Medicaid Managed Care Organization

Value-Based Purchasing Activities Report

Final Report

Calendar Year 2009

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

Calendar Year 2009 Value-Based Purchasing Report

Introduction

Value-based purchasing improves quality by awarding business and incentives to contractors based on their performance along a range of dimensions. 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. 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 requirements of the Federal Balanced Budget Act of 1997 (BBA). See Appendix III for more information on compliance with federal law and regulations.

In compliance with the BBA, Maryland's DHMH has contracted with Delmarva to serve as the EQRO for HealthChoice. Among the functions that Delmarva performs is the annual validation of performance measure data reported for the preceding calendar year by the State of Maryland, its contractors, and the MCOs. Delmarva uses the Centers for Medicare & Medicaid Services (CMS') protocols in validating VBP measure results.

Delmarva and HealthcareData Company, LLC (HDC) validated the Calendar Year (CY) 2009 VBP measurement data. HDC performed the validation of the HEDIS-based VBP measurement data for all seven of the HealthChoice MCOs using NCQA's *HEDIS Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures.*

2009 Performance Measures

DHMH solicits input from stakeholders including MCOs, the Medicaid Advisory Committee, the Hilltop Institute, and identified legislative priorities in selecting the performance measures. Measures may be added or removed, based upon evolving DHMH priorities and enrollee health care needs.

The measures address several dimensions of plan performance which fall into one of the following two categories:

- 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.

Measurement of Claims Timeliness performance is also reviewed; however, the standards are set by the Maryland Insurance Administration (MIA), and therefore no financial based targets are applied.

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;
3) prevention-oriented and associated with improved outcomes;
4) measurable with available data;
5) comparable to national performance measures for benchmarking;
6) consistent with how CMS is developing a national set of performance measures for Medicaid MCOs; and
7) possible for MCOs to affect change.

Table 1 shows the CY 2009 VBP measures and their targets.

Table 1. 2009 Value-Based Purchasing Measures

Performance Measure	Data Source	2009 Target
Adolescent Well Care: % of adolescents ages 12-21 (enrolled 320 or more days) receiving at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	HEDIS	Incentive: ≥73% Neutral: 64%–72% Disincentive: ≤63%
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 measurement year	Encounter Data	Incentive: ≥84% Neutral: 79%–83% Disincentive: ≤78%
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 measurement year	Encounter Data	Incentive: ≥78% Neutral: 72%–77% Disincentive: ≤71%
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: ≥75% Neutral: 67%–74% Disincentive: ≤66%
Childhood Immunization Status (Combo 3): % 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, 3 IPV, 1 MMR, 2 H influenza type B, 3 hepatitis B, 1 chicken pox vaccine (VZV), and pneumococcal conjugate by the time period specified and by the child's second birthday	HEDIS	Incentive: ≥76% Neutral: 68%–75% Disincentive: ≤67%
Eye Exams for Diabetics: % of diabetics ages 18-75 (continuously enrolled during measurement year) receiving a retinal or dilated eye exam during the measurement year, consistent with American Diabetes Association recommendations	HEDIS	Incentive: ≥71% Neutral: 62%–70% Disincentive: ≤61%
Lead Screenings for Children Ages 12–23 Months: % of children ages 12–23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year	Lead Registry, Encounter & Fee for Service Data	Incentive: ≥63% Neutral: 51%–62% Disincentive: ≤50%
Postpartum Care: % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS	Incentive: ≥79% Neutral: 72%–78% Disincentive: ≤71%
Use of Appropriate Meds for Asthma: % of members 5–56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year	HEDIS	Incentive: ≥91% Neutral: 89%–90% Disincentive: ≤88%
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 measurement year, consistent with American Academy of Pediatrics & EPSDT recommended number of visits	HEDIS	Incentive: ≥85% Neutral: 81%–84% Disincentive: ≤80%

2009 Value-Based Purchasing Results

The CY 2009 performance results presented in Table 2 were validated by Delmarva and DHMH's contracted HEDIS Compliance Audit™ firm, HDC. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and the VBP program. In CY 2009, there were seven HealthChoice MCOs:

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

Table 2. MCO CY 2009 VBP Performance Summary

Performance Measure	CY 2009 Target	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)						
Adolescent Well Care	Incentive: ≥73% Neutral: 64%–72% Disincentive: ≤63%	52% (D)	51% (D)	80% (I)	65% (N)	61% (D)	65% (N)	65% (N)
Ambulatory Care Services for SSI Adults	Incentive: ≥84% Neutral: 79%–83% Disincentive: ≤78%	78% (D)	73% (D)	85% (I)	82% (N)	82% (N)	83% (N)	79% (N)
Ambulatory Care Services for SSI Children	Incentive: ≥78% Neutral: 72%–77% Disincentive: ≤71%	74% (N)	68% (D)	81% (I)	77% (N)	79% (I)	77% (N)	71% (D)
Cervical Cancer Screening for Women Ages 21–64	Incentive: ≥75% Neutral: 67%–74% Disincentive: ≤66%	67% (N)	66% (D)	76% (I)	68% (N)	68% (N)	68% (N)	64% (D)
Childhood Immunization Status—Combo 3	Incentive: ≥76% Neutral: 68%–75% Disincentive: ≤67%	74% (N)	71% (N)	81% (I)	76% (I)	84% (I)	68% (N)	78% (I)
Eye Exams for Diabetics Ages 18-75	Incentive: ≥71% Neutral: 62%–70% Disincentive: ≤61%	51% (D)	52% (D)	78% (I)	74% (I)	75% (I)	65% (N)	71% (I)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥63% Neutral: 51%–62% Disincentive: ≤50%	57% (N)	49% (D)	77% (I)	56% (N)	51% (N)	56% (N)	50% (D)
Postpartum Care	Incentive: ≥79% Neutral: 72%–78% Disincentive: ≤71%	67% (D)	59% (D)	79% (I)	72% (N)	79% (I)	67% (D)	63% (D)
Use of Appropriate Meds for Asthma	Incentive: ≥91% Neutral: 89%–90% Disincentive: ≤88%	89% (N)	95% (I)	90% (N)	91% (I)	93% (I)	90% (N)	87% (D)
Well-Child Visits for Children Ages 3–6	Incentive: ≥85% Neutral: 81%–84% Disincentive: ≤80%	76% (D)	70% (D)	92% (I)	86% (I)	79% (D)	87% (I)	82% (N)

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2009 VBP Incentive and Disincentive Methodology

As described in the Code of Maryland Regulations 10.09.65.03, DHMH uses financial incentives and disincentives to promote performance improvement. There are three levels of performance: incentive, neutral and disincentive for all measures. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance is at or below the minimum target. All measures are evaluated separately and are of equal weight in the methodology. For any measure that the MCO does not meet the minimum target, a disincentive of 1/10 of 1 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO meets or exceeds the incentive target, the MCO shall be paid an incentive payment of up to 1/10 of 1 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 plus any additional funds allocated by the Department for a quality initiative. MCOs' CY 2009 performance is shown in Table 3.

