

Sustaining Excellence—Making Progress

North Dakota Department of Human Services Medical Services Division

***Healthy Steps – Children’s Health Insurance Program
And
North Dakota Medicaid Expansion Program***

External Quality Review

Measurement Year 2016 Results



Delmarva Foundation

A subsidiary of Quality Health Strategies

Presentation Overview

- **Delmarva Foundation – the External Quality Review Organization**
- **What is an External Quality Review?**
- **External Quality Review**
 - **Activities & Results**
 - **Quality, Access, Timeliness Summary**
 - **Recommendations**



Quality Health Strategies and Corporate Entities

Mission: *Creating Solutions to Transform Health*



Delmarva Foundation

*Operational Offices in Easton, Maryland;
Columbia, Maryland; Washington, DC;
Tampa, Florida; Tallahassee, Florida;
and Atlanta, Georgia*



Other Subsidiaries of QHS



Delmarva Foundation

- Delmarva Foundation is an External Quality Review Organization (EQRO)
- External Quality Review (EQR) contracts:
 - West Virginia
 - Maryland
 - District of Columbia
 - North Dakota – CHIP
 - North Dakota – Medicaid Expansion



What is an EQR?

- An EQR is an independent, external assessment of the quality, accessibility, and timeliness of care and services provided to CHIP and Medicaid Expansion beneficiaries.
- The EQR assessment is a retrospective review and assesses compliance and performance in the previous Measurement Year (MY).
- Delmarva Foundation has conducted annual EQR activities for Blue Cross Blue Shield of North Dakota (BCBSND) since 2011, for Delta Dental of Minnesota (Delta Dental) since 2013 and Sanford Health Plan (SHP) since 2015.



EQR Activities

- The regulations at 42 CFR § 438, External Quality Review outlines these activities:
 - Compliance Review
 - Performance Measure Validation
 - Performance Improvement Project Review/Validation
 - Encounter Data Validation
 - Network Adequacy Validation



Compliance Review (CR)

- CRs are designed to assess MCO compliance with structural and operational standards which may impact the quality, timeliness, or accessibility of services provided to enrollees.
- Standards are outlined in 42 CFR and include:
 - Information Requirements
 - Enrollee Rights
 - MCO Standards
 - Quality Assessment and Performance Improvement Program
 - Grievance and Appeal System



CR Activities

- Document review
 - Includes an assessment of:
 - Member materials
 - Policies and procedures
 - Reports
 - Quality Work Plans and Evaluations
 - Meeting minutes
- Interview session
 - Q&A with management and line staff



MY 2016 BCBSND CR Results

- MY 2015 results:
 - Enrollee Rights 100%
 - Grievance Systems 100%
 - Quality Assessment and Performance Improvement 97%
- MY 2016 is a new baseline due to the new managed care standards.
- Recommendations for BCBSND:
 - Minor policy and procedure revisions and ensuring compliance with new requirements. For example, BCBSND must provide cultural competence training to providers.
 - Develop a formal Enrollee Rights Policy and Procedure.
 - Continue to demonstrate compliance with Quality Assessment and Performance Improvement Program Standard requirements.
 - Will need to adjust its grievance and appeal member filing and MCO resolution timelines to meet the revised federal requirements.



BCBSND Member Satisfaction Results

| Question | 2015 | 2016 |
|--|-------|-------|
| Child has a personal doctor | 85.0% | 83.3% |
| Child visited personal doctor (at least once) | 76.2% | 61.4% |
| Child usually or always received care as soon as it was needed | 92.9% | 94.5% |
| Usually or always easy to obtain care, tests, or treatment needed for child | 91.5% | 94.2% |
| Usually or always received information or help requested from health plan customer service | 90.8% | 85.8% |
| Rating of child's health care: 8+9+10 (0 worst, 10 best) | 72.0% | 80.1% |
| Rating of child's health plan: 8+9+10 | 85.3% | 80.9% |
| Rating of child's overall mental or emotional health: excellent + very good | 76.4% | 76.8% |



MY 2016 Delta Dental CR Results

- MY 2015 results:
 - Enrollee Rights 100%
 - Grievance Systems 98%
 - Quality Assessment and Performance Improvement 95%
- MY 2016 is a new baseline due to the new managed care standards.
- Recommendations for Delta Dental:
 - Revising member materials and updating the Enrollee Rights Policy and Procedure.
 - Ensure that providers are credentialed and recredentialed in a timely manner.
 - Continue to demonstrate compliance with Quality Assessment and Performance Improvement Program Standard requirements.
 - Revise policies and procedures to reflect new requirements and adjust timelines related to members filing grievances and appeals.



Delta Dental Member Satisfaction Results

| Question | 2016 |
|---|------|
| Getting Care Quickly Composite | 96% |
| Has your child seen a regular dentist for a check-up or routine care in the last 6 months? | 91% |
| Did your child receive dental appointments with his/her regular dentist as soon as you wanted? | 97% |
| If your child does not have a regular dentist, did your child still get a check-up or other routine dental care in the last six months? | 40% |
| How many times did your child see his/her regular dentist for a check-up or routine care in the last 12 months? Assessment based on receiving two check-ups. | 64% |
| In the last 12 months, did your child's dentist treat you and your child with courtesy and respect? (always) | 89% |
| Using any number from 0-10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate your child's dental care in the last 12 months? (8+9+10) | 93% |
| Using any number from 0-10, where 0 is the worst dental plan and 10 is the best dental plan, what number would you use to rate your child's dental plan? (8+9+10) | 88% |
| How would you rate your child's overall dental health? (excellent + very good + good) | 96% |



MY 2016 SHP CR Results

- MY 2015 results:
 - Enrollee Rights 100%
 - Grievance Systems 94%
 - Quality Assessment and Performance Improvement 97%
- MY 2016 is a new baseline due to the new managed care standards.
- Recommendations for SHP:
 - SHP should make required adjustments in its grievance and appeal procedures to ensure compliance with timelines related to member filing and MCO resolution requirements.
 - SHP should complete an annual comprehensive quality program evaluation.
 - SHP should review annual performance and identify and prioritize opportunities for improvement.



SHP CAHPS Survey Results

| Measure | 2015 | 2016 |
|---|-------|-------|
| Customer Service Composite | 88.4% | 92.7% |
| Getting Needed Care Composite | 82.8% | 83.0% |
| Getting Care Quickly Composite | 81.0% | 83.9% |
| How Well Doctors Communicate Composite | 93.1% | 92.8% |
| Shared Decision Making Composite | 81.8% | 83.0% |
| Health Promotion and Education Composite | 69.2% | 73.4% |
| Coordination of Care Composite | 85.6% | 85.4% |
| Rating of Health Plan (8+9+10) | 73.8% | 75.1% |
| Rating of All Health Care (8+9+10) | 74.6% | 72.5% |
| Rating of Personal Doctor (8+9+10) | 84.6% | 85.8% |
| Rating of Specialist Seen Most often (8+9+10) | 82.1% | 79.1% |



Performance Measure Validation (PMV)

- Performance measures offer a snapshot of MCO quality of care provided during a given time period. PMV assures that MCOs produce reliable and accurate measures in accordance with required specifications.
- The validation process includes an assessment of the MCO's systems, procedures, and algorithms used to calculate the performance measures.



PMV Activities

- Conduct an Information Systems Capabilities Assessment.
- Review source code for the performance measures.
- Interview staff, review documentation, and observe key processes used by the MCO to calculate performance measures.
- Assign an audit designation for each measure.



MY 2016 BCBSND PMV Results

- The MCO had a satisfactory process for data integration, data control, and interpretation of the performance measures for MY 2016.
- Rates for all measures were found to be compliant with measure specifications and assessed as “reportable”.



BCBSND Performance Measure Results: Prevention and Health Promotion

| Prevention and Health Promotion Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Childhood Immunization Status: Combination 2 | 50%* | 11%* | 4%* |
| Childhood Immunization Status: Combination 3 | 50%* | 5%* | 4%* |
| Immunizations for Adolescents: Combination 1 | 73% | 65% | 50%* |
| Well-Child Visits in the First 15 Months of Life, 6 or More Visits | 38% | 0%* | 40% |
| Well-Child Visits in the 3 rd , 4 th , 5 th , and 6 th Years of Life | 52% | 53% | 41% |
| Well Care Visits of 12-18 Years of Age with a Primary Care Provider or Gynecologist | 33% | 45% | 43% |
| Human Papillomavirus (HPV) Vaccine for Female Adolescents | 21% | 33%* | 20%* |

*Denominator of ≤ 30 observations; caution is advised when using the rate to gauge performance.



