Medicaid Managed Care Organization

Value-Based Purchasing Activities Report

Final Report

Calendar Year 2007

Submitted by;
Delmarva Foundation
November 2008

HealthChoice and Acute Care Administration
Division of HealthChoice Management
and Quality Assurance

Calendar Year 2007 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 State Children's Health Insurance Program (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 was an early adopter 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

[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

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

2007 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. 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 to deliver services to improve health outcomes.
- Administration: Structure of the health care delivery system that enables delivery of services.

DHMH selects 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 (CMS) are developing a national set of performance measures for Medicaid MCOs; and (7) possible for MCOs to affect so that they can be held accountable.

Table 1 shows the CY 2007 measures and their targets.

Table 1. 2007 Value-Based Purchasing Performance Measures

Performance Measure	Data Source	2007 Target
Well-Child Visits for Children Ages 3 – 6 Years: % 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: >82% Neutral: 74%–82% Disincentive: <74%
Dental Services for Children Ages 4 – 20 Years: % of children ages 4–20 (enrolled 320 or more days) receiving at least one dental service during the year	Encounter Data	Incentive: >49% Neutral: 42%–49% Disincentive: <42%
Ambulatory Care Services for SSI Adults Ages 21 – 64 Years: % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the year	Encounter Data	Incentive: >85% Neutral: 80%–85% Disincentive: <80%
Ambulatory Care Services for SSI Children Ages 0 – 20 Years: % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the year	Encounter Data	Incentive: >79% Neutral: 71%–79% Disincentive: <71%
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: >91% Neutral: 85%–91% Disincentive: <85%
Cervical Cancer Screening for Women Ages 21–64 Years: % 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: >71% Neutral: 64%–71% Disincentive: <64%
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: >56% Neutral: 50%–56% Disincentive: <50%
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: 54%–64% Disincentive: <54%
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 (Combo 2)	HEDIS	Incentive: >83% Neutral: 74%–83% Disincentive: <74%

In accordance with legislation from the 2005 Maryland General Assembly, DHMH changed regulations to focus on targets for clinical measures. Measures may be added, removed, or rotated in or out of the measure set. The flexibility of this strategy provides the opportunity to change measures based on evolving DHMH priorities and enrollee health care needs.

2007 Results

The 2007 performance results were validated by Delmarva, and DHMH's contracted HEDIS Compliance Audit™ firm, HealthcareData Company, 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 the Value Based Purchasing program. See Appendix III for more information on the validation process and results.

In calendar year (CY) 2007, there were seven HealthChoice MCOs:

- AMERIGROUP Community Care (ACC),
- Diamond Plan from Coventry Health Care of Delaware (DIA),
- Jai Medical Systems, Inc. (JMS),
- Maryland Physicians Care (MPC),
- MedStar Family Choice (MSFC),
- Priority Partners (PPMCO), and
- UnitedHealthcare (UHC).

™ NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA)

The results are presented in Table 2.

Table 2. Performance Summary

Performance Measure	2007 Target	MCO						
		ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)						
Well-Child Visits for Children Ages 3–6	Incentive: >82% Neutral: 74%–82% Disincentive: <74%	77.5% (N)	66.4% (D)	89.1% (I)	79.1% (N)	74.1% (N)	77.4% (N)	76.3% (N)
Dental Services for Children Ages 4–20	Incentive: >49% Neutral: 42%–49% Disincentive: <42%	49.0% (N)	39.6% (D)	59.8% (I)	52.8% (I)	56.5% (I)	52.4% (I)	52.0% (I)
Ambulatory Care Services for SSI Adults	Incentive: >85% Neutral: 80%–85% Disincentive: <80%	76.1% (D)	76.0% (D)	81.4% (N)	80.9% (N)	79.3% (D)	81.8% (N)	77.7% (D)
Ambulatory Care Services for SSI Children	Incentive: >79% Neutral: 71%–79% Disincentive: <71%	70.3% (D)	61.9% (D)	70.7% (D)	74.2% (N)	73.4% (N)	71.9% (N)	68.1% (D)
Timeliness of Prenatal Care	Incentive: >91% Neutral: 85%–91% Disincentive: <85%	90.9% (N)	85.0% (N)	89.7% (N)	84.0% (D)	90.0% (N)	91.1% (I)	91.7% (I)
Cervical Cancer Screening for Women Ages 21–64	Incentive: >71% Neutral: 64%–71% Disincentive: <64%	61.4% (D)	48.0% (D)	73.8% (I)	64.1% (N)	64.7% (N)	65.6% (N)	64.8% (N)
Lead Screenings for Children Ages 12–23 Months	Incentive: >56% Neutral: 50%–56% Disincentive: <50%	53.4% (N)	41.0% (D)	71.3% (I)	55.2% (N)	52.5% (N)	54.4% (N)	47.6% (D)
Eye Exams for Diabetics	Incentive: >64% Neutral: 54%–64% Disincentive: <54%	57.5% (N)	43.3% (D)	75.3% (I)	54.4% (N)	66.2% (I)	63.3% (N)	58.2% (N)
Childhood Immunization Status—Combo 2	Incentive: >83% Neutral: 74%–83% Disincentive: <74%	89.8% (I)	68.1% (D)	85.0% (I)	72.2% (D)	84.7% (I)	86.5% (I)	78.0% (N)

2007 Incentive and Disincentive Methodology

The value-based purchasing approach employed by DHMH uses financial incentives and disincentives to promote the desired MCO performance. There are three levels of performance: incentive, neutral and disincentive for all measures. Financial incentives are earned when performance is above the incentive target for a measure while disincentives are assessed when performance is below the minimum target. All measures are evaluated separately and are of equal weight in the methodology.

Incentive and disincentive amounts are determined using a methodology described in the Code of Maryland Regulations 10.09.65.03. For any measure that the MCO does not meet the minimum target, a disincentive of

1/9 of 1/2 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO exceeds the incentive target, the MCO shall be paid an incentive payment of up to 1/9 of 1/2 percent of the total capitation amount paid to the MCO during the measurement year. The amounts are calculated for each measure and the total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year.

The MCOs' incentive and disincentive amounts for CY 2007 performance are shown in Table 3.