Table 3. MCO CY 2009 VBP Incentive/Disincentive Amounts

Performance Measure	MCO						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Adolescent Well Care	($619,512.62)	($34,169.38)	$69,781.98	$0	($97,415.32)	$0	$0
Ambulatory Care Services for SSI Adults	($619,512.62)	($34,169.38)	$69,781.98	$0	$0	$0	$0
Ambulatory Care Services for SSI Children	$0	($34,169.38)	$69,781.98	$0	$97,415.32	$0	($433,311.58)
Cervical Cancer Screening for Women Ages 21–64	$0	(34,169.38)	$69,781.98	$0	$0	$0	($433,311.58)
Childhood Immunization Status—Combo 3	$0	$0	$69,781.98	$439,904.28	$97,415.32	$0	$433,311.58
Eye Exams for Diabetics Ages 18-75	($619,512.62)	($34,169.38)	$69,781.98	$439,904.28	$97,415.32	$0	$433,311.58
Lead Screenings for Children Ages 12–23 Months	$0	($34,169.38)	$69,781.98	$0	$0	$0	($433,311.58)
Postpartum Care	($619,512.62)	($34,169.38)	$69,781.98	$0	$97,415.32	($587,278.01)	($433,311.58)
Use of Appropriate Meds for Asthma	$0	$34,169.38	$0	$439,904.28	$97,415.32	$0	($433,311.58)
Well-Child Visits for Children Ages 3–6	($619,512.62)	($34,169.38)	$69,781.98	$439,904.28	($97,415.32)	$587,278.01	$0
Total Incentive/ Disincentive Amount	($3,097,563.10)	($170,846.91)*	$628,037.82	$1,759,617.12	$292,245.96	$0	($1,299,934.74)

*In accordance with COMAR 10.09.65.03b(3)(h)(iv), DIA's disincentive total is limited to $170,846.91.

Conclusion

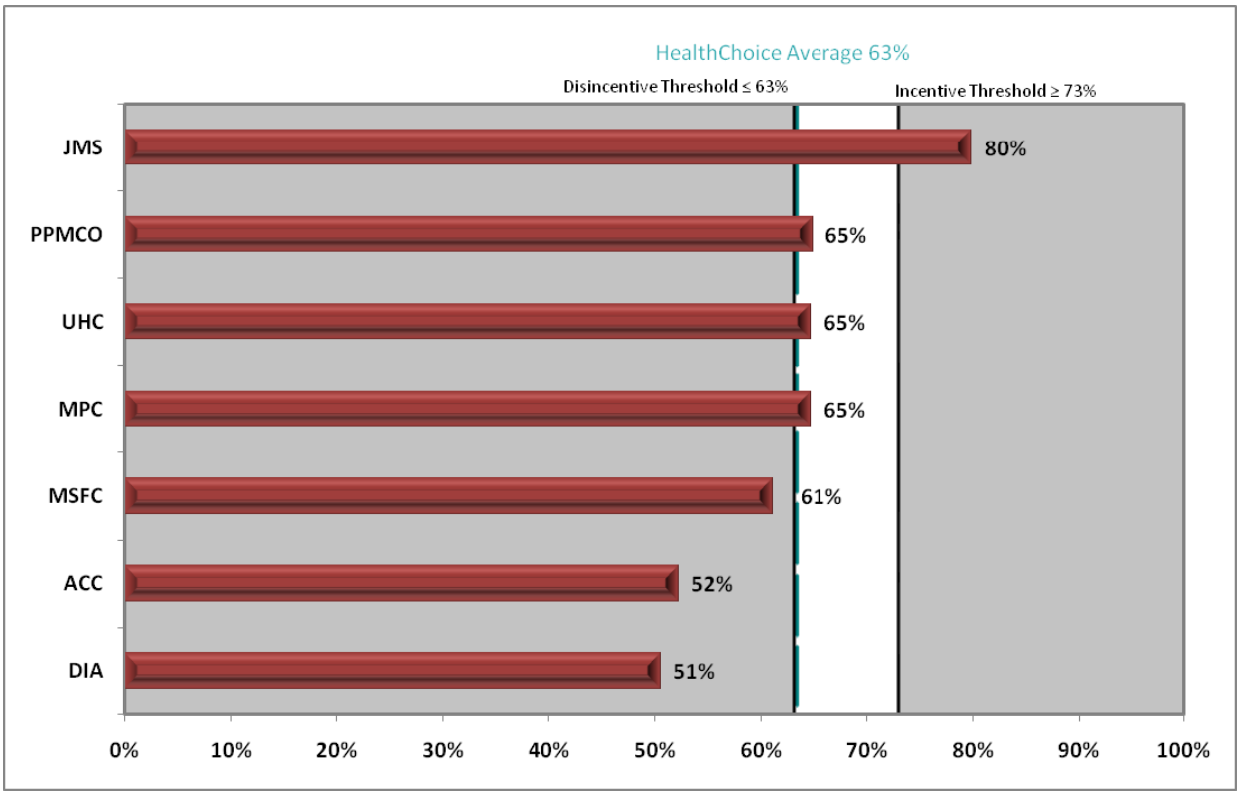
The HealthChoice Value-Based Purchasing quality strategy emphasizes continuous quality improvement and evidence-based medicine, making it consistent with trends in the larger health care market. The strategy increases the comparability of Maryland's performance to that of other states, enabling the sharing 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 to meet the changing needs and priorities of its population. 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.