BCBSND Performance Measure Results: Management of Acute Conditions

| Management of Acute Conditions Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Medication Management for People with Asthma, 50% Compliance, Ages 5-11 | 4% | 100%* | 100%* |
| Medication Management for People with Asthma, 50% Compliance, Ages 12-18 | 3% | 67%* | 100%* |
| Medication Management for People with Asthma, 50% Compliance, Ages ≥ 19 | 0%* | 0%* | 0%* |
| Medication Management for People with Asthma, 75% Compliance, Ages 5-11 | 1% | 0%* | 0%* |
| Medication Management for People with Asthma, 75% Compliance, Ages 12-18 | 2% | 17%* | 60%* |

*Denominator of ≤ 30 observations; caution is advised when using the rate to gauge performance.

^As reported using HEDIS software



BCBSND Performance Measure Results: Management of Chronic Conditions

| Management of Chronic Condition Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Follow-Up Care for Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication, Initiation Phase | 1% | 30%* | 28% |
| Follow-Up Care for Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, Continuation and Maintenance Phase | 2% | 0%* | 25%* |
| Follow-Up After Hospitalization for Mental Illness, Within 7 Days | 0%* | 83%* | 73%* |
| Follow-Up After Hospitalization for Mental Illness, Within 30 Days | 0.2%* | 83%* | 87%* |
| *Denominator of ≤ 30 observations; caution is advised when using the rate to gauge performance. | | | |



BCBSND Performance Measure Results: Availability

| Availability Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Child and Adolescent Access to Primary Care Practitioners, 12-24 Months | 100% | 95%* | 94%* |
| Child and Adolescent Access to Primary Care Practitioners, 25 Months-6 Years | 80% | 85% | 83% |
| Child and Adolescent Access to Primary Care Practitioners, 7-11 Years | 77% | 91% | 86% |
| Child and Adolescent Access to Primary Care Practitioners, 12-19 Years | 82% | 93% | 94% |
| *Denominator of ≤ 30 observations; caution is advised when using the rate to gauge performance. | | | |



MY 2016 Delta Dental PMV Results

- The organization has a satisfactory process for data integration, data control, and interpretation for one CHIP measure.
- Incorrect continuous enrollment was applied when measures were calculated. Delta Dental was asked to correct the source code and rerun the rate. Delta Dental corrected the source code and provided final rates that were evaluated as reliable and accurate.
- After revisions, rates for the dental measures were found to be compliant with measure specifications and assessed as “reportable”.



Delta Dental PMV Results

| Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Percentage of Eligibles Receiving Preventive Dental Services | 38% | 36% | 35% |
| Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk | ~ | 15% | 12% |
| ~ New measure for MY 2015; no performance measure result for MY 2014 | | | |



MY 2016 SHP PMV Results

- The procedures and documentation used to calculate performance measures with the MCO's certified HEDIS[®] software were reviewed and found to be acceptable.
- Source code (programming language) and test cases were reviewed and approved for core measures not calculated with the certified software.
- Samples and methodology for medical record abstraction, were also found to be adequate and were approved.
- Medical records were examined during the site visit for several measures and two measures were selected for further medical record over-read. Agreement rates for the selected measures exceeded the 90% minimum requirement.



SHP PMV Results

| Adult Performance Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Breast Cancer Screening | ^ | ^ | 50.44% |
| Adherence to Antipsychotics for Individuals with Schizophrenia | 68.75% | 70.31% | 62.12% |
| HIV Viral Load Suppression # | ^ | ^ | # |
| Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs) | 83.66% | 86.46% | 84.44% |
| Annual Monitoring for Patients on Persistent Medications: Digoxin | ^ | ^ | 36.36% |
| Annual Monitoring for Patients on Persistent Medications: Diuretics | 83.60% | 86.73% | 85.04% |
| Annual Monitoring for Patients on Persistent Medications: Total Rate | 83.38% | 86.57% | 84.42% |
| Antidepressant Medication Management: Effective Acute Phase Treatment | 78.07% | 66.59% | 61.38% |
| Antidepressant Medication Management: Effective Continuation Phase Treatment | 71.12% | 55.00% | 48.17% |
| Cervical Cancer Screening | 19.77% | 26.26% | 31.84% |
| Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24 | 31.91% | 40.52% | 38.99% |
| Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 7 Days | 21.88% | 27.44% | 24.91% |
| Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 30 Days | 38.84% | 49.62% | 47.06% |



SHP PMV Results

| Adult Performance Measure | MY 2014 | MY 2015 | MY 2016 |
|---|----------|---------|---------|
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiated Treatment Through an Inpatient Alcohol or Other Drug (AOD) Admission, Outpatient Visit, Intensive Outpatient Encounter, or Partial Hospitalization Within 14 Days of the Diagnosis (Initiation) | 37.63% | 37.44% | 40.01% |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiated Treatment and Who Had Two or More Additional Services With a Diagnosis of AOD Within 30 Days of the Initiation Visit (Engagement) | 13.44% | 13.15% | 17.38% |
| PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 18-64 ~ | 32.55** | 33.00** | 39.31** |
| PQI 08 Congestive Heart Failure Admission Rate, Ages 18-64 ~ | 69.17** | 18.19** | 18.26** |
| PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64 ~ | 264.59** | 46.85** | 46.59** |
| PQI 15 Asthma in Younger Adults Admission Rate, Ages 18-39 ~ | 39.21** | 8.09** | 8.99** |
| Plan All-Cause Readmissions Rate: Ages 18-44 ~ | 22.35% | 18.79% | 18.46% |
| Plan All-Cause Readmissions Rate: Ages 45-54 ~ | 17.34% | 21.92% | 17.25% |
| Plan All-Cause Readmissions Rate: Ages 55-64 ~ | 14.04% | 14.50% | 13.83% |
| Plan All-Cause Readmissions Rate: Total ~ | 18.88% | 18.78% | 16.92% |
| Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit | 79.22% | 75.09% | 73.29% |



SHP PMV Results

| Adult Performance Measure | MY 2014 | MY 2015 | MY 2016 |
|--|---------|---------|---------|
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications | 47.06% | 48.11% | 48.42% |
| Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies | 47.71% | 47.44% | 48.63% |
| Flu Vaccinations for Adults, Ages 18-64 | 32.30% | 37.95% | 37.67% |
| Adult Body Mass Index Assessment | NA | 91.73% | 94.56% |
| Care Transition - Timely Transmission of Transition Record (Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care) # | 15.82% | 17.40% | # |
| Comprehensive Diabetes Care: Hemoglobin A1c Testing | 89.18% | 91.42% | 91.15% |
| Comprehensive Diabetes Care: HbA1c Poor Control (>9%) + ~ | + | + | 31.68% |
| Comprehensive Diabetes Care: HbA1c Control (<8%) + | + | + | 57.52% |
| Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population + | + | + | 42.82% |
| Comprehensive Diabetes Care: Eye Exam + | + | + | 48.14% |
| Comprehensive Diabetes Care: Medical Attention for Nephropathy + | + | + | 93.27% |
| Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg + | + | + | 80.35% |
| Controlling High Blood Pressure | 68.13% | 68.61% | 72.78% |



SHP PMV Results

| Adult Performance Measure | MY 2014 | MY 2015 | MY 2016 |
|---|---------|---------|---------|
| Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia + | + | + | ^ |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication + | + | + | 79.15% |
| Diabetes Monitoring for People With Diabetes and Schizophrenia + | + | + | ^ |
| Comprehensive Diabetes Care: LDL-C Screening (retired measure in 2014★) # | 74.52% | 77.55% | # |
| PC-01 Elective Delivery # | ^ | ^ | # |
| PC-03 Antenatal Steroids # | ^ | ^ | # |
| Prenatal and Postpartum Care: Postpartum Care Rate # | ^ | 56.90% | # |
| Screening for Clinical Depression and Follow-Up Plan # | 11.78% | 14.69% | # |

* Benchmark data source: Quality Compass 2016 (Measurement Year 2015 data) National Medicaid Average for All Lines of Business. This is the most current benchmark source at the time of report production.

** Member observations per 100,000 members.

~ A lower rate is better.

^ Denominator of less than 30 observations; too small to calculate a reliable rate.

Measure retired from Quality Strategy.

+ New measure for Quality Strategy for MY 2016.

-- Benchmark not available.

