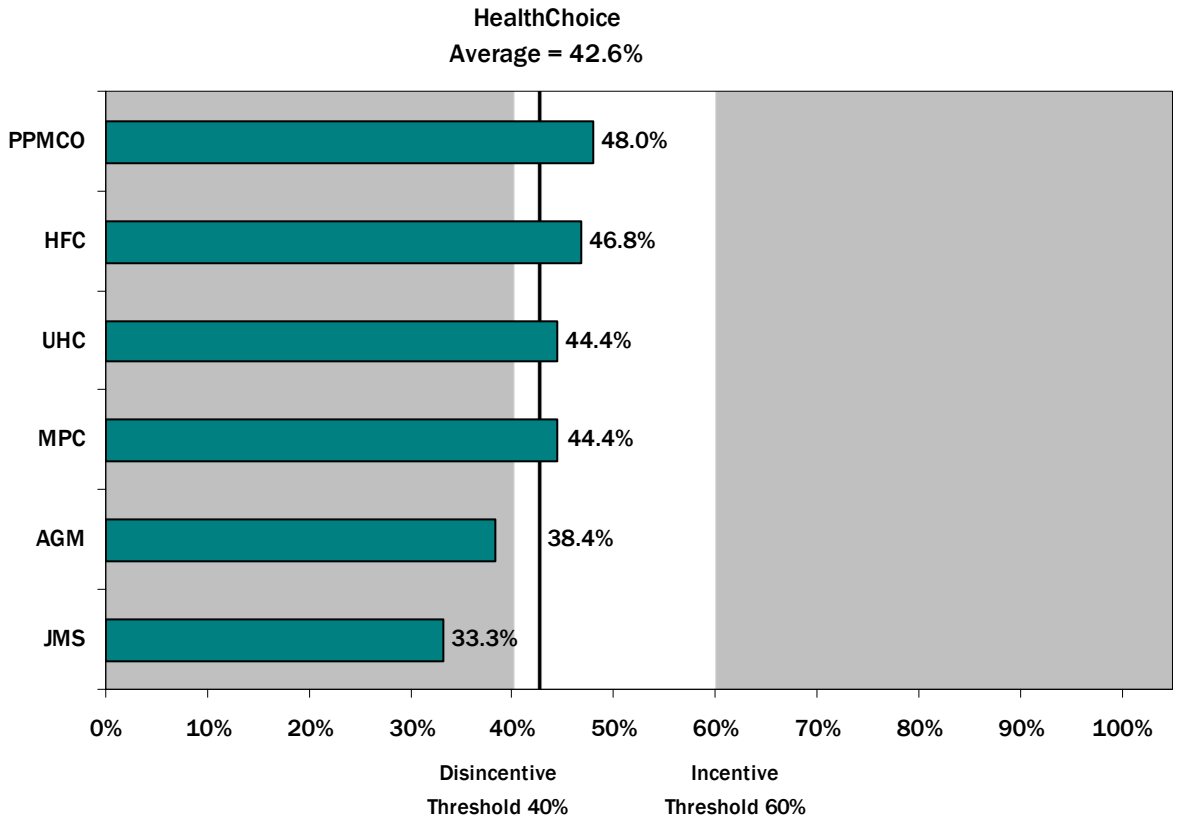
The following graphs represent the performance rates for each Value-Based Purchasing measure. Each graph presents each MCO's rate, the disincentive and incentive threshold, as well as the HealthChoice average. The HealthChoice Average is an un-weighted average of all MCO rates.

Well-Child Visits for Children Ages 3 through 6



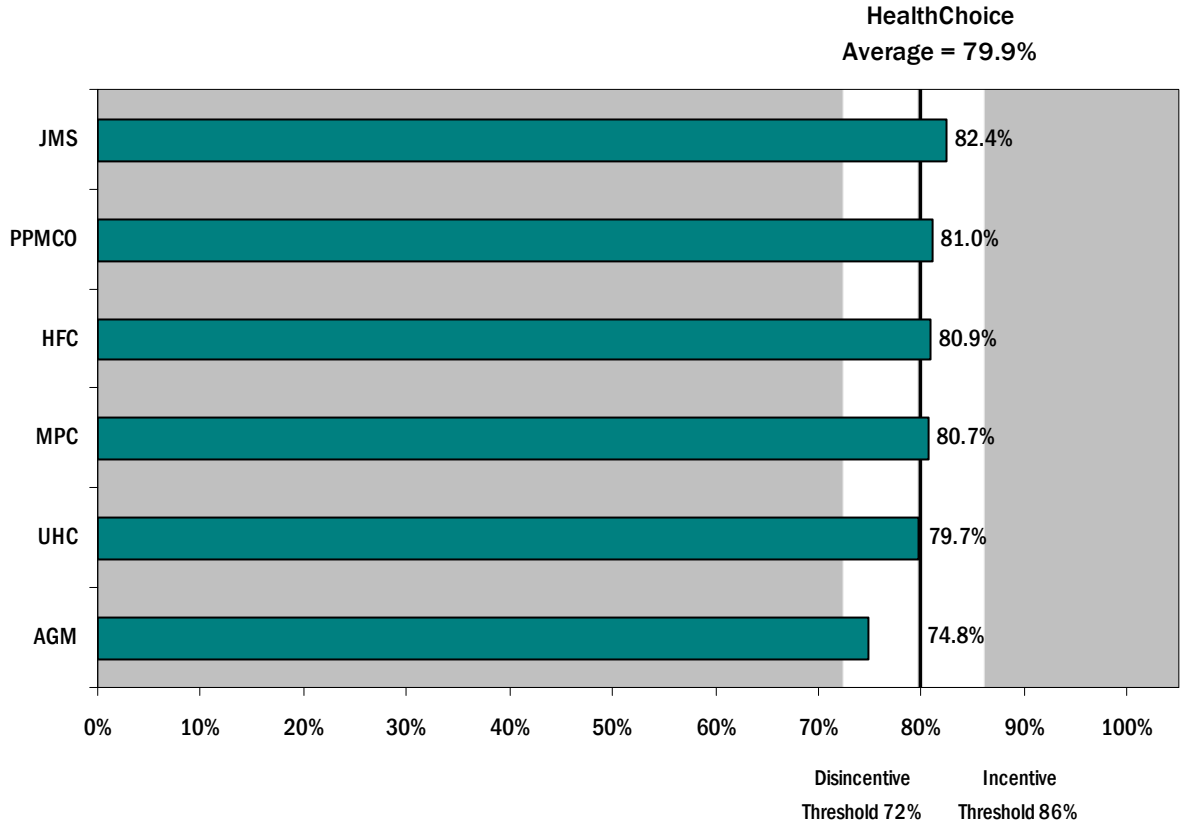
All MCOs performed above the disincentive threshold (<61%). Performance rates for all MCOs ranged from 67.8% to 79.1%. One MCO, MPC, performed within the neutral range (61% through 68%) and five MCOs performed above the incentive target (>68%). The highest performer was JMS.