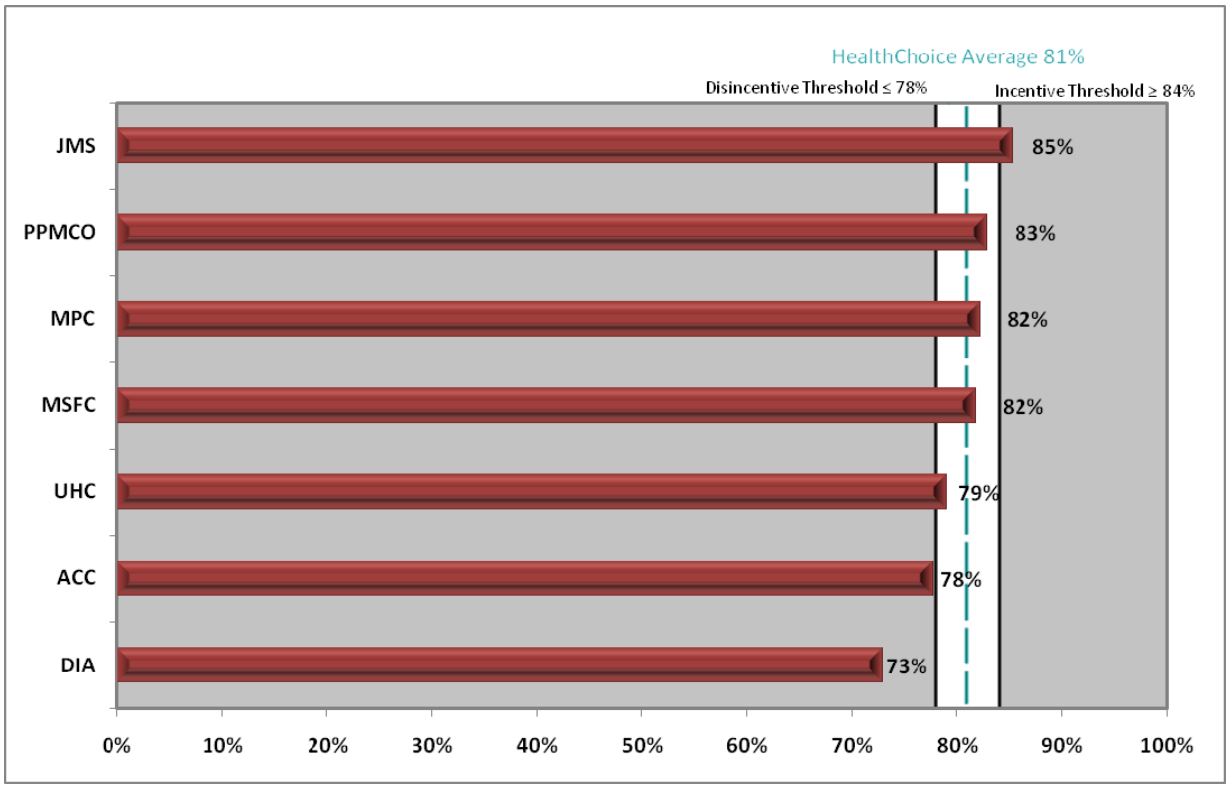
MCO Performance By Individual Performance Measures

The following graphs represent the performance rates for each VBP measure. Each graph presents each MCO's performance, the disincentive and incentive threshold, and the HealthChoice average. The HealthChoice Average is an unweighted average of all MCO rates.