★ Measure retired in 2014; benchmark is from Quality Compass 2014 (Measurement year 2013) National Medicaid Average for All lines of Business.



Performance Improvement Project (PIP) Review

- Conducted for ND CHIP and ND Medicaid Expansion.
- PIPs serve as an effective tool in assisting an MCO in identifying issues and implementing targeted interventions to obtain and sustain improvement in clinical or non-clinical processes.
- Targets have been set to improve performance by two percentage points annually.

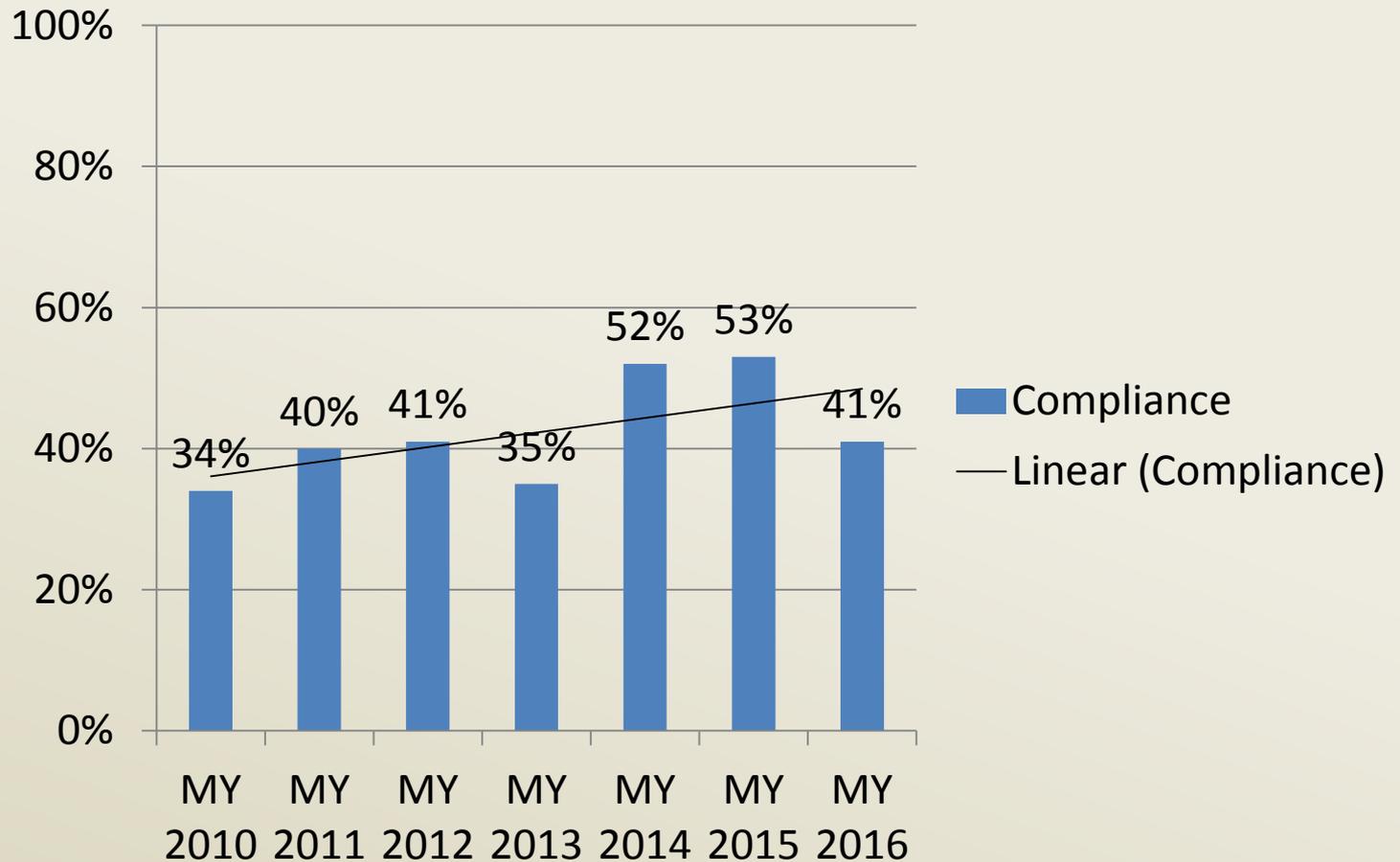


PIP Review Activities

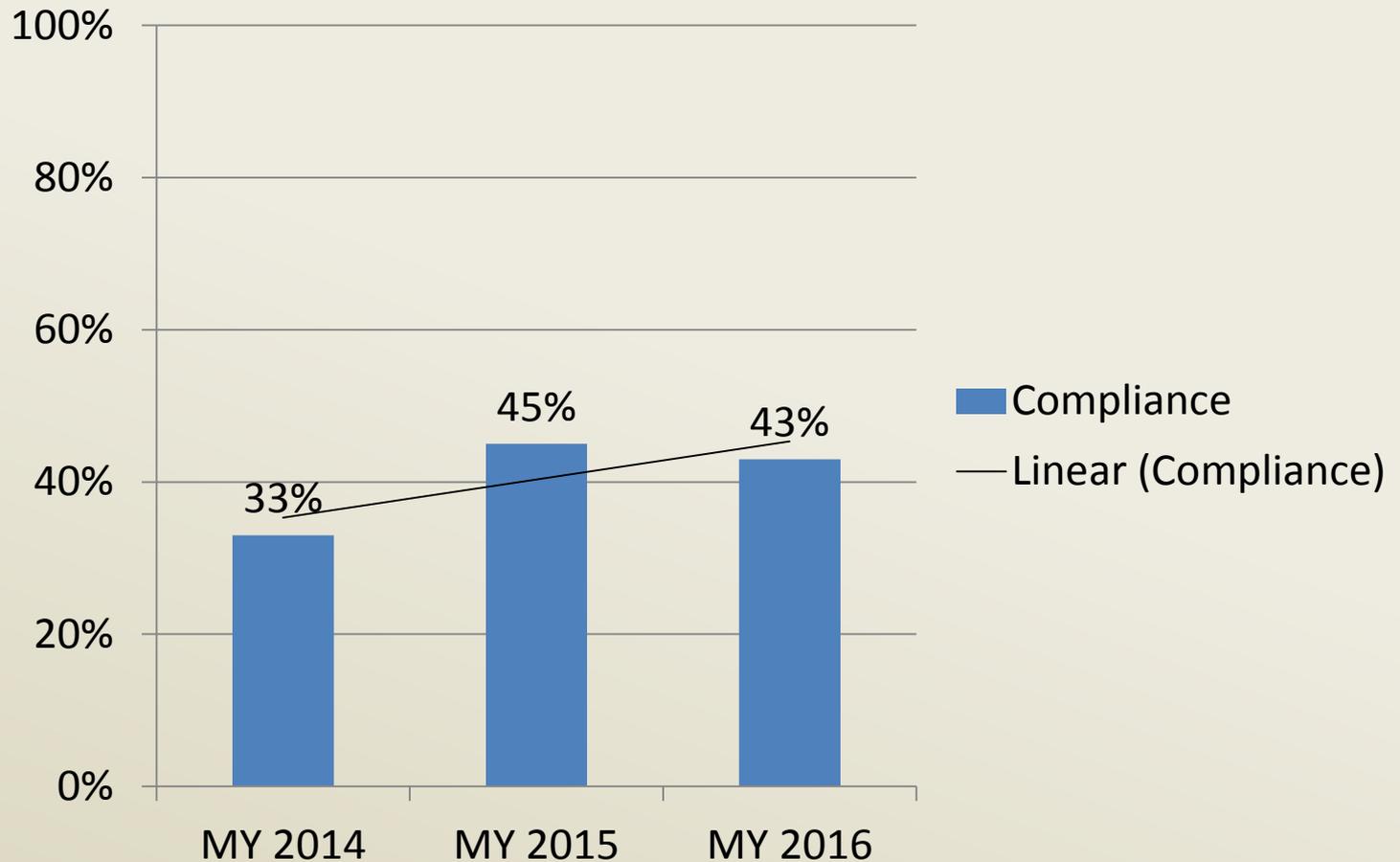
- Delmarva Foundation uses a 10 step validation approach that assesses the following:
 - 1. Study topic
 - 2. Study question
 - 3. Study indicators
 - 4. Study population
 - 5. Sampling method
 - 6. Data collection procedures
 - 7. Improvement strategies
 - 8. Study findings
 - 9. Real improvement
 - 10. Sustained improvement



