STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

October 20, 2014

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2014 Joint Chairmen's Report (p. 88) – Report on Value-Based Purchasing Program

Dear Chairmen Kasemeyer and Conway:

In keeping with the requirements of the 2014 Joint Chairmen's Report (p. 88), enclosed is the Department's report on its value-based purchasing program. The report details the current value-based purchasing methodology and the problem identified by the JCR, describes the analysis that went into devising a solution and provides the Department's proposal for a new value-based purchasing methodology.

Thank you for your consideration of this information. If you have any questions or need more information on this subject, please contact Allison Taylor, Director of Governmental Affairs at (410) 767-6481.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Chuck Lehman
Tricia Roddy
Allison Taylor

Revisiting HealthChoice Value-Based Purchasing Methodologies

Submitted by the Maryland Department of Health and Mental Hygiene

2014 Joint Chairmen's Report, p. 88

Introduction

Pursuant to page 88 of the Joint Chairmen's Report of 2014, the Department of Health and Mental Hygiene (Department) respectfully submits this report on the value-based purchasing program.

Specifically, the Joint Chairman's Report requires the Department to re-visit its value-based purchasing program allocation methodology so that Medicaid managed care organizations with more negative outcomes than positive outcomes are not eligible to receive payments under the program.

This report details the current value-based purchasing methodology, describes the options to improve the current system, and provides the Department's proposal for a new value-based purchasing methodology.

Background

The Maryland Department of Health and Mental Hygiene began working with the Center for Health Care Strategies in 1999 to develop a value-based purchasing program for HealthChoice, Maryland's Medicaid managed care program. The goal of Maryland's strategy is to improve quality of care and access by tying a portion of each managed care organization's capitation to its performance on a number of prescribed performance indicators. The current value-based purchasing program uses penalties assessed against lower-performing managed care organizations to pay rewards to higher-performing managed care organizations based on a set of established measures.

The current system sets targets using the un-weighted average score[1] for all managed care organizations from two years prior and the highest managed care organization score from that year, which are averaged to set the midpoint. The incentive target is equal to the midpoint plus 15 percent of the difference between the midpoint and 100 percent, and the disincentive target is set at the midpoint minus the same amount. For every measure on which a managed care organization scores less than or equal to the disincentive target, it must pay a penalty of one-thirteenth[2] of one percent of its total capitation for the performance year. For every measure on which a managed care organization scores greater than or equal to the incentive target, it will receive a reward in the same amount. If a measure falls between the disincentive benchmark and the incentive benchmark, no money is exchanged in association with that

[1] "Score" refers to a combination of scores in the Healthcare Effectiveness Data and Information Set (HEDIS) by the National Committee for Quality Assurance (NCQA) and encounter data.

[2] This fraction is equal to 1/n where n is the total number of performance measures, so that no MCO will ever pay or receive more than one percent of its total capitation in disincentive or incentive payments, respectively.

measure. The incentives paid out of the program each year cannot exceed the amount of penalties paid in through disincentive payments.

When disincentive payments exceed incentive payments, the money left over after the incentives are paid out is distributed to the four managed care organizations with the highest average normalized scores.[3] This second round of payments is adjusted for the enrollment size of the managed care organization.

The General Assembly requested the Department revisit the current methodology due to a logical disconnect between the rewards and penalties based on benchmarks (the first round) and the distribution of left over funds (the second round) built into the current value-based purchasing program. Theoretically, receiving a reward or owing a penalty should function as a discrete indicator of a managed care organization's success during the performance year. However, the allocation of monies in the second round of funding does not disregard managed care organizations with net disincentives; it is possible that a managed care organization that owed a penalty in the first round (indicating a weak performance) could earn money in the second round (indicating a strong performance).[4] Such an outcome could send an inconsistent signal to consumers or to the managed care organizations themselves about which managed care organizations are meeting the goals of the value-based purchasing program. The General Assembly has tasked the Department with addressing this issue for future calculations.

