Medicaid Managed Care Organization

Value-Based Purchasing Activities Report

Final Report

Calendar Year 2003

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

Calendar Year 2003 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.

2003 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 2003. 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 2003 measures and their targets. More information on data sources and target rationale is included in Appendix III.

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Table 1. 2003 Value-Based Purchasing Performance Measures

Performance Measure	Data Source	2003 Target
Claims Adjudication Within 30 days of Receipt: **% of claims paid/denied by MCO within 30 days of receipt**	Claims Audit—EQRO	Neutral: 90%–100% Disincentive: <90%
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 **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	***SSI Adults*** Incentive: >86% Neutral: 72%–86% Disincentive: <72% ***SSI Children*** 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%

Performance Measure	Data Source	2003 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	Incentive: <4% Neutral: 4%–13% Disincentive: >13%
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%

* Note: Dental incentive target is a legislative mandate.

For 2003, two measures, practitioner turnover and childhood immunization status, were added for a total of ten measures. In future years, other measures may be added to the set of ten 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.

2003 Results

The 2003 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) 2003, 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
- United Healthcare Family First (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, 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	2003 Target	MCO					
		AGM	HFC	JMS	MPC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)					
Claims adjudication within 30 days	Neutral: 90%–100% Disincentive: <90%	97.2% (N)	99.3% (N)	98.3% (N)	99.0% (N)	88.7% (D)	97.2% (N)
Well-child visits for children ages 3–6	Incentive: >68% Neutral: 61%–68% Disincentive: <61%	77.3% (I)	72.5% (I)	69.8% (I)	64.8% (N)	65.2% (N)	69.8% (I)
Dental services for children ages 4–20	Incentive: >60% Neutral: 40%–60% Disincentive: <40%	44.0% (N)	38.0% (D)	29.7% (D)	39.6% (D)	44.6% (N)	45.3% (N)
Ambulatory care services for SSI adults	Incentive: >86% Neutral: 72%–86% Disincentive: <72%	76.1% (N)	79.6% (N)	80.4% (N)	77.7% (N)	80.9% (N)	78.3% (N)
Ambulatory care services for SSI children	Incentive: >77% Neutral: 63%–77% Disincentive: <63%	71.6% (N)	74.8% (N)	59.5% (D)	71.5% (N)	72.7% (N)	66.8% (N)
Timeliness of prenatal care	Incentive: >89% Neutral: 72%–89% Disincentive: <72%	91.7% (I)	96.8% (I)	82.9% (N)	82.0(%) (N)	81.5% (N)	81.0% (N)
Cervical cancer screening for women ages 21–64	Incentive: >77% Neutral: 47%–77% Disincentive: <47%	63.3% (N)	64.7% (N)	53.8% (N)	62.8% (N)	63.7% (N)	58.2% (N)
Lead screenings for children ages 12–23 months	Incentive: >53% Neutral: 41%–53% Disincentive: <41%	48.0% (N)	49.9% (N)	48.5% (N)	50.9% (N)	49.8% (N)	37.5% (D)
Eye exams for diabetics	Incentive: >64% Neutral: 42%–64% Disincentive: <42%	48.2% (N)	45.3% (N)	54.9% (N)	44.9% (N)	37.8% (D)	49.9% (N)
Practitioner turnover	Incentive: <4% Neutral: 4%–13% Disincentive: >13%	7.8% (N)	9.1% (N)	1.5% (I)	2.1% (I)	1.8% (I)	12.4% (N)
Childhood immunization status—Combo 2	Incentive: >68% Neutral: 50%–68% Disincentive: <50%	77.5% (I)	67.6% (N)	75.0% (I)	60.6% (N)	68.1% (I)	53.5% (N)

2003 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 measures except for dental. 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 2003), 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. 2003 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. 2003 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 2003 performance are shown in Table 5. Sanction amounts are shown in parenthesis.

Table 5. 2003 MCO Incentive/Sanction Amounts

Performance Measure	MCO					
	AGM	HFC	JMS	MPC	PPMCO	UHC
Claims adjudication within 30 days	$0	$0	$0	$0	($7,800)	$0
Well-child visits for children ages 3–6	$119,040	$8,550	$1,260	$0	$0	$18,900
Dental services for children ages 4–20	$0	($8,000)	($10,300)	($7,800)	$0	$0
Ambulatory care services for SSI adults	$0	$0	$0	$0	$0	$0
Ambulatory care services for SSI children	$0	$0	($1,225)	$0	$0	$0
Timeliness of prenatal care	$34,560	$14,820	$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	$0	$0	$0	$0	($18,375)
Eye exams for diabetics	$0	$0	$0	$0	($25,200)	$0
Practitioner turnover	$0	$0	$1,750	$17,290	$26,400	$0
Childhood immunization status—Combo 2	$121,600	$0	$4,900	$0	$1,200	$0
Total Incentive/Sanction Amount	$275,200	$15,370	($3,615)	$9,490	($5,400)	$525

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.

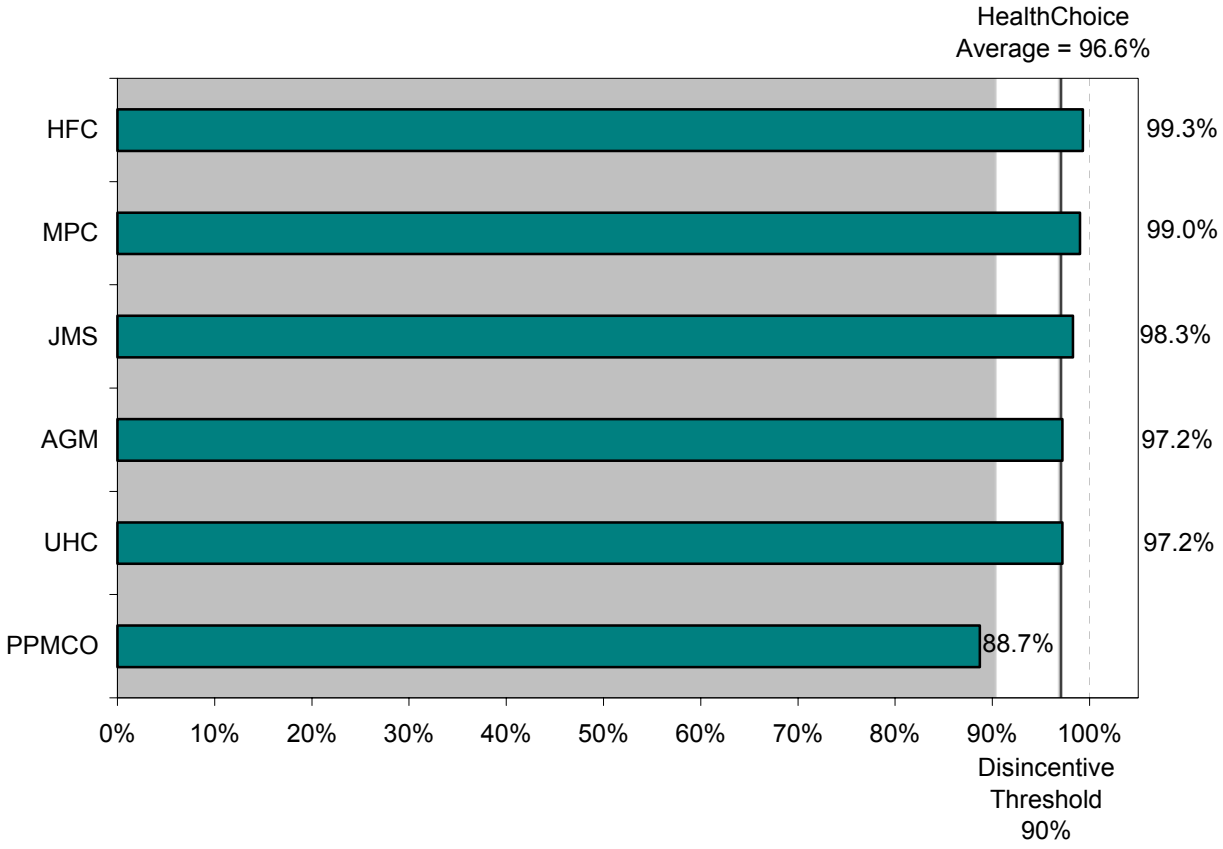
In future years, more measures may be added or measures may be rotated. This flexibility allows DHMH and participating MCOs to better meet changing health needs. If budgetary pressures continue and prevent DHMH from offering monetary incentives, DHMH will continue to explore other methods of providing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