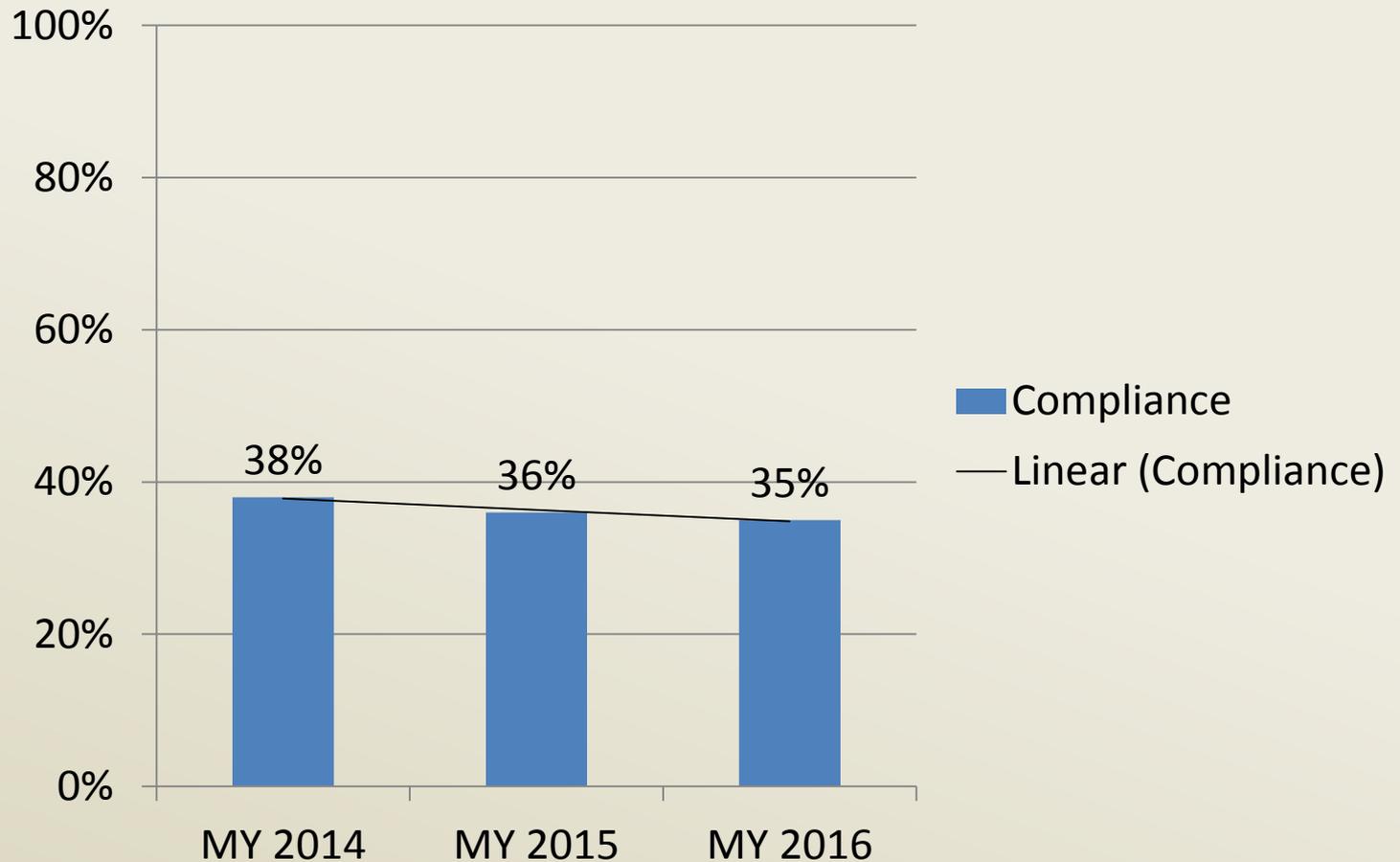
BCBSND's Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life PIP Results



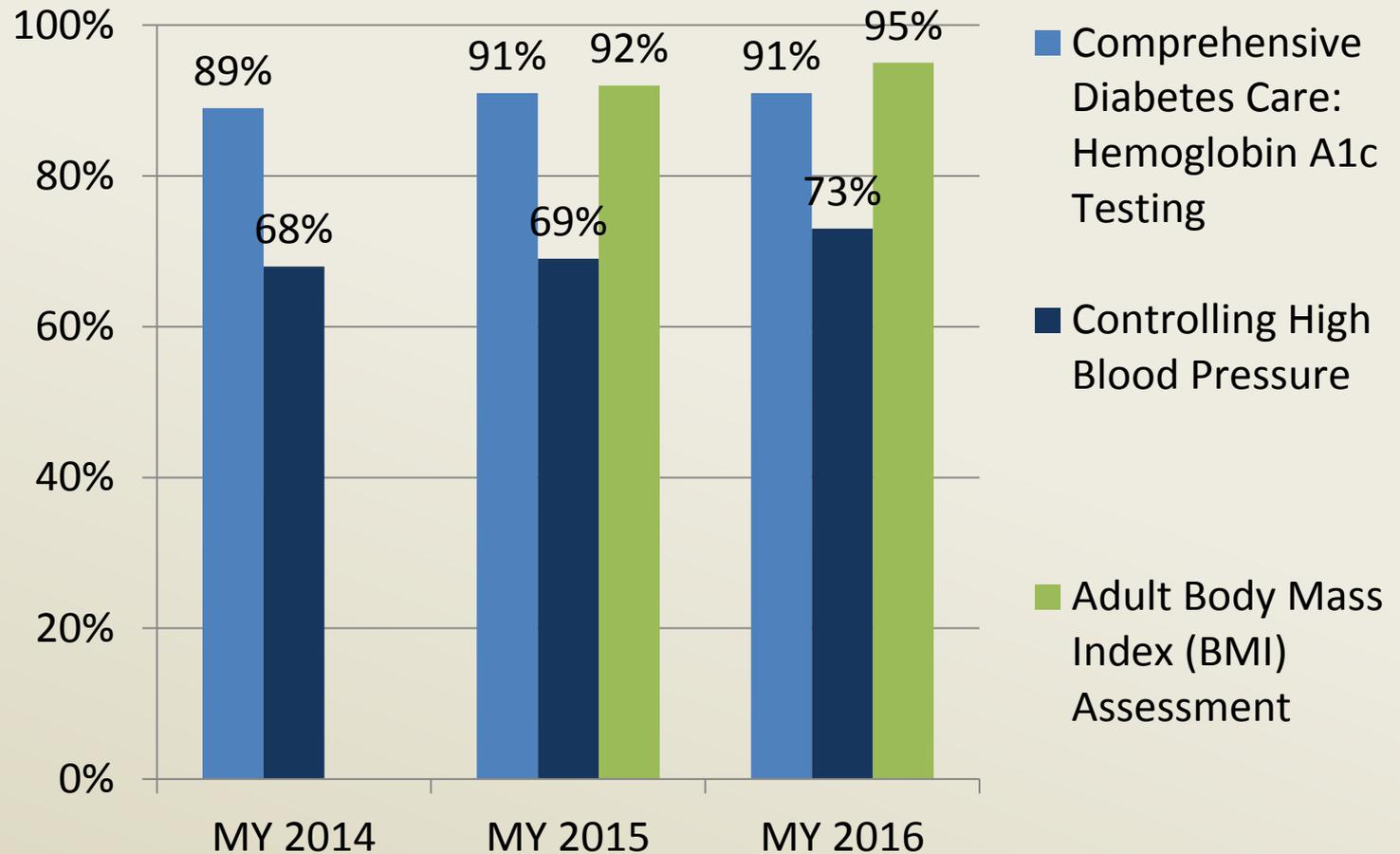
BCBSND's Well Care Visits for 12-18 Years of Age with a PCP PIP Results



