Medicaid Managed Care Organization

Value-Based Purchasing Activities Report

Final Report

Calendar Year 2008

Submitted by:
Delmarva Foundation
January 2010

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

Calendar Year 2008 Value-Based Purchasing Report

Introduction

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

The protocol most relevant to VBP is entitled "Validating Performance Measures". The purpose of this protocol is to specify the activities to be undertaken by an EQRO in order to evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, a Managed Care Organization (MCO). Additionally, it determines the extent to which Medicaid-specific performance measures calculated by an MCO (or entity acting on behalf on an MCO) followed specifications for the calculation of performance measures. The protocol was developed using the National Committee for Quality Assurance (NCQA), Island Peer Review Organization (IPRO), and MedStat protocols and tools for auditing performance measures. The activities outlined in the protocol include a review of the data management processes of the entity that produced the measure, an evaluation of algorithmic compliance with specifications defined by the state, and verification of either the entire set or a sample of the state-specified performance measures to confirm that the reported results are based on accurate source information. 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, Maryland's Department of Health and Mental Hygiene (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 CMS' protocols in validating VBP measure results.

Delmarva and HealthcareData Company, LLC (HDC) validated the Calendar Year (CY) 2008 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*.

Value-Based Purchasing Measure Validation

Data Sources

Several sources of measures (Table 1) are included in the CY 2008 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 1. CY 2008 VBP Measures

Performance Measure	Quality Dimension	Measure	Reporting Entity
Well-child visits for children ages 3–6	Use of Services	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	Effectiveness of Care	HEDIS	MCO
Lead screenings for children ages 12–23 months	Effectiveness of Care	Encounter , Lead Registry, & Fee For Service Data	DHMH
Eye exams for diabetics ages 18-75	Effectiveness of Care	HEDIS	MCO
Childhood immunization status (Combo 2 only)	Effectiveness of Care	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). Five of the CY 2008 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 2008, 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 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 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 five of the HEDIS audit measure determinations as VBP measure determinations. The five HEDIS measures in the VBP program are:

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Prenatal and Postpartum Care (timeliness of prenatal care indicator only)
- Cervical Cancer Screening
- Comprehensive Diabetes Care (eye exam indicator only)
- Childhood Immunization Status (Combo 2 only)

EQRO's Data Measure Validation

Four CY 2008 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:

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

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 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 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. Table 4 indicates the audit designations for the CY 2008 VBP measurement data for each HealthChoice MCO (Designations are explained in Table 2).

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

Table 4. HEDIS VBP Measure Audit Determinations

Measure	MCO						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Report	Report	Report	Report	Report	Report	Report
Prenatal and Postpartum Care (timeliness of prenatal care indicator only)	Report	Report	Report	Report	Report	Report	Report
Cervical Cancer Screening	Report	Report	Report	Report	Report	Report	Report
Comprehensive Diabetes Care (eye exam indicator only)	Report	Report	Report	Report	Report	Report	Report
Childhood Immunization Status (Combo 2 only)	Report	Report	Report	Report	Report	Report	Report

Table 5 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 5. EQRO 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

Calendar Year 2008 Value-Based Purchasing Activities

DHMH's VBP strategy has been to contract with MCOs that provide high quality and value for the care and services rendered to its enrollees. The concept of VBP is that providers of health care should be held accountable for both the cost and the quality of services provided. In its broadest terms, VBP can be defined as:

VALUE = QUALITY ÷ COST

The Agency for Healthcare Research and Quality (AHRQ) defines VBP similarly, and suggests that any VBP strategy must align several key elements to be successful. These elements include:

- **Contracts** that spell out the responsibilities of health care purchasers and suppliers.
- **Information** that supports the management of purchasing activities.
- **Quality management** that drives continuous improvements in the process of health care purchasing and the delivery of health care services.
- **Incentives** that encourage and reward desired practices by providers and consumers.
- **Education** that helps enrollees become better health care consumers.

2008 Performance Measures

DHMH solicits input from various stakeholders including MCOs, the Medicaid Advisory Committee, the Hilltop Institute, and identified legislative priorities in selecting 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:

- **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, and therefore are not included as a value-based purchasing measure.

DHMH selects measures that are (1) relevant to the core populations served by HealthChoice, including children, pregnant women, special needs children, disabled adults, and adults with chronic conditions; (2) relevant to the State of Maryland's priority areas for improvement, such as dental services and lead screening; (3) prevention oriented and associated with improved health outcomes; (4) measurable with available data; (5) comparable to national performance measures for benchmarking; (6) consistent with the way in which the Centers for Medicare & Medicaid Services (CMS) are developing a national set of performance measures for Medicaid MCOs; and (7) possible for MCOs to affect change.

Table 6 shows the CY 2008 VBP measures and their targets.

Table 6. 2008 Value-Based Purchasing Performance Measures

Performance Measure	Data Source	2008 Target
Well-Child Visits for Children Ages 3 – 6 Years: % of children ages 3–6 (enrolled 320 or more days) receiving at least one well-child visit during the year, consistent with American Academy of Pediatrics and EPSDT recommended number of visits	HEDIS	Incentive: >87% Neutral: 73%–87% Disincentive: <73%
Dental Services for Children Ages 4 – 20 Years: % of children ages 4–20 (enrolled 320 or more days) receiving at least one dental service during the year	Encounter Data	Incentive: >50% Neutral: 47%–50% Disincentive: <47%
Ambulatory Care Services for SSI Adults Ages 21 – 64 Years: % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the year	Encounter Data	Incentive: >86% Neutral: 80%–86% Disincentive: <80%
Ambulatory Care Services for SSI Children Ages 0 – 20 Years: % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the year	Encounter Data	Incentive: >76% Neutral: 71%–76% Disincentive: <71%
Timeliness of Prenatal Care: % of pregnant women (enrolled 43 days prior to delivery through 56 days after delivery) who receive a prenatal visit during the first trimester or within 42 days of enrollment	HEDIS	Incentive: >97% Neutral: 86%–97% Disincentive: <86%
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: >73% Neutral: 66%–73% Disincentive: <66%
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	Encounter, Lead Registry, and Fee for Service Data	Incentive: >58% Neutral: 50%–58% Disincentive: <50%
Eye Exams for Diabetics: % of diabetics ages 18-75 (continuously enrolled during reporting year) receiving a retinal or dilated eye exam during the year, consistent with American Diabetes Association recommendations	HEDIS	Incentive: >79% Neutral: 65%–79% Disincentive: <65%
Childhood Immunization Status (Combo 2): % 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, 2 H influenza type B, 3 hepatitis B, and 1 chicken pox vaccine (VZV) by the time period specified and by the child's second birthday (Combo 2)	HEDIS	Incentive: >91% Neutral: 82%–91% Disincentive: <82%

