

North Dakota
Department of Human Services



North Dakota
Medicaid Expansion
Annual Technical Report
Measurement Year 2014



Delmarva Foundation

A subsidiary of Quality Health Strategies

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North Dakota Medicaid Expansion Program Measurement Year 2014 Annual Technical Report

Executive Summary

Introduction

Effective January 1, 2014, the North Dakota Department of Human Services (DHS) contracted with Sanford Health Plan (SHP) to provide services to the Medicaid Expansion population. In its oversight and assurance for quality, DHS subsequently contracted with Delmarva Foundation for Medical Care, Inc. (Delmarva Foundation) to complete an external quality review (EQR) of the North Dakota Medicaid Expansion Program.

The comprehensive assessment, conducted in 2015, assessed SHP's measurement year (MY) 2014 compliance with federal and state requirements, as identified in the Code of Federal Regulations (42 CFR § 438), the SHP MCO Contract, the North Dakota Medicaid Expansion Quality Strategy Plan, and the North Dakota Section 1915(b) Waiver Proposal for MCO Program: Waiver for Managed Care Enrollment of Medicaid Expansion of New Adult Group. Following the Centers for Medicare and Medicaid Services (CMS) EQR protocols, Delmarva Foundation evaluated the quality, access, and timeliness of services provided to the Medicaid Expansion program enrollees by assessing the MCO performance through the following EQR activities:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review (CR)
- Encounter Data Validation (EDV)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

This annual technical report describes results of the EQR activities and summarizes MCO strengths and recommendations in regard to providing quality, accessible, and timely healthcare services to the Medicaid Expansion population. The 2014 baseline results can be used in future years to compare performance and recommendations should be used to direct quality improvement initiatives.

Key Findings

Performance Improvement Project Review

SHP met all applicable requirements for its two PIPs, Prevention and Treatment of Chronic Conditions and Follow-Up for Mental Health. The MCO provided project rationales that demonstrated the relevancy and

importance of the projects. The study questions and performance measures identified were applicable to and supported the PIPs. Additionally, SHP described interventions that the organization plans to implement during 2015. Reported interventions address barriers and are expected to improve performance in outcomes.

Performance Measure Validation

SHP had satisfactory processes for data integration, data control, and interpretation of the CMS Adult and Child Core Measures for 2014. 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. Sampling and medical record review activities were evaluated and met requirements. SHP successfully reported performance measure results for its 2014 baseline year.

Several measures, however, had denominators that were too small to calculate reliable rates (less than 30 observations). Reasons for small denominators include:

- Some performance measures require two years of enrollment. SHP was limited with one year of enrollment. Enrollment began January 1, 2014.
- Most pregnant women disenroll from the Medicaid Expansion Program and enroll in traditional Medicaid.
- In general, the child core measures have a small eligible population—19-20 years of age. The ND Medicaid Expansion program serves individuals 19-64 years of age.

Lastly, measures with reported rates were found to be compliant with corresponding performance measure specifications and received “reportable” audit designations. SHP was unable to calculate a performance rate for the measure, HIV Viral Load Suppression, as the MCO does not collect the required LOINC codes. Therefore, this measure's audit designation was assessed as “not reportable.”

Specific performance measure results are displayed in Tables 11 and 12 of the Annual Technical Report.

Compliance Review

In general, SHP demonstrated compliance with federal and state regulations and requirements during 2014, as it served the North Dakota Medicaid Expansion population. Three key areas of regulation were assessed and their results are as follows:

- Enrollee Rights Standard: 99% compliant
- Grievance Systems Standard: 98% compliant
- Quality Assessment and Performance Improvement Standard: 98% compliant

At the time of the site review, conducted in May 2015, SHP had already addressed some of its deficiencies and revised policies and member materials to meet requirements. Revisions will assist the MCO in meeting requirements for its 2015 evaluation.

Encounter Data Validation

By the 2014 year end, 17,212 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the first year of operation, 62% of the enrollees utilized health care services. The progressive increase in SHP's claims volume correlated with the increase in membership in 2014. Overall, SHP has well documented data integration and claims processing procedures. Member files and claims files were largely complete. Each file type had less than 1% missing data. In regard to accuracy, the overall match rate (medical record documentation supporting the encounter data submitted) in MY 2014 was 96.0%.

SHP is advised to add a field to encounter data to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 120 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims. Additionally, with the transition to ICD-10, SHP should review a stratified sample of medical records to ensure the integrity of claims submitted from providers and to identify non-conformities and focus areas for further education. The MCO should also conduct provider audits to ascertain the extent to which providers are adherent to ICD-10 coding principles.

CAHPS® Survey

SHP contracted with a certified CAHPS® vendor to conduct the 2015 CAHPS 5.0H Member Satisfaction Survey. On January 19, 2015, 1,350 surveys were mailed to a random sample of members who had been continuously enrolled in the MCO for at least five of the last six months of the measurement year. The survey, capturing member feedback about the MCO, providers, and member perception about getting needed care, getting care quickly, customer service, etc., had a 31% response rate. The majority of respondents indicated that they were: in excellent/very good overall health and mental/emotional health; in the 18-34 age range (very closely followed by the 55 and older range); female; with an education of high school or less; and white. SHP's CAHPS® Survey results were compared to NCQA Quality Compass benchmarks (Medicaid – All Lines of Business) to gauge performance and identify opportunities for improvement. Results are displayed in Table 19 of the Annual Technical Report.