Options for Changing the System

To maintain a high level of managed care organization support for the value-based purchasing system and HealthChoice in general, the Department solicited proposals from each managed care organization on how to adjust the system to solve the "net negative" problem described above. In total, six managed care organizations submitted proposals, not just on the specific question raised by the General Assembly, but also providing comprehensive plans for reforming the entire VBP system. Though each proposal was unique, several managed care organizations vocalized similar concepts and concerns. The following four options were carefully considered by the Department for adoption in the Calendar Year 2015:

1. <u>Using HEDIS National Medicaid Distributions to Set Targets and Barring Net Negatives from the Second Round</u>

   Several managed care organizations echoed the same concerns expressed by the General Assembly pertaining to net negatives. The new destination of the funding that would have

[3] A managed care organization's average normalized score is equal to the average of the managed care organization's score on each measure divided by each measure's incentive benchmark.
[4] Referred to hereafter as the "net negative problem".

gone to net negatives varied from proposal to proposal, from simply distributing all the funding to the top performers with net positive incentives, to using the funds for other projects that advance the health and well-being of HealthChoice enrollees.

Many of the same managed care organizations expressed a concern that the current system sets targets that unduly punish managed care organizations that actually perform well on a national scale (see Table 1). In response, one managed care organization suggested that the incentive and disincentive targets be set at the 90th and 75th percentile of the national HEDIS Medicaid managed care organization distribution, respectively. While this strategy to use national HEDIS scores to set targets would recognize Maryland's managed care organizations for their national preeminence, it does not provide a challenging standard for managed care organizations into the future. Considering the high level of attainment of the State's managed care organizations in the past and the improvement exhibited, it is feasible that all the managed care organizations could consistently be above the 75th national percentile, inhibiting the value-based purchasing program from achieving its goal of improving quality of care and access. For this reason, the Department does not want to pursue using a national norm-reference—such as HEDIS—to establish targets for its value-based purchasing program.

Table 1. MCOs With Net Negatives in 2012 Compared to National HEDIS Averages

Measure	National HEDIS Average	MedStar Family Choice Scores	Percentage Point Difference	Amerigroup Score	Percentage Point Difference
Adolescent Well Care	50%	69%	20[5]%	68%	18%
Childhood Immunization Status—Combination 3	71%	84%	13%	84%	13%
Post-partum Care	64%	74%	10%	72%	7%
Use of Appropriate Medications for Asthma	88%	89%	1%	87%	-2%
Well-Child Visits for Children Ages 3–6	72%	80%	8%	84%	12%
Cervical Cancer Screening for Women Ages 21-64	67%	71%	4%	74%	7%
Eye Exams for Diabetics Ages 18-75	53%	73%	19%	69%	16%
		Average Difference	+11%	Average Difference	+10%

[5] These numbers are rounded and therefore are slightly different than the reported scores.

Additionally, because the Department is committed to using the actual performance of the HealthChoice managed care organizations to set targets, the Department does not recommend barring managed care organizations with net disincentives from receiving monies in the second round. Program data from 2012 shows the undesirable punitive impact such a change would have on managed care organizations that are often among the nation's best performers (see Table 2). In 2012, according to the most-recent Value-Based Purchasing Activities Report,[6] two managed care organizations were subject to the net negative problem. MedStar Family Choice and Amerigroup Community Care both had more disincentives than incentives and average normalized scores that were in the top four of the seven participating managed care organizations, thus qualifying them for second-round incentive payments.

Table 2. 2012 Average Normalized Score, Rank and Net Incentives

MCO	Average Normalized Score	Rank of Average Normalized Score	Number of Incentives minus Number of Disincentives
JMS	1.03	1	10
PP	0.95	2	1
MSFC	**0.94**	**3**	**-3**
ACC	**0.93**	**4**	**-2**
MPC	0.90	5	-5
UHC	0.85	6	-7
DIA	0.83	7	-10

The logic behind barring net negatives from the second round of funding is that managed care organizations that are not performing well do not deserve payments from the program. However, to the extent that a national comparison provides a clearer and more robust picture of the absolute level of service provided by a managed care organization, it is apparent that Amerigroup Community Care and MedStar Family Choice do provide a comparatively high level of service to their enrollees. On average, MedStar Family Choice and Amerigroup Community Care outscored national Medicaid HEDIS averages by 11 and 10 percentage points, respectively (see Table 1). Indeed, the targets set in the first round are not intended to define managed care organizations as discretely good or bad, but are instead supposed to set a challenging bar toward which managed care organizations should strive.