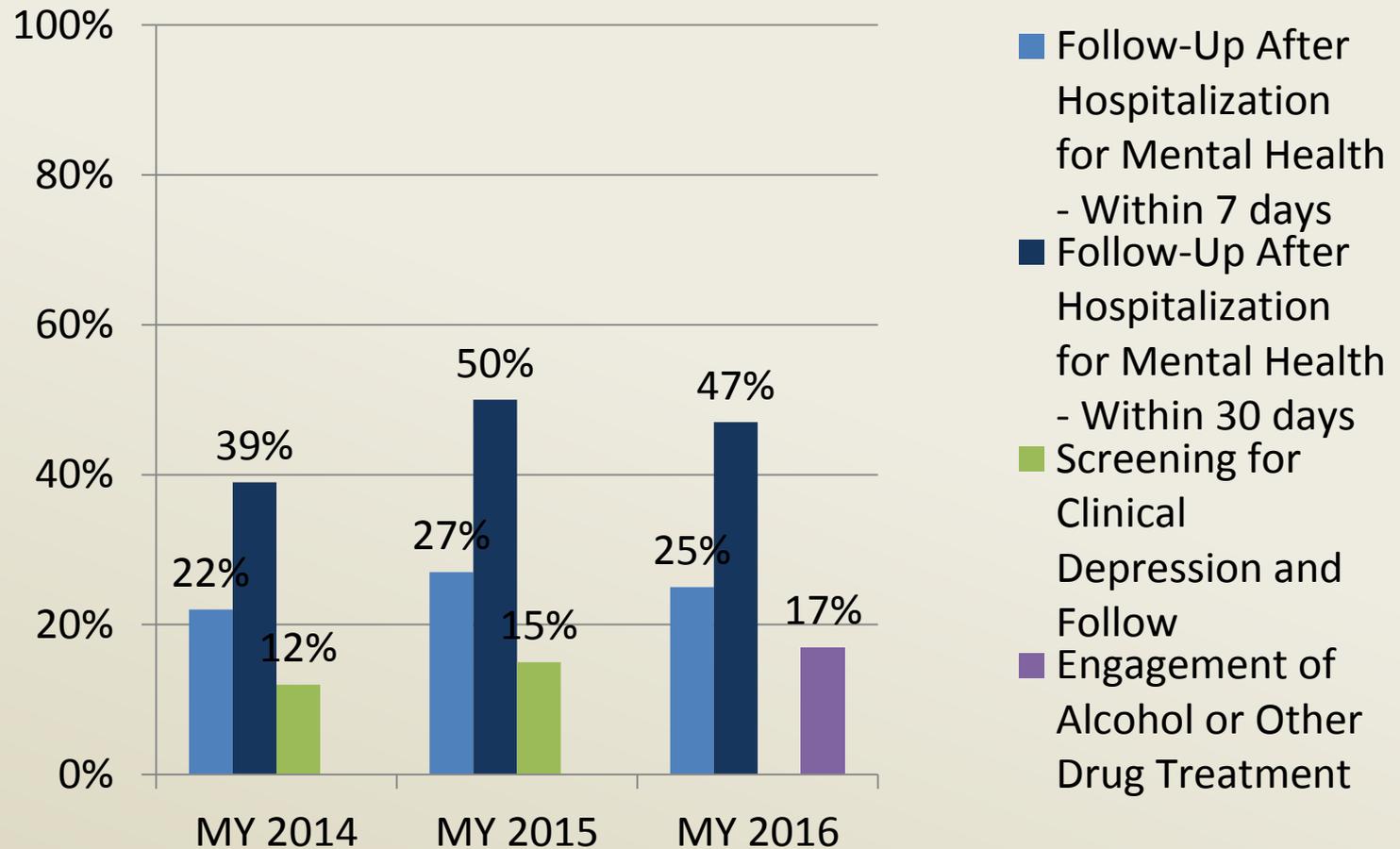
Delta Dental's Children's Preventive Dental Services PIP Results



SHP's Prevention and Treatment of Chronic Conditions PIP Results



SHP's Follow-Up for Mental Health PIP Results



Encounter Data Validation (EDV)

- Encounter data are essential for measuring and monitoring MCO quality, service utilization, finances, and compliance with contract requirements.
- Medical record reviews validate the accuracy of claims/encounter data.



EDV Activities

- Delmarva follows these 4 sequential activities when conducting the EDV task:
 - 1. Review state requirements for collecting and submitting encounter data.
 - 2. Review the MCO's capacity to produce accurate and complete encounter data.
 - 3. Analyze MCO electronic encounter data for accuracy and completeness.
 - 4. Review medical records for confirmation of findings of analysis of encounter data.



MY 2016 BCBSND EDV Results

| Encounter Type | Percentage of Matched Elements |
|----------------|--------------------------------|
| | MY 2016 |
| Inpatient | 98% |
| Outpatient | 99% |
| Office Visit | 88% |
| Total | 91% |

During MY 2016, BCBSND achieved a total match rate of 91%—meaning 91% of claims data submitted was supported by medical record documentation. Outpatient records registered the highest match rate at 99%. Inpatient records followed closely with 98%.



MY 2016 Delta Dental EDV Results

| Encounter Type | Percentage of Matched Elements |
|----------------|--------------------------------|
| | MY 2016 |
| Office Visits | 94% |

DF's review of Delta Dental's encounter data yielded a 94% procedure code match.



MY 2016 SHP EDV Results

| Encounter Type | Percentages of Matched Elements | |
|----------------|---------------------------------|------------|
| | MY 2015 | MY 2016 |
| Inpatient | 89% | 96% |
| Outpatient | 95% | 97% |
| Office Visit | 92% | 89% |
| Total | 92% | 93% |

During MY 2016, SHP achieved a total match rate of 93%—meaning 93% of claims data submitted was supported by medical record documentation. The increase of 1 percentage point from MY 2015 was driven by increases in both Inpatient and Outpatient match rates, which rose by 7 and 2 percentage points respectively, despite a 3 percentage point decline for Office Visits.



Network Adequacy Validation (NAV)

- Network adequacy is essential to ensure that provider services are available and accessible to enrollees.
- Provider networks that satisfactorily meet requirements facilitate member access and opportunity to obtain preventive and diagnostic medical care, as well as treatment.
- An adequate network may enhance appropriate utilization of care and services.



NAV Activities

- NAV CMS protocol is expected to be released from CMS in 2018. Until such protocol is released, Delmarva Foundation conducts the NAV activity using a methodology approved by North Dakota DHS.
- Provider Directory Validation
- Appointment Availability Assessment
- After-Hours Availability Assessment
- Weekend Availability Assessment



MY 2016 BCBSND NAV Results

- The provider directory validation survey concluded that 73% of BCBSND provider information was valid and correct. Most frequently, provider names were not correct.
- The assessment of compliance with appointment availability timeframes concluded that members have more timely access to PCPs than specialists. Urgent care access to specialists within two calendar days was low at 20% compliance. In regard to PCPs, compliance was 80% and above.
- After-hours and weekend access and direction for care varied among PCPs. The after-hours survey concluded 60% compliance with instruction on accessing care, while the weekend survey provided a higher compliance rate of 90%.



MY 2016 Delta Dental NAV Results

- The provider directory validation survey concluded that 77% of Delta Dental provider information was valid and correct. Most frequently, provider names were not correct.
- 85% of the routine, non-urgent appointment calls made were able to schedule an appointment within 30 calendar days.
- 80% of the urgent appointment calls made were able to schedule an appointment within 2 calendar days.



Quality, Access, Timeliness for BCBSND

- BCBSND has matured in its efforts to promote quality.
- It has designed a Quality Management Annual Work Plan that encompasses elements that are critical for the success of its quality program.
- The MCO continues to strive for improvement in two PIPs.
- Healthy Steps Survey Results for MY 2016 provided evidence of satisfaction among its members.
- The MCO demonstrated an adequate provider network in 2016.
- Timely access to PCPs: 80% compliance.



Quality, Access, Timeliness for Delta Dental

- Since its contract implementation in July 2013, Delta Dental is continuing to develop a quality program that tracks, monitors, and assesses quality related elements and initiatives.
- Delta Dental successfully completed its first annual member satisfaction survey. Overall, respondents indicated satisfaction with dental providers and the dental plan.
- Delta Dental maintains a provider network that exceeds the minimum standard established by DHS, which requires the participation of at least 70% of dentists within the state of North Dakota
- The dental plan's policies and procedures confirm timely grievance and appeal resolution.
- Based on the member satisfaction survey, 97% of respondents indicated they obtained an appointment as soon as it was wanted.



Quality, Access, Timeliness for SHP

- The MCO should continue to expand its quality program, measure and monitor performance, and implement interventions and quality initiatives in order to improve enrollee health related outcomes.
- SHP's quality program measures and monitors quality related elements such as access and availability, utilization management functions, performance improvement, performance measurement, etc.
- DHS also has a 50 mile radius access standard for PCPs. Even taking into account the many rural geographic areas of North Dakota, SHP exceeded the minimum requirements for access to primary care services.
- The MCO's Provider Access and Availability Standards require providers to be available 24 hours a day, 7 days a week. SHP maintains procedures to monitor timely access and is able to take corrective action if there is failure to comply.