2008 Value-Based Purchasing Results

The CY 2008 performance results presented in Table 7 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 avoided bias, allowing the results to be used for public reporting and the VBP program. In CY 2008, there were seven HealthChoice MCOs:

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

Table 7. MCO CY 2008 VBP Performance Summary

Performance Measure	CY 2008 Target	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)						
Well-Child Visits for Children Ages 3–6	Incentive: >87% Neutral: 73%–87% Disincentive: <73%	74% (N)	70% (D)	90% (I)	73% (N)	79% (N)	75% (N)	75% (N)
Dental Services for Children Ages 4–20	Incentive: >50% Neutral: 47%–50% Disincentive: <47%	54% (I)	45% (D)	59% (I)	58% (I)	57% (I)	57% (I)	54% (I)
Ambulatory Care Services for SSI Adults	Incentive: >86% Neutral: 80%–86% Disincentive: <80%	76% (D)	74% (D)	84% (N)	81% (N)	83% (N)	82% (N)	79% (D)
Ambulatory Care Services for SSI Children	Incentive: >76% Neutral: 71%–76% Disincentive: <71%	70% (D)	66% (D)	80% (I)	74% (N)	74% (N)	73% (N)	69% (D)
Timeliness of Prenatal Care	Incentive: >97% Neutral: 86%–97% Disincentive: <86%	91% (N)	87% (N)	88% (N)	87% (N)	87% (N)	91% (N)	90% (N)
Cervical Cancer Screening for Women Ages 21–64	Incentive: >73% Neutral: 66%–73% Disincentive: <66%	68% (N)	63% (D)	78% (I)	66% (N)	66% (N)	63% (D)	66% (N)
Lead Screenings for Children Ages 12–23 Months	Incentive: >58% Neutral: 50%–58% Disincentive: <50%	57% (N)	45% (D)	67% (I)	55% (N)	52% (N)	57% (N)	52% (N)
Eye Exams for Diabetics Ages 18-75	Incentive: >79% Neutral: 65%–79% Disincentive: <65%	50% (D)	52% (D)	77% (N)	66% (N)	72% (N)	55% (D)	66% (N)
Childhood Immunization Status—Combo 2	Incentive: >91% Neutral: 82%–91% Disincentive: <82%	82% (N)	73% (D)	87% (N)	75% (D)	89% (N)	82% (N)	85% (N)

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2008 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 is above the incentive target for a measure. Conversely, disincentives are levied when performance is 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 1/9 of 1/2 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO exceeds the incentive target, the MCO shall be paid an incentive payment of up to 1/9 of 1/2 percent of the total capitation amount paid to the MCO during the measurement year. The amounts are calculated for each measure and the total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year. MCOs' CY 2008 performance is shown in Table 8.

Table 8. MCO CY 2008 VBP Incentive/Disincentive Amounts

Performance Measure	MCO						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Well-Child Visits for Children Ages 3–6	$0	($15,341.32)	$31,150.66	$0	$0	$0	$0
Dental Services for Children Ages 4–20	$318,834.43	($15,341.32)	$31,150.66	$202,393.52	$48,025.41	$267,825.24	$201,689.32
Ambulatory Care Services for SSI Adults	($318,834.43)	($15,341.32)	$0	$0	$0	$0	($201,689.32)
Ambulatory Care Services for SSI Children	($318,834.43)	($15,341.32)	$31,150.66	$0	$0	$0	($201,689.32)
Timeliness of Prenatal Care	$0	$0	$0	$0	$0	$0	$0
Cervical Cancer Screening for Women Ages 21–64	$0	($15,341.32)	$31,150.66	$0	$0	($267,825.24)	$0
Lead Screenings for Children Ages 12–23 Months	$0	($15,341.32)	$31,150.66	$0	$0	$0	$0
Eye Exams for Diabetics Ages 18-75	($318,834.43)	($15,341.32)	$0	$0	$0	($267,825.24)	$0
Childhood Immunization Status—Combo 2	$0	($15,341.32)	$0	($202,393.52)	$0	$0	$0
Total Incentive/ Disincentive Amount	($637,668.86)	($122,730.56)	$155,753.30	$0	$48,025.41	($267,825.24)	($201,689.32)

Conclusion

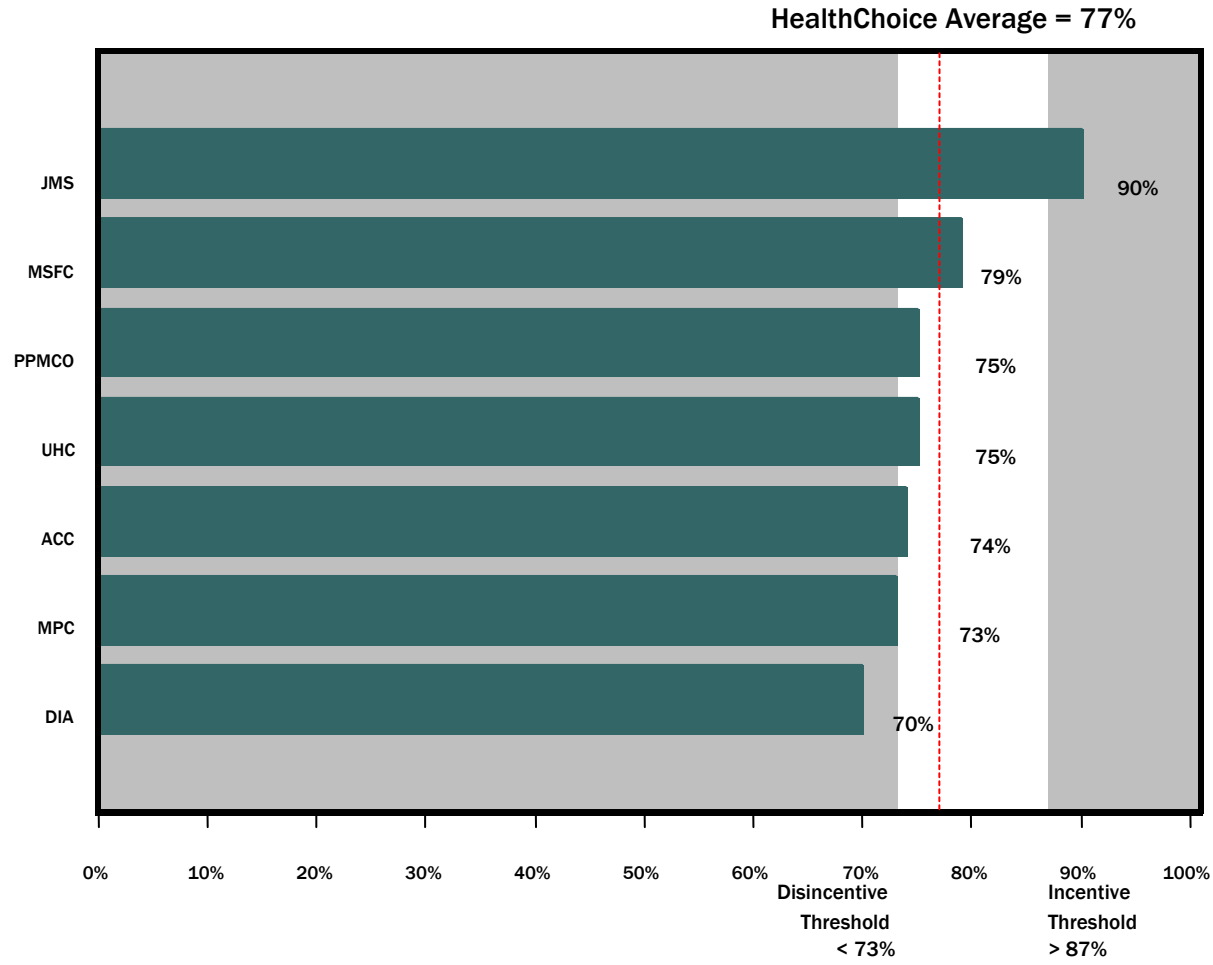
The HealthChoice Value-Based Purchasing quality strategy has multiple strengths. It emphasizes continuous quality improvement and evidence-based medicine, making it consistent with trends in the larger health care market. The strategy increases the comparability of Maryland's performance to that of other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