Table 3. 2007 MCO Incentive/Disincentive Amounts

Performance Measure	MCO						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Well-Child Visits for Children Ages 3–6	$0	($15,819.06)	$27,585.34	$0	$0	$0	$0
Dental Services for Children Ages 4–20	$0	($15,819.06)	$27,585.34	$184,881.30	$49,053.31	$256,205.76	$191,934.28
Ambulatory Care Services for SSI Adults	($300,857.17)	($15,819.06)	$0	$0	($49,053.31)	$0	($191,934.28)
Ambulatory Care Services for SSI Children	($300,857.17)	($15,819.06)	($27,585.34)	$0	$0	$0	($191,934.28)
Timeliness of Prenatal Care	$0	$0	$0	($184,881.30)	$0	$256,205.76	$191,934.28
Cervical Cancer Screening for Women Ages 21–64	($300,857.17)	($15,819.06)	$27,585.34	$0	$0	$0	$0
Lead Screenings for Children Ages 12–23 Months	$0	($15,819.06)	$27,585.34	$0	$0	$0	($191,934.28)
Eye Exams for Diabetics	$0	($15,819.06)	$27,585.34	$0	$49,053.31	$0	$0
Childhood Immunization Status—Combo 2	$300,857.17	($15,819.06)	$27,585.34	($184,881.30)	$49,053.31	$256,205.76	$0
Total Incentive/ Disincentive Amount	($601,714.34)	($126,552.48)	$137,926.70	($184,881.30)	$98,106.62	$768,617.28	($191,934.28)

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.

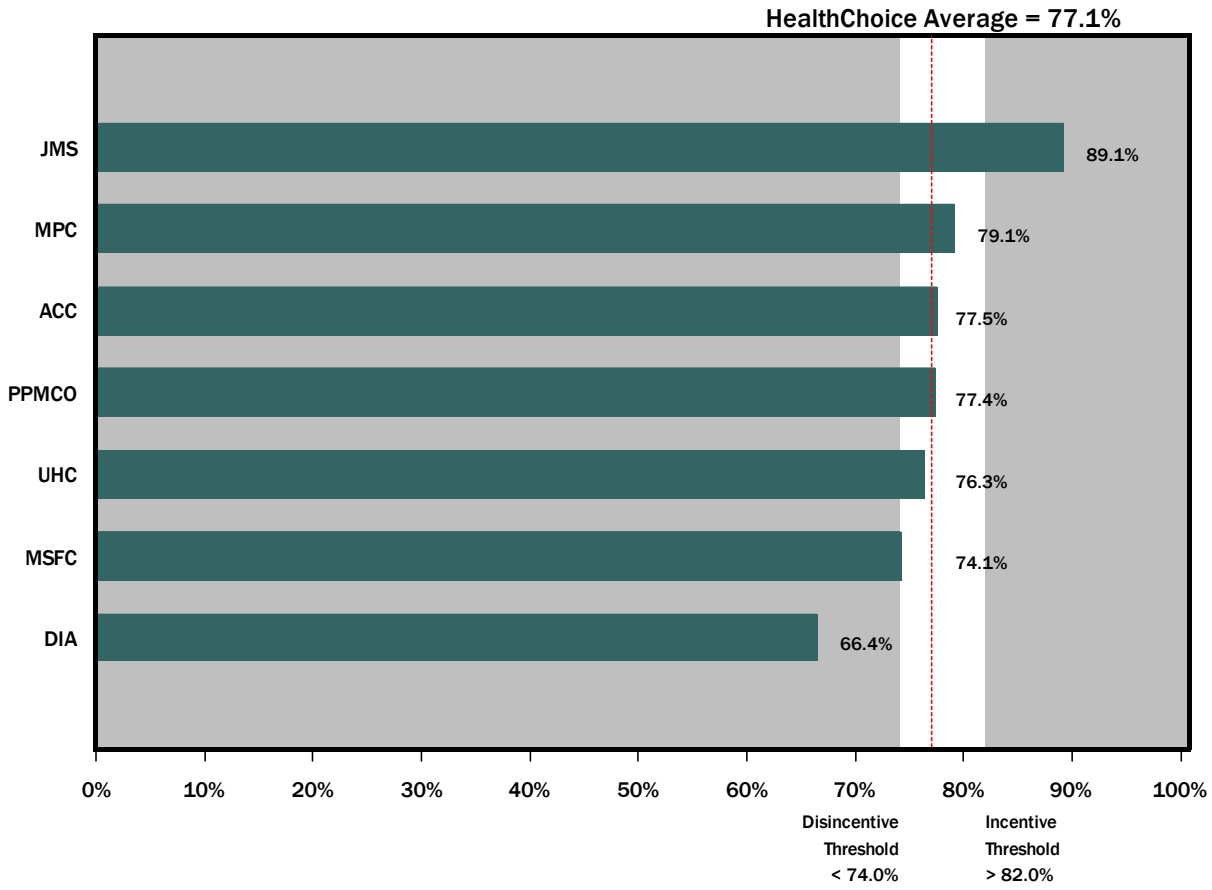
In future years, measures may be added, removed, or rotated. This flexibility allows DHMH and participating MCOs to better meet changing health needs. In years when DHMH is unable to provide monetary incentives, other methods of providing incentives, such as offsetting disincentives or reducing administrative burdens will be explored.