Dental Services for Children Ages 4 through 20



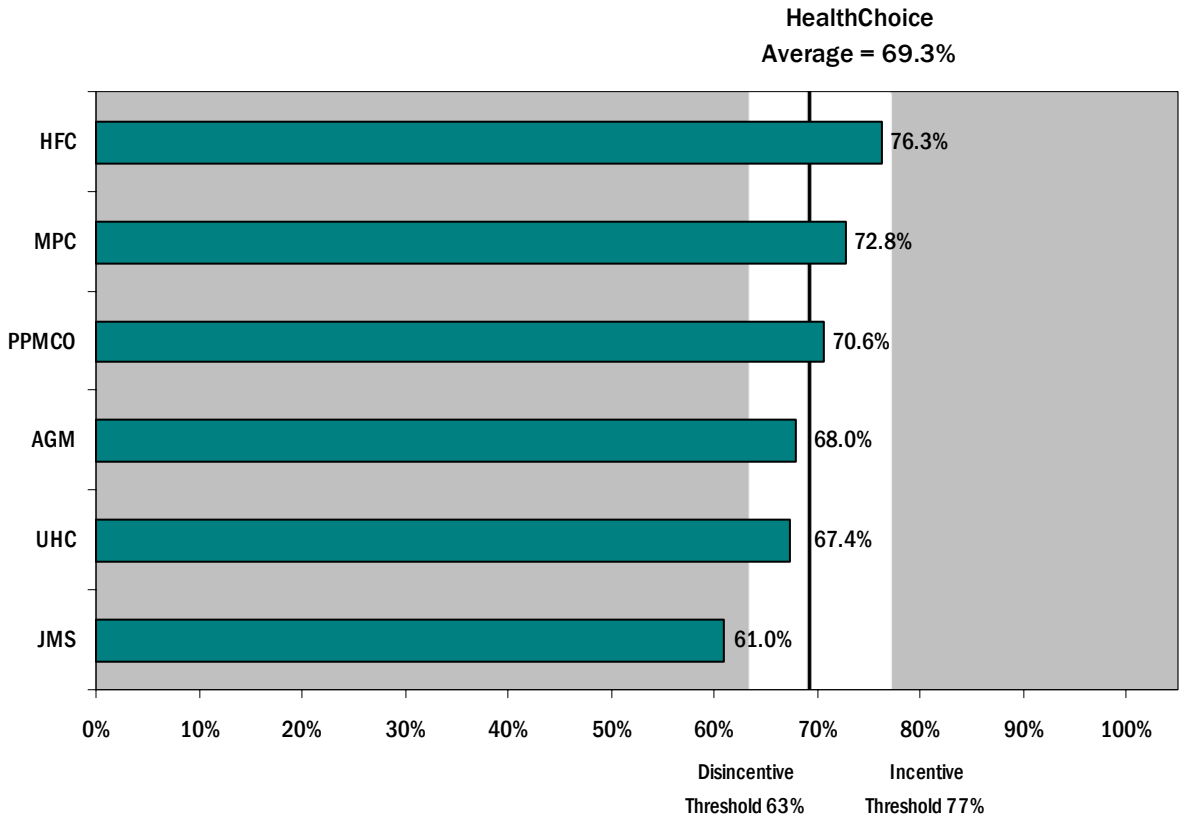
The range of scores was 33.3% to 48.0%. JMS and AGM performed below the disincentive threshold (<40%). MPC, UHC, HFC, and PPMCO performed in the neutral range between 40% and 60%. The highest performer was PPMCO with a score of 48.0%.