In future years, measures may be added, removed, or rotated. This flexibility allows DHMH to incentivize priority health services and access. 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

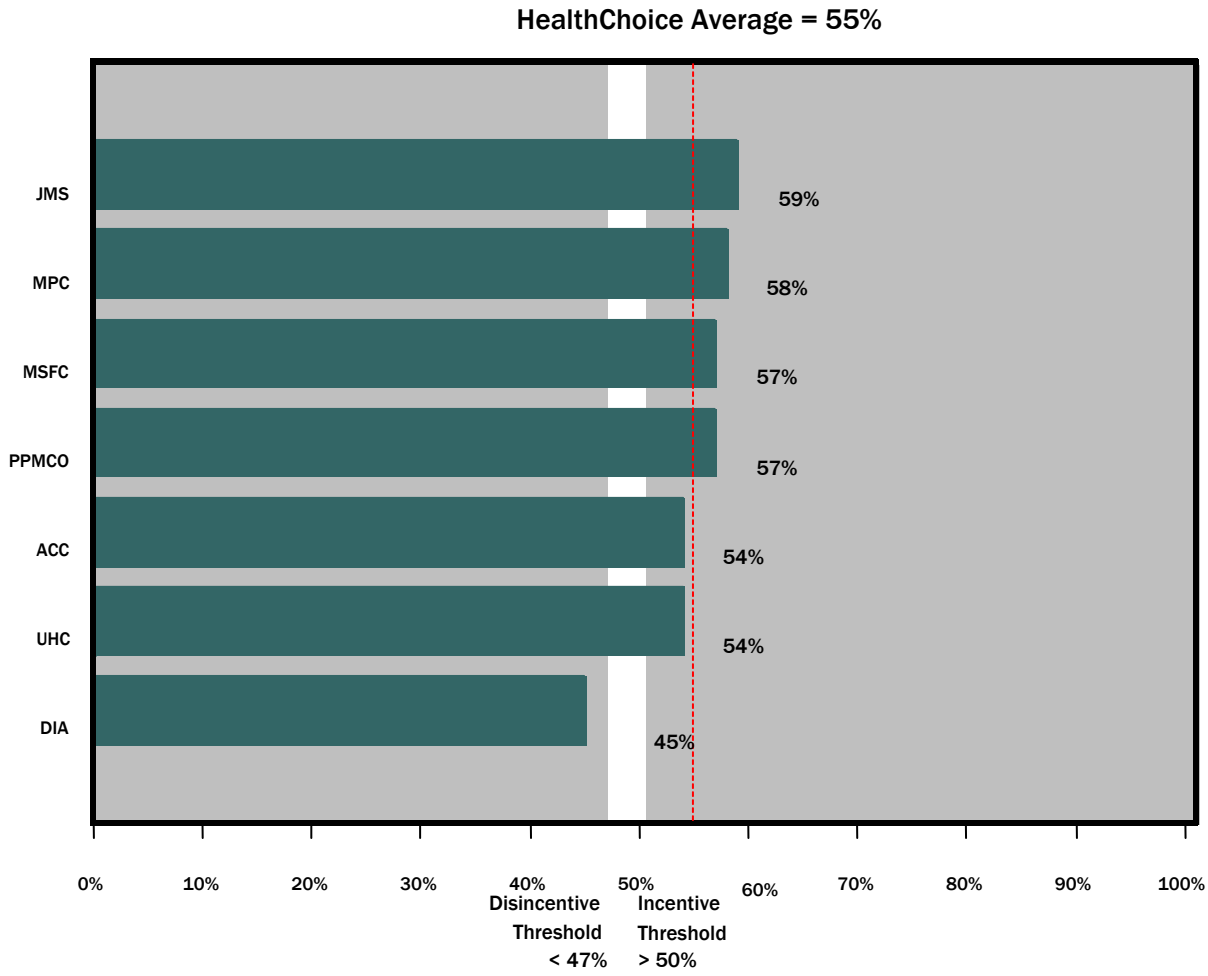
The following graphs represent the performance rates for each VBP measure. Each graph presents each MCO's performance, the disincentive and incentive threshold, and the HealthChoice average. The HealthChoice Average is an unweighted average of all MCO rates.