Recommendations for BCBSND

- Focus efforts to improve performance in the measures where a negative trend is noted.
- Develop an Enrollee Rights Policy and Procedure that is comprehensive and addresses all enrollee rights and related requirements.
- Revise member filing requirements and MCO resolution timelines for grievances and appeals to align with new standards.
- Provide cultural competence training to providers.
- Educate providers on procedures for maintaining 24/7 access.
- Continue efforts to improve indicator performance in PIPs and develop new strategies as needed.



Recommendations for Delta Dental

- The dental plan must demonstrate improvement and meet the North Dakota Healthy Steps Quality Strategy Plan that requires an annual two percentage point improvement in PIPs. Delta Dental must revise its current interventions or introduce new interventions to appropriately target barriers.
- Revise numerous policies and procedures in order to meet all requirements of the new regulations.
- Continue to develop a comprehensive quality program that tracks, monitors, and assesses quality related elements and initiatives.
- Include specific Healthy Steps measurable goals/benchmarks/thresholds in the Quality Work Plan. Identify responsible parties, reporting requirements, and appropriate timelines.
- Continue to be mindful of continuous enrollment and other parameters outlined in performance measure specifications to ensure complete and accurate results and analysis.
- Provide cultural competence training to providers.
- Ensure that providers are credentialed and recredentialed in a timely manner.



Recommendations for SHP

- Continue with current PIP interventions and explore additional opportunities that address barriers for the Follow-Up for Mental Health PIP in an effort to improve performance.
- Close out the Prevention and Treatment of Chronic Conditions PIP and replace it with a new topic where there is opportunity for improvement.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet national averages.
- Review and act on specific recommendations made by the EQRO in the Compliance Review report. Ensure compliance with new Medicaid managed care standards.
- Revise member filing requirements and MCO resolution timelines for grievances and appeals to align with new standards.
- Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next available appointments.
- Continue administration of disease management programs and engage members in self-management initiatives. Focus efforts to improve participation.
- Conduct an annual Quality Program Evaluation that evaluates Quality Work Plan activities and outcomes. Trend annual results in the evaluation to facilitate an understanding of performance year over year.



Recommendations for DHS related to ND CHIP

- Continue to encourage the expansion of interventions for the PIPs. Significant improvement is most likely to occur when multiple, robust interventions are underway. Provider incentives are likely to have a positive impact.
- Consider requiring BCBSND prioritize low performing measures, identify barriers, and initiate activities to boost performance.
- Revise the Healthy Steps Quality Strategy Plan annually to identify and prioritize areas of focus and performance goals.
- Clearly define the State's objectives and articulate measurable goals for encounter data completeness and accuracy. The usual standard is 95%.
- Ensure compliance with new 120 day standard for members filing a State fair hearing.
- Consider developing access standards for Delta Dental.



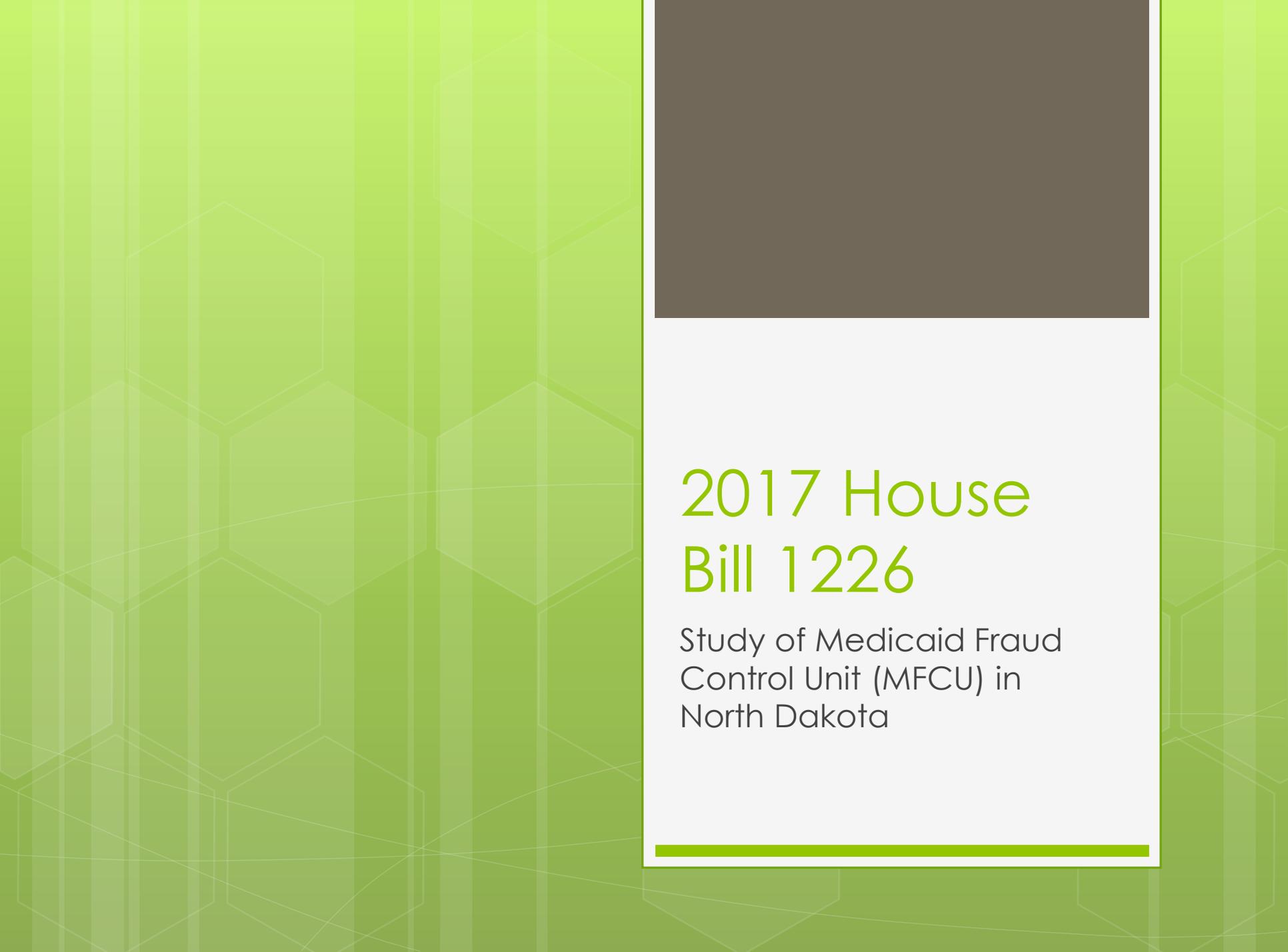
Recommendations for DHS related to ND Medicaid Expansion

- Require SHP to follow up on recommendations made by the EQRO in the Compliance Review.
- Ensure compliance with new 120 day standard for members filing a State fair hearing.
- Continue to review and revise the North Dakota Medicaid Expansion Quality Strategy annually, and:
 - Establish minimum performance thresholds for performance measures.
 - Include new requirements or shift priorities as opportunities present themselves.
 - Work with the EQRO and SHP to identify performance measures that are meaningful to the Medicaid Expansion population.



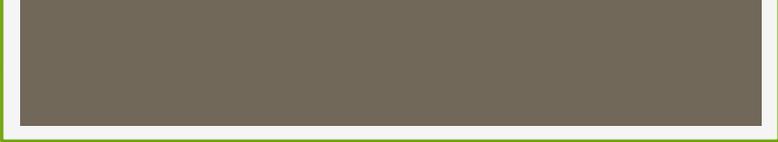
Questions?





2017 House Bill 1226

Study of Medicaid Fraud
Control Unit (MFCU) in
North Dakota



Background and History

Code of Federal Regulations

- **42 CFR §1007.5 Basic requirement.** A State Medicaid fraud control unit must be a single identifiable entity of the State government certified by the Secretary as meeting the requirements of §§ 1007.7 through 1007.13 of this part.