Summary of Quality, Access, and Timeliness

Quality

SHP developed a strong foundation for its quality program and completed baseline measurements for 2014. The MCO should be able to expand its quality program, measure and monitor performance, and implement interventions and quality initiatives in order to improve enrollee health related outcomes. The MCO successfully developed and reported on two PIPs that aim to improve health outcomes. In regard to PMV,

CMS Adult and Child Core Measure results were found to be compliant with corresponding performance measure specifications and were assessed as “reportable” for all but one measure, in which the MCO did not report a result. The baseline assessments and benchmarking activities identify areas where SHP is performing well and areas that may possibly require intervention. This also applies to SHP’s CAHPS® Survey measure results.

The MCO performed well on the Quality Assessment and Performance Improvement Standard in the CR, indicating that the MCO understands quality and what is required to provide an effective program that will continuously measure and monitor outcomes in an effort to improve performance. The detailed CR Report identifies very specific recommendations that should assist SHP with obtaining full compliance during 2015.

The MCO should identify benchmarks, goals, and/or thresholds in which to measure itself against. When performance does not meet an acceptable goal or threshold, the MCO should identify barriers and develop and implement activities that aim to improve performance.

Access

Numerous elements within the CR assessed access to vital member information and access to providers and healthcare services. SHP provided members with information on available benefits and instructions on how to access such services. Member materials communicate how to select and access providers and how to obtain after hours and emergency services. In order to promote the delivery of healthcare in a culturally competent manner, the MCO communicated the availability of oral interpretation services and how to obtain written translated materials. Additionally, SHP explained members’ rights to access and utilize the grievance system.

SHP provides members with access to an adequate primary care provider (PCP) network, as measured in numbers of providers and geography. Additionally, in regard to access, female enrollees have direct access to women’s health specialists, all members have access to second opinions, and members may obtain necessary healthcare services outside of the provider network should SHP providers not be able to adequately provide them.

The MCO also provides transportation services to members requiring the service. SHP can arrange to transport members to provider offices for routine, non-emergency care. Members may also pick up prescriptions or durable medical equipment on the day of appointments.

SHP is encouraged to actively monitor and review any access related complaints or grievances to quickly identify and resolve access related issues.

Timeliness

SHP maintains a policy and procedure that addresses timely access to provider appointments. Based on the CR, it was determined that members have timely access to urgent care and routine/preventive care appointments 95% of the time. In the event of an emergency, members are instructed to access emergency services immediately. Members may go to the closest emergency room or call 911. The MCO's Provider Access and Availability Standards require providers to be available 24 hours a day, 7 days a week. SHP has developed procedures to monitor timely access and is able to take corrective action if there is a failure to comply.

Members also have rights to timely resolution for grievances and appeals, and timely utilization management decisions. During the CR, a random sample of appeals was reviewed and all were resolved timely.

In addition to monitoring timely access to urgent care and routine/preventive care visits, SHP should also monitor timely access for sick visits and timely access to specialty providers. Additionally, the MCO should actively monitor and review any timeliness related complaints or grievances to quickly identify and resolve timeliness related issues.

Conclusions

By the 2014 year end, 17,212 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the first year, 62% of the enrollees utilized health care services. North Dakota DHS has effectively managed oversight and collaboratively worked with SHP and the EQRO to ensure successful implementation, monitoring, and evaluation of the program.

SHP provided evidence of meeting almost all federal, state, and quality strategy requirements. In the few instances where the MCO did not meet requirements in its first year of operation, it has since demonstrated that it is actively working to develop plans and policies to meet requirements. SHP has developed a quality program that measures and monitors performance. The MCO has established a baseline and will be able to compare future performance to the 2014 measurement year. As the program matures and collects additional data and performance results, SHP and DHS will easily be able to identify opportunities for improvement in an effort to improve the health outcomes of the Medicaid Expansion population.

The EQRO will evaluate MCO progress in the next annual report. Performance will be compared to baseline results.

Recommendations

MCO Recommendations

It is recommended that SHP:

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- Review and act on explicit recommendations made by the EQRO in the separate, detailed Compliance Review report.
- Revise enrollee materials to clearly communicate the grievance timely filing requirement of 90 days from the date of incident. Revise policies to eliminate the requirement for written grievances.
- Continue with efforts to develop a formal Fraud and Abuse Program supported by relevant policies that outline procedures to prevent, detect, investigate, and report suspected or actual fraud, waste, and abuse.
- Ensure that timely access surveys include all provider types and situations, including consultations with specialists, as the MCO did not monitor access to all provider types during 2014.
- Implement new disease management programs as planned: Coronary Artery Disease, Attention Deficit Hyperactivity Disorder, and Asthma. Encourage participation and engagement in new and existing programs.
- Implement interventions for PIPs that aim to improve member outcomes.
- Review the CMS Adult and Child Core Measure Set performance measure results and the CAHPS® Survey results and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet the national Medicaid averages.
- Add a field to encounter data to document the date a claim is received to monitor provider claim submission timeliness and SHP claim payment timeliness.