Well-Child Visits for Children Ages 3 through 6



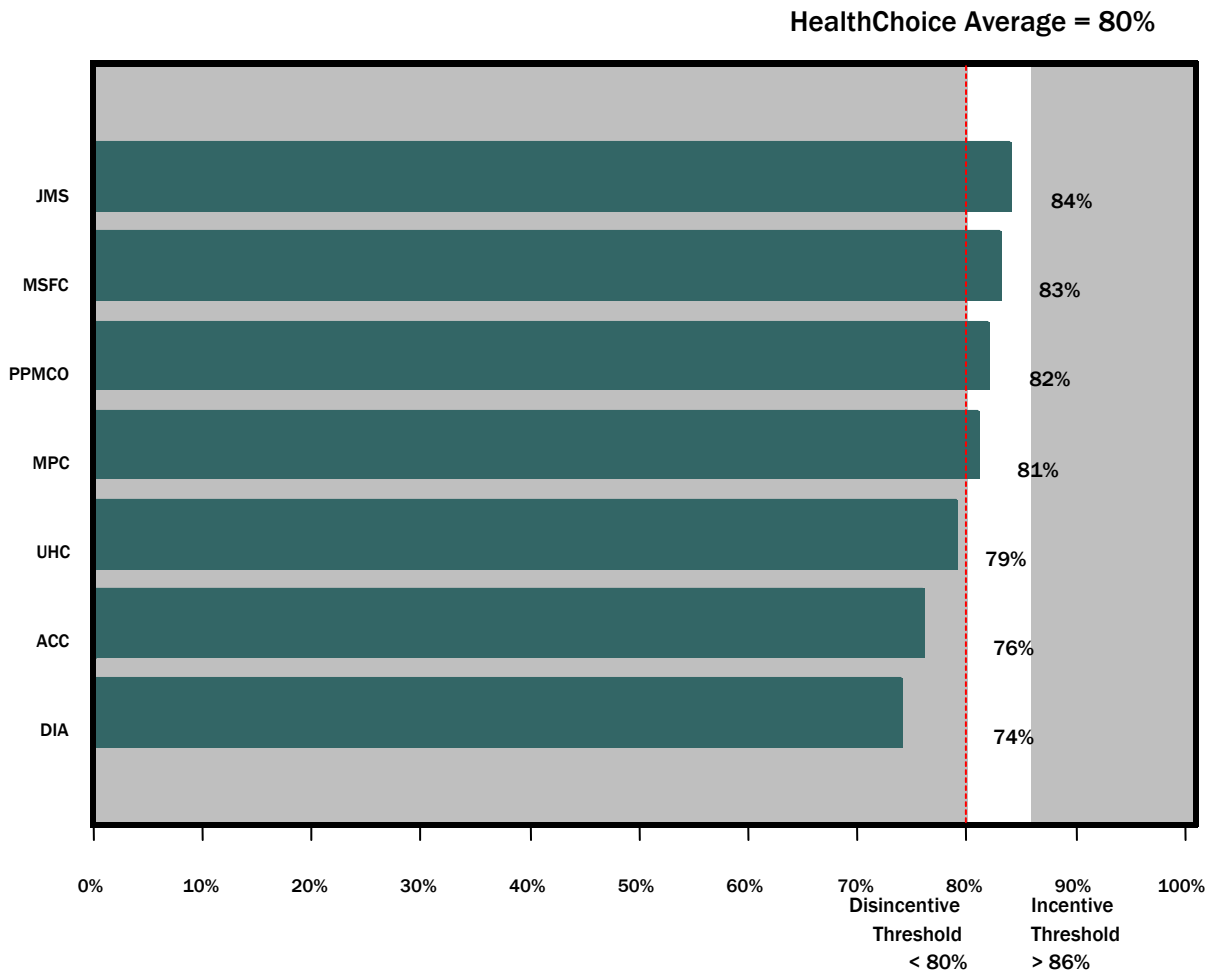
MCO performance scores range from 70% to 90% with the highest performer being JMS. One MCO, JMS scored above the incentive threshold of > 87%. Five MCOs, MSFC, PPMCO, UHC, ACC, and MPC performed within the neutral range (73% through 87%). DIA performed below the minimum target of 73%. The HealthChoice average was 77% which was within the neutral range.

Dental Services for Children Ages 4 through 20



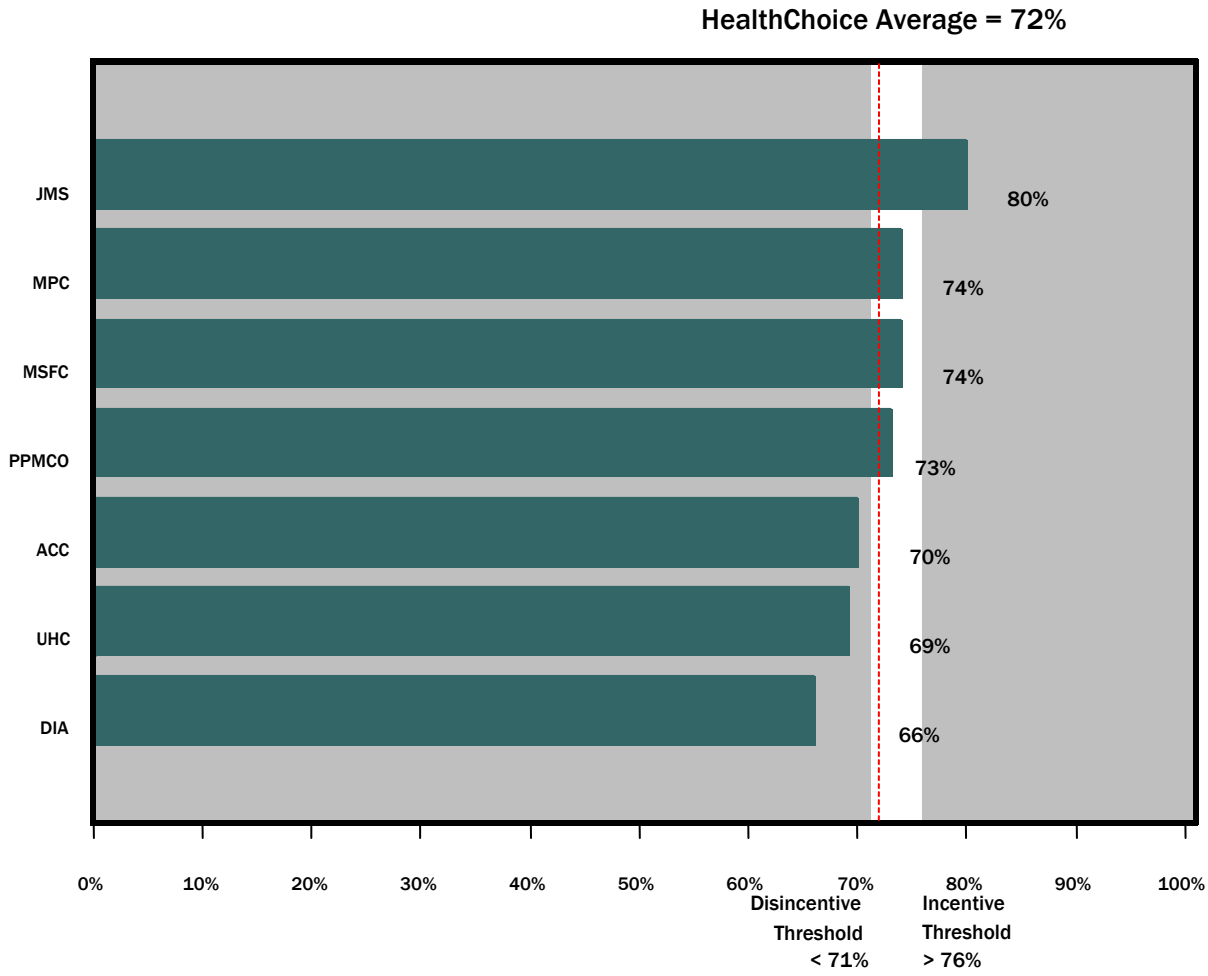
MCO performance scores range from 45% to 59% with the highest performer being JMS. Six MCOs, JMS, MPC, MSFC, PPMCO, ACC, and UHC performed above the incentive threshold of >50%. DIA performed below the minimum target of 47%. The HealthChoice average was 55% which was above the incentive threshold.