Appendix I

MCO Performance By Individual Performance Measures

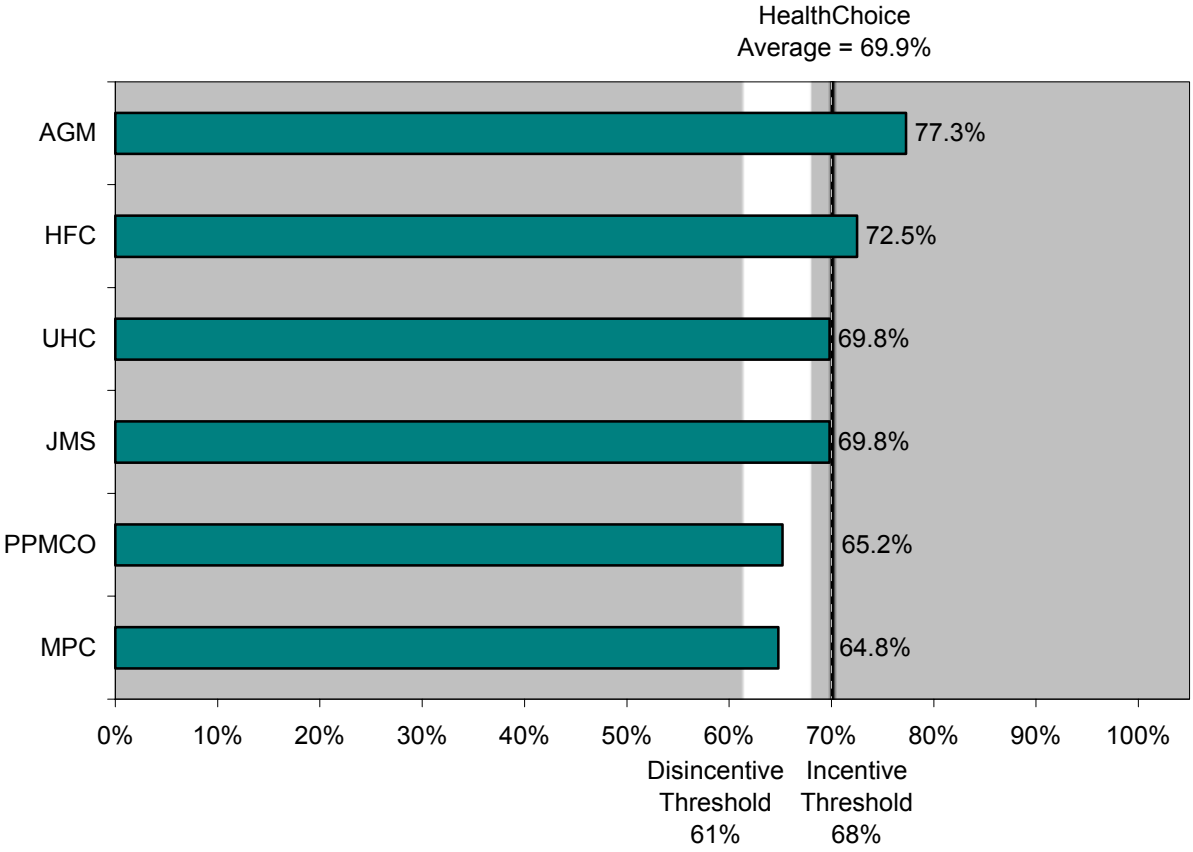
The following graphs represent the performance rates for each Value-Based Purchasing measure. Each graph presents each MCO's rate, the disincentive and incentive threshold, as well as the HealthChoice average. The HealthChoice Average is an un-weighted average of all MCO rates.

Claims Adjudication Within 30 Days of Receipt



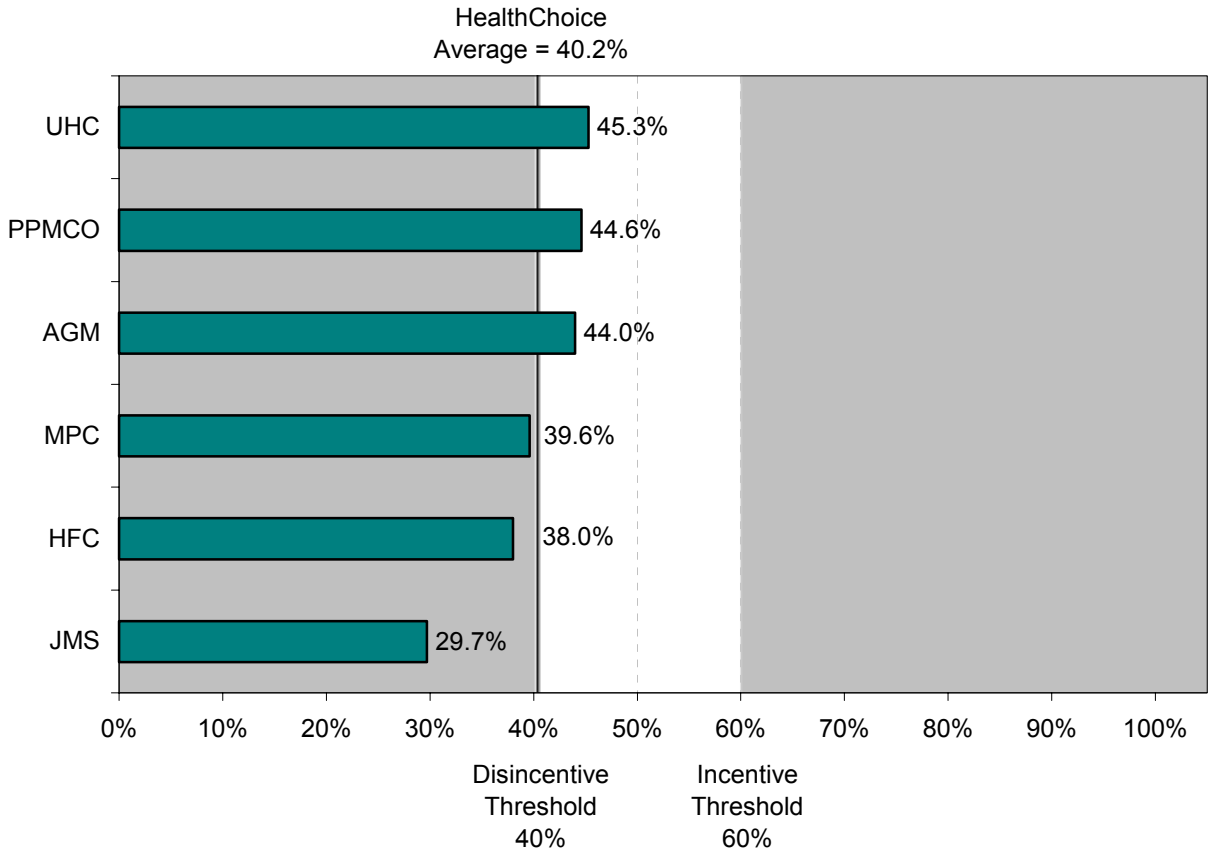
All MCOs performed above the disincentive threshold (<90%) except PPMCO with a rate of 88.7%. Performance rates for all remaining MCOs ranged from 97.2% to 99.3%. The highest performer was HFC.