Ambulatory Care Services for SSI Adults



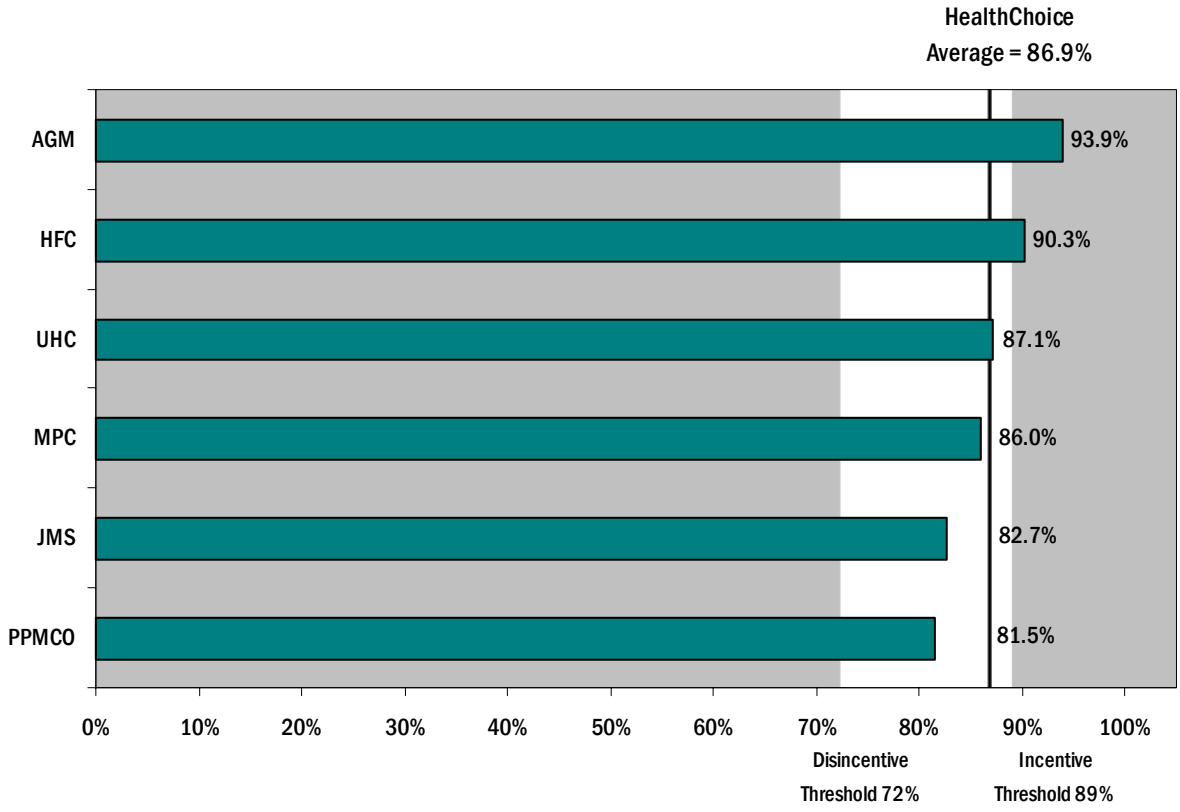
All MCOs performed above the disincentive threshold (<72%). Performance rates ranged from 74.8% to 82.4%. The highest performer was JMS.

Ambulatory Care Services for SSI Children



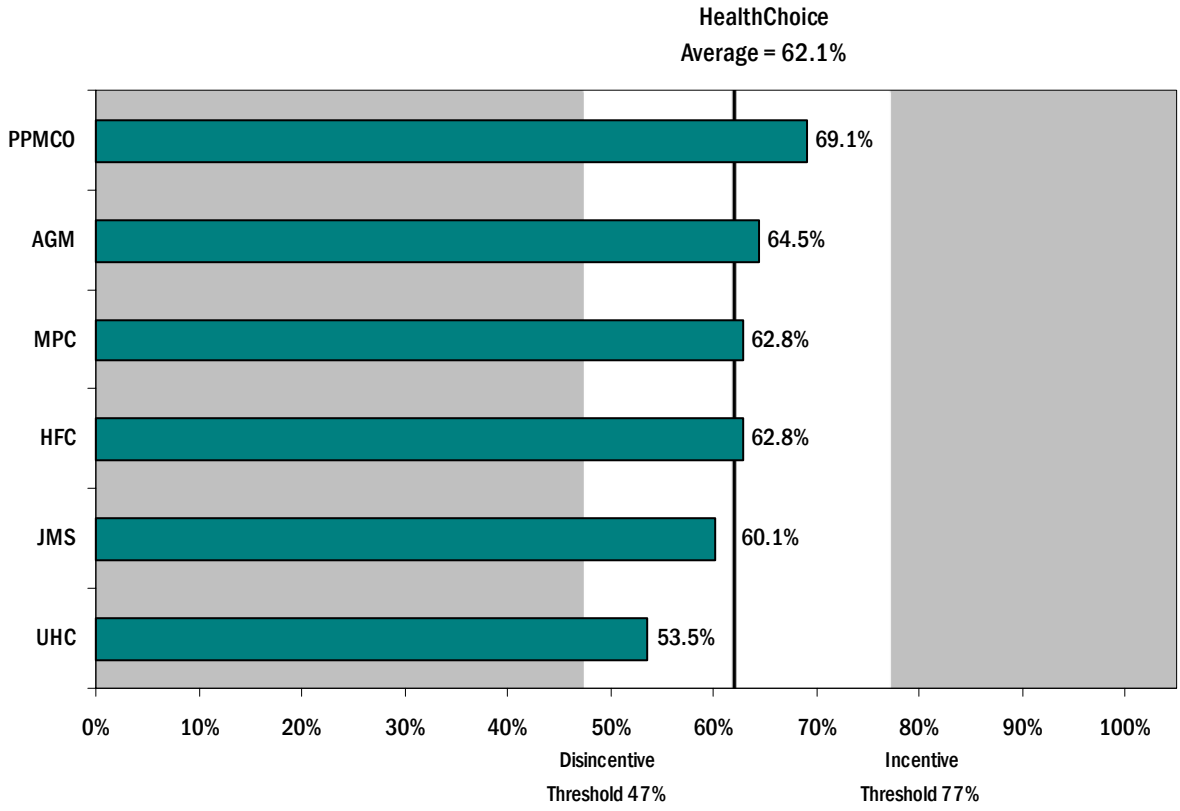
Five MCOs performed within the neutral range, with rates ranging from 67.4% to 76.3%. The highest performer was HFC. JMS performed below the disincentive threshold of 63% with a rate of 61.0%.