Ambulatory Care Services for SSI Adults



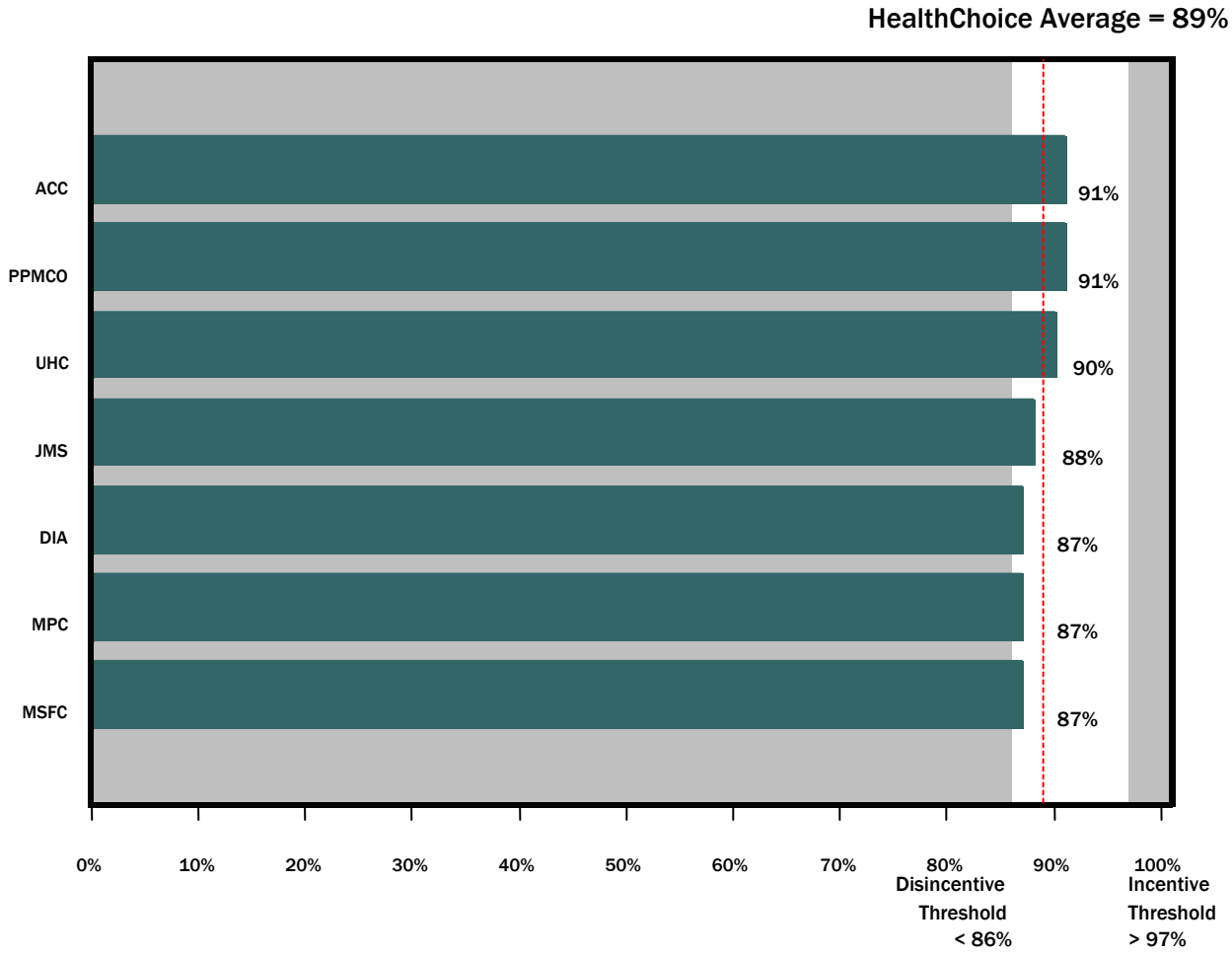
MCO performance scores range from 74% to 84% with the highest performer being JMS. Four MCOs, JMS, MSFC, PPMCO, and MPC performed within the neutral range (80% through 86%). Three MCOs, DIA, ACC, and UHC performed below the minimum target of 80%. The HealthChoice average was 80% which was within the neutral range.