State Recommendations

It is recommended that ND DHS:

- Continue to support, provide guidance, and work collaboratively with SHP as the organization works to meet all requirements.
- Continue to work with the EQRO to develop acceptable standards and to identify opportunities for improvement.
- Continue to review reports from SHP and provide recommendations as needed. Monitor results for trends and intervene early should concerns arise.
- Require SHP to follow up on recommendations made by the EQRO in the Compliance Review.
- Define high volume specialists to member ratios to assure adequate provider access.
- Define geographic access requirements for high volume specialists.
- Review the list of measures that the EQRO recommends to eliminate based on pregnant women disenrollment, the MCO not capturing necessary LOINC codes, and measure retirement.

- Work with the EQRO and MCO to identify new replacement measures that are meaningful to the Medicaid Expansion population.
- Define measureable goals for encounter data completeness and accuracy; 95% is recommended.
- Review and revise the North Dakota Medicaid Expansion Quality Strategy annually, and:
 - Establish minimum performance thresholds for performance measures; national Medicaid average is recommended.
 - Include new requirements or shift priorities as opportunities present themselves.

North Dakota Medicaid Expansion Program

Measurement Year 2014 Annual Technical Report

Introduction and Overview

The Affordable Care Act (ACA), enacted in March 2010, included a mandate, effective January 1, 2014, to expand the Medicaid program to cover individuals under the age of 65 with incomes below 133 percent of the federal poverty level (plus a five percent income disregard). The ACA was challenged and on June 28, 2012, the United States Supreme Court's ruling upheld the 2014 Medicaid Expansion, but allowed individual states to decide whether to expand their Medicaid program. Consequently, the 2013 North Dakota Legislative Assembly authorized the implementation of the Medicaid Expansion through House Bill 1362.

Subsequently, the North Dakota Department of Human Services (DHS) requested a Section 1915(b) Waiver for the Medicaid Expansion: Waiver for Managed Care Enrollment of the Medicaid Expansion of New Adult Group. With the Centers for Medicare and Medicaid Services (CMS) approval of the waiver, in December 2013, North Dakota awarded the contract for the Medicaid Expansion population to Sanford Health Plan (SHP). Enrollment in the managed care organization (MCO) for individuals 19-64 years of age meeting eligibility requirements began January 1, 2014.

The Medicaid Expansion product is a managed care model; therefore, CMS requires an External Quality Review Organization (EQRO) to perform an independent review of the managed care program. DHS contracted with Delmarva Foundation for Medical Care, Inc. (Delmarva Foundation) to perform such external quality review (EQR) services. Following CMS EQR Protocols, Delmarva Foundation evaluated the quality, access, and timeliness of services provided to the Medicaid Expansion program enrollees by assessing the MCO performance through the following EQR activities:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review (CR)
- Encounter Data Validation (EDV)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The comprehensive assessment, conducted in 2015, assessed SHP's measurement year (MY) 2014 compliance with federal and state requirements, as identified in the Code of Federal Regulations (42 CFR § 438), the SHP MCO Contract, the North Dakota Medicaid Expansion Quality Strategy Plan, and the North Dakota Section 1915(b) Waiver Proposal for MCO Program: Waiver for Managed Care Enrollment of Medicaid Expansion of New Adult Group.

This annual technical report describes EQR methodologies for completing activities; provides SHP baseline results for MY 2014, which can be used in future years to compare performance; and includes an overview of the quality, access, and timeliness of healthcare services provided to Medicaid Expansion enrollees. Finally, recommendations for improvement are made, and if acted upon, may positively impact enrollee outcomes.

External Quality Review Methodology

Delmarva Foundation began planning and coordinating EQR activities with DHS and SHP in October 2014. Actual review and auditing activities began in March 2015 and concluded in July 2015. In addition to reviewing electronic reports, policies, data, and systems, a three day site visit was conducted where SHP staff members were interviewed, procedures were observed, and files were reviewed to assess compliance with requirements. This comprehensive review aided in providing a complete picture of structural and operational standards, performance measure data collection processes, and quality assurance and improvement initiatives. The independent review aims to provide an accurate and objective portrait of MCO capabilities which can be used to promote accountability, improve important aspects of organizational achievement, and positively impact the quality of services provided to enrollees.

Performance Improvement Project Validation

PIPs are designed to use a systematic approach to quality improvement. A PIP serves as an effective tool in assisting the MCO in identifying issues and implementing targeted interventions to obtain and sustain improvement in clinical or non-clinical processes. These improvements should lead to improved health outcomes.

Delmarva Foundation uses the CMS protocol, *Validating Performance Improvement Projects (PIPs)—A Mandatory Protocol for External Quality Reviews, Protocol 3, Version 2.0, September 2012*, as a guide in PIP review activities. The MCO must measure performance using objective quality indicators, implement system interventions to achieve quality improvement, evaluate the effectiveness of the interventions, and plan and initiate activities for increasing or sustaining improvements. Table 1 describes Delmarva Foundation’s PIP validation steps and summarizes the requirements for the project.