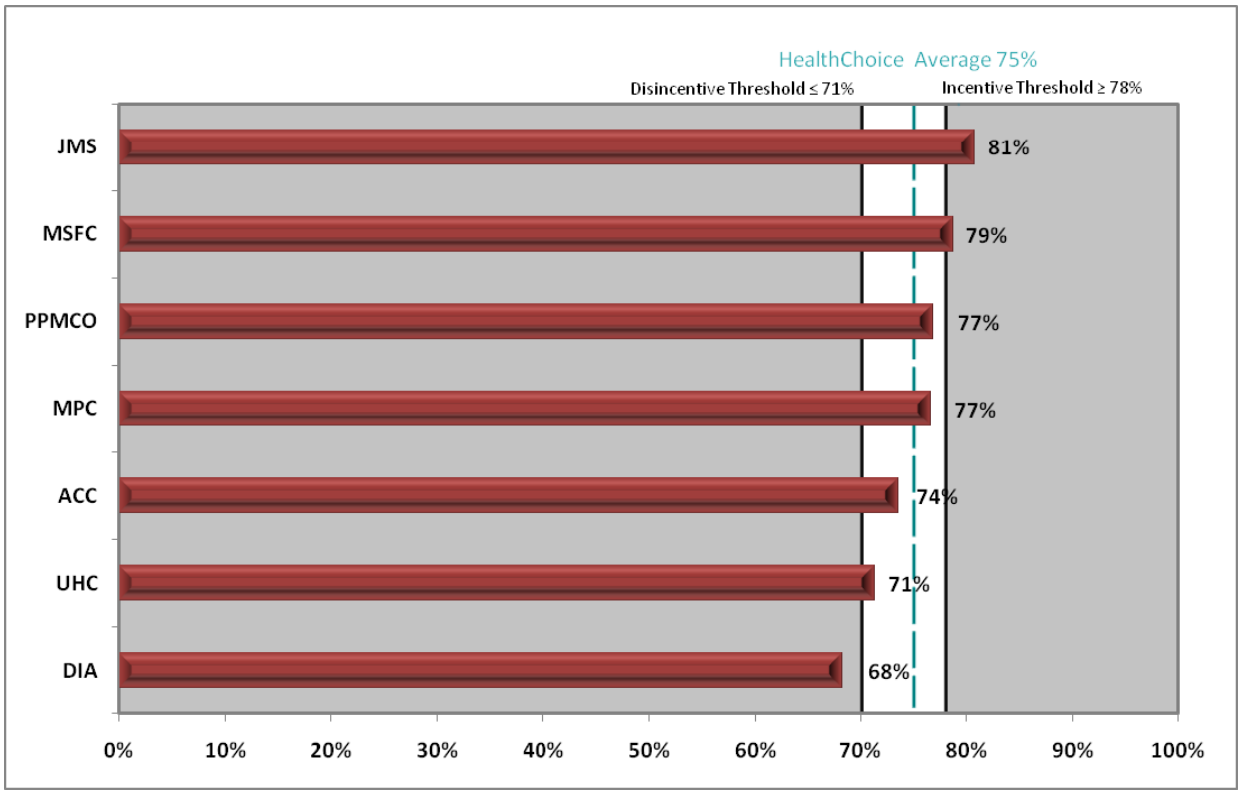
Adolescent Well Care



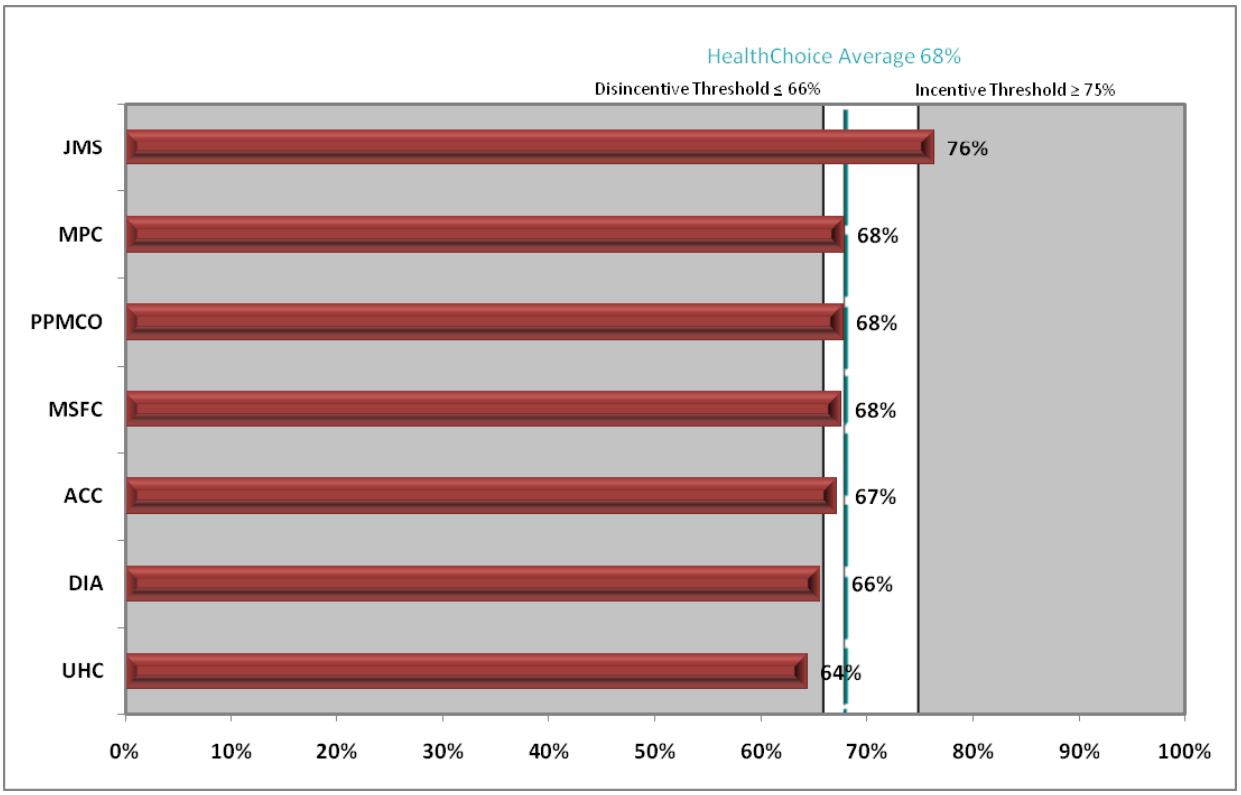
Ambulatory Care Services for SSI Adults Ages 21 – 64 Years



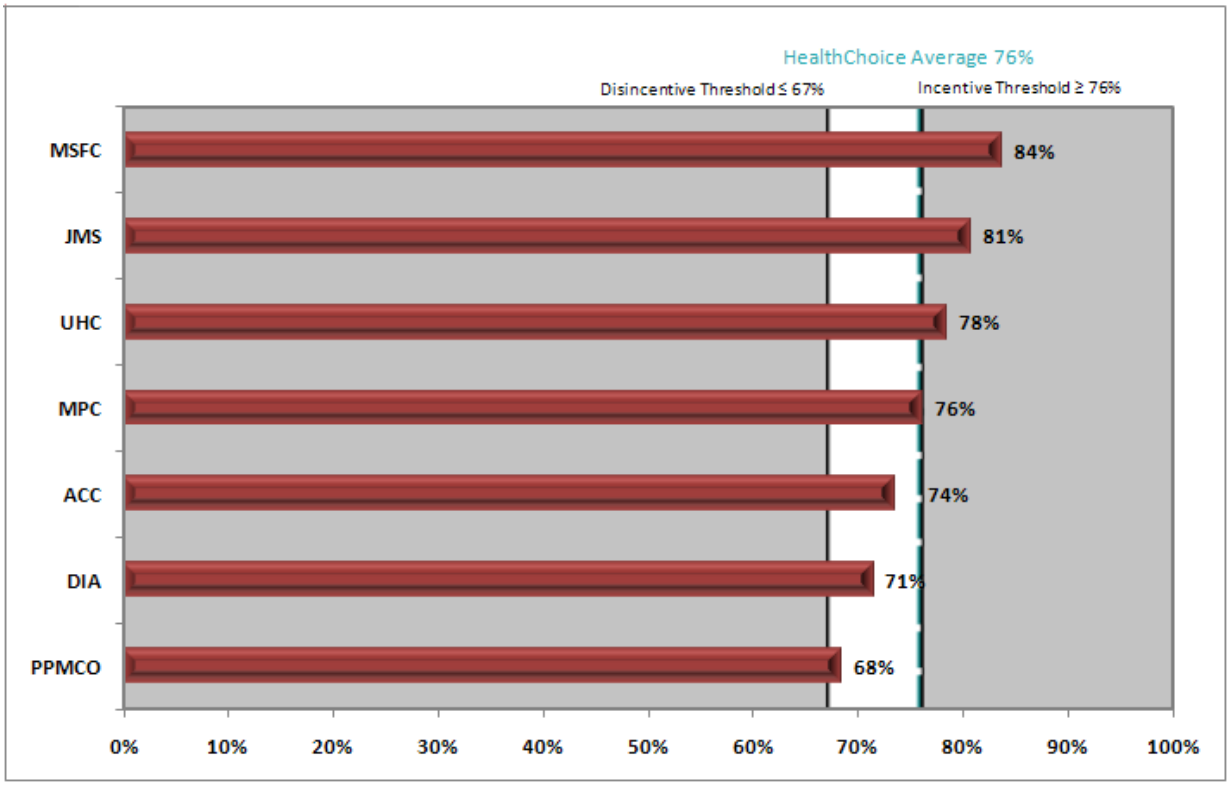
Ambulatory Care Services for SSI Children Ages 0 – 20 Years