Well-Child Visits for Children Ages 3 through 6



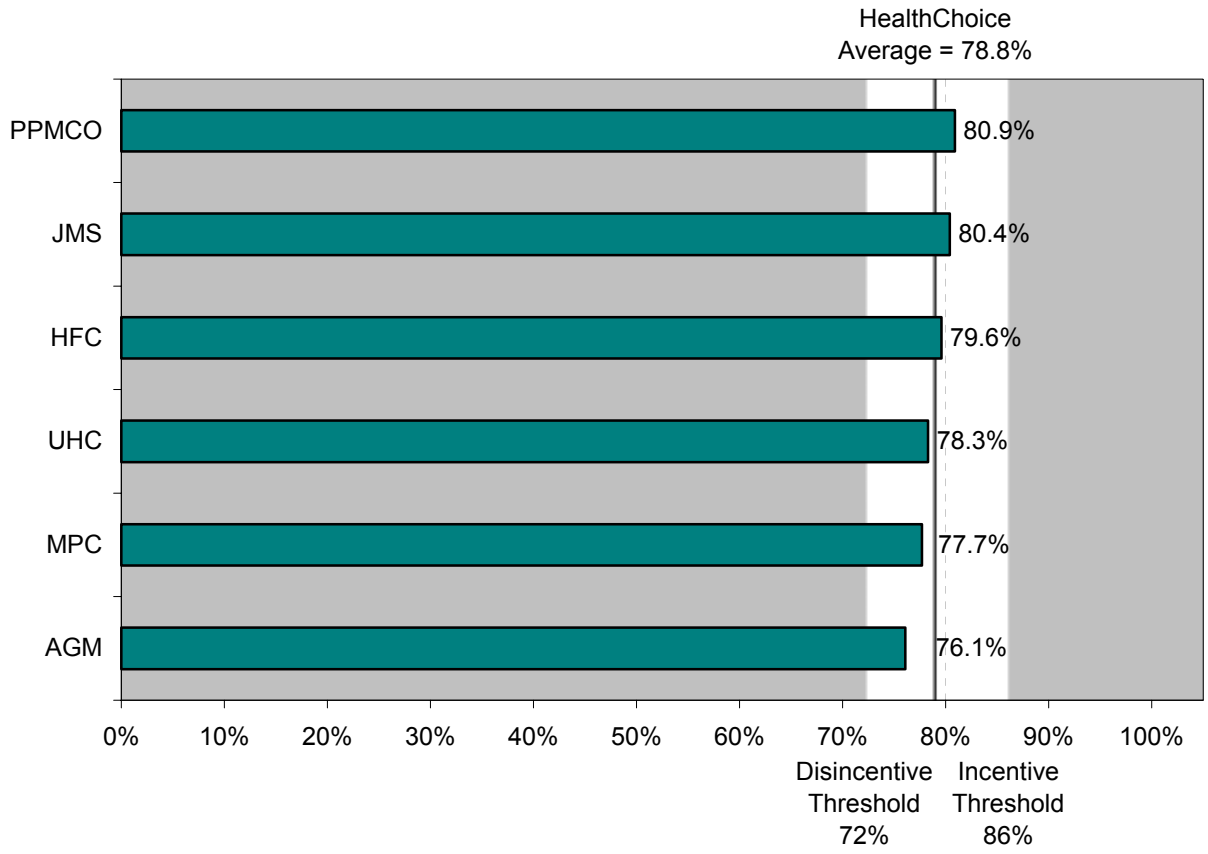
All MCOs performed above the disincentive threshold (<61%). Performance rates for all MCOs ranged from 64.8% to 77.3%. Two MCOs performed within the neutral range (61% through 68%) and four MCOs performed above the incentive target (>68%). The four MCOs that performed above the incentive benchmark are AGM, HFC, UHC, and JMS. The highest performer was AGM.

Dental Services for Children Ages 4 through 20



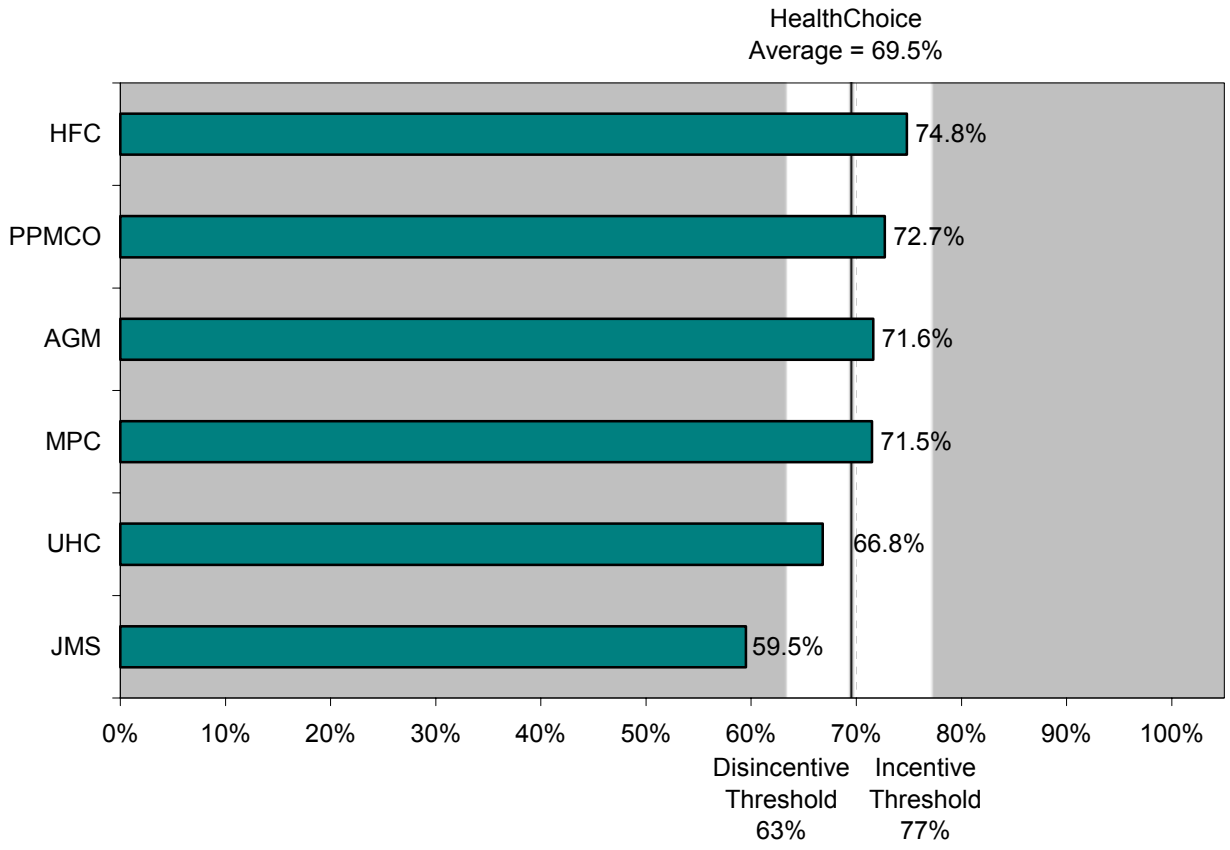
The range of scores was 29.7% to 45.3%. Three MCOs—JMS, HFC, and MPC—performed below the disincentive threshold (<40%). AGM, PPMCO, and UHC performed in the neutral range between 40% and 60%. The highest performer was UHC with a score of 45.3%.