Ambulatory Care Services for SSI Children



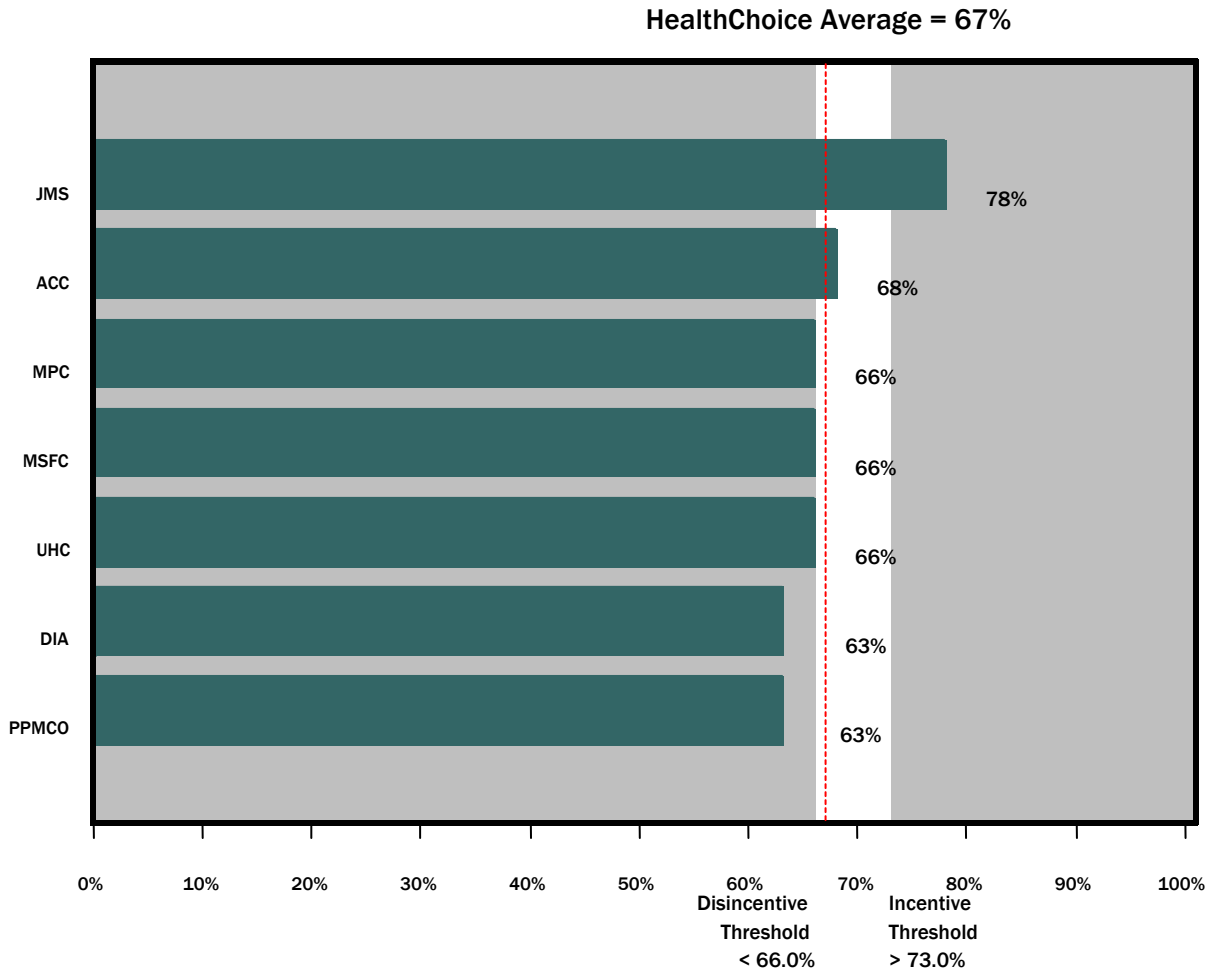
MCO performance scores range from 66% to 80% with the highest performer being JMS. One MCO, JMS scored above the incentive threshold of > 76%. Three MCOs, MPC, MSFC, and PPMCO performed within the neutral range (71% through 76%). Three MCOs, DIA, UHC, and ACC performed below the minimum target of 71%. The HealthChoice average was 72% which was within the neutral range.

Timeliness of Prenatal Care



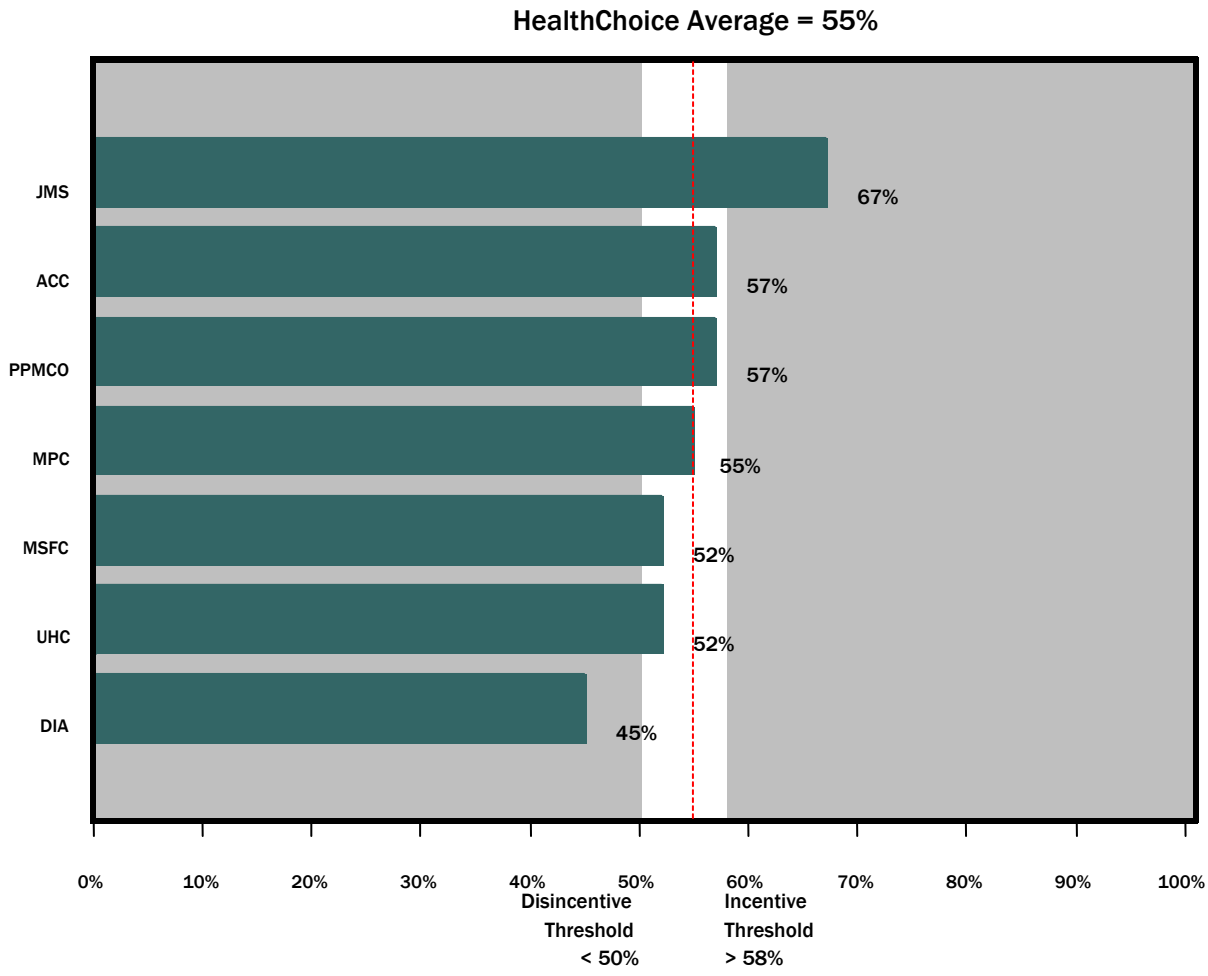
MCO performance scores range from 87% to 91% with the highest performer being ACC. All seven MCOs performed within the neutral range (86% through 97%). The HealthChoice average was 89% which was within the neutral range.