Timeliness of Prenatal Care



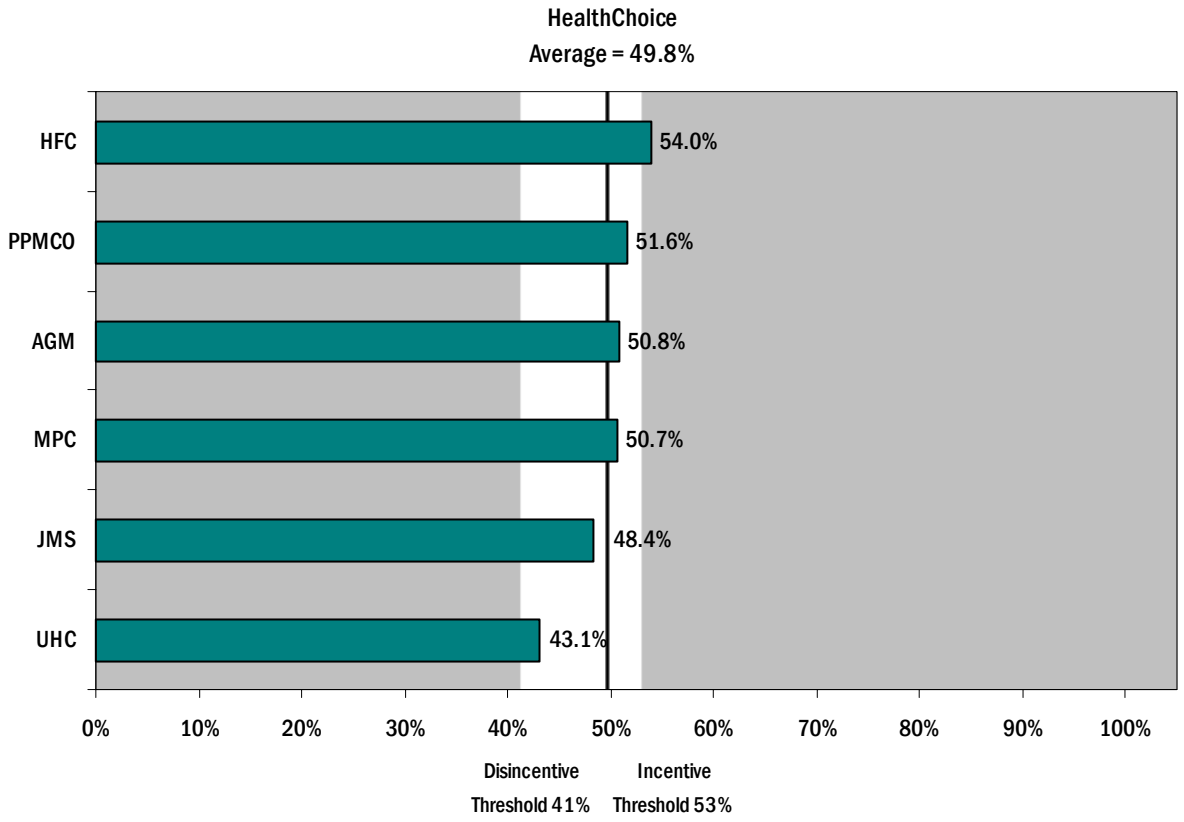
The range of scores was 81.5% to 93.9%. The highest performer was AGM. None of the MCOs scored below the disincentive threshold of 72%.