Ambulatory Care Services for SSI Adults



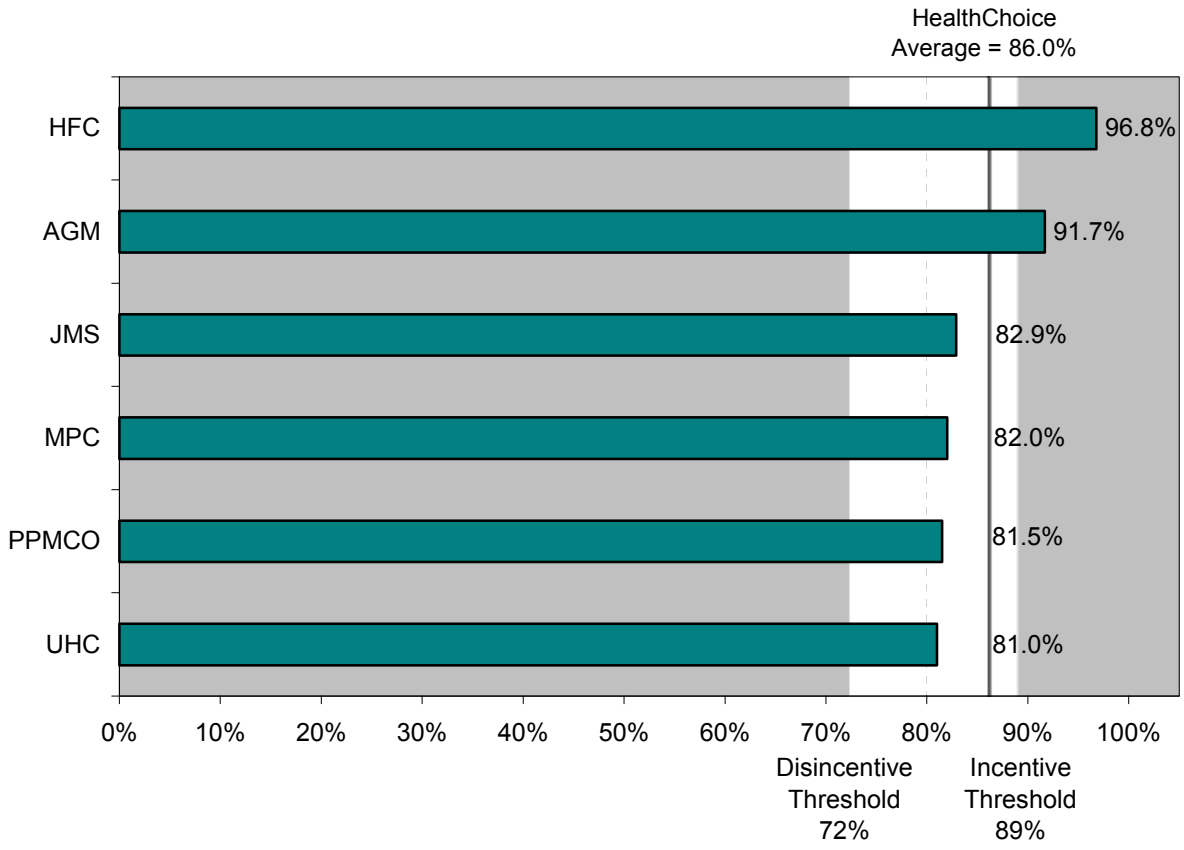
All MCOs performed above the disincentive threshold (<72%). Performance rates ranged from 76.1% to 80.9%. The highest performer was PPMCO.

Ambulatory Care Services for SSI Children



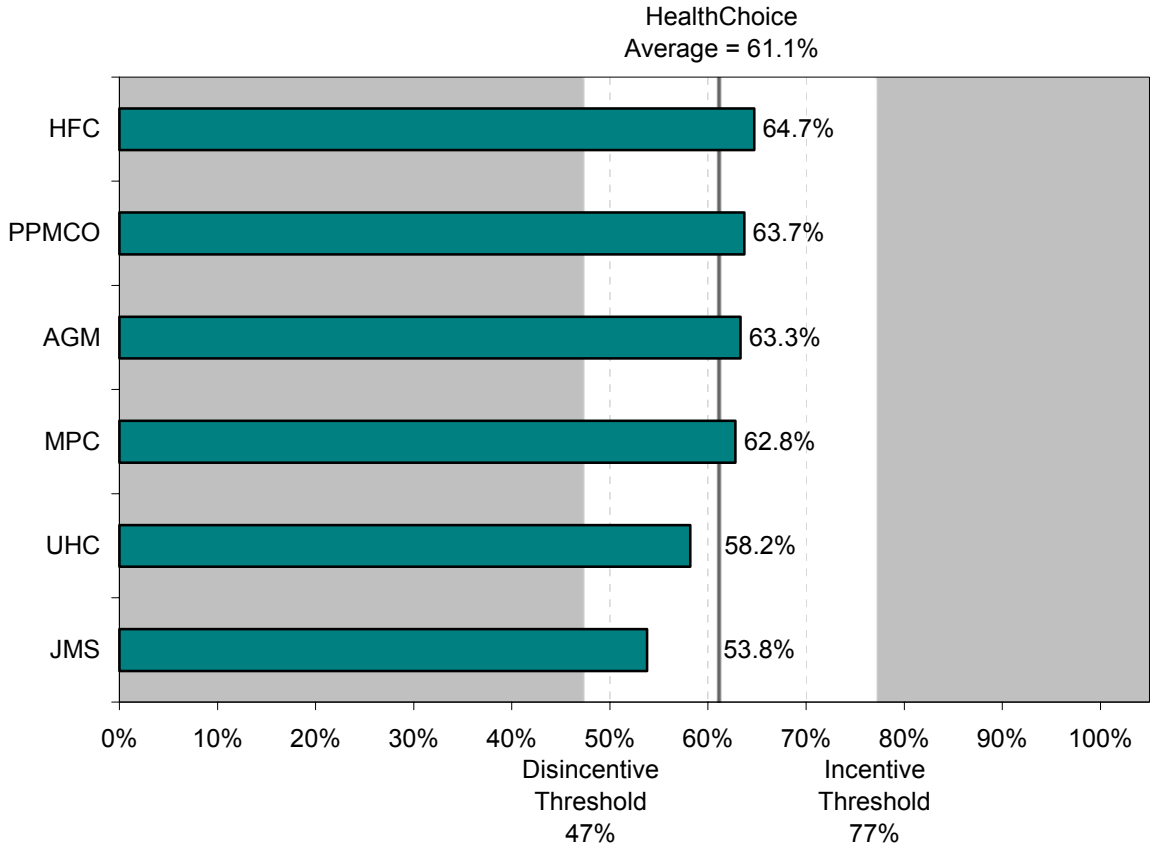
Five MCOs performed within the neutral range, with rates ranging from 66.8% to 74.8%. The highest performer was HFC. JMS performed below the disincentive threshold of 63% with a rate of 59.5%.