Cervical Cancer Screening for Women Ages 21–64



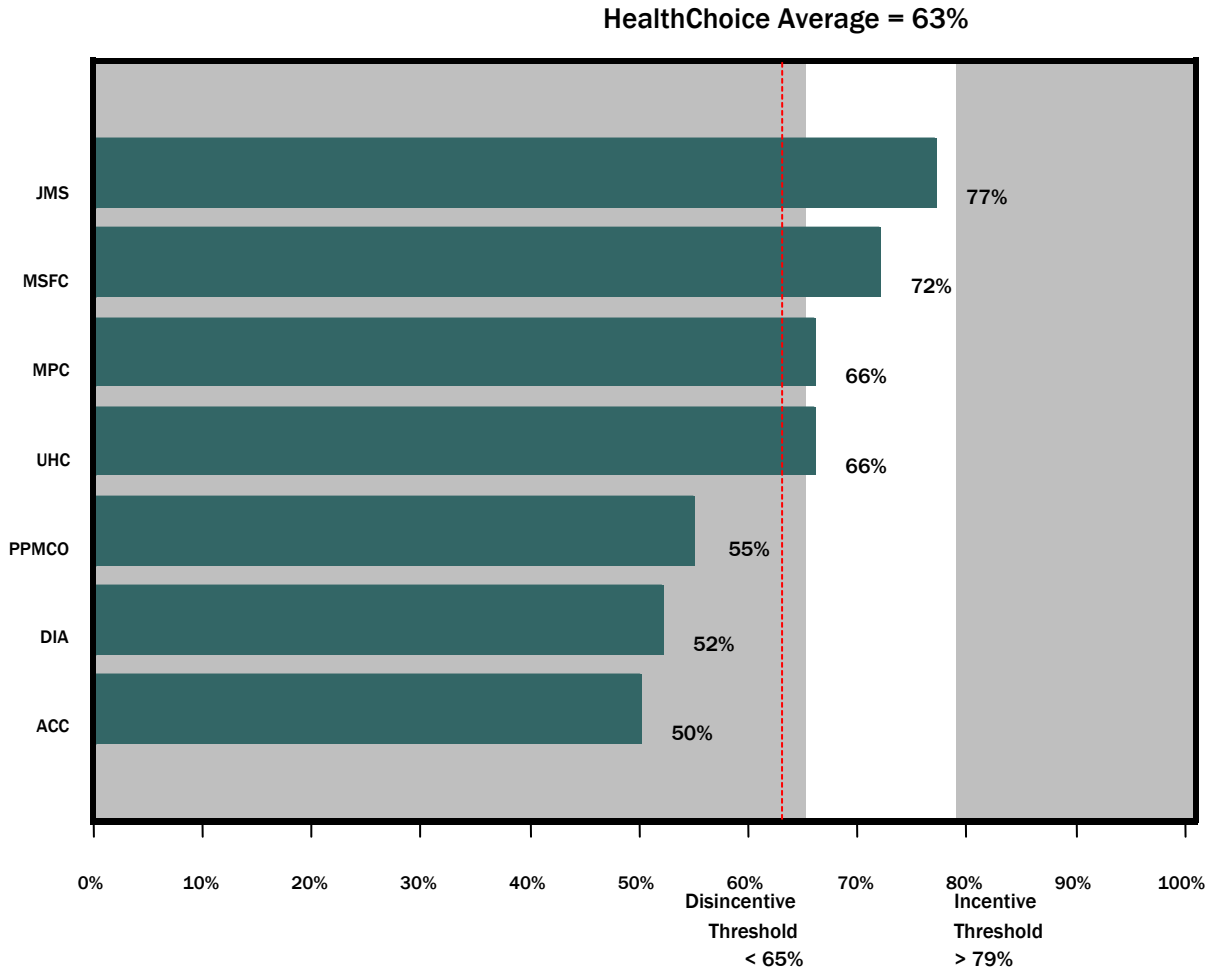
MCO performance scores range from 63% to 78% with the highest performer being JMS. One MCO, JMS performed above the incentive threshold of >73%. Four MCOs, ACC, MPC, MSFC, and UHC performed within the neutral range (66% through 73%). Two MCOs, DIA and PPMCO performed below the minimum target of 66%. The HealthChoice average was 67% which was within the neutral range.

Lead Screenings for Children Ages 12–23 Months



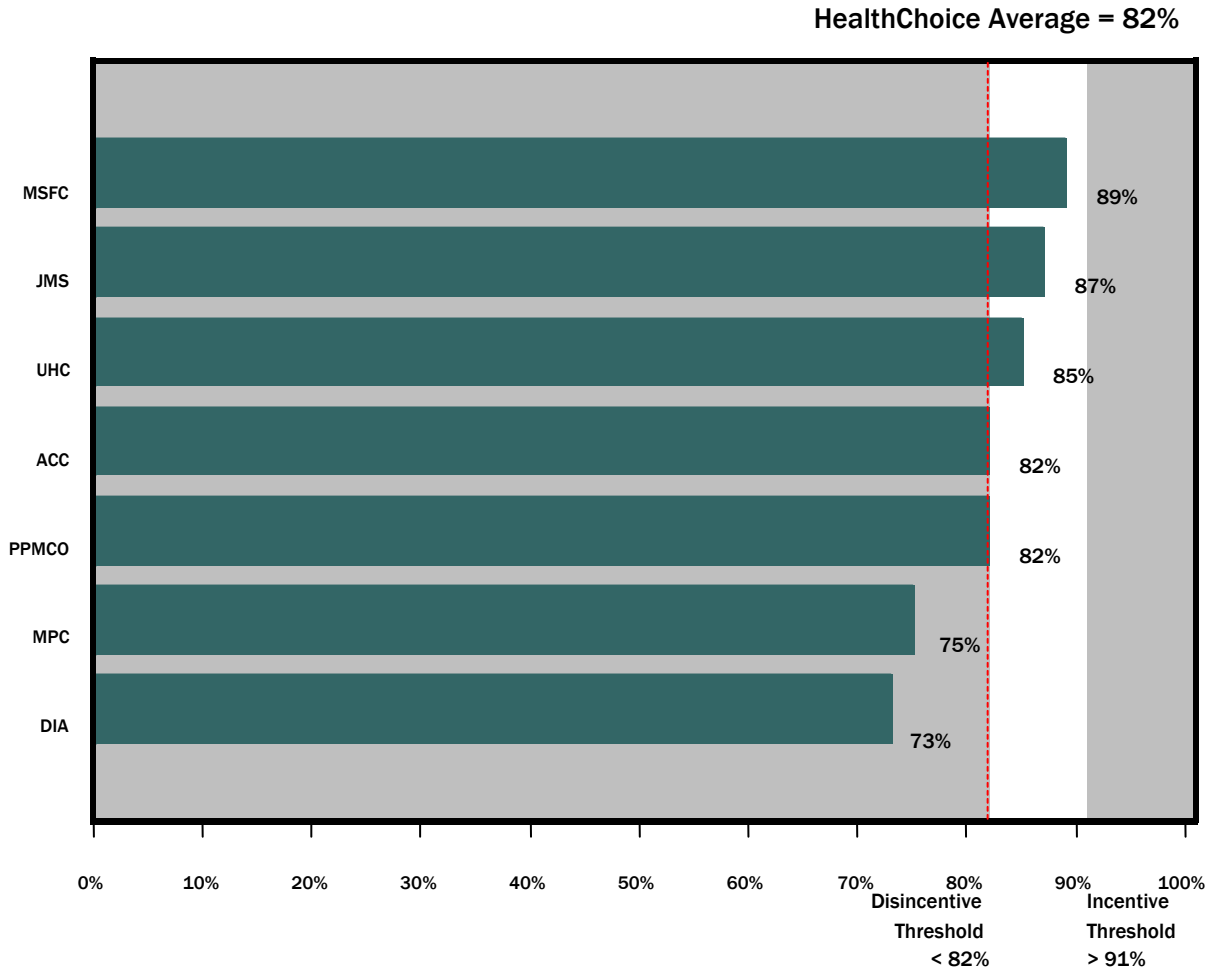
MCO performance scores range from 45% to 67% with the highest performer being JMS. One MCO, JMS performed above the incentive threshold of >58%. Five MCOs, ACC, PPMCO, MPC, MSFC, and UHC performed within the neutral range (50% through 58%). One MCO, DIA performed below the minimum target of 50%. The HealthChoice average was 55% which was within the neutral range.