Table 1. PIP Validation Steps

PIP Validation Steps	
Step	Validation Requirement
1. Study Topic	The study topic should be appropriate and relevant to the MCO’s population.
2. Study Question	The study question(s) should be clear, simple, and answerable.
3. Study Indicator(s)	The study indicator(s) should be meaningful, clearly defined, and measurable.

PIP Validation Steps	
Step	Validation Requirement
4. Study Population	The study population should reflect all individuals to whom the study questions and indicators are relevant.
5. Sampling Methodology	The sampling method should be valid and protect against bias.
6. Data Collection Procedures	The data collection procedures should use a systematic method of collecting valid and reliable data that represents the entire study population.
7. Improvement Strategies	The improvement strategies, or interventions, should be reasonable and address barriers on a system-level.
8. Data Analysis/Interpretation	The study findings, or results, should be accurately and clearly stated. A comprehensive quantitative and qualitative analysis should be provided.
9. Real Improvement	Project results should be assessed as real improvement.
10. Sustained Improvement	Sustained improvement should be demonstrated through repeated measurements.

Delmarva Foundation evaluates each step following a series of questions within the validation tool, which is based on the CMS PIP Review Worksheet. As reviewers conduct the validation, each component within a step is assessed for compliance and results for each step are rolled up and receive a determination of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. A description of each determination is provided below:

- Met – All required components are present.
- Partially met – At least one, but not all components are present.
- Not Met – None of the required components are present.
- Not Applicable – None of the components are applicable.

Performance Measure Validation

The purpose of conducting the PMV activity is to evaluate the accuracy and reliability of the measures produced and reported by the MCO and to determine the extent to which the MCO followed specifications for calculating and reporting measures. The validation process allows DHS to have confidence in MCO performance measure results. Quality improvement results from a combination of measurement, reporting performance, actions to improve performance, and remeasurement.

Delmarva Foundation uses the CMS protocol, *Validation of Performance Measures Reported by the MCO—A Mandatory Protocol for External Quality Review, Protocol 2, Version 2.0, September 2012*, as a guide in performance measure review activities. Validation activities include a review of data systems and processes used by the MCO to construct performance measure rates; an assessment of the calculated rates for algorithmic compliance to defined specifications; and verification that the reported rates are based on accurate sources of information. The PMV audit is divided into three phases: pre-site, on-site, and post-site. The associated PMV activities are described below in Table 2.

Table 2. PMV Activities

PMV Activities	
Audit Phase	Audit Activities
Pre-site Phase	Delmarva Foundation confirms measures and specifications with DHS and reviews prior audits, if available. An audit methodology is developed that is appropriate for the selected performance measures and is compliant with the CMS PMV protocol. The auditor has a conference call with the MCO to provide an overview, answer questions, and schedule an on-site visit. The MCO is asked to complete the Information Systems Capabilities Assessment (ISCA) and to provide the source code for the measures selected. Next, the auditor reviews the completed ISCA and other supporting documents to determine areas for further discussion during the on-site visit. Finally, there is a conference call with the MCO to finalize on-site review plans.
On-site Phase	Delmarva Foundation begins the on-site review with an opening conference and reviews the purpose and objectives of the PMV audit. The auditor interviews staff, reviews documentation, and observes key processes used by the MCO to calculate performance measures. Staff interviews provide insight into the accuracy and reliability of the reporting processes by allowing the MCO to clarify and provide more detail on any issues identified through the auditor’s review of the ISCA. The auditor reviews the information systems structure, protocols and procedures, and performance measure data collection methods. Lastly, a closing conference is held where the auditor identifies issues warranting follow-up, discusses post-site activities, and provides opportunity for the MCO to respond to preliminary findings.
Post-site Phase	Delmarva Foundation conducts a source code review, medical record over-read (if applicable), and follows up on any open items. The MCO must demonstrate that it has the automated systems, information management practices, and data control procedures needed to ensure that all information required for performance measure reporting is adequately captured, translated, stored, analyzed, and reported. All outstanding issues must be resolved prior to the MCO calculating its final rates. The auditor then assigns a validation reporting designation for each performance measure.

Compliance Review

CRs are designed to assess MCO compliance with federal regulations and contractual requirements. The review provides an impartial assessment and includes recommendations for improvement which are developed to positively impact the quality, timeliness, or accessibility of healthcare services provided to Medicaid enrollees.

The standards used to assess MCO performance were developed using the Balanced Budget Act (BBA) and the MCO’s contractual requirements with DHS. The BBA governs all aspects of Medicaid managed care programs, as set forth in Section 1932 of the Social Security Act and title 42 of the Code of Federal Regulations (CFR), part 438 et seq. Three key areas of the regulations are assessed:

- Enrollee Rights and Protections (ER) - 42 CFR § 438 Subpart C, Enrollee Rights and Protections, details requirements to ensure that managed care enrollees have the right to receive information about available healthcare services, how to access services, policies and procedures relative to obtaining services, and the right to make healthcare decisions.