Timeliness of Prenatal Care



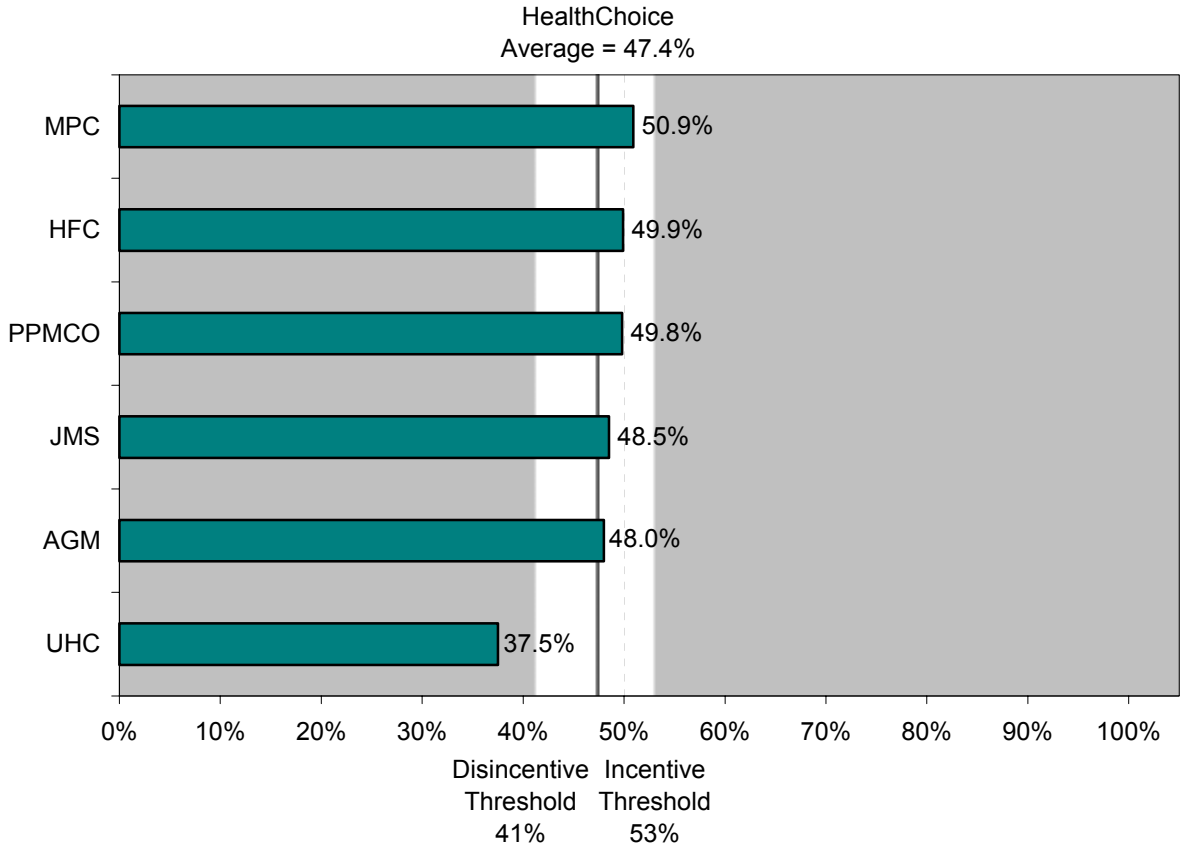
The range of scores was 81.0% to 96.8%. The highest performer was HFC. None of the MCOs scored below the disincentive threshold of 72%.

Cervical Cancer Screening for Women Ages 21–64



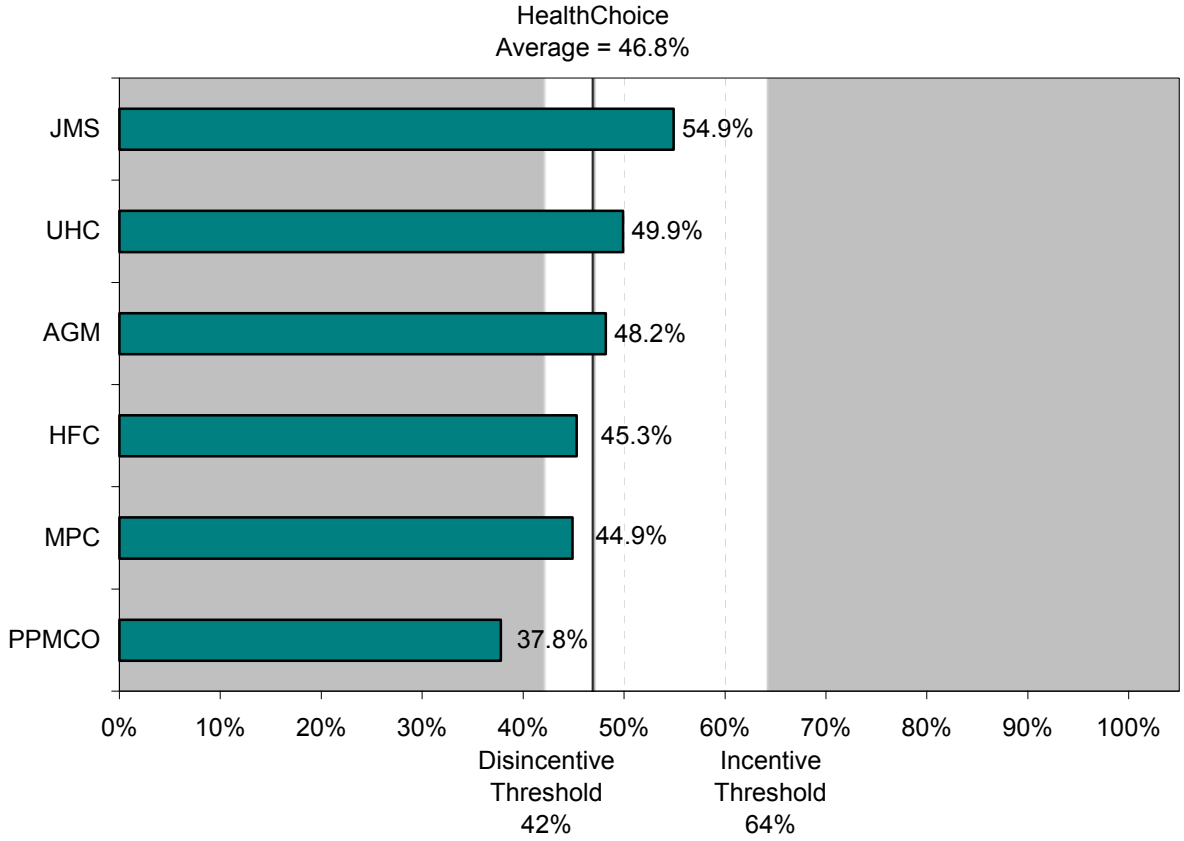
All MCOs performed within the neutral range. Rates ranged from 53.8% to 64.7%. The highest performer was HFC.

Lead Screenings for Children Ages 12–23 Months



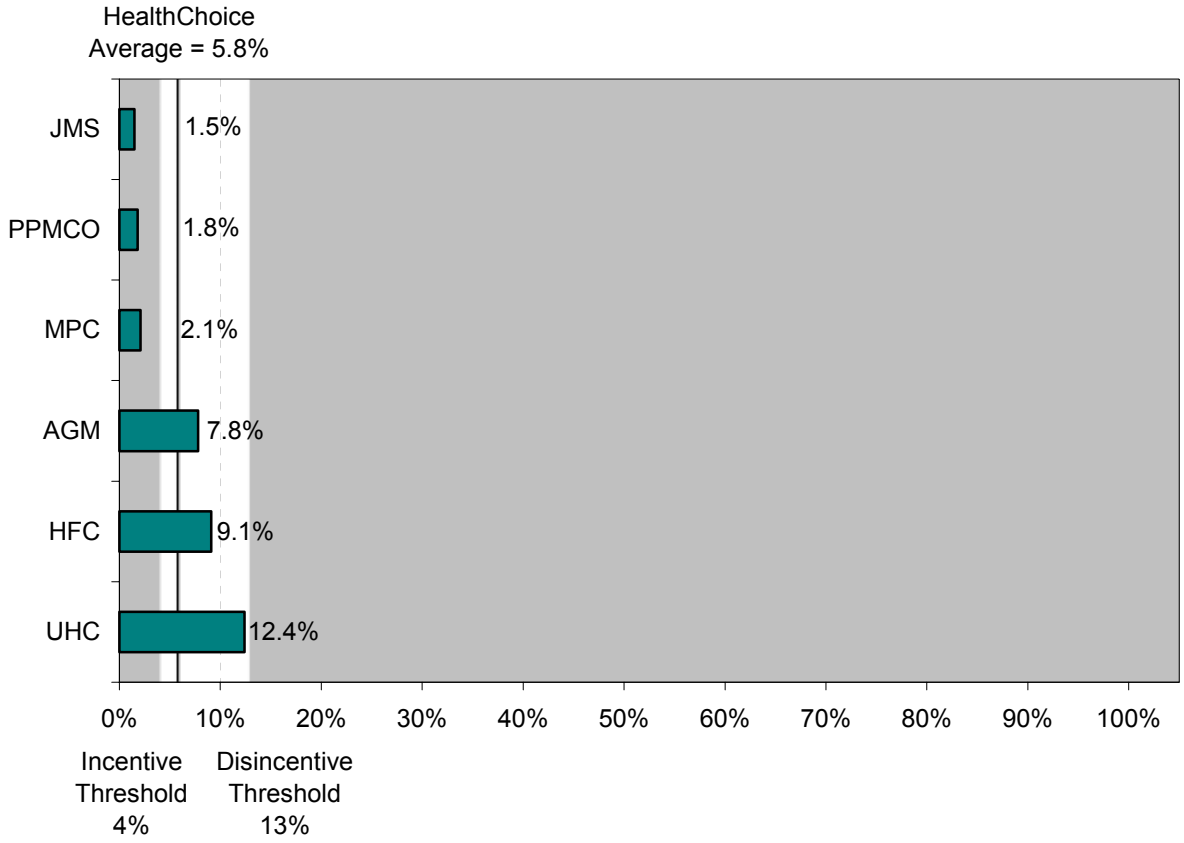
Five of the six MCOs performed above the disincentive threshold (<41%). Rates ranged from 48.0% to 50.9%. The highest performer was MPC. UHC was the only MCO to perform below the disincentive threshold with a rate of 37.5%.