Eye Exams for Diabetics Ages 18-75



MCO performance scores range from 50% to 77% with the highest performer being JMS. Four MCOs, JMS, MSFC, MPC, and UHC performed within the neutral range (65% through 79%). Three MCOs, DIA, PPMCO and ACC performed below the minimum target of 65%. The HealthChoice average was 63% which was below the minimum target.

Childhood Immunization Status—Combo 2



MCO performance scores range from 73% to 89% with the highest performer being MFSC. Five MCOs, MSFC, JMS, UHC, ACC, and PPMCO performed within the neutral range (82% through 91%). Two MCOs, DIA and MPC performed below the minimum target of 82%. The HealthChoice average was 82% which was within the neutral range.

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 2008 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 2008 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.

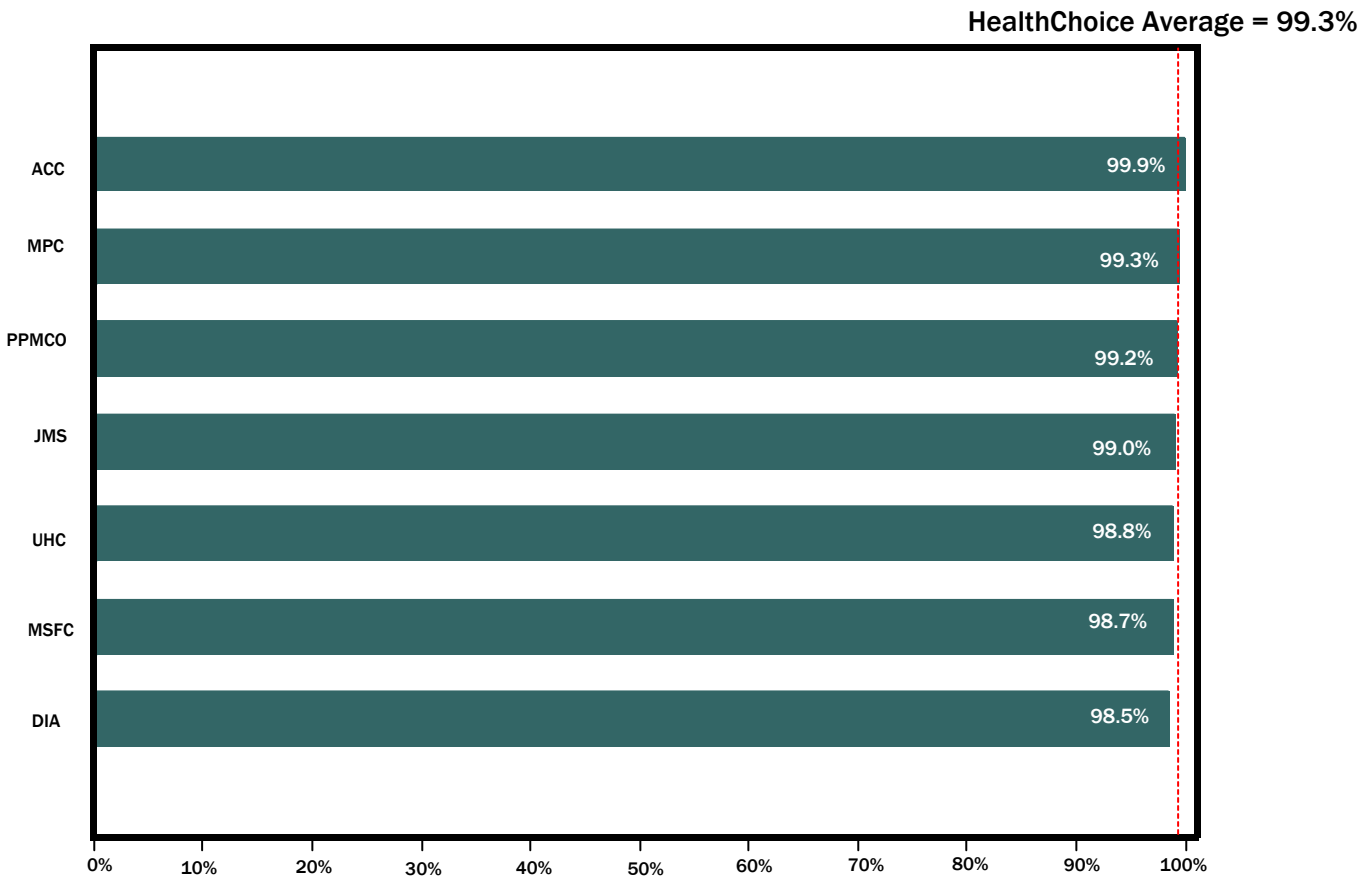
Validation of the data contained in the MCO-submitted files was conducted by requesting a validation sample of the paper claims and subsequent documentation generated in the adjudication process. Each MCO was supplied with the claim numbers for a sample of 30 claims. The MCO was required to submit the 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



MCO performance scores range from 98.5% to 99.9% with the highest performer being ACC. The HealthChoice average is 99.3%.