[6] https://mmcp.dhmh.maryland.gov/healthchoice/Documents/2012%20VBP%20Report_FINAL%20(1).pdf

Additionally, it is conceivable that a managed care organization could perform marginally below the disincentive target on half of the measures but perform so well on two or three other measures that overall, it could have a higher average normalized score than a managed care organization that performs just marginally above the disincentive measure on all its measures and which, therefore, would be eligible for participating in the second round of funding.[7] Though this did not exactly occur in 2012 (see Table 2 above), for example, MedStar Family Choice—which would have been barred from participating under the proposed net negatives rule—was only .01 average normalized score points behind Priority Partners, which would have received an incentive of millions of dollars in the second round. Amerigroup Community Care was only another .01 points behind MedStar Family Choice and would have also been barred.

The Department is committed to setting targets that spur continued improvement without effectively punishing those managed care organizations that still have high performance levels when compared nationally and on an overall basis against the other HealthChoice managed care organizations.

2. Using Report Card Performance to Distribute Second-Round Funds

A few managed care organizations commented that the current system focuses too narrowly on the value-based purchasing performance measures to evaluate the plans, and that using Consumer Report Cards[8] would provide a more holistic evaluation. This option would circumvent the logical disconnect pertaining to the net negatives by simply using a different standard than net incentives to evaluate managed care organizations in the second round.

While this option may be a rational workaround to the net negative problem, it is inconsistent with the goals of the value-based purchasing program. Specifically, the performance indicators used in the value-based purchasing program are chosen strategically as areas of focus for the managed care organizations due to a particular need, or because they are especially of interest to consumers or the Department. In contrast, Consumer Report Cards are informed by a broader set of measures intended for enrollee information. Given the usual size of the pool of leftover money, using Consumer Report Cards to distribute funds could diminish managed care organizations' focus on the value-

[7] Average calculations are based on normalized scores.
[8] https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/HealthChoice%20Quality%20Assurance%20Activities.aspx. Example Consumer Report Card: https://mmcp.dhmh.maryland.gov/healthchoice/Documents/Maryland%20Health%20Coice%20Consumer%20Report%20Card%202012.pdf

based purchasing performance indicators. Therefore, the Department has opted not to include this change in its value-based purchasing system.

3. Weighting Targets

The most commonly-expressed grievance over the current value-based purchasing system was that managed care organizations with smaller enrollments, smaller geographical representation, and greater control over provider and enrollee behavior had a disproportionate level of influence over the incentive and disincentive targets.

In 2012, Jai Medical Systems had 1.8 percent of the total HealthChoice enrollment and 57 percent of the influence over the level of targets. With this consideration in mind, and because the concept was so broadly supported by other HealthChoice managed care organizations, the Department proposes a new methodology for creating targets that uses managed care organization enrollment-weighted scores from previous years to determine target levels. The system for finding the midpoint of the incentive and disincentive targets will be altered from setting it halfway between the *unweighted* average and the high score from two years prior to the *weighted* average score from two years prior plus a set amount. In addition to making the target system more equitable by giving each managed care organization influence over the target levels according to enrollment, it will also help to stem the net negative problem. In the past, larger managed care organizations have been more likely to become subject to the net negative problem than smaller ones as demonstrated in the 2012 data above. By shaping the targets to more closely reflect the performance of the larger managed care organizations, those organizations will be less likely to have net negatives going into the second round, diminishing the likelihood that net negatives receive money in the second round.

4. Creating an Improvement Incentive

A few managed care organizations commented that the current methodology—which focuses exclusively on attainment—unfairly neglects the sustained improvements achieved by some historically low-performing managed care organizations. For instance, a managed care organization may have improved its scores by an average of three or four percentage points but still score below the disincentive thresholds and therefore lose money in the VBP program.

The Department supports the notion that rewarding sustained improvement on performance indicators is consistent with the goals of the value-based purchasing program, on the condition that managed care organizations with a very high level of attainment are given an equal opportunity to gain under the system. However, the Department is interested in achieving a higher level of equity at this time by weighting targets according to

enrollment. It is preferable to move forward with one change to the system at a time, allowing both the managed care organizations and the Department to better predict the outcomes of the new system and avoid the unintended incentives or consequences inherent in compounding changes. The Department is willing to consider an improvement incentive in the future, but will not move forward with one in 2015.

Department of Health and Mental Hygiene Proposal

The Department's main goal for the value-based purchasing program is to spur continued improvement without effectively punishing those managed care organizations that have high performance levels nationally but score lower against the other HealthChoice managed care organizations. For this reason and the others cited above, the Department has elected not to propose an incentive payment methodology that prevents managed care organizations with more disincentives than incentives from receiving funding in the second round. Instead, starting in calendar year 2015, the Department will focus on changing how it calculates the initial value-based purchasing target calculations to reflect both managed care organization enrollment size and performance (see Attachment 1 for detail on measures and targets).