Cervical Cancer Screening for Women Ages 21–64



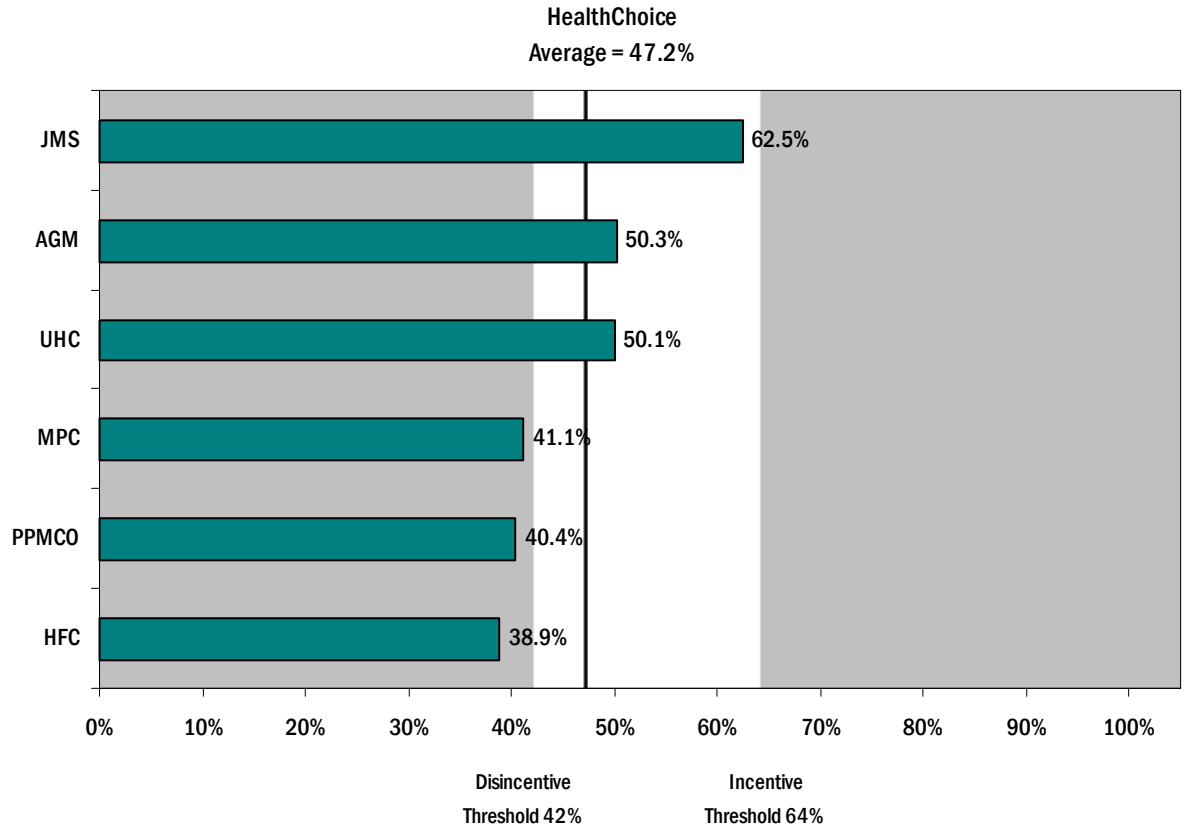
All MCOs performed within the neutral range. Rates ranged from 53.5% to 69.1%. The highest performer was PPMCO.

Lead Screenings for Children Ages 12–23 Months



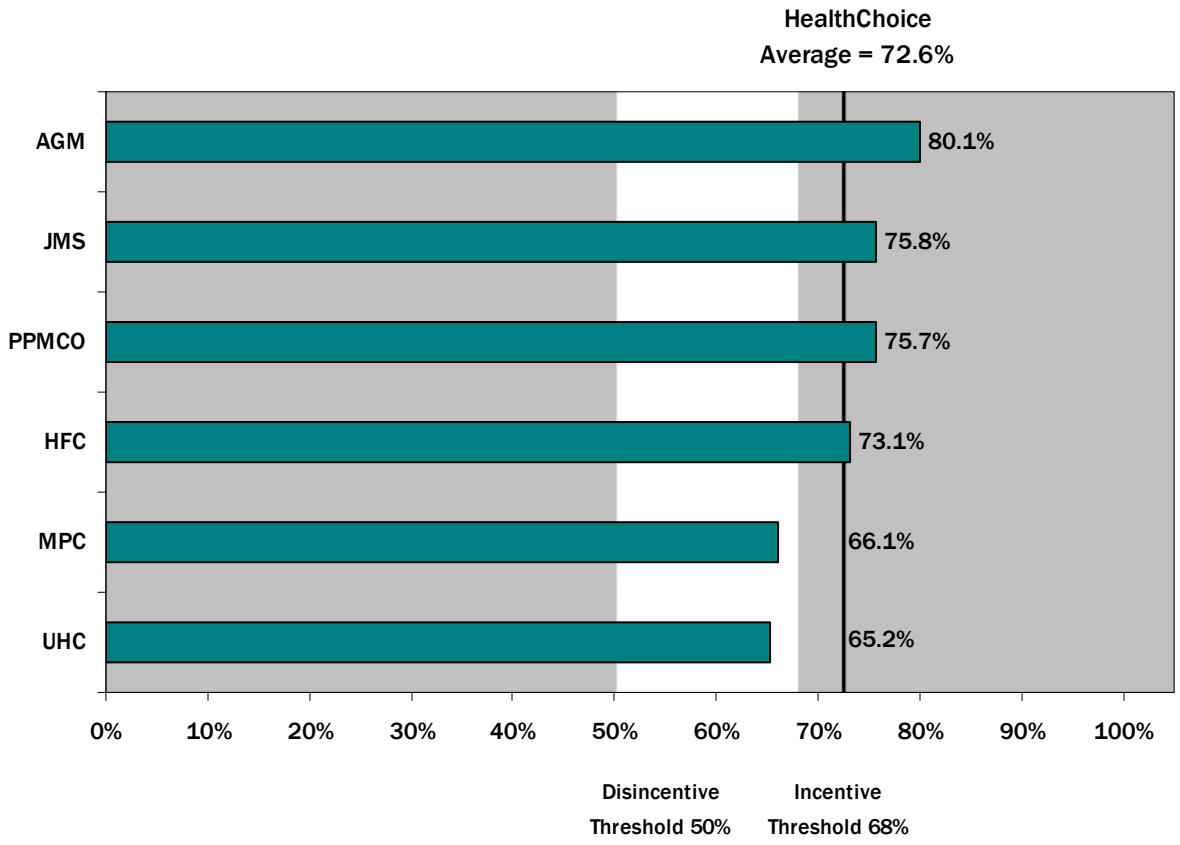
All MCOs performed above the disincentive threshold (<41%). Rates ranged from 43.1% to 54.0%. The highest performer was HFC, the only plan to perform above the incentive threshold (>53%).