- Grievance Systems (GS) - 42 CFR § 438 Subpart F, Grievance Systems, mandates that each MCO has in effect a grievance system that meets specific requirements to ensure notification of enrollees in a timely manner for all types of grievances and appeals. Access to a grievance system affords enrollees with the right to express dissatisfaction with care or services provided by the MCO or its providers and the ability for MCOs to potentially identify issues that need to be addressed (e.g. requesting payment from enrollees, inappropriate denial of payment or services).
- Quality Assessment and Performance Improvement (QA) - 42 CFR § 438 Subpart D, Quality Assessment and Performance Improvement, sets forth MCO specifications for quality strategies to ensure the delivery of high quality healthcare and customer service. MCOs must measure performance (e.g. immunization rates, preventive screening rate) and use their data to improve the quality of services provided to enrollees through quality of care studies and other activities. Standards for quality, access, and timeliness of care are defined and MCOs must monitor these to ensure enrollees receive the benefits and services to which they are entitled.

The CR is conducted in accordance with the CMS protocol, *Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review, Protocol 1, Version 2.0, September 2012*. Delmarva Foundation’s systematic approach to completing the structural and operational systems review includes three phases of activities: pre-site review, on-site review, and post-site review. These activities are described below in Table 3.

Table 3. CR Activities

CR Activities	
Review Phase	Audit Activities
Pre-site Phase	Delmarva Foundation develops and confirms CR standards and elements with DHS. The standards and elements are provided to the MCO and discussed during an orientation conference call. The MCO is asked to complete a pre-site survey to allow reviewers to gain organizational insight and information on any changes to the MCO within the last year. The MCO posts (uploads) its electronic documents (written plans, policies, and procedures) to Delmarva Foundation’s secure web-based portal approximately 30 days prior to the on-site assessment. After this information is posted, auditors begin the document review. Completing a large portion of the document review during the pre-site phase optimizes on-site review time and allows the auditors time to focus on questions or areas of concern.
On-site Phase	Delmarva Foundation begins the three day on-site review with an opening conference and reviews the purpose and objectives of the CR. On-site review time is spent reviewing documentation, files, and records that were not available during the pre-site review. The review team also conducts staff interviews, observes processes, and follows up on Corrective Action Plans (CAPs), if necessary. Auditors are looking to make sure policies and procedures are followed and processes are consistent with requirements. A closing conference is held where auditors describe general findings, identify issues warranting follow up, discuss post-site activities, and provide opportunity for the MCO to respond to preliminary findings.

CR Activities	
Review Phase	Audit Activities
Post-site Phase	Delmarva Foundation develops and provides the MCO with an “exit” letter that officially notifies the MCO staff of items that were not fully met during the review. The MCO then has 10 business days to provide additional information to support compliance with identified standards. The information that is received is reviewed and integrated into the findings, and final determinations are made.

Assessment Procedures

Delmarva Foundation evaluates each standard by assessing compliance with all related elements and components. Standards (ER, GS, and QA) are comprised of elements and components, all of which are individually reviewed and scored. Each standard breaks down into elements and most elements break down into components. The following provides an example:

➤ **Enrollee Rights (ER) (standard)**

- **ER.1 (element)**

The MCO must provide the enrollees with written information in a manner and format that is easily understood.

- **ER 1.a (component)**

The MCO must provide to enrollee all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that is easily understood.

- **ER 1.b (component)**

The MCO must make its written information available in the prevalent non-English languages in its particular service area.

SHP is expected to demonstrate 100% compliance with each standard, element, and component. Delmarva Foundation uses a three-point scale for scoring compliance: *Met—100%*, *Partially Met—50%*, and *Unmet—0%*. Components for each element are assessed. Component assessments are then rolled up to the element level, and finally the standard level. Each component and element receives a review determination. When comprehensive CRs are completed, the aggregate compliance results are reported by standard and receive a numeric compliance score.

Encounter Data Validation

Encounter data are essential for measuring and monitoring MCO quality, service utilization, finances, and compliance with contract requirements. The data are also a critical source of information used to set capitation rates and perform risk adjustment to account for differences in beneficiary health status. As federal programs transition toward payment reform for demonstrated quality of care, validation of encounter data in the use of performance data will become increasingly significant.

Delmarva Foundation conducts EDV activities following the CMS Protocol, *Validation of Encounter Data Reported by the MCO, A Voluntary Protocol for External Quality Review, Protocol 4, Version 2.0, September 2012*. The protocol specifies procedures for EQROs to use in assessing the completeness and accuracy of encounter data submitted by MCOs to the state and consists of four sequential activities, which are defined in Table 4.

Table 4. EDV Activities

EDV Activities	
1.	Delmarva Foundation reviews state requirements for collecting and submitting encounter data. Auditors review MCO contractual requirements for collection and submission of encounter data to ensure that the MCO follows the state’s specifications for file format and types of encounters that must be submitted.
2.	Delmarva Foundation reviews the MCO’s capacity to produce accurate and complete encounter data. Auditors assess the MCO’s encounter/claims data processes and system through a detailed review of information systems documentation submitted by SHP as a component of the PMV activity and through interviews with key MCO staff. The ISCA is performed to identify any potential system or processing vulnerabilities that could potentially contribute to inaccurate or incomplete encounter data.
3.	Delmarva Foundation analyzes MCO encounter data for accuracy and completeness. Analysts examine electronic encounter data for consistency, accuracy, and completeness. This is accomplished by verifying that critical fields are populated in the correct format, the values are within the required ranges, and the volume of data is consistent with the MCO’s enrollment. To complete this activity, the state or MCO submits to Delmarva Foundation all encounter data for all claims/encounters for which payment was rendered during the measurement year.
4.	Delmarva Foundation reviews medical records for confirmation of findings of analysis of encounter data. Nurse reviewers/coders compare electronic encounter data to medical record documentation to confirm the accuracy of the reported encounters. A sample of encounters for inpatient, outpatient, and provider office visit service claims are reviewed to assess whether the electronic encounter was documented in the medical record and whether the level of documentation supports the billed service codes. The reviewer validates the date of service, place of service, primary and secondary diagnosis and procedure codes, and, if applicable revenue and DRG codes.