Code of Federal Regulations

- **42 CFR §1007.7 Organization and location requirements.** Any of the following three alternatives is acceptable:
- (a) The unit is located in the office of the State Attorney General or another department of State government which has Statewide authority to prosecute individuals for violations of criminal laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing title XIX of the Act;
- (b) If there is no State agency with Statewide authority and capability for criminal fraud prosecutions, the unit has established formal procedures that assure that the unit refers suspected cases of criminal fraud in the State Medicaid program to the appropriate State prosecuting authority or authorities, and provides assistance and coordination to such authority or authorities in the prosecution of such cases; or
- (c) The unit has a formal working relationship with the office of the State Attorney General and has formal procedures for referring to the Attorney General suspected criminal violations occurring in the State Medicaid program and for effective coordination of the activities of both entities relating to the detection, investigation and prosecution of those violations. Under this requirement, the office of the State Attorney General must agree to assume responsibility for prosecuting alleged criminal violations referred to it by the unit. However, if the Attorney General finds that another prosecuting authority has the demonstrated capacity, experience and willingness to prosecute an alleged violation, he or she may refer a case to that prosecuting authority, as long as the Attorney General's Office maintains oversight responsibility for the prosecution and for coordination between the unit and the prosecuting authority.

Code of Federal Regulations

- **42 CFR §1007.9 Relationship to, and agreement with, the Medicaid agency.**
- (a) The unit must be separate and distinct from the Medicaid agency.
- (b) No official of the Medicaid agency will have authority to review the activities of the unit or to review or overrule the referral of a suspected criminal violation to an appropriate prosecuting authority.
- (c) The unit will not receive funds paid under this part either from or through the Medicaid agency.
- (d) The unit will enter into an agreement with the Medicaid agency under which the Medicaid agency will agree to comply with all requirements of §455.21 (a)(2) of this title.
- (e)
 - (1) The unit may refer any provider with respect to which there is pending an investigation of a credible allegation of fraud under the Medicaid program to the State Medicaid agency for payment suspension in whole or part under §455.23 of this title.
 - (2) Referrals may be brief, but must be in writing and include sufficient information to allow the State Medicaid agency to identify the provider and to explain the credible allegations forming the grounds for the payment suspension.
- (f) Any request by the unit to the State Medicaid agency to delay notification to the provider of a payment suspension under §455.23 of this title must be in writing.
- (g) When the unit accepts or declines a case referred by the State Medicaid agency, the unit notifies the State Medicaid agency in writing of the acceptance or declination of the case.

Code of Federal Regulations

- **42 CFR §1007.11 Duties and responsibilities of the unit.**
- (a) The unit will conduct a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan.
- (b)
 - (1) The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities.
 - (2) If the initial review indicates substantial potential for criminal prosecution, the unit will investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority.
 - (3) If the initial review does not indicate a substantial potential for criminal prosecution, the unit will refer the complaint to an appropriate State agency.
- (c) If the unit, in carrying out its duties and responsibilities under paragraphs (a) and (b) of this section, discovers that overpayments have been made to a health care facility or other provider of medical assistance under the State Medicaid plan, the unit will either attempt to collect such overpayment or refer the matter to an appropriate State agency for collection.
- (d) Where a prosecuting authority other than the unit is to assume responsibility for the prosecution of a case investigated by the unit, the unit will insure that those responsible for the prosecutive decision and the preparation of the case for trial have the fullest possible opportunity to participate in the investigation from its inception and will provide all necessary assistance to the prosecuting authority throughout all resulting prosecutions.
- (e) The unit will make available to Federal investigators or prosecutors all information in its possession concerning fraud in the provision or administration of medical assistance under the State plan and will cooperate with such officials in coordinating any Federal and State investigations or prosecutions involving the same suspects or allegations.
- (f) The unit will safeguard the privacy rights of all individuals and will provide safeguards to prevent the misuse of information under the unit's control.

ND MFCU Waiver

- In August 1994 the Office of Inspector General at HHS approved the request from ND for a waiver from the requirement to establish a Medicaid Fraud Control Unit.
- The waiver did not have an end date.

Other Background

- DHS has had multiple findings from the State Auditor's office for not having a MFCU in ND.
- 2007 Legislative Assembly did not adopt a DHS bill requesting establishment of a False Claims Act.
- 2009 Legislative Assembly did not adopt legislation introduced to establish a MFCU.

Other Background

- May 2016 Letter from CMS Acting Administrator to Governor Dalrymple requesting notification of intent to establish a MFCU or the submission of a new waiver request.
- September 2016 Letter from Governor Dalrymple to CMS Acting Administrator requesting a new waiver.

Other Background

- January 2017 – Letter from CMS to Governor requesting North Dakota submit an implementation plan for establishing a MFCU.
- January 2017 Letter from Governor Burgum to CMS outlining the 2017 legislation that was under consideration; and assuring that ND would keep CMS informed of outcomes.

2017 Legislation

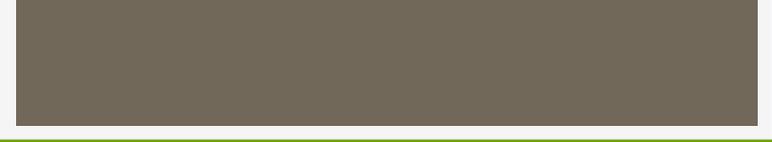
- HB 1174 – False Claims Act (Not Adopted)
- HB 1226 Medicaid Fraud Control Unit (Amended and Adopted)
- HB 1227 Medicaid Fraud Statute (Not Adopted)

Activity Since Session

- Workgroup meetings
- DHS Letter to Seema Verma (CMS Administrator)

2017 HB 1226 States:

- During the 2017- 18 interim, the department of human services, with the cooperation of the governor and the attorney general, shall study the feasibility and desirability of establishing a medicaid fraud control unit. Before August 1, 2018, the department of human services shall report to the legislative management the outcome of this study, together with any legislation required to implement the recommendations.



Medicaid Program Integrity

Medicaid Program Integrity Unit (PIU)

- If ND implements a MFCU, all of the preliminary provider fraud, waste or abuse investigations that the PIU conducts, that result in suspected fraud, waste or abuse, would be referred to the MFCU for further investigation and potential prosecution.
- The PIU would also assist with explaining Medicaid program policies and procedures.
- Collaboration would be expected to discuss fraud trends, areas of concerns, and continued clarification of intersects of activity.

Compare MFCU to PIU

| | PIU | MFCU |
|--|-----|------|
| Medicaid Program Integrity Oversight | X | |
| Managed Care Organization PI Oversight | X | |
| Policy Creation/Revision | X | |
| Third Party Liability Functions | X | |
| Provider Enrollment Functions | X | |
| PERM Audits | X | |
| RAC Audits* | X | |
| Other Federal Audits (GAO, etc.) | X | |
| Data mining | X | X |
| Recipient Audits | X | |
| Recipient Investigations | X | |
| Recipient Fraud Referrals | X | |
| Recipient Lock in Program | X | |
| Recipient Overpayment Collection | X | |
| Recipient Abuse and Neglect Investigations | | X |
| Provider Audits | X | X |
| Provider Preliminary Investigations | X | X |
| Provider Full Investigation | | X |
| Provider Referrals | X | X |
| Provider Prosecution | | X |
| Provider Overpayment Collection | X | X |
| Assessing Civil Monetary Penalties | | X |
| Funding at 50% federal, 50% state | X | |
| Funding at 75% federal, 25% state | | X |
| <i>*Division currently has a RAC waiver in place</i> | | |

Scope of MFCU

Scope of MFCU

- Primary function and scope is Medicaid provider fraud.
 - Billing for services not performed;
 - Billing for a more expensive procedure;
 - Billing twice for the same service;
 - Billing for services that should be combined into one billing (unbundling)
 - Billing for durable medical equipment
 - O₂ machines and diabetic supplies

Scope of MFCU

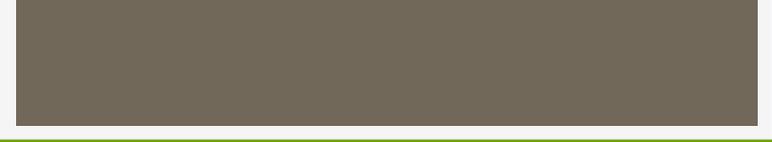
- Primary function and scope is Medicaid provider fraud.
 - Billing for home health services
 - Elderly taking their medicine
 - Elderly being bathed, dishes being done, etc.
 - Billing for transportation
 - Those that are wheelchair bound, etc.
 - Healthcare providers
 - Any bills for service: hospital, chiropractor or optometrist

Scope of MFCU

- With permission from HHS/OIG Investigations, they can investigate losses to the Medicare program as part of their Medicaid fraud case if OIG declines to be involved and gives them authorization to do so.
- Prescription drug fraud concerning prescriptions paid through the Medicaid program.