Eye Exams for Diabetics



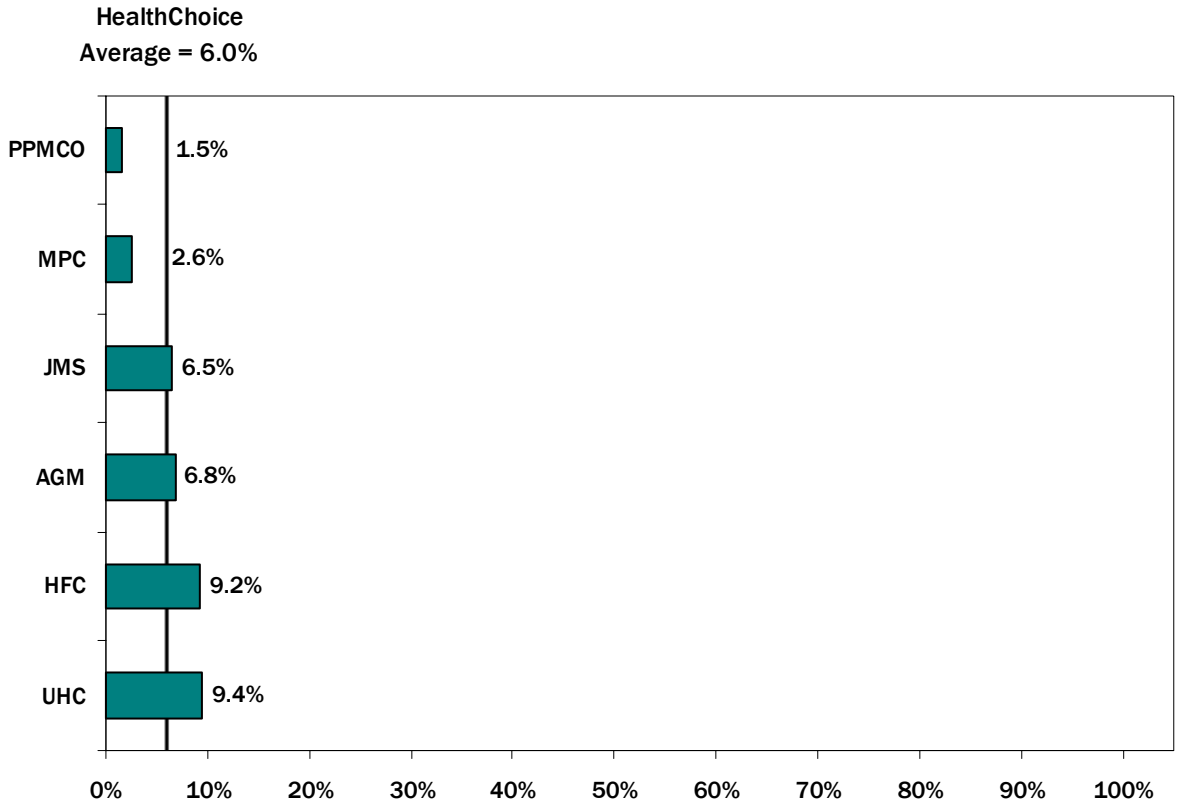
Three MCOs performed within the neutral range (42% to 64%). MPC, PPMCO, and HFC performed below the disincentive threshold with rates below 42%. The highest performer was JMS.

Childhood Immunization Status—Combo 2



All MCOs performed above the disincentive threshold (<50%). Performance rates for all MCOs ranged from 65.2% to 80.1%. Two MCOs performed within the range of 50% through 68%, and four MCOs performed above the incentive target (>68%). The HealthChoice average was above the incentive threshold as well. The highest performer was AGM.

Practitioner Turnover



All MCOs performed well with rates below 10%. Performance rates for all MCOs ranged from 1.5% to 9.4%. The highest performer was PPMCO with a rate of 1.5%.

Claims Timeliness

In 2005, the Claims Timeliness measure was a new HEDIS measure (1st Year Measure) for DHMH and NCQA reporting. Nationally reported results for all new measures are subject to further review by NCQA's Committee on Performance Management (CPM). A decision is then made by the CPM on the continued reporting of the measure by applicable MCOs. For the Claims Timeliness measure, the CPM made the decision in September 2005 to not publicly report any audited results for the measure or require MCOs to submit data in 2006. The measure was placed on hiatus, pending further evaluation and revision of the measure's specifications by NCQA staff. Based on advice from NCQA and in concert with the CPM decision, DHMH has elected to remove all MCO-specific audited rates from the report and to take no further action regarding MCO comparison until additional instructions and guidelines are published by NCQA.

Appendix II

Compliance with the Federal Balanced Budget Act of 1997

The Medicaid Managed Care Provisions of the Balanced Budget Act of 1997 (BBA) directed the U.S. Department of Health and Human Services to develop protocols to serve as guidelines for use in conducting EQRO activities and validating performance measures such as those included in the HealthChoice value-based purchasing (VBP) program. Nine protocols were developed for the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) with input from several contractors, State Medicaid agencies, and advocates for Medicaid beneficiaries. The protocols were developed to be consistent with industry standards, accommodate continued evolution of quality assessment, and provide technical assistance to State Medicaid agencies with a clear description of the scope and depth of quality review activities that are consistent with the current state of the art. The protocols were released in draft format on October 23, 2001, with the final versions issued between May 1, 2002, and February 11, 2003, after publication in the *Federal Register* and a comment period.