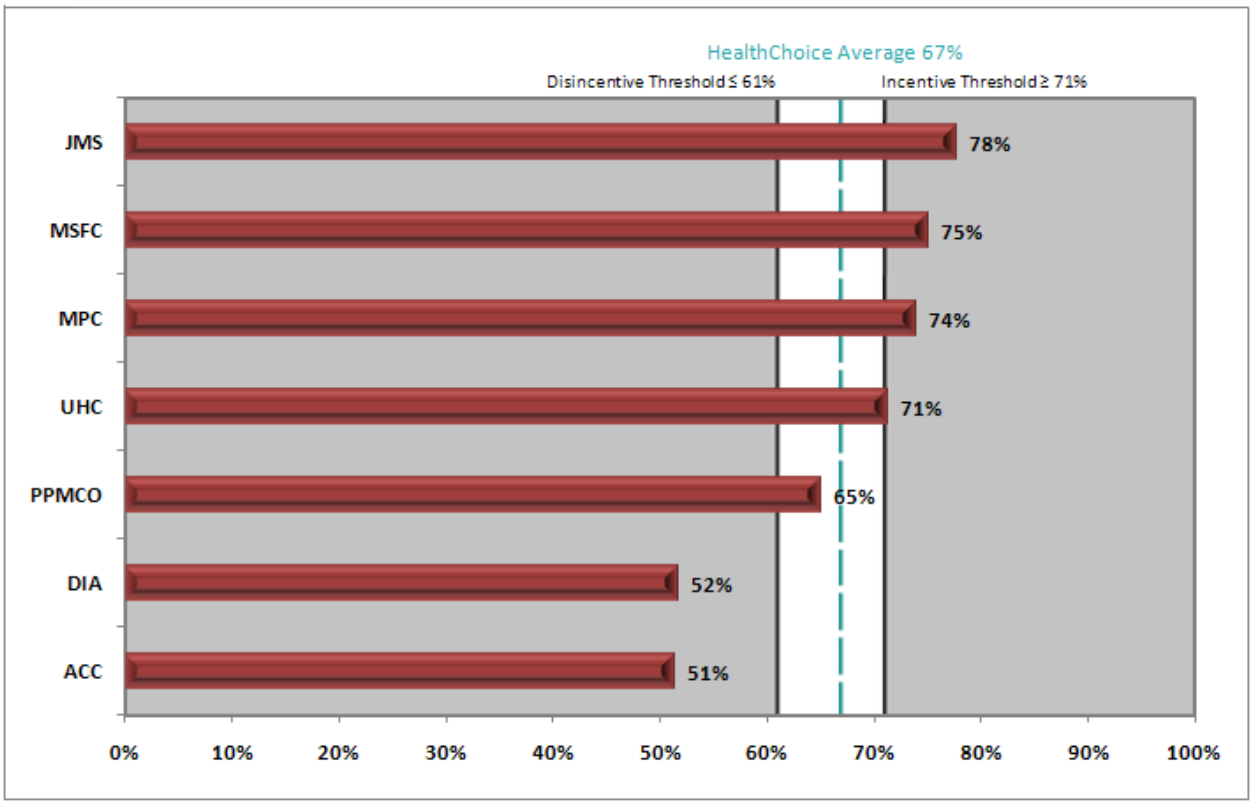
Cervical Cancer Screening for Women Ages 21 – 64 Years