Appendix I

MCO Performance By Individual Performance Measures

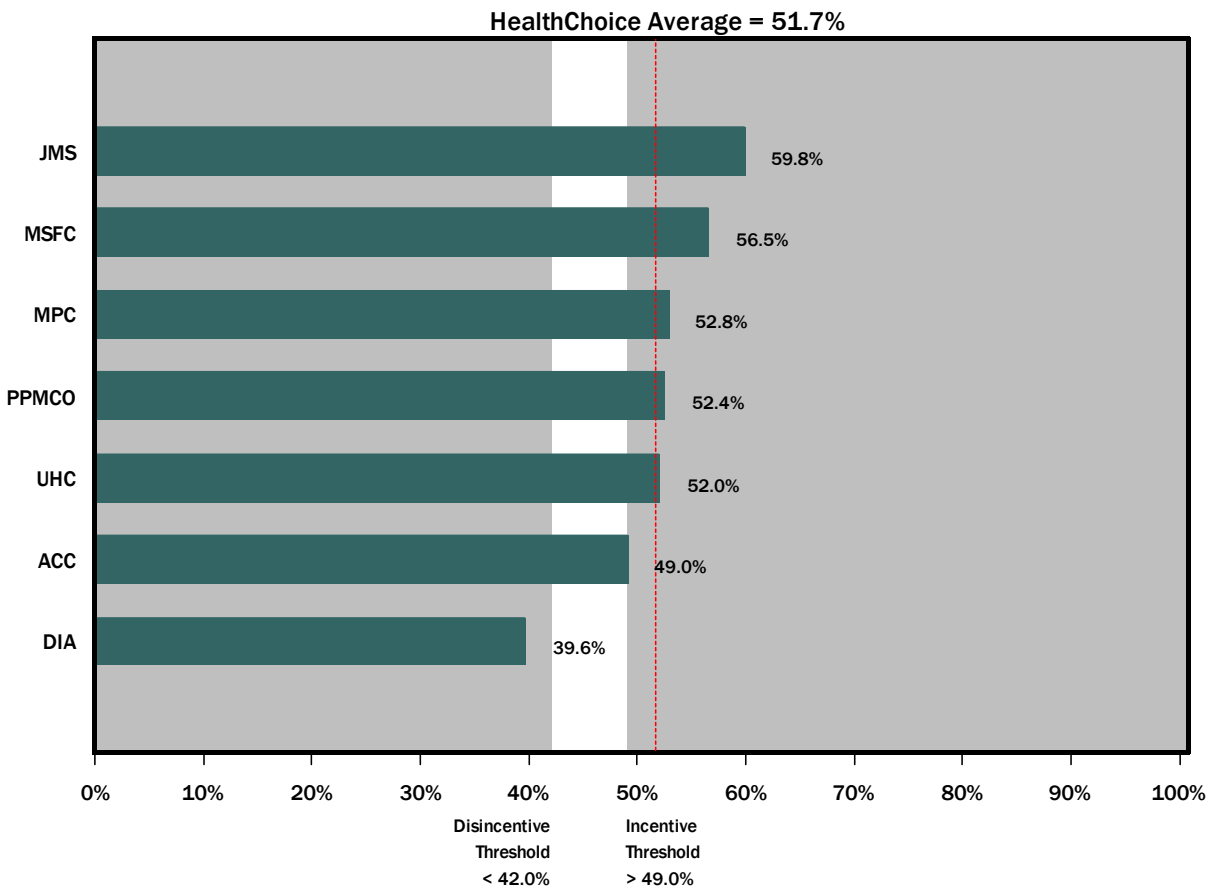
The following graphs represent the performance rates for each Value-Based Purchasing measure. Each graph presents each MCO's rate, the disincentive and incentive threshold, as well as the HealthChoice average. The HealthChoice Average is an unweighted average of all MCO rates.

Well-Child Visits for Children Ages 3 through 6



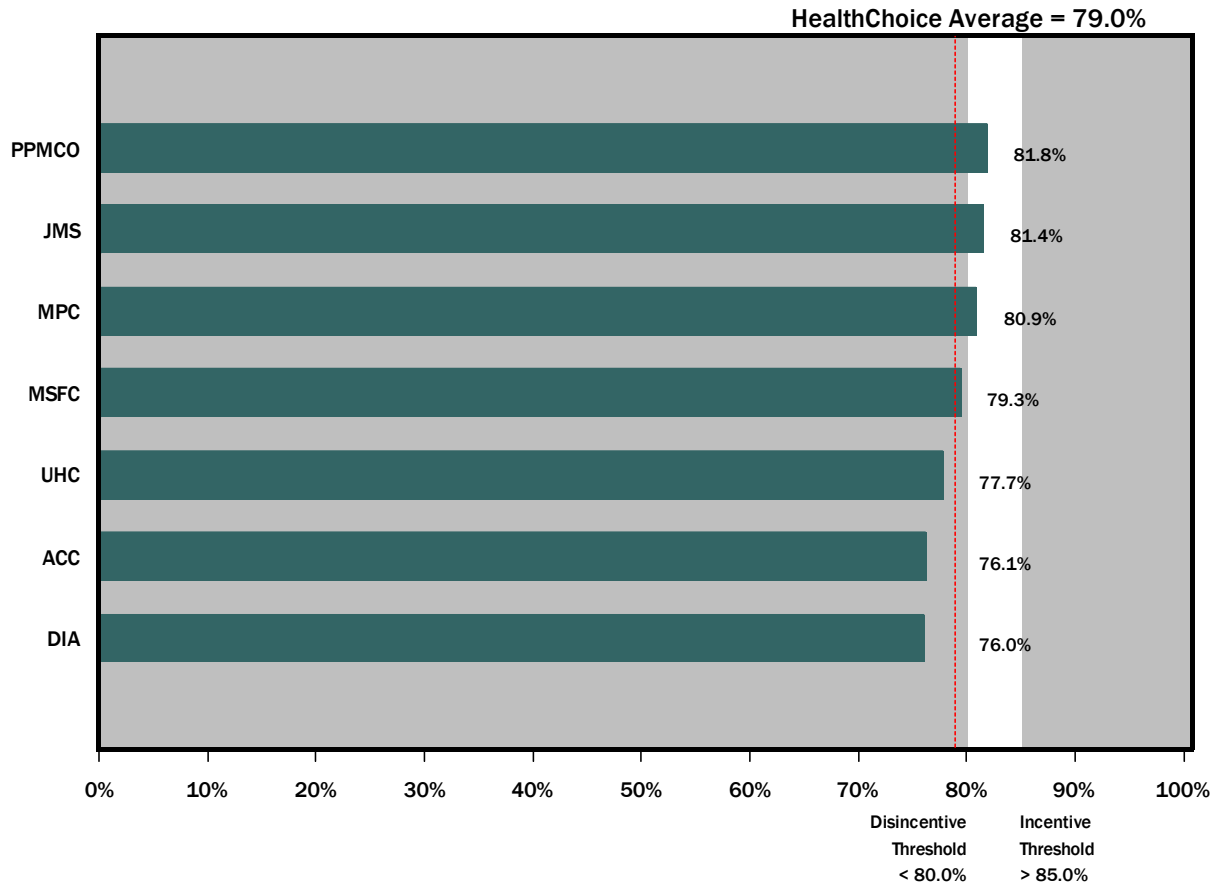
Performance rates range from 66.4% to 89.1% with the highest performer being JMS. One MCO scored above the incentive threshold of 82%. Five MCOs, MSFC, UHC, PPMCO, ACC, and MPC performed within the neutral range (74% through 82%). DIA performed below the disincentive threshold of 74%. The HealthChoice average was 77.1% which was within the neutral range.