The protocol most relevant to VBP is entitled "Validating Performance Measures." The purpose of the Validating Performance Measures protocol is to specify the activities to be undertaken by an EQRO in order to evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, an MCO and to determine the extent to which Medicaid-specific performance measures calculated by an MCO (or entity acting on behalf on an MCO) followed specifications for the calculation of performance measures. This protocol was developed using National Committee for Quality Assurance (NCQA), Island Peer Review Organization (IPRO), and MedStat protocols and tools for auditing performance measures. The activities outlined in the protocol include a review of the data management processes of the entity that produced the measure, an evaluation of algorithmic compliance with specifications defined by the state, and possibly verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported results are based on an accurate source information. There are three phases to the validation activities: pre-onsite, onsite, and post-onsite. During each phase, information is gathered and analyzed with results communicated to the entity producing the measure indicating identified issues or requests for clarification. The result of all validation activities is to determine the extent to which the entity has complied with the requirements for calculating and reporting the performance measures, and to issue a validation finding for each performance measure.

In compliance with the BBA, DHMH has contracted with Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the EQRO for HealthChoice. Among the functions that Delmarva has been contracted to perform is the annual validation of performance measures reported during the preceding 12 months by the State of Maryland, its contractors, and the MCOs. DHMH uses CMS protocols in validating VBP measure results.

Delmarva and DHMH's contracted HEDIS Compliance Audit™ firm, HealthcareData.com, LLC, validated the CY 2004 VBP measures. HealthcareData.com, an NCQA-certified HEDIS Compliance Audit firm, performed the validation of HEDIS-based VBP measures for four of the HealthChoice MCOs using NCQA's *HEDIS Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures*. Two remaining MCOs contracted with other certified vendors to perform the HEDIS Compliance Audit with all results and final audit reports tabulated by HealthcareData.com and forwarded to Delmarva.

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Appendix III

Value-Based Purchasing Measure Validation

Data Sources

Two types of measures are included in the CY 2004 VBP measures: (1) measures from NCQA's HEDIS and (2) measures based on encounter data computed by DHMH's Office of Planning and Finance. Table A-1 shows the quality dimension, the types of measure, and the reporting entity for each measure. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table A-1. CY 2004 VBP Measures

Performance Measure	Quality Dimension	Measure Type	Reporting Entity
Well-child visits for children ages 3–6	Access to Care	HEDIS	MCO
Dental services for children ages 4–20	Access to Care	Encounter Data	DHMH
Ambulatory care services for SSI adults	Access to Care	Encounter Data	DHMH
Ambulatory care services for SSI children	Access to Care	Encounter Data	DHMH
Timeliness of prenatal care	Access to Care	HEDIS	MCO
Cervical cancer screening for women ages 21–64	Quality of Care	HEDIS	MCO
Lead screenings for children ages 12–23 months	Quality of Care	Encounter Data and Lead Registry Data	DHMH
Eye exams for diabetics	Quality of Care	HEDIS	MCO
Childhood immunization status	Quality of Care	HEDIS	MCO
Practitioner turnover	Administration	HEDIS	MCO
Claims Timeliness	Administration	HEDIS	MCO

Validation Methodology

Validation is the process by which an independent entity evaluates the accuracy of Medicaid performance measures reported by, or on behalf of, an MCO and determines the extent to which Medicaid-specific performance measures calculated by an MCO (or entity acting on behalf on an MCO) followed established calculation specifications. A validation (or audit) determination is assigned to each measure, indicating whether the measure and its result is fully compliant, substantially compliant, and/or not valid.

HEDIS Measure Validation

HealthChoice MCOs are required to produce and report audited HEDIS data under COMAR 10.09.65.03.B(2). Seven of the CY 2004 VBP measures are HEDIS measures and are validated under the provisions of the HEDIS Compliance Audit. In 1997, NCQA first released the *HEDIS Compliance Audit Standards and Guidelines*. The guidelines are updated annually and include standards for assessing the MCO information system characteristics and specification compliance for each HEDIS measure. The goal of the HEDIS audit is to ensure accurate, reliable, and publicly reportable data. DHMH has contracted with HealthcareData.com to perform the validation of HEDIS measures for the HealthChoice MCOs. In CY 2004, four MCOs utilized the DHMH-contracted audit firm. Two MCOs contracted with other certified vendors to perform the HEDIS Compliance Audit with all results and final audit reports tabulated by HealthcareData.com. One MCO, DIA, was not required to undergo an audit in 2004 because it did not meet enrollment requirements for the program. All audit findings and performance measure rates are reported to Delmarva by HealthcareData.com.

The HEDIS Compliance Audit is conducted in three phases: offsite, onsite, and the post - onsite and reporting phases. The offsite audit phase includes a review of each MCO's Baseline Assessment Tool (BAT). The BAT is used to supply information about an MCO's data systems and HEDIS data reporting structure and processes. Other activities undertaken during the offsite audit process include the selection of a core set of HEDIS measures to audit in detail (results are then extrapolated to the rest of the HEDIS measures), investigation of measure rotation strategies, and finally, validation of the medical record review process by the certified audit firm.

During the onsite phase, auditors investigate issues identified in the BAT and observe the systems used to collect and produce HEDIS data. The audit team interviews MCO staff members; reviews MCO information system structure, protocols, and processes; and reviews MCO measure-specific data collection processes with the staff responsible for selected measures.