CAHPS® Survey

CAHPS® Surveys capture member feedback about the MCO, providers, and experiences in obtaining health care services. Survey results provide a general indication of how well member expectations are being met. Reported results, compared to benchmarks, identify areas meeting expectations and areas needing improvement.

The Adult CAHPS® survey is part of the CMS Adult Core Set of Measures and follows HEDIS® protocols. SHP contracted with a certified HEDIS® survey vendor to administer the survey. The NCQA Survey Vendor Certification Program assures the vendor administers the survey according to HEDIS® protocols and ensures standardization of data collected by multiple survey vendors which allows comparability among MCO results.

Using a validated sample frame validated by the HEDIS® Auditor according to HEDIS® protocols found in *HEDIS® 2015 Volume 3: Specifications for Survey Measures*, SHP’s contracted survey vendor administered the

2015 CAHPS 5.0H Member Satisfaction Survey. Members enrolled in the MCO for at least five of the last six months of the measurement year were selected via simple random sample. On January 19, 2015, the vendor mailed 1,350 surveys and received 412 completed surveys (via mail and phone), providing a 31% response rate for the survey.

Rating scores show the results of survey questions that ask respondents to rate four health care concepts on a scale of 0-10, where 0 is the worst possible assessment and 10 is the best possible assessment. The scores presented in the results table are the sum of positive responses that were scored 8, 9, and 10. The four concepts for respondents to rate included: (1) all health care, (2) personal doctor, (3) health plan, and (4) specialist seen most often.

Composite scores provide insight into areas of focus or areas of concern. Composite scores are obtained from responses to several survey questions that ask respondents how often they received care under certain conditions. Each composite looks at a specific situation and has two or more underlying questions. All questions for each composite have the same potential response categories: *Never*, *Sometimes*, *Usually*, or *Always*. The composite scores in the results table are summary rates based on the sum of proportional averages for questions in each composite where the response was either *Usually* or *Always*. The composite categories are Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making.

External Quality Review Results

Performance Improvement Project Review

SHP is conducting two PIPs, per requirements of the North Dakota Medicaid Expansion Quality Strategy. DHS requires at least one project to have a behavioral health focus. The MCO's PIP topics include:

- Prevention and Treatment of Chronic Conditions
- Follow-Up for Mental Health

MY 2014 is serving as the baseline year for the PIPs. Results of the project submissions are below in Tables 5 (Prevention and Treatment of Chronic Conditions PIP) and Table 7 (Follow-Up for Mental Health PIP).

Prevention and Treatment of Chronic Conditions PIP Results

SHP met all applicable requirements for its Prevention and Treatment of Chronic Conditions PIP, as identified in Table 5.

Table 5. Prevention and Treatment of Chronic Conditions PIP Results

Prevention and Treatment of Chronic Conditions PIP Results				
	Met	Partially Met	Not Met	Not Applicable
Step 1. Study Topic	X			
Step 2. Study Question	X			
Step 3. Study Indicator(s)	X			
Step 4. Study Population	X			
Step 5. Sampling Methods	X			
Step 6. Data Collection Procedures	X			
Step 7. Improvement Strategies				X
Step 8. Data Analysis/Interpretation	X			
Step 9. Real Improvement				X
Step 10. Sustained Improvement				X

Baseline performance measure results for the Prevention and Treatment of Chronic Conditions PIP are identified in Table 6.

Table 6. Prevention and Treatment of Chronic Conditions PIP Performance Measure Results

Prevention and Treatment of Chronic Conditions PIP Performance Measure Results	
Comprehensive Diabetes Care: Hemoglobin A1c Testing	
MY 2014 (baseline)	89.18%
MY 2015 (remeasurement 1)	To be determined
MY 2016 (remeasurement 2)	To be determined
Controlling High Blood Pressure	
MY 2014 (baseline)	68.13%
MY 2015 (remeasurement 1)	To be determined
MY 2016 (remeasurement 2)	To be determined
Adult Body Mass Index (BMI) Assessment	
MY 2014	Rate not available. Indicator specifications require continuous enrollment (2 years).
MY 2015 (baseline)	To be determined
MY 2016 (remeasurement 1)	To be determined

Strengths

- SHP provided a comprehensive project rationale indicating the need for the PIP. Chronic conditions have significant physical and financial impacts. As identified by the MCO, the obesity rate in North Dakota could reach 57.1% by 2030. Obesity can lead to multiple chronic conditions and negatively impact enrollee health.
- The baseline analysis, which was both quantitative and qualitative, included a system wide barrier analysis and identified potential interventions/opportunities for improvement.
- SHP has developed Diabetes and Hypertension Health Management Programs and aims to actively engage members with these conditions. In general, members are unsure how to effectively manage these chronic conditions. The programs are expected to have a positive impact on member health outcomes.