Dental Services for Children Ages 4 through 20



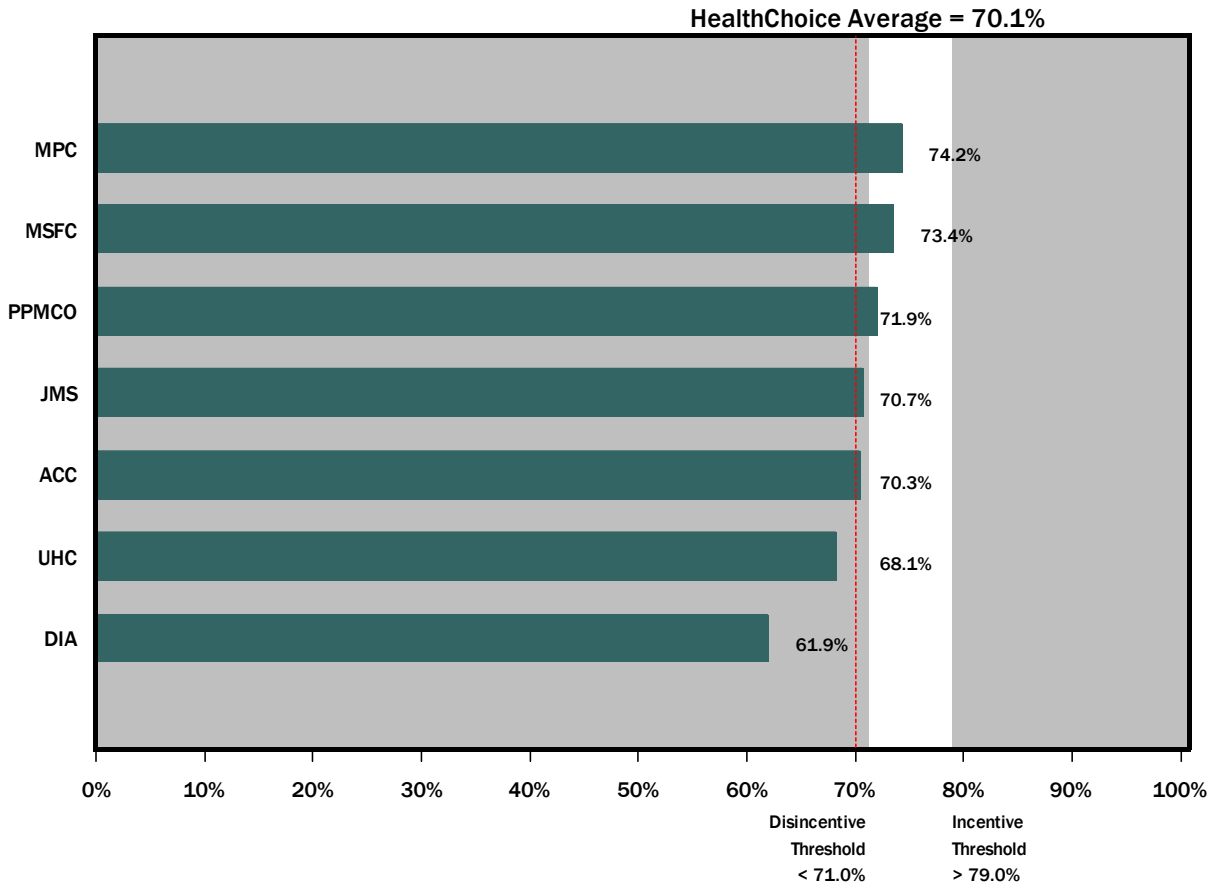
Performance rates range from 39.6% to 59.8% with the highest performer being JMS. Five MCOs, UHC, PPMCO, MPC, MSFC, and JMS performed above the incentive threshold of 49%. One MCO, ACC performed within the neutral rage (42% through 49%). DIA performed below the disincentive threshold of 42%. The HealthChoice average was 51.7% which was above the incentive threshold.

Ambulatory Care Services for SSI Adults



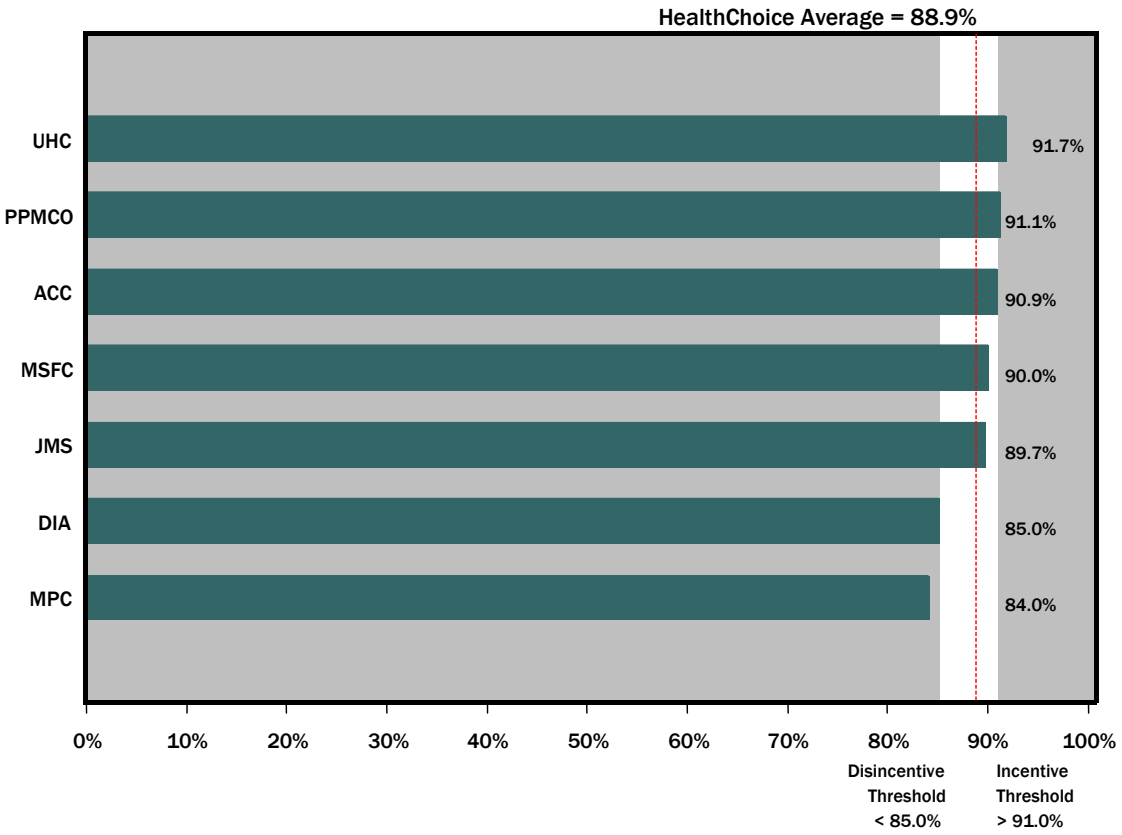
Performance rates range from 76.0% to 81.8% with the highest performer being PPMCO. Three MCOs, MPC, JMS, and PPMCO performed within the neutral range (80% through 85%). Four MCOs, DIA, ACC, UHC, and MSFC performed below the disincentive threshold of 80%. The HealthChoice average was 79% which was below the disincentive threshold.