Eye Exams for Diabetics



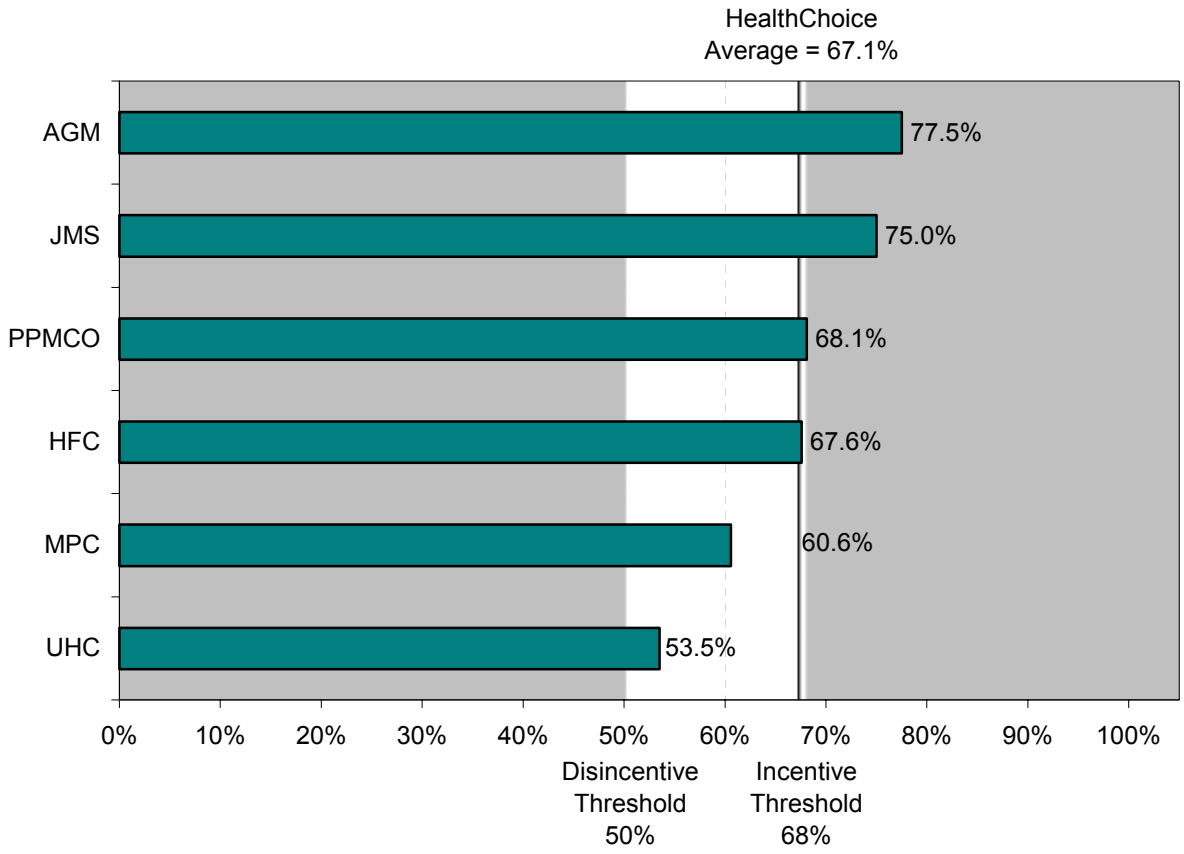
Five MCOs performed within the range of 44.9% to 54.9%. PPMCO performed below the disincentive threshold with a rate of 37.8%. The highest performer was JMS.

Practitioner Turnover



All MCOs performed favorably compared to the disincentive threshold (<13%). Performance rates for all MCOs ranged from 1.5% to 12.4%. The highest performers were JMS, PPMCO, and MPC with rates of 1.5%, 1.8%, and 2.1% respectively.

Childhood Immunization Status—Combo 2



All MCOs performed above the disincentive threshold (<50%). Performance rates for all MCOs ranged from 53.5% to 77.5%. Three MCOs performed within the range of 50% through 68%, and three MCOs performed above the incentive target (>68%). The three MCOs that performed above the incentive threshold of 68% are AGM, JMS, and PPMCO. The highest performer was AGM.

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 2003 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

Three types of measures are included in the CY 2003 VBP measures: (1) measures from NCQA's HEDIS, (2) measures based on encounter data computed by DHMH's Office of Planning and Finance, and (3) a measure based on data supplied by the HealthChoice MCOs and calculated by Delmarva. 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 2003 VBP Measures

Performance Measure	Quality Dimension	Measure Type	Reporting Entity
Claims adjudication within 30 days	Administration	Claims Audit EQRO	EQRO
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
Practitioner turnover	Administration	HEDIS	MCO
Childhood immunization status	Quality of Care	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 complaint, 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). Six of the CY 2003 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 2003, 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 participate in the HealthChoice program for the entire year. 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 six of the HEDIS audit measure determinations as VBP measure determinations. The six 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),
- Practitioner Turnover, and
- Childhood Immunization Status (Combo 2 Only).

Encounter Data Measure Validation

Three CY 2003 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 and 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 complaint 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.

EQRO-Reported Measure Validation

One CY 2003 VBP measure is calculated by the EQRO. The prompt adjudication of claims measure was calculated using data supplied by the HealthChoice MCOs and compared to information reported to the Maryland Insurance Administration (MIA) on the required Semi-annual Claims Data Filing Forms (example and instructions provided). The goal of this VBP measure is to characterize the performance of each MCO in paying claims for reimbursement within 30 days of receipt by the MCO. In addition to completing a review of the claims payment processes, policies and procedures, and systems in place at HealthChoice MCOs as part of the Annual Systems Performance Review, Delmarva analyzed the HealthChoice MCO data files for timeliness of claims adjudication between April 1 and June 30, 2003, or October 1 and December 31, 2003. The files submitted by the HealthChoice MCOs were analyzed to determine if claims were adjudicated within 30 days of receipt. The 30-day adjudication threshold is outlined in Insurance Article §15-1005 of the *Annotated Code of Maryland.*

The EQRO produced and internally validated this measure because the MIA collects the Semi-annual Claims Data Filing Forms submitted by HealthChoice MCOs, but does not validate the data reported. Semi-annual Claims Data Filing Forms submitted by commercial HMOs and their respective sub-contracted entities are reviewed by the MIA under the market conduct review phase of HMO licensing in Maryland. HealthChoice MCOs are not subject to the same reviews by MIA. DHMH determined, therefore, that an annual independent assessment conducted by the EQRO was appropriate to ensure that MCOs are accurately reporting the information included on the required report format and adjudicating claims in a timely manner.