Recommendations

- SHP is encouraged to implement planned interventions and explore other possible opportunities for improvement.
- In regard to the Hemoglobin A1c Testing indicator, SHP’s baseline rate is very close to meeting its goal of 90%. SHP should consider revising its goal to the NCQA Quality Compass 90th Percentile. For HEDIS 2014, the Medicaid 90th Percentile was 91.73% for all lines of business (LOB).

Follow-Up for Mental Health PIP Results

SHP met all applicable requirements for its Follow-Up for Mental Health PIP. Results are identified in Table 7 below.

Table 7. Follow-Up for Mental Health PIP Results

Follow-Up for Mental Health PIP Results				
	Met	Partially Met	Not Met	Not Applicable
Step 1. Study Topic	X			
Step 2. Study Question	X			
Step 3. Study Indicator(s)	X			
Step 4. Study Population	X			
Step 5. Sampling Methods	X			
Step 6. Data Collection Procedures	X			
Step 7. Improvement Strategies				X
Step 8. Data Analysis/Interpretation	X			
Step 9. Real Improvement				X
Step 10. Sustained Improvement				X

Baseline performance measure results for the Follow-Up for Mental Health PIP are identified in Table 8.

Table 8. Follow-Up for Mental Health PIP Performance Measure Results

Follow-Up for Mental Health PIP Performance Measure Results	
Follow-Up After Hospitalization for Mental Health – Within 7 Days	
MY 2014 (baseline)	21.88%
MY 2015 (remeasurement 1)	To be determined
MY 2016 (remeasurement 2)	To be determined
Follow-Up After Hospitalization for Mental Health – Within 30 Days	
MY 2014 (baseline)	38.84%
MY 2015 (remeasurement 1)	To be determined
MY 2016 (remeasurement 2)	To be determined
Screening for Clinical Depression and Follow-Up Plan	
MY 2014	11.78%
MY 2015 (baseline)	To be determined
MY 2016 (remeasurement 1)	To be determined

Strengths

- SHP provided a comprehensive project rationale indicating the need for the PIP. Not only is mental health a concern for North Dakota, but based on the MCO's baseline performance, opportunity for improvement strongly exists within the Medicaid Expansion population.
- The baseline analysis, which was both quantitative and qualitative, included a system wide barrier analysis and identified potential interventions/opportunities for improvement.
- SHP plans to make contact with inpatient facilities to arrange 7 day follow up appointments prior to an inpatient discharge for mental illness. This intervention will directly target a significant barrier and is expected to positively impact performance.

Recommendation

- SHP is encouraged to implement planned interventions and explore other possible opportunities for improvement.

Performance Measure Validation

Validation Results

The MCO completed and submitted an ISCA, which reports information on the MCO's information system (IS) related to collecting and processing the required CMS Adult and Child Core Quality Measures. Based on a review of the ISCA, it appeared that SHP had satisfactory processes for data integration, data control, and interpretation of the performance measures for 2014. The site visit for the PMV audit included interviews with staff regarding the IS and associated procedures to fully explore and understand the claims systems and processes; enrollment system and processes; performance measurement team (programmers and analysts) quality assurance; and data warehouse overview.

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. Microsoft Access was used to calculate these measures. Samples and methodology for medical record abstraction, for measures requiring review, 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. Results are displayed in Table 9 below.

Table 9. Performance Measure Medical Record Over-Read Results

Medical Record Over-Read Results		
Performance Measure	Records Reviewed	Agreement Rate
Care Transition – Transition Record Transmitted to Health Care Professional	30	93%
Screening for Clinical Depression and Follow-Up Plan	30	100%

Performance Measure Results

SHP MY 2014 results for the CMS Adult and Child Core Quality Measures are displayed in Table 11 (adult results) and Table 12 (child results). Performance measure results are compared to benchmarks, which are largely based on the Quality Compass 2014 National Medicaid Average for All Lines of Business.

Comparisons are made using a diamond rating system. The following table describes the rating system:

Table 10. Diamond Rating System Used to Compare SHP Performance to Benchmarks

Diamond Rating System Used to Compare SHP Performance to Benchmarks	
Diamonds	SHP's Performance Compared to the Benchmarks
◆◆◆◆	MCO rate is equal to or exceeds the NCQA Quality Compass 90 th Percentile.
◆◆◆	MCO rate is equal to or exceeds the NCQA Quality Compass 75 th Percentile, but does not meet the 90 th Percentile.
◆◆	MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75 th Percentile.
◆	MCO rate is below the NCQA Quality Compass National Average.

The more diamonds that are displayed indicates a higher level of performance compared to the benchmarks.