Ambulatory Care Services for SSI Children



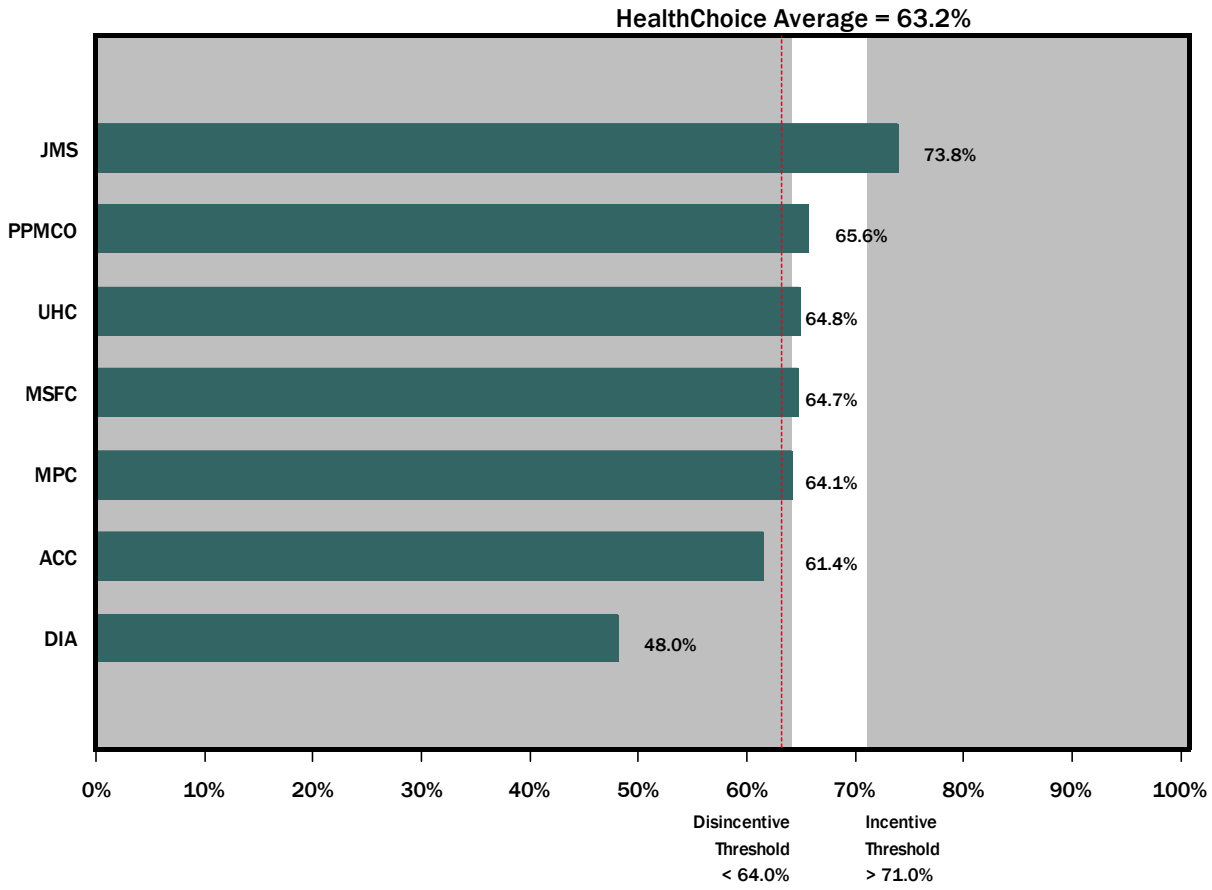
Performance rates range from 61.9% to 74.2% with the highest performer being MPC. Three MCOs, PPMCO, MSFC, and MPC performed within the neutral range (71% through 79%). Four MCOs, DIA, UHC, ACC, and JMS performed below the disincentive threshold of 71%. The HealthChoice average was 70.1% which was just below the disincentive threshold.

Timeliness of Prenatal Care



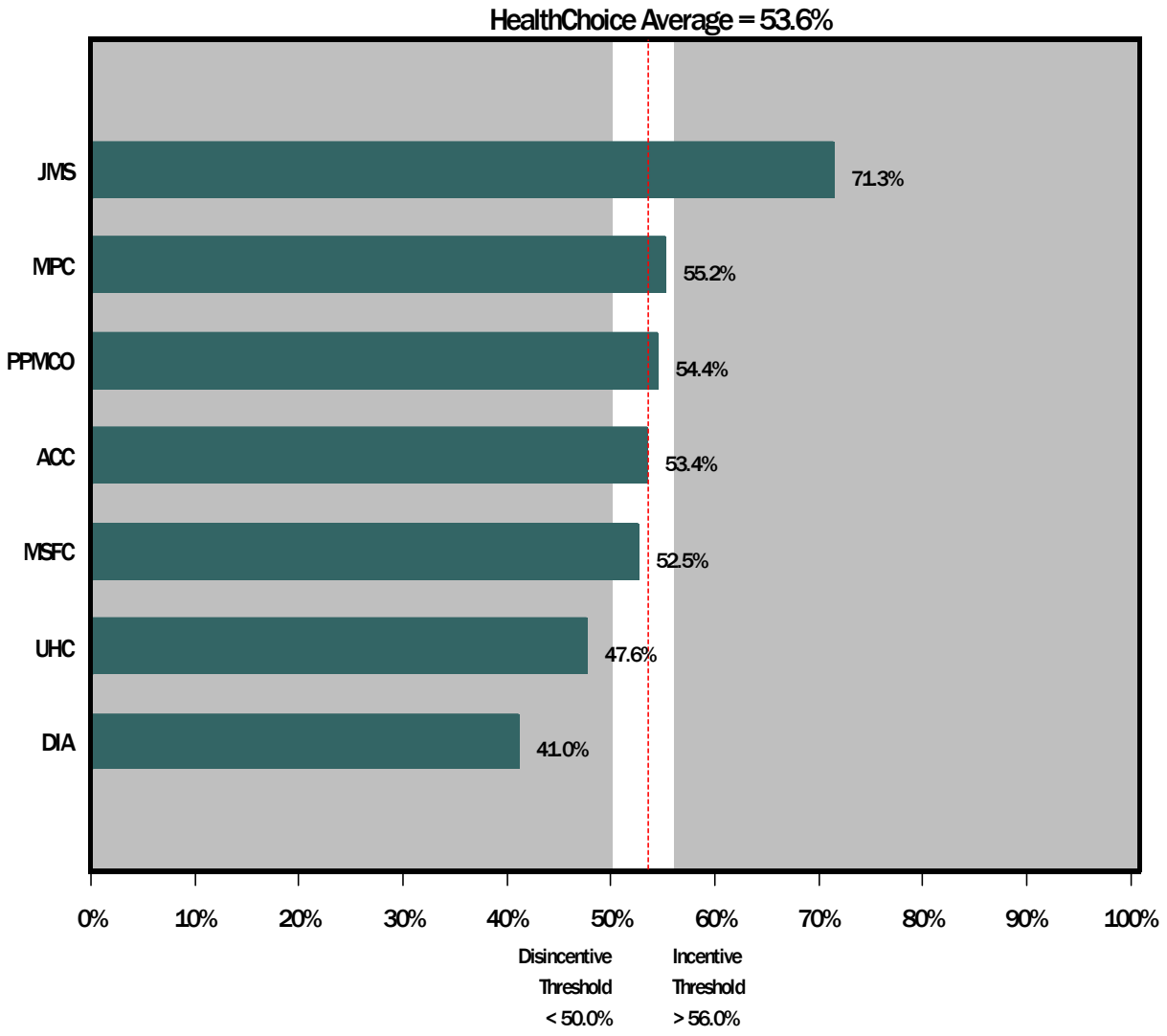
Performance rates range from 84% to 91.7% with the highest performer being UHC. Two MCOs, PPMCO and UHC performed above the incentive threshold of 91%. Four MCOs, DIA, JMS, MSFC, and ACC performed within the neutral range (85% through 91%). MPC performed below the disincentive range of 85%. The HealthChoice average was 88.9% which was within the neutral range.