The use of the entire population of claims adjudicated in the second or fourth quarter of CY 2003 was chosen in order to avoid several disadvantages and complexities of a sample-based system related to sampling error and confidence intervals. A result that is based on the population does not contain sampling error and the need to take a confidence interval into account. It is the true rate of occurrence in the population studied. This allowed MCOs to supply only one claim file for the period under review.

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 2003 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	Report	Report	Report	Report	Report	Report
Prenatal and Postpartum Care (prenatal care portion only)	Report	Report	Report	Report	Report	Report
Cervical Cancer Screening	Report	Report	Report	Report	Report	Report
Comprehensive Diabetes Care (eye exam portion only)	Report	Report	Report	Report	Report	Report
Practitioner Turnover	Report	Report	Report	Report	Report	Report
Childhood Immunization Status (Combo 2 only)	Report	Report	Report	Report	Report	Report

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.

Validation of the rates calculated by the EQRO 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 at the EQRO.

Delmarva requested that each MCO supply data sets of all claims adjudicated in either the second or the fourth quarter of CY 2003. Data submissions were received and a standard data verification process was employed to ensure that data values submitted were within acceptable parameters and that the number of records received was in accordance with approximately half of the number reported to the MIA on the Semi-annual Claims Data Filing Forms that included the same period. Communication with the MCOs was initiated in cases where 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 small validation sample of the paper claims and subsequent documentation generated by the claim adjudication process. Each MCO was supplied with the claim numbers for a sample of 30 claims indicated by the MCO to have been submitted to the MCO for payment in a paper (non-electronic) format. Required date stamps and EOB/Remittance Advice dates were matched to the data sets submitted by the MCOs.

Results of the data validation activities conducted are summarized in Table A-6. A notation of "met" indicates that the EQRO determined that the MCO-submitted data set was within the acceptable range. Expected ranges for the volume of claims data and the proportion of CMS 1500 and UB 92 forms were derived from MCO-submitted Semi-annual Claims Data Filing Forms and the HealthChoice MCO average (as calculated by the EQRO), respectively.

Table 6. Validity of MCO-Submitted Claims Data

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

TO: Maryland Insurance Administration **Attn: _____Unit** **525 St. Paul Place** **Baltimore, MD 21202-2272**

SEMI-ANNUAL CLAIMS DATA FILING FORM

(Check one and complete for reporting period)

_____ September 1, 20____, for claims received for the period of January 1 – June 30, of the same calendar year	**_____ March 1, 20____, for claims received for the period of July 1 – December 31 of the preceding calendar year**

(Check one for reporting period)

_____ Clean Claims data reported below is based on claims containing <u>all</u> of the essential data elements required by COMAR 31.10.11.	**_____ Clean Claims data reported below is based on claims containing <u>fewer than all</u> of the essential data elements required by COMAR 31.10.11. *(Complete Attachment A.)***

<u>Part I. Clean Claims</u> *(HCFA 1500 & UB92 only)*

A. **Total number of Clean Claims received:** _____

B. **Total number of claims denied because necessary data elements of Clean Claim not received:** _____

C. **Number of claims denied:**

(1) **Because HCFA 1500/UB 92 Form data incomplete or missing:** _____

(2) **Because attachment incomplete or missing:** _____

<u>Part II. Claims Adjudication</u> *(Applies to all claims)*

<u>All Claims</u>

A. **Total number of all claims received:** _____

B. **Number of claims paid (includes partially paid):** _____

C. **Number of claims denied payment:** _____

D. **Number of claims denied payment based on the following five most prevalent reasons:**
(Use exact denial reason code explanations or submit text on Attachment B.)

(1) _____ _____

(2) _____ _____

(3) _____ _____

(4) _____ _____

(5) _____ _____

SEMI-ANNUAL CLAIMS DATA FILING FORM

Part III. Claims Inventory *(Applies to all claims)* **All Claims**

A. Beginning inventory at start of report period: _____

B. Number of claims pending for legitimate dispute/ additional information at end of report period: _____

C. Number of claims received but not yet processed as of last day of report period: _____

D. Ending inventory at end of report period _____

Part IV. Prompt Payment *(Applies to all claims)*

(*Time frames are calculated from the date a payor receives a clean claim, or additional information pursuant to a legitimate dispute is received, to the date the claim is adjudicated.*)

Claims adjudicated in	Number	Dollar Amount Paid	Interest
A. 30 days or less	_____	_____	**N/A**
B. 31-60 days	_____	_____	_____
C. Over 60 days	_____	_____	_____
D. Total	_____	_____	_____

Part V. Payor Information

_____ _____
Payor Name **NAIC Number**

_____ _____
Delegated Agent (Yes/No) **Processing Claims on Behalf of**

_____
Payor Address (line 1)

_____
Payor Address (line 2)

_____
City/State/Zip Code

_____ _____
Payor Contact Person (Please print) **Phone Number**

_____ _____
Signature of Contact Person **Date Submitted**

Signer certifies that the information submitted on this form and its attachments is correct and accurately represents the claims filing and processing activity of the Payor for the reporting period indicated.

ATTACHMENT A

Payor Name: _____

Clean Claims data reported on the SEMI-ANNUAL CLAIMS DATA FILING FORM is based on claims containing fewer than all of the essential data elements required by COMAR 31.10.11. Following is the list of essential data elements used by our organization to define clean claims for claim processing purposes.

UB 92 Data Elements	HCFA 1500 Data Elements

ATTACHMENT B

Payor Name: _____

Following is the exact denial reason code explanation text for the five most prevalent reasons claims are denied payment by our organization as reported on the SEMI-ANNUAL CLAIMS DATA FILING FORM:

1.

2.

3.

4.

5.

INSTRUCTIONS FOR COMPLETING THE SEMI-ANNUAL CLAIMS DATA FILING FORM

Claims Data Filing

Who must file – the Claims Data Filing Form shall be completed and submitted to the Maryland Insurance Administration ("MIA") semi-annually by third-party payors of health care claims in Maryland. Third-party payors ("Payors") include insurers, HMOs, MCOs, and their delegated agents acting as Payors on their behalf.

What to file – Payors shall report information on health care claims received for processing according to Code of Maryland Regulations ("COMAR") Title 31, Subtitle 10, Chapter 11. Claims for health care benefits under a policy, contract, plan, or certificate issued or delivered in Maryland shall be reported. Claims for Medicare, Federal Employee Health Benefit Plan, and self-insured health care programs are excluded from reporting.

Also, health care claims submitted by insureds, subscribers, or members (hereinafter referred to as "members") are exempt from reporting under **Part I** of the **SEMI-ANNUAL CLAIMS DATA FILING FORM** as described below.

When to file - the completed form is due by September 1 for the claims reporting period of January 1 through June 30 of the same calendar year and by March 1 for the claims reporting period of July 1 through December 31 of the preceding calendar year.

- Although the regulation for claims data filing became effective 9/7/01, the first reporting period is for claims received by Payors from 1/1/02 through 6/30/02. The first claims filing report is due 9/1/02.
- The second claims data filing report is for claims received by Payors from 7/1/02 through 12/31/02. The second report is due 3/1/03.
- Subsequent reports follow this semi-annual schedule for data collection and submission.
- When submitting the required report, the Payor must identify the reporting period by checking and completing the appropriate claims filing report description box at the top of **page 1** of the **SEMI-ANNUAL CLAIMS DATA FILING FORM.**
- The Payor must also specify whether the data reported is based on the Clean Claims definition of COMAR 31.10.11, or whether essential data elements needed to process a claim are fewer than the list of *essential data elements* specified in COMAR 31.10.11 (applies to HCFA 1500/UB 92 only). If at any time during the reporting period, fewer data elements are used by the Payor to define a Clean Claim, the Payor must complete **Attachment A** to the **SEMI-ANNUAL CLAIMS DATA FILING FORM** and list the data elements it required to process a claim.