Scope of MFCU

- Nursing home neglect and abuse complaints, and misuse/theft of nursing home resident personal funds;
- They do not investigate beneficiary fraud unless there is an allegation of a conspiracy between the beneficiary and a bad Medicaid provider.



Comparison to Similar States

Comparison to Similar States

States of Comparison

- South Dakota
- Montana
- Wyoming

*Data also collected from the National Association of Medicaid Fraud Control Units (NAMFCU)

Comparison to Similar States

States of Comparison

- South Dakota, Montana and Wyoming were asked to explain the number of individuals assigned to their respective MFCUs and to share their recommendations with ND regarding personnel needs.

Comparison to Similar States

Approximate Population of Similar states as of 2017 (www.worldpopulationreview.com)

- Wyoming: 589,713
- **North Dakota: 790,701**
- South Dakota: 868,799
- Montana: 1,052,343

Wyoming MFCU Staffing

MFCU Personnel in WY MFCU

- Four (4) Current MFCU members
- One (1) attorney/director
- One (1) investigator
- One (1) auditor
- One (1) administrative assistant

Certified on 01/01/1995

Wyoming Recommendations for ND

- **SOURCE: Mr. Travis Kirchhefer**
 - **Assistant Attorney General, WY Medicaid Fraud Control Unit, WY Office of Attorney General.**
- Wyoming struggles greatly with only one(1) attorney and one(1) investigator. When these people are out, cases stop and continued progression is hindered. The Wyoming attorney was out for a month and no prosecution or case development occurred.

Wyoming Recommendations for ND

- With only one investigator assigned to the WY MFCU, other WY Department of Criminal Investigations employees outside of the MFCU are required to assist with investigations. WY indicated that they felt at least two (2) investigators are needed for most MFCU cases due to the amount of work required for conducting interviews and obtaining and reviewing documentation.

Wyoming Recommendations for ND

- Wyoming was audited in 2016 by US Health and Human Services (HHS) Office of Inspector General (OIG). MFCUs are audited every five (5) years by HHS-OIG.
- WY MFCU was issued a finding that Wyoming was in need of an additional investigator to adequately handle the case load assigned to the unit.

Wyoming Recommendations for ND

- Wyoming recommended that ND initially request a higher number of unit members. This is based on WY experience that once the legislative authority is initially granted, permission to increase staff is very difficult to obtain.
- The WY AG is on a Governor's panel that reviews each state full time employee position when a person leaves or retires to ensure it is "needed" before it can be filled, due to state budget restrictions.

Wyoming Recommendations for ND

- Wyoming recommends a second attorney be part of the ND MFCU as they are now seeing that states that are not qui tam are not getting favorable consideration on global settlements.
- Settlement from HHS OIG are more favorable to qui tam states.

Wyoming Recommendations for ND

- Wyoming is seeing that their auditor is spending up to five (5) full days, per global settlement information request.
- The auditor is spending full time hours gathering paperwork data for the investigator and then helping with global settlement requests for information from other MFCUs.

South Dakota MFCU Staffing

MFCU Personnel in SD MFCU

- Five (5) current MFCU members
- One (1) attorney/director
- Two (2) investigators
- One (1) auditor
- One (1) support staff/administrative analyst

Certified on 07/01/1990

South Dakota Recommendations for ND

- **SOURCE: Mr. Paul Cremer**
 - **Assistant Attorney General, SD Medicaid Fraud Control Unit, SD Office of Attorney General.**
- With their current staffing levels, SD stated their efforts would be enhanced if they could add an additional attorney to their unit.

South Dakota

Recommendations for ND

- SD explained that having two (2) attorneys would allow one attorney to serve as the director. The director manages workflow, handles some cases, conducts outreach with providers and the public, and ensures compliance with federal regulations. The second attorney would primarily handle the legal casework.

South Dakota

Recommendations for ND

- SD stated it is important to note that SD does not have state qui tam provisions, and if they did, SD MFCU staff would need to be larger to be able to investigate and handle the qui tam filings.
- States that have enacted qui tam provisions have needed to substantially supplement their MFCU staffing levels.

Montana MFCU Staffing

MFCU Personnel in MT MFCU

Nine (9) current MFCU members

- One (1) unit director/investigator
- Three (3) investigators
- Two (2) auditors
- One (1) attorney
- One (1) legal assistant/paralegal
- One (1) administrative assistant

Certified on 11/08/1995

Montana Recommendations for ND

- **SOURCE: Mrs. Debrah Fosket**
 - **Supervising Agent, MT Medicaid Fraud Control Unit,
MT Division of Criminal Investigation.**

At the inception of the MT MFCU, there were eight (8) members that consisted of:

- One (1) unit director
- Three (3) agents/investigators
- Two (2) auditors
- One (1) administrative assistant
- One (1) attorney

Montana Recommendations for ND

- In the years since the unit's inception, the MT Attorney General's Office provided the services of a paralegal/legal assistant, as needed, to the MFCU's Prosecutor.
- In the last three (3) years, the work load at the MT Attorney General's Office increased to the point that the paralegal/legal assistant could not assist the MFCU any longer.

Montana Recommendations for ND

- The caseload of the MT MFCU similarly increased to the point that the unit prosecutor was in dire need of help in preparing cases for prosecution and trial preparation needs.
- In late 2016, the MFCU was able to obtain funds for a legal assistant to work for the MFCU's attorney.

Montana Recommendations for ND

- MT stated that at the time of creation of the unit, and for several years after, the staffing (eight (8) people) was adequate for the number of referrals received and investigations conducted by the fraud unit.
- In the last two (2) to three (3) years, MT referrals have increased considerably and they would benefit from having one more attorney; at least one more auditor and one more agent/investigator.

Montana Recommendations for ND

- MT would prefer not to have temporary positions, but they may be the most obvious way to increase personnel for the work that needs to be accomplished.
- The increased caseload may be a temporary issue, but is believed to be directly related to MT being a Medicaid Expansion state for the last two years.

Staffing - Code of Federal Regulations

- **42 CFR §1007.13 Staffing requirements.**
- (a) The unit will employ sufficient professional, administrative, and support staff to carry out its duties and responsibilities in an effective and efficient manner. The staff must include:
 - (1) One or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases, who are capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors;
 - (2) One or more experienced auditors capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud; and
 - (3) A senior investigator with substantial experience in commercial or financial investigations who is capable of supervising and directing the investigative activities of the unit.
- (b) The unit will employ, or have available to it, professional staff who are knowledgeable about the provision of medical assistance under title XIX and about the operation of health care providers.

Recommended number of MFCU members for ND

Six (6) Recommended Members for ND MFCU

- One (1) attorney/director (criminal focus)
- One (1) attorney (civil focus)
- Two (2) investigators
- One (1) auditor
- One (1) support staff/administrative analyst

Estimated certification date of 07/01/19

Medicaid Med Adv Comm

- Seek your input on the feasibility and desirability of establishing a MFCU
- Why establish?
- Why not establish?
- Considerations and Feedback:

Medicaid Medical Advisory Committee
November 9, 2017
Developmental Disabilities Division Updates

DD Waiver Amendment:

The DD home and community based traditional waiver was approved by CMS on 10/16/17. Changes include:

- Replacing extended services with prevocational, small group and individual employment.
- New rate methodology for some of the services as outlined by legislation.
- Updates to the service plan section due to the new services being added.
- The effective date for these changes is 4/1/18.

Rate Setting System:

The division conducted statewide training for DD provider and regional human service center staff in September. Work continues on policies, procedures, and other related tasks. There will be a public comment period and oral hearing for the proposed changes to NDAC 75-04 in December. The official notice will be issued soon. The changes to NDAC 75-04 are consistent with the changes identified in the waiver that received CMS approval. Continue to check the division's website (<http://www.nd.gov/dhs/services/disabilities/dd.html>) for updated information.

Technical Assistance:

The Department has received the final report for the technical assistance project. The purpose of the technical assistance was to study the eligibility and service options across all ND Medicaid 1915(c) waivers and provide information and recommend tools/strategies related to person-centered practices and planning. The final report contains many recommendations for consideration that will be reviewed by the Department to determine next steps. The final report is available on our website (<http://www.nd.gov/dhs/services/disabilities/docs/2017-final-report-for-nd-dd-eligibility-service-array-practices.pdf>).