Cervical Cancer Screening for Women Ages 21–64



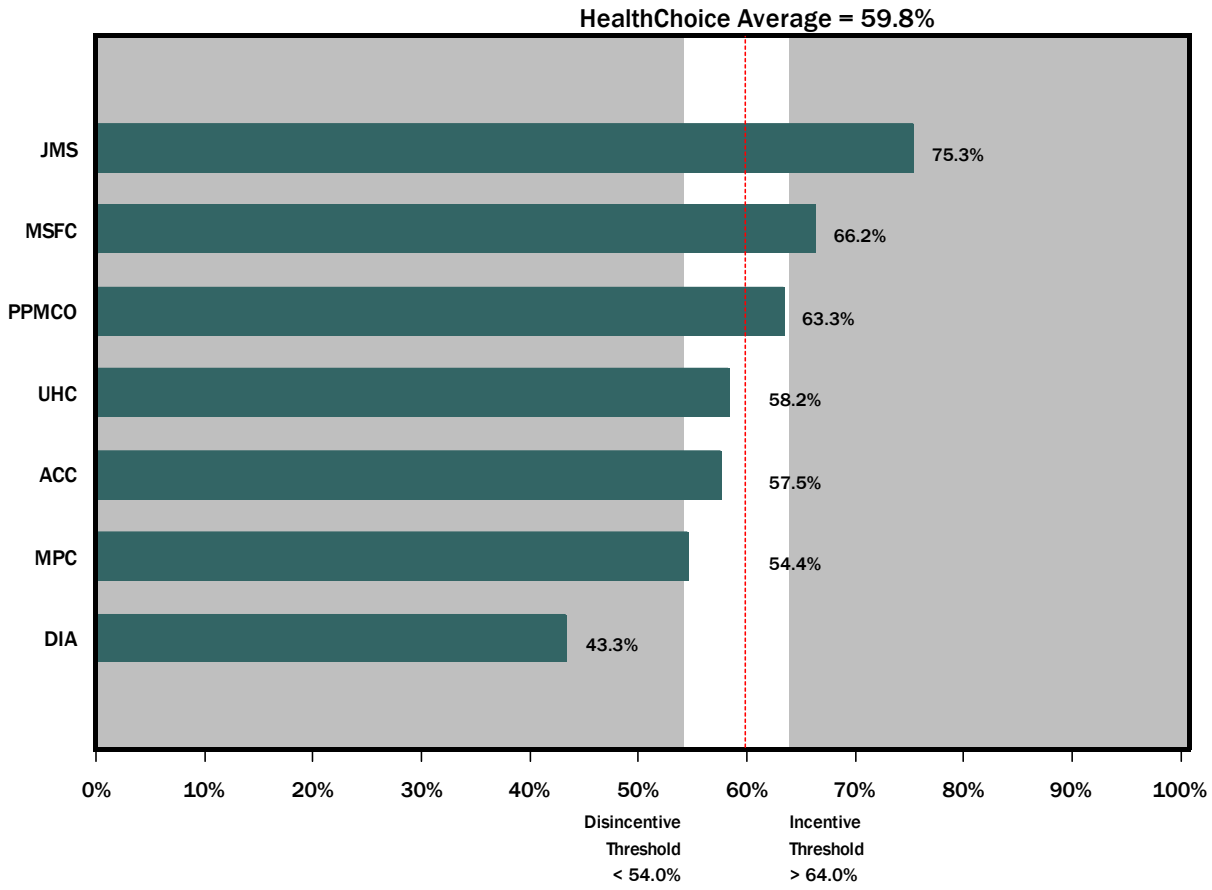
Performance rates range from 48.0% to 73.8% with the highest performer being JMS. One MCO, JMS performed above the incentive threshold of 71%. Four MCOs, MPC, MSFC, UHC, and PPMCO performed within the neutral range (64% through 71%). Two MCOs, DIA and ACC performed below the disincentive threshold of 64%. The HealthChoice average was 63.2% which was below the disincentive threshold.