The post - onsite and reporting phase of the HEDIS Compliance Audit includes the issuance of a follow-up letter to the MCO that lists any items the auditors still require to complete the audit, a list of corrective

actions for problems found in the BAT or onsite as well as the necessary completion dates, and preliminary audit findings specifically indicating the measures at risk for a *Not Report* designation. When the MCO has provided all requested documents and performed the recommended corrective actions, the auditor completes a final audit report and assigns audit designations for each measure. The audit designations indicate the suitability of measures for public reporting. The two possible audit designations are *Report* and *Not Report*, as explained in Table A-2 below. The final activity in the post - onsite phase of the audit consists of the MCO submitting data to NCQA using the NCQA data submission tool.

Table A-2. HEDIS Compliance Audit Designations and Rationales

Audit Designation	Rationale
Report (R)	1. The MCO followed the specifications and produced a reportable rate for the measure. 2. The MCO followed the specifications for producing a reportable denominator but the denominator was too small to report a valid rate, resulting in a Not Applicable (NA). 3. The MCO indicated that it did not offer a health benefit (e.g., Mental Health/Chemical Dependency) for which the measure is reported, resulting in a Not Applicable (NA). 4. The MCO produced an accurate survey sample frame and is using an NCQA-certified Survey Vendor (survey measures only).
Not Report (NR)	5. The MCO calculated the measure but the rate was materially biased. 6. The MCO did not calculate the measure even though a population existed for which the measure could have been calculated. 7. The MCO calculated the measure but chose not to report the rate. 8. The MCO was not required to calculate the measure because it was not included in the scope of the Partial Audit or Full Audit required by a purchaser (e.g., CMS). 9. The MCO did not produce an accurate survey sample frame (survey measures only). 10. The MCO did not use an NCQA-certified survey vendor (survey measures only).

In order to avoid duplicating efforts and placing undue administrative burden on the HealthChoice MCOs, DHMH used seven of the HEDIS audit measure determinations as VBP measure determinations. The seven HEDIS measures in the VBP program are:

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

- Prenatal and Postpartum Care (prenatal care portion only),
- Cervical Cancer Screening,
- Comprehensive Diabetes Care (eye exam portion only),
- Childhood Immunization Status (Combo 2 Only),
- Practitioner Turnover, and
- Claims Timeliness.

Encounter Data Measure Validation

Four CY 2004 VBP measures were calculated by DHMH, using encounter data submitted by the MCOs. The measures calculated utilizing encounter data are:

- Dental services for children ages 4–20,
- Ambulatory care services for SSI adults,
- Ambulatory care services for SSI children, and
- Lead screenings for children ages 12–23 months.

Utilizing the framework proposed in the CMS protocol "Validating Performance Measures," Delmarva validated these measures. The protocol outlines a validation procedure that includes three phases: pre-onsite, onsite, and post-onsite.

Information gathered as a result of the pre-onsite meeting included the specifications for each encounter data-based VBP measure, source code for each of the encounter data-based VBP measures to determine algorithmic compliance with the measure specifications, information regarding the encounter data processing system, and analysis of the encounter data process.

The onsite phase followed up on the findings from the review of information systems (encounter data capture, storage, and integration) and the detailed review of the source code programming in place to produce the VBP measures. Policies, procedures, reports, data flow sheets, source code, and source code logic flow charts were provided and reviewed during this phase of the validation process. Clarifications and corrections to source codes were conducted to ensure algorithmic compliance with VBP measure specifications.

Following the detailed review and interview processes, Delmarva completed the evaluation of the data gathered as part of the pre-onsite and onsite phases. Validation determinations were used to characterize the findings of the EQRO. Table A-3 indicates the possible determinations of the EQRO-validated measures.

Table A-3. Possible Validation Findings for EQRO-Validated Measures (encounter data)

Validation Determination	Definition
Fully Compliant (FC)	Measure was fully compliant with State specifications.
Substantially Compliant (SC)	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures where no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Measure was not reported because the entity did not have any Medicaid enrollees that qualified for the denominator.

Validation Results

Validation of the methodologies, criteria, and processes employed in creating the VBP measures results in a determination of the effect of bias on the resulting statistic. Validation determinations for HEDIS-based VBP measures determined by HealthcareData.com are reported using the audit designations and rationales outlined by NCQA as part of the HEDIS Compliance Audit. Table A-4 indicates the audit designations for the CY 2004 VBP measures for each HealthChoice MCO (designations are explained in Table A-2 above).

Table A-4. HEDIS-Based VBP Measure Audit Determinations

Measure	MCO					
	AGM	HFC	JMS	MPC	PPMCO	UHC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	R	R	R	R	R	R
Prenatal and Postpartum Care (prenatal care portion only)	R	R	R	R	R	R
Cervical Cancer Screening	R	R	R	R	R	R
Comprehensive Diabetes Care (eye exam portion only)	R	R	R	R	R	R
Childhood Immunization Status (Combo 2 only)	R	R	R	R	R	R
Practitioner Turnover	R	R	R	R	R	R
Claims Timeliness	R	R	R	R	R	R

All of the VBP measures audited by HealthcareData.com were determined to be reportable.

Table A-5 shows the results of the EQRO-led validation activities related to the VBP measures based on encounter data. The Office of Planning and Finance within DHMH was responsible for producing these VBP measures at the MCO level and working with the EQRO to validate the measures (see Table A-3 for types of validation findings).

Table 5. Encounter Data-Based VBP Measure Validation Determinations

Measure	Validation Determinations
Dental services for children ages 4–20	Fully Compliant
Ambulatory care services for SSI adults	Fully Compliant
Ambulatory care services for SSI children	Fully Compliant
Lead screenings for children ages 12–23 months	Fully Compliant

During the validation process undertaken by the EQRO, no issues were identified that could have introduced bias to the resulting statistics.