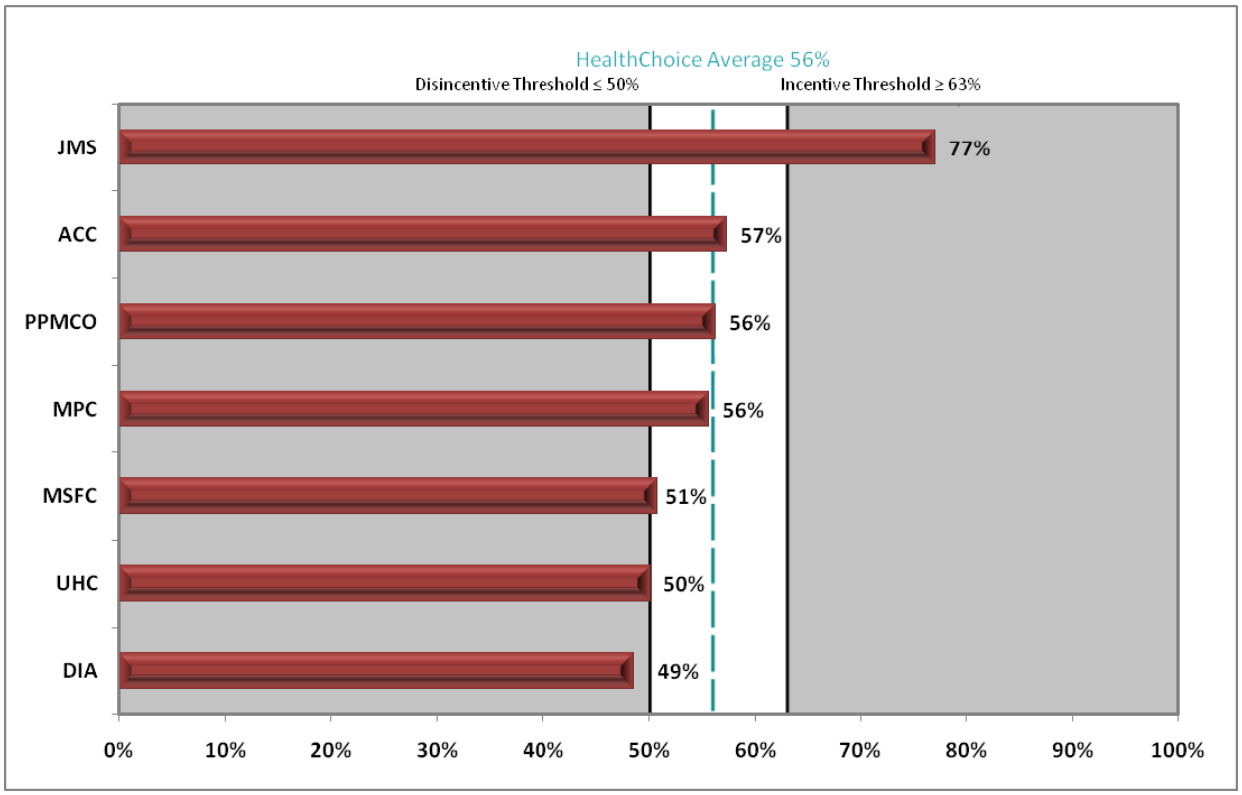
Childhood Immunization Status—Combo 3



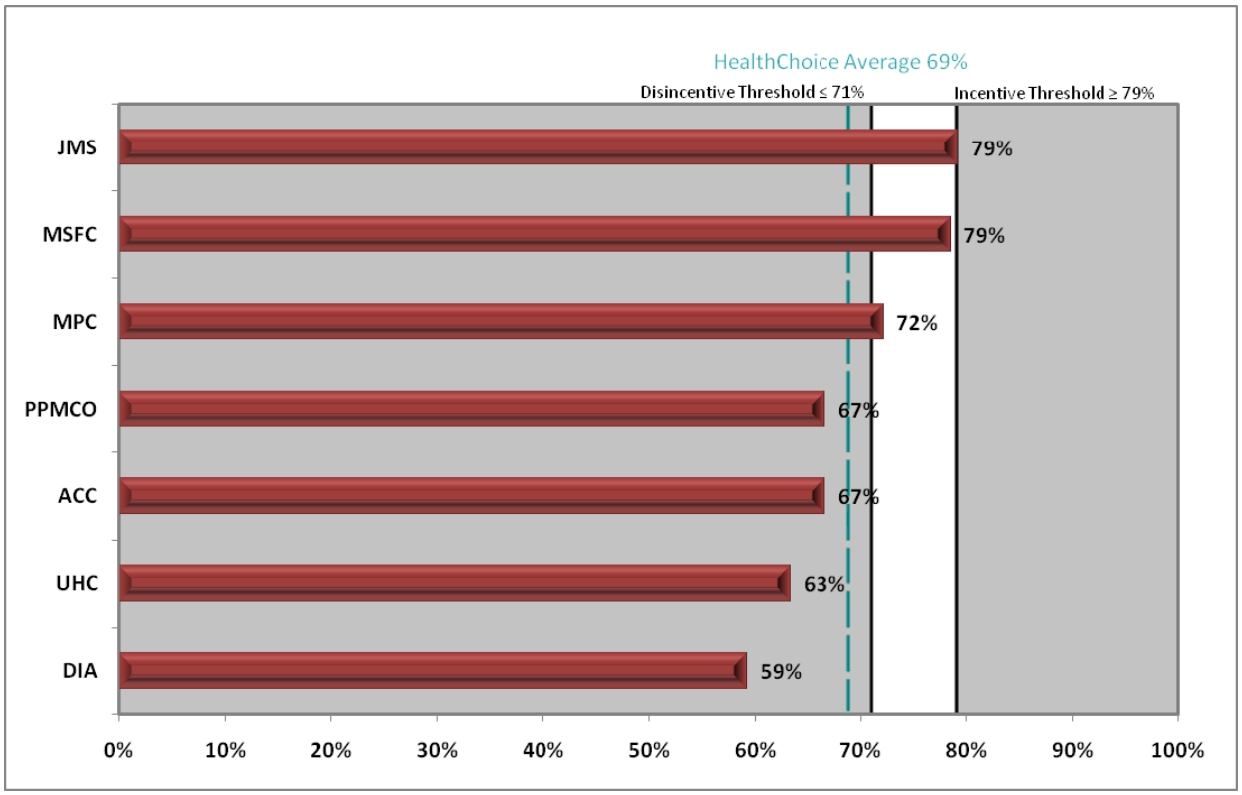
Eye Exams for Diabetics



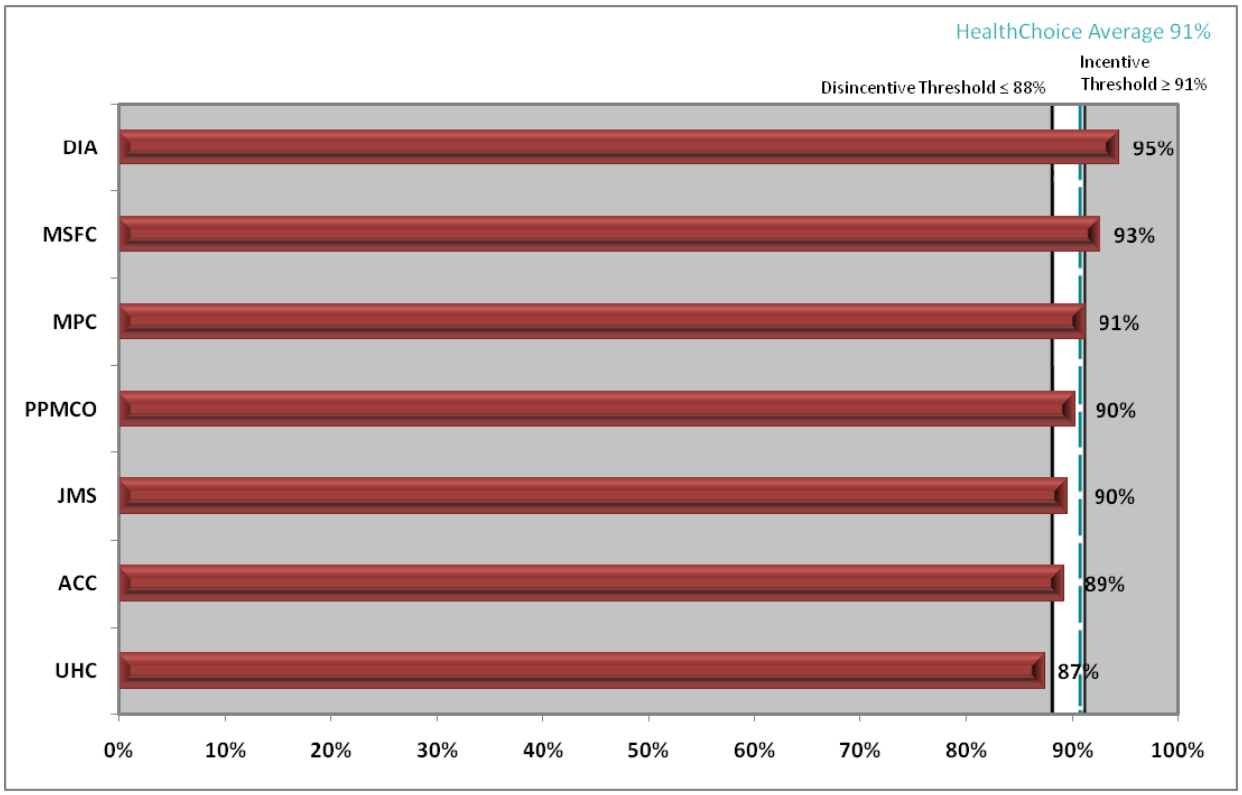
Lead Screenings for Children Ages 12 – 23 Months