Lead Screenings for Children Ages 12–23 Months



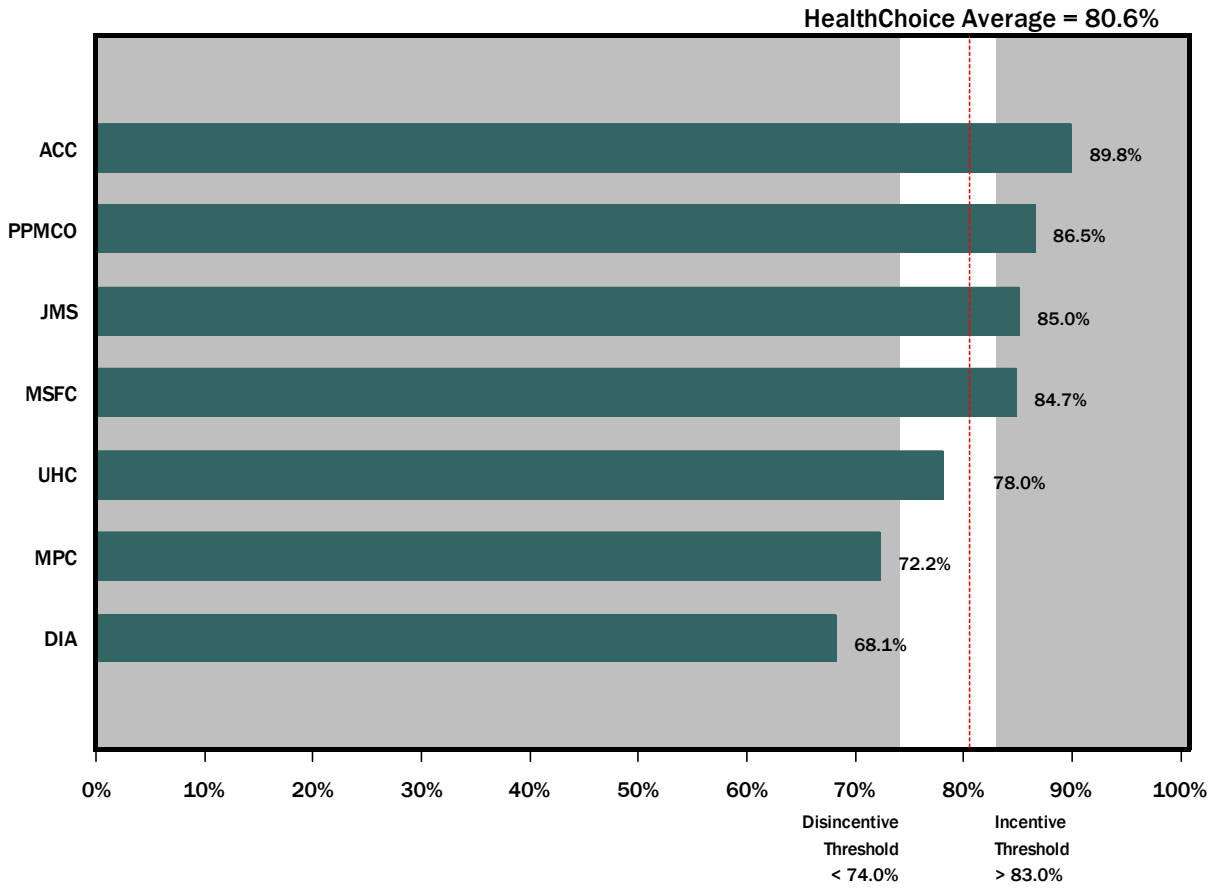
Performance rates range from 41.0% to71.3% with the highest performer being JMS. One MCO, JMS performed above the incentive threshold of 56%. Four MCOs, MSFC, ACC, PPMCO, and MPC, performed within the neutral range (50% through 56%). Two MCOs, DIA and UHC performed below the disincentive threshold of 50%. The HealthChoice average was 53.6% which was within the neutral range.

Eye Exams for Diabetics



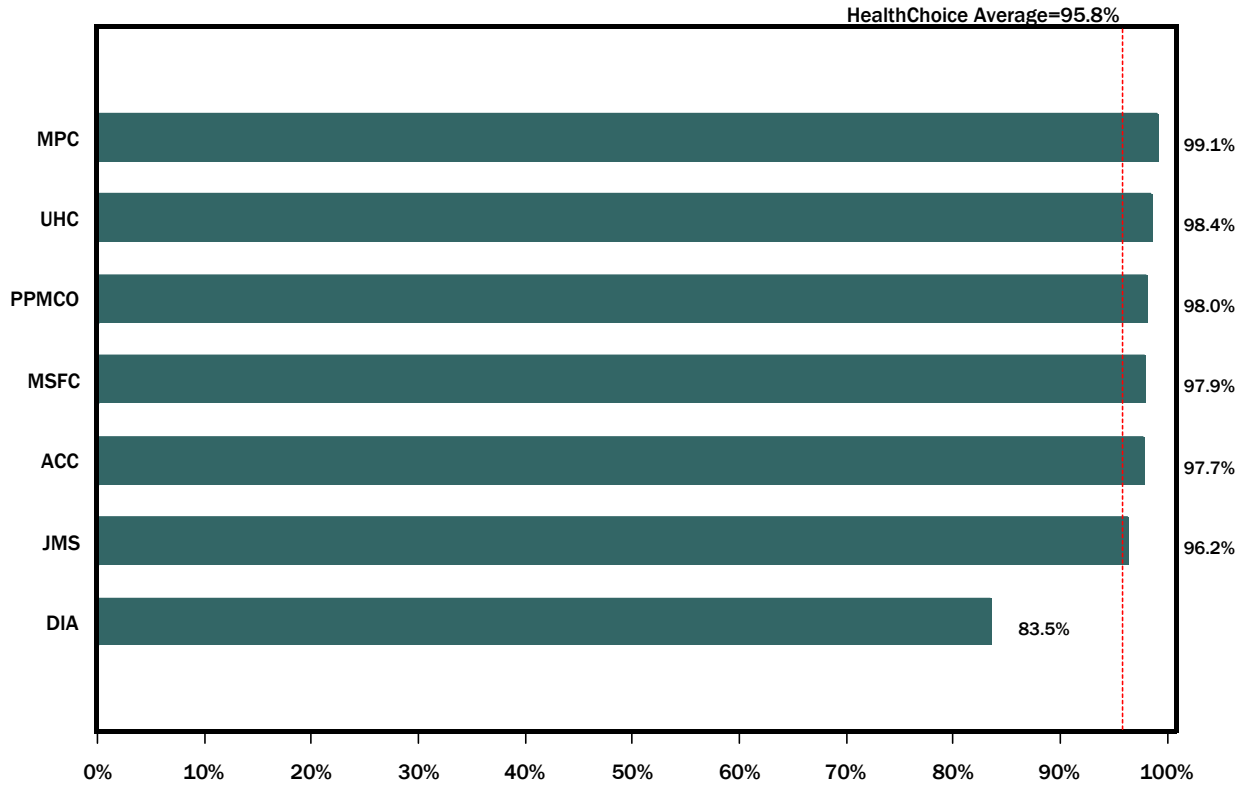
Performance rates range from 43.3% to 75.3% with the highest performer being JMS. Two MCOs, MSFC, and JMS performed above the incentive threshold of 64%. Four MCOs, MPC, ACC, UHC, and PPMCO performed within the neutral range (54% through 64%). DIA performed below the disincentive threshold of 54%. The HealthChoice average was 59.8% which was within the neutral range.

Childhood Immunization Status—Combo 2



Performance rates range from 68.1% to 89.8% with the highest performer being ACC. Four MCOs, MSFC, JMS, PPMCO, and ACC performed above the incentive threshold of 83%. One MCO, UHC performed within the neutral range (74% through 83%). DIA and MPC performed below the disincentive threshold of 74%. The HealthChoice average was 80.6% which was within the neutral range.