ATTACHMENT 1

Calendar Year 2015 Value-Based Purchasing Measures and Targets

In accordance with requirements established in HB 85 (Chapter 193 of the Acts of 2005) the following table provides notification of the Calendar Year 2015 core performance measures and targets:

CY 2015 Measures and Targets

Measure	*Disincentive*	*Neutral*	*Incentive*
Adolescent Well-Care Visits	≤ 67%	68-72%	≥ 73%
Ambulatory Care Visits for SSI Adults	≤ 83%	84-86%	≥ 87%
Ambulatory Care Visits for SSI Children	≤ 82%	83-85%	≥ 86%
Adult BMI Assessment	≤ 76%	77-80%	≥ 81%
Breast Cancer Screening	≤ 58%	59-65%	≥ 66%
Childhood Immunization Status - Combination 3	≤ 78%	79-81%	≥ 82%
Comprehensive Diabetes Care- HbA1 testing	≤ 81%	82-84%	≥ 85%
Immunization for Adolescents - Combination 1	≤ 70%	71-75%	≥ 76%
Lead Screenings for Children - Ages 12–23 Months	≤ 61%	62-67%	≥ 68%
Controlling High Blood Pressure	≤ 53%	54-61%	≥ 62%
Postpartum Care	≤ 73%	74-77%	≥ 78%
Medication Management for People with Asthma – Medication Compliance 75%	≤ 30%	31-42%	≥ 43%
Well-Child Visits for Children - Ages 3–6	≤ 84%	85-87%	≥ 88%

For these measures, there will be three levels of performance. The following methodology is used to set the Incentive, Disincentive, and Neutral ranges:

1. Targets for the current performance year are based on the enrollment-weighted performance average of all managed care organizations from two years prior (the base year). The enrollment weight assigned to each managed care organization is the 12-month average enrollment of the base year.
2. The midpoint of the incentive and disincentive benchmarks of each measure is the sum of the weighted average of managed care organization performance on that measure in the base year and 15% of the difference between that number and 100%
3. The *incentive benchmark* is the sum of the midpoint and 10% of the difference between the midpoint and 100%.[9]
4. The *disincentive benchmark* is equal to the midpoint minus 10% of the difference between the midpoint and 100%.
5. If the difference between the incentive threshold and disincentive threshold is less than 4 percentage points, then the incentive and disincentive thresholds will be the midpoint +/-2

[9] Incentives and disincentives are rounded to the nearest 1/100th. (EX: .81253=81%)

percentage points. For example, if steps 1.a-1.d yield a disincentive benchmark of 90%, an incentive benchmark of 92% and a midpoint of 91%, then the actual disincentive and incentive benchmarks would be 93% and 89%, respectively.

Example of Benchmark Calculations		
Member Weighted MCO average from the base year is:	75%	X
New Mid-Point will be (Y=X+((100-X)*0.15))	78.75%	Y
Incentive will be (I=Y+((100-Y)*0.10))	81%	I
Disincentive will be (D=Y-((100-Y)*0.10))	77%	D

1. **Incentive**

On any measure for which the managed care organization's score is greater than or equal to the incentive benchmark, as determined by the Department, the managed care organization will be paid an incentive payment of up to one thirteenth of one percent of the total capitation paid to the managed care organization during the same measurement year.

2. **Disincentive**

On any measure for which the managed care organization's score is less than or equal to the disincentive benchmark, as determined by the Department, a penalty of one thirteenth of one percent of the total capitation amount paid to the managed care organization during the measurement year shall be collected. The total amount of penalties may not exceed one percent of the total capitation amount paid to the managed care organization during the same measurement year.

3. **Neutral**

On any measure for which the managed care organization's score falls within the Neutral Range, no incentive or disincentive is due.

The total amount of the incentive payments paid to the managed care organizations each year may not exceed the total amount of the penalties collected from the managed care organizations in that same year, plus any additional funds allocated to the Department for a quality initiative. Any funds remaining after the payment of the incentives due shall be distributed to the managed care organizations receiving the four highest average normalized scores in proportion to enrollment after the managed care organization with the highest average normalized score is multiplied by four, the managed care organization with the second highest average normalized score is multiplied by three, the managed care organization with the third highest average score by two and the fourth highest by one.