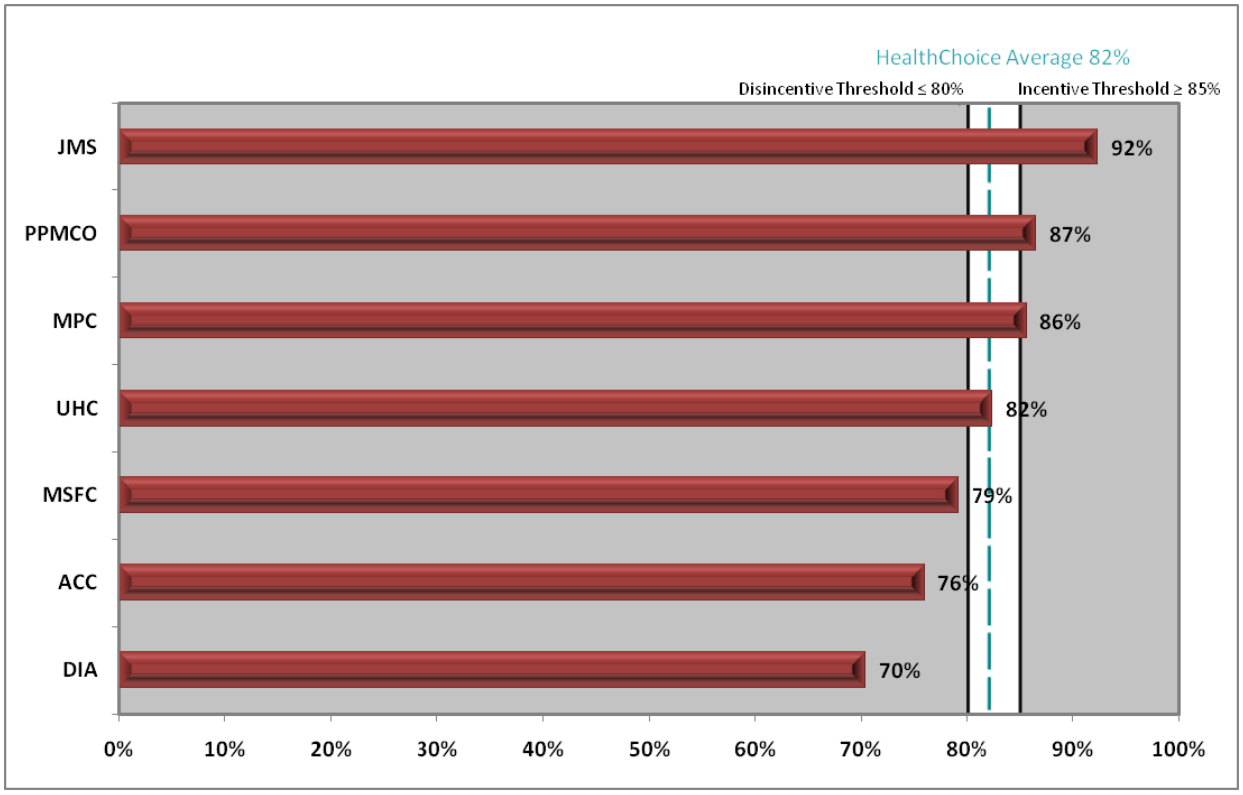
Postpartum Care



Use of Appropriate Meds for Asthma



Well-Child Visits for Children Ages 3 – 6 Years



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 CY 2009 from each MCO. 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. (A clean claim is one submitted on industry standard billing forms e.g. CMS Form 1500 or CMS UB 04 and includes the essential data elements so it can be processed without obtaining further information from the provider.) 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 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.

Upon receipt of the third quarter CY 2009 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 04 claims as compared both to previous submissions and among plans was 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.