Claims Timeliness



Performance rates range from 83.5% to 99.1% with the highest performer being MPC. The HealthChoice average is 95.8%.

Appendix II

Compliance with the Federal Balanced Budget Act of 1997

The Medicaid Managed Care Provisions of the 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 by the Joint Commission on 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. 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 this 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. Additionally, it determines 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. The protocol was developed using the 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 verification of either the entire set or a sample of the State-specified performance measures to confirm that the reported results are based on 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 to serve as the EQRO for HealthChoice. Among the functions that Delmarva performs is the annual validation of performance measures reported during the preceding calendar year by the State of Maryland, its contractors, and the MCOs. Delmarva uses CMS protocols in validating VBP measure results.

Delmarva and DHMH's contracted HEDIS Compliance Audit™ firm, HealthcareData Company, LLC, validated the CY 2007 HEDIS-based VBP measures. HealthcareData Company, LLC performed the validation of the HEDIS-based VBP measures for all seven of the HealthChoice MCOs using NCQA's *HEDIS Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures.*

™ NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA)

Appendix III

Value-Based Purchasing Measure Validation

Data Sources

Three types of measures are included in the CY 2007 VBP measures: (1) measures from NCQA's HEDIS, (2) measures based on encounter data computed by DHMH's Office of Planning, and (3) a measure based on data supplied by the HealthChoice MCOs and calculated by Delmarva. Table A-1 shows the quality dimension, the type 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 2007 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 , Lead Registry, & Fee For Service Data	DHMH
Eye exams for diabetics	Quality of Care	HEDIS	MCO
Childhood immunization status	Quality of Care	HEDIS	MCO
Claims timeliness	Administration	Claims Audit EQRO	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). Five of the CY 2007 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 Company, LLC to perform the validation of HEDIS measures for the HealthChoice MCOs. In CY 2007, all seven MCOs utilized the DHMH-contracted audit firm.

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 of the offsite audit process include the selection 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; 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 designations indicate the suitability of measures for public reporting. The four possible audit designations are explained in Table A-2. The final activity of the post onsite phase of the audit consists of the MCO submitting data to NCQA, using NCQA's Interactive Data Submission System (IDSS).

Table A-2. HEDIS Compliance Audit Designations

Audit Findings	Description	Rate/Result
Reportable rate or numeric result for HEDIS measures.	Reportable Measure	0-XXX
The MCO followed the specifications but the denominator was too small to report a valid rate.	Denominator <30.	NA
The MCO did not offer the health benefits required by the measure (e.g., mental health/chemical dependency).	No Benefit	NB
• The MCO calculated the measure but the rate was materially biased, **or** • The MCO chose not to report the measure.	Not Reportable	NR

In order to avoid duplicating efforts and placing undue administrative burden on the HealthChoice MCOs, DHMH used five of the HEDIS audit measure determinations as VBP measure determinations. The five 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 indicator only)
- Cervical Cancer Screening
- Comprehensive Diabetes Care (eye exam indicator only)
- Childhood Immunization Status (Combo 2 only)

Encounter Data Measure Validation

Four CY 2007 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
- 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 code 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 Company, LLC 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 2007 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						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Report	Report	Report	Report	Report	Report	Report
Prenatal and Postpartum Care (prenatal care portion only)	Report	Report	Report	Report	Report	Report	Report
Cervical Cancer Screening	Report	Report	Report	Report	Report	Report	Report
Comprehensive Diabetes Care (eye exam portion only)	Report	Report	Report	Report	Report	Report	Report
Childhood Immunization Status (Combo 2 only)	Report	Report	Report	Report	Report	Report	Report

All of the VBP measures audited by HealthcareData Company, LLC 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 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 a description of validation findings).

Table A-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 Delmarva, no issues were identified that could have introduced bias to the resulting statistics.

Validation of the rates calculated by Delmarva was reached through a process by which the measure creation process and source code were reviewed and approved by two analysts and an analytic scientist.

Claims Payment Validation

An additional measure of performance is calculated for each MCO. The measure of timeliness of claims payment does not have incentive or disincentive targets set by the Department since the standard is established in § 15-1005 of MD Insurance Administration codes.

To determine Claims Timeliness, Delmarva requested all claims adjudicated (paid or denied) from the third quarter CY2007 from each MCO to calculate the measure. A standardized data submission format was defined that included the necessary fields to determine if a claim was adjudicated within 30 days of receipt. For the purpose of identifying adjudication of "clean claims", Delmarva asked that the MCO identify whether the claim was considered a "clean claim" at the time of receipt. An additional field identifying whether the claim was submitted in paper or electronic format was included in order to select a sample for validation.

The validation sample consisted of 30 randomly selected paper claims. The purpose of the validation sample was to verify that receipt dates and check dates included in the electronic submission were consistent with those on the paper records.

Delmarva computed the total number and percent of claims adjudicated within 30 days of receipt, and total number and percent of "clean claims" adjudicated within 30 days of receipt.

After receipt of the third quarter CY 2007 MCO data submissions, a standard data verification process was employed to ensure that data values submitted were within acceptable parameters and the number of records received was in accordance with approximately half of the number reported to the Maryland Insurance Administration on the Semi-Annual Claims Data Filing Forms for the same period. The reasonableness of the proportion of CMS 1500 and UB 92 claims as compared both to previous submissions and among plans is also determined.

Communication with the MCOs was initiated when data was not supplied in the appropriate format, values were outside of expected parameters, or the volume of claims data was inconsistent with previously reported data. Any outstanding issues were resolved, and the corrected or updated data files were used to create SAS data sets for calculation of the VBP claims adjudication measure.

Validation of the data contained in the MCO-submitted files was conducted by requesting a validation sample of the paper claims and subsequent documentation generated in the adjudication process. Each MCO was supplied with the claim numbers for a sample of 30 claims. The MCO was required to submit the paper claim which was processed on a CMS 1500 or a UB 92 with the required date stamps. The Explanation of Benefits/Remittance Advice dates were matched to the data sets submitted by the MCOs.

Table A-6 summarizes the results of the data validation activities. A notation of "Met" indicates that the EQRO determined that the MCO-submitted data set was within the acceptable range.

Table A-6. Validity of MCO-Submitted Claims Data

Data Validation Activity	MCO						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Actual Claims Volume Within 10% of Expected Volume	Met	Met	Met	Met	Met	Met	Met
Proportion of CMS 1500 Claims and UB 92 Claims is Reasonable	Met	Met	Met	Met	Met	Met	Met
Validation Sample Data Correspond to Electronic Data Submitted	Met	Met	Met	Met	Met	Met	Met