Part I. Clean Claims (HCFA 1500/UB 92 Only)

What are Clean Claims – Defined by COMAR 31.10.11, a Clean Claim is a health care claim (HCFA 1500/UB 92 only) submitted by a health care provider and received by a Payor that contains all of the *essential data elements* of the Uniform Claims Form and meets the uniform standards of required attachments to the Uniform Claims Form. If a received claim does not meet this definition, it is not considered to be a Clean Claim.

As stated above, Payors may report claim data based on their modified definitions of Clean Claims. **Attachment A** to the **SEMI-ANNUAL CLAIMS DATA FILING FORM** must be completed to delineate the Payor's modified definition of a Clean Claim according to their requirement of fewer data elements for processing.

The accepted Uniform Claim Forms are the HCFA 1500 and the Revenue Summary UB 92 forms or their electronic equivalents. The *essential data elements* are identified by COMAR 31.10.11.08 for HCFA 1500s and by COMAR 31.10.11.09 for UB 92s.

Claims submitted by insureds, subscribers, or members ("members"), or submitted by health care providers on forms other than the Uniform Claim Forms are exempt from reporting under **Part I** of the **SEMI-ANNUAL CLAIMS DATA FILING FORM.**

To complete **Part I**, enter the following information:

Line A. –Total number of Clean Claims received. For the claims data filing period specified, Payors must enter the total number of Clean Claims received from providers on Uniform Claim Forms (HCFA 1500/UB 92).

Line B. – Total number of claims denied because necessary data elements of Clean Claims are not received. For the claims data filing period specified, Payors must enter the total number of claims received from providers on Uniform Claim Forms and denied processing or reimbursement because *essential data elements* are missing. Essential data elements may be those required by COMAR 31.10.11.08 for HCFA 1500s and by COMAR 31.10.11.09 for UB 92s or those used by the Payor under a modified approach and listed on **Attachment A**.

Line C. – Number of claims received and denied. For the claims data filing period specified, Payors must enter the number of claims received from providers that were not processed or reimbursed because essential data was missing for the following reasons:

- **Line C. (1) – Number of claims denied because HCFA 1500/UB 92 Form data incomplete or missing**. For the claims data filing period specified, Payors must enter the total number of claims received that were denied because the *essential data elements* required by COMAR 31.10.11.08 for HCFA 1500s, by COMAR 31.10.11.09 for UB 92s, or the Payor under a modified approach, were not contained on the submitted Uniform Claim Form.
- **Line C. (2) – Number of claims denied because attachment missing or incomplete.** For the claims data filing period specified, Payors must enter the total number of claims received that were denied because the required attachment was not submitted or did not meet the uniform standards of COMAR 31.10.11.10 for required attachments to the Uniform Claim Form.

Part II. Claims Adjudication
(Applies to All Claims)

What are adjudicated claims – For the purpose of completing this form, adjudication means paying or denying a claim received by a Payor for reimbursement for health care services.

All claims received by the Payor including those submitted by insureds or members as well as those submitted by health care providers on forms other than the Uniform Claim Forms must be included in the data of this Part of the **SEMI-ANNUAL CLAIMS DATA FILING FORM.**

To complete **Part II**, enter the following information:

Line A. – Total number of claims received. For the claims data filing period specified, Payors must enter the total number of all health care claims received from providers and members.

Line B. – Number of claims paid. For the claims data filing period specified, Payors must enter the total number of all health care claims paid out of the total number of claims received (*as reported on Line A. above*). Paid claims include partially paid claims.

Line C. – Number of claims denied payment. For the claims data filing period specified, Payors must enter the total number of health care claims denied payment out of the total number of claims received (*as reported on Line A. above*). Partially denied claims should be reported on Line B above.

Line D. – Number of claims denied payment based on the five most prevalent reasons. For the claims data filing period specified, Payors must enter the total number of claims denied payment *(as reported on Line C above*) out of the total number of claims received (*as reported on Line A. above*) for the five most prevalent or frequent reasons according to the Payor's own denial categories.

The Payor must give the exact denial reason explanation for each of the five most prevalent denial reasons using the same wording as sent to the provider or member. A brief, distinctive description of each denial category in the spaces provided may be used on the **SEMI-ANNUAL CLAIMS DATA FILING FORM** provided **Attachment B** is completed and submitted showing the actual text (wording) for each denial reason cited on the report.

Part III. Claims Inventory
(All Claims)

What is a claims inventory – For the purpose of completing this form, a claims inventory is the Payor's total work-in-process comprised of pended claims and unprocessed claims received from providers or members for adjudication. *Unprocessed claims* have not yet been paid, denied, or pended.

What are pended claims – For the purpose of completing this form, a pended claim means a claim received by a Payor for reimbursement for health care services that is not a Clean Claim and for which the Payor has requested additional information from external sources to facilitate processing and complete adjudication.

To complete **Part III**, enter the following information:

Line A. – Beginning inventory. The beginning inventory is the number of *unprocessed claims* on hand as of the beginning of the reporting period.

Line B - Number of claims pended for legitimate dispute/ additional information. For the claims data filing period specified, Payors must enter the total number of health care claims that have been pended for additional information or dispute at the end of the report period.

Line C. Number of claims received but not yet processed. For the claims data filing period specified, Payors must enter the total number of claims that have been received from providers or members for adjudication but are as yet unprocessed at the end of the report period.

Line D. – Ending inventory. The ending inventory is the Payor's total work-in-process *(line B above plus line C above)* at the end of the report period. The difference between the beginning and

ending inventory numbers represents the net change (increase or decrease) in the total number of health care claims received and awaiting processing by the Payor.

Part IV. Prompt Payment
(All Claims)

How is prompt payment determined – Prompt payment of claims is determined according to §15-1005 of the Insurance Article of the Annotated Code of Maryland. Time frames are calculated from the date a Payor receives a clean claim, or additional information pursuant to a legitimate dispute is received, to the date the claim is adjudicated (paid or denied).

For the purpose of completing this form, the adjudication date is considered to be the date the payment or denial notice is issued by the Payor.

Payment categories – To complete Part IV of the form properly, claim data for the reporting period must be reported by the Payor for all paid claims:

Claims adjudication time frames – For the report period, Payors must give a breakdown of payments made according to the following time frames:

- 30 calendar days or less
- 31 to 60 calendar days
- Over 60 calendar days.

For each time frame, the Payor must enter the total number of claims adjudicated (paid or denied), the total dollar amount of benefits paid on adjudicated claims, and the total interest amount paid on delayed claims processed in excess of 30 calendar days.

Part V. Payor Information.

Payor information - Payors must complete the **SEMI-ANNUAL CLAIMS DATA FILING FORM by** providing the name, address, and contact information requested. Indicate the Payor's National Association of Insurance Commissioners ("NAIC") number identification number, if applicable.

If the Payor is a delegated Payor for another organization, it must indicate that it is a delegated entity (enter "yes") and properly identify the delegating organization for which it processes health care claims

Sign and date the completed form. Signature of the form certifies that the information given is correct and accurately represents the Payor's claims processing activity for the reporting period.

Send the completed form to the address noted at the top of **page 1** of the **SEMI-ANNUAL CLAIMS DATA FILING FORM**.

Don't forget to complete and submit **Attachments A and B** with the completed **SEMI-ANNUAL CLAIMS DATA FILING FORM**, when appropriate.

Questions
Questions may be addressed to the Maryland Insurance Administration, Life and Health Section, 525 St. Paul Place, Baltimore, Maryland 21202-2272. Or, call the Maryland Insurance Administration at 410.468.2000.