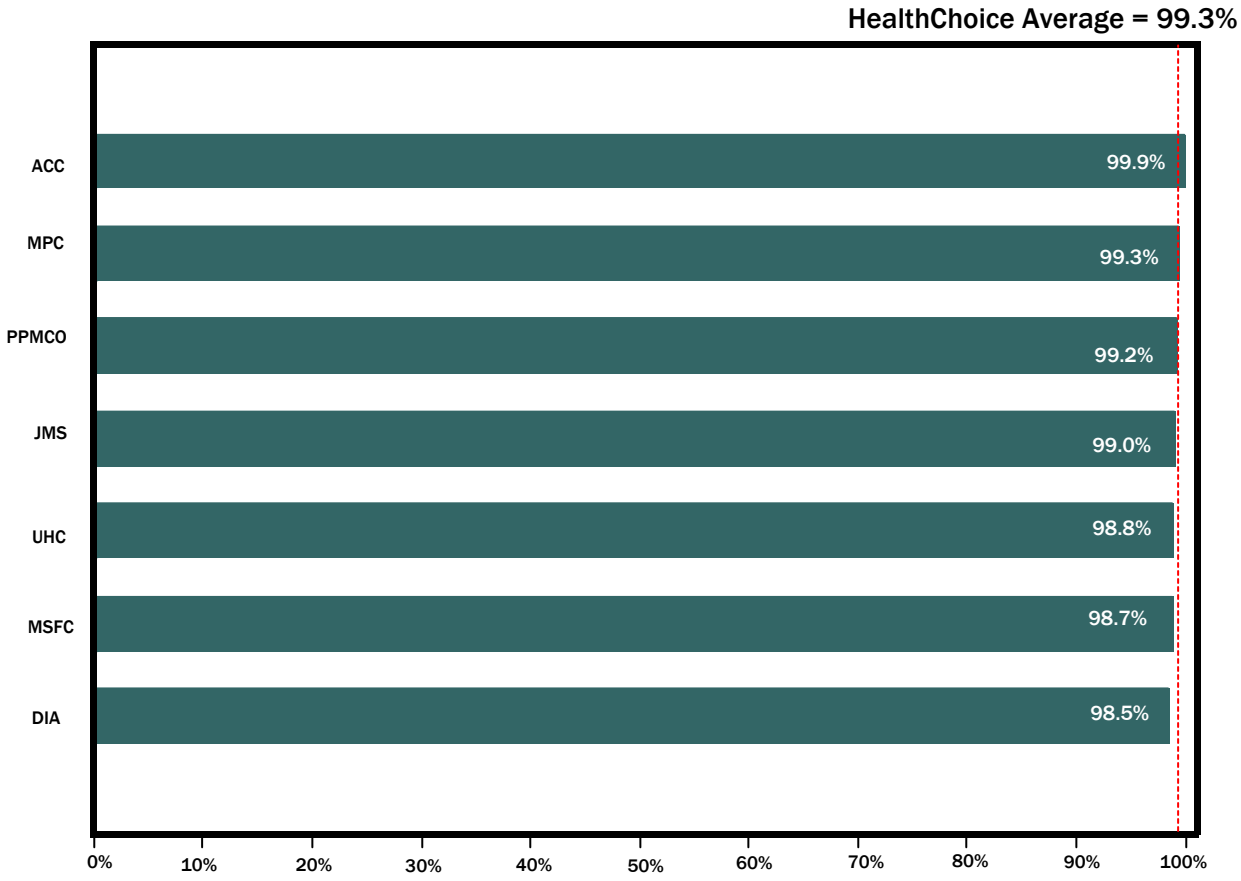
Validation of the data contained in the MCO-submitted files was conducted by requesting a validation sample of the paper claims and subsequent documentation generated in the adjudication process. Each MCO was supplied with the claim numbers for a sample of 30 claims. The MCO was required to submit the paper claim which was processed on a CMS 1500 or a UB 04 with the required date stamps. The Explanation of Benefits/Remittance Advice dates were matched to the data sets submitted by the MCOs.

Delmarva computed the total number and percent of claims adjudicated within 30 days of receipt. Table A-1 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-1. 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 04 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

Claims Timeliness



Value-Based Purchasing Validation

Several sources of measures (Table A-1) are included in the CY 2009 VBP program. They are chosen from NCQA's HEDIS data set, encounter data, and data supplied by the HealthChoice MCOs, and subsequently validated by Delmarva. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table A-1. CY 2009 VBP Measures

Performance Measure	Quality Dimension	Measure	Reporting Entity
Adolescent well care	Use of Services	HEDIS	MCO
Ambulatory care services for SSI adults	Access to Care	Encounter Data	DHMH
Ambulatory care services for SSI children	Access to Care	Encounter Data	DHMH
Cervical cancer screening for women ages 21–64	Effectiveness of Care	HEDIS	MCO
Childhood immunization status (Combo 3 only)	Effectiveness of Care	HEDIS	MCO
Eye exams for diabetics ages 18-75	Effectiveness of Care	HEDIS	MCO
Lead screenings for children ages 12–23 months	Effectiveness of Care	Encounter , Lead Registry, & Fee For Service Data	DHMH
Postpartum care	Access to Care	HEDIS	MCO
Appropriate meds for asthma (Comb.)	Effectiveness of Care	HEDIS	MCO
Well-child visits for children ages 3–6	Use of Services	HEDIS	MCO

Validation Methodology

Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data by or on behalf of, another entity and determines the extent to which specific performance measures calculated by an entity (or one acting on behalf of another) 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, 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 2009 VBP measures are HEDIS measures and are validated under the provisions of the HEDIS Compliance Audit. The goal of the HEDIS audit is to ensure accurate, reliable, and publicly reportable data. DHMH contracted with HDC to perform the validation of HEDIS measures for the HealthChoice MCOs. In CY 2009, all seven MCOs utilized the DHMH-contracted audit firm.

The HEDIS Compliance Audit is conducted in three phases: offsite, onsite, and post onsite (reporting). The offsite audit phase includes a review of each MCO's Roadmap. The roadmap 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 validation of the medical record review process by the certified audit firm.

During the onsite phase, auditors investigate issues identified in the roadmap 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 MCO staff.

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 roadmap 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 indicating 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., specialty mental health).	No Benefit	NB
The MCO calculated the measure but the rate was materially biased, or The MCO was not required to report the measure.	Not Reportable	NR

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 HEDIS measures in the VBP program are:

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well Care
- Childhood Immunization Status (Combo 3 only)
- Cervical Cancer Screening
- Postpartum Care
- Use of Appropriate Medications for People With Asthma
- Comprehensive Diabetes Care (eye exam indicator only)

EQRO's Data Measure Validation

Three CY 2009 VBP measures were calculated by DHMH, using encounter data submitted by the MCOs, Maryland Department of the Environment's Lead Registry data, and Fee-for-Service data. The measures calculated utilizing encounter data are:

- Ambulatory care services for SSI children
- Lead screenings for children ages 12–23 months
- Ambulatory care services for SSI adults

Delmarva validated the measurement data for each of the above VBP measures including the specifications for each encounter data-based measure, source code to determine algorithmic compliance with the measure specifications, information regarding the encounter data processing system, and analysis of the encounter data process. Clarifications and corrections to source code were conducted to ensure algorithmic compliance with VBP measure specifications.

Validation determinations were used to characterize the findings of the EQRO. Table A-3 indicates the possible determinations of the EQRO-validated measures. 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.

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 and reportable.
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 by HDC are reported using the audit designations and rationales outlined by NCQA as part of the HEDIS Compliance Audit.

All of the VBP measures audited by HDC were determined to be reportable for all MCOs.

Table A-4 shows the results of the EQRO-led validation activities related to the VBP measures. The DHMH was responsible for producing these VBP measures at the MCO level and working with the EQRO to validate the measurement data. During the validation process undertaken by Delmarva, no issues were identified that could have introduced bias to the resulting statistics.

Table A-4. EQRO VBP Measure Validation Determinations

Measure	Validation Determinations
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