Table 11. Adult Performance Measure Results Compared to Benchmarks

Adult Performance Measure Results Compared to Benchmarks		
Measure	MCO MY 2014 Rate	Comparison to Benchmarks*
Breast Cancer Screening	^	-
Adherence to Antipsychotics for Individuals with Schizophrenia	68.75%	◆◆◆
HIV Viral Load Suppression	NR	-
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Enrollees on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	83.66%	◆
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Enrollees on Digoxin	^	-
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Enrollees on Diuretics	83.60%	◆
Annual Monitoring for Patients on Persistent Medications - Total Rate	83.38%	◆
Antidepressant Medication Management - Effective Acute Phase Treatment	78.07%	◆◆◆◆
Antidepressant Medication Management - Effective Continuation Phase Treatment	71.12%	◆◆◆◆
Cervical Cancer Screening	19.77%	-
Chlamydia Screening in Women	31.91%	◆

Adult Performance Measure Results Compared to Benchmarks		
Measure	MCO MY 2014 Rate	Comparison to Benchmarks*
Follow-Up After Hospitalization for Mental Illness, Ages 21-64- Follow-Up Within 7 Days	21.88%	◆
Follow-Up After Hospitalization for Mental Illness, Ages 21-64- Follow-Up Within 30 Days	38.84%	◆
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%	◆
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%	◆◆
PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 18-64~	32.55**	◆◆
PQI 08 Congestive Heart Failure Admission Rate, Ages 18-64~	69.17**	◆◆
PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64~	264.59**	◆◆
PQI 15 Asthma in Younger Adults Admission Rate, Ages 18-39~	39.21**	◆◆
Plan All-Cause Readmissions Rate - Ages 18-44~	22.35%	-
Plan All-Cause Readmissions Rate - Ages 45-54~	17.34%	-
Plan All-Cause Readmissions Rate - Ages 55-64~	14.04%	-
Plan All-Cause Readmissions Rate - Total~	18.88%	-
Medical Assistance With Smoking and Tobacco Use Cessation - Advising Smokers and Tobacco Users to Quit	79.22%	◆◆
Medical Assistance With Smoking and Tobacco Use Cessation - Discussing Cessation Medications	47.06%	◆◆
Medical Assistance With Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	47.71%	◆◆◆
Flu Vaccinations for Adults, Ages 18-64	32.30%	◆
Adult Body Mass Index Assessment	^	-
Care Transition - Timely Transmission of Transition Record (Discharges From an Inpatient Facility to Home/Self Care or Any Other Site of Care)	15.82%	-
Comprehensive Diabetes Care - Hemoglobin A1c Testing	89.18%	◆◆◆
Comprehensive Diabetes Care - LDL-C Screening (retired measure in 2014)	74.52%	◆
Controlling High Blood Pressure	68.13%	◆◆◆
PC-01 Elective Delivery	^	-
PC-03 Antenatal Steroids	^	-
Prenatal and Post Partum Care: Postpartum Care Rate	^	-
Screening for Clinical Depression and Follow-Up Plan	11.78%	-

* Benchmark data source: Quality Compass 2014 (Measurement Year 2013 data) National Medicaid Average for All Lines of Business.

** Member observations per 100,000 members.

~ A lower rate is better.

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

NR MCO did not report a rate for this measure.

- Rate not available; no comparison could be made to the benchmarks. Or benchmarks are not available.

◆◆◆◆ MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.

◆◆◆ MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.

◆◆ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.

◆ MCO rate is below the NCQA Quality Compass National Average.

Table 12. Child Performance Measure Results Compared to Benchmarks

Child Performance Measure Results Compared to Benchmarks		
Measure	MCO MY 2014 Rate	Comparison to Benchmarks*
Medication Management for People With Asthma, Ages 19-20 - Percentage of Children Who Remained on an Asthma Controller Medication for At Least 50% of Their Treatment Period	^	-
Medication Management for People With Asthma, Ages 19-20 - Percentage of Children Who Remained on an Asthma Controller Medication for At Least 75% of Their Treatment Period	^	-
Follow-Up After Hospitalization for Mental Illness, Ages 19-20 - Follow-Up Within 7 Days	^	-
Follow-Up After Hospitalization for Mental Illness, Ages 19-20 - Follow-Up Within 30 Days	^	-
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication - Initiation Phase	^	-
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase	^	-
Adolescent Well Care Visits	7.14%	◆
Percentage of Eligibles that Received Preventive Dental Services (PDENT)	8.14%	◆
Percentage of Eligibles that Received Dental Treatment Services (TDENT)	6.44%	◆

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

* Benchmark data source: Quality Compass 2014 (Measurement Year 2013 data) National Medicaid Average for All Lines of Business.

- Rate not available; no comparison could be made to the benchmarks. Or benchmarks are not available.

◆◆◆ MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.

◆◆ MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.

◆ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.

◆ MCO rate is below the NCQA Quality Compass National Average.

The MCO performed above average on the following measures.

➤ Adult Performance Measures:

- Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Adherence to Antipsychotics for Individuals with Schizophrenia
- Initiation and Engagement of Alcohol and Other Drug Dependence(AOD) Treatment: Engagement of AOD Treatment
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
- PQI 08: Congestive Heart Failure (CHF) Admission Rate
- PQI 15: Adult Asthma Admission Rate

➤ Child Performance Measures:

- SHP did not perform above average for any child performance measures.

SHP performed below average on the following performance measures.

➤ Adult Performance Measures:

- Flu Vaccinations for Adults
- Chlamydia Screening in Women
- Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 7 Days)
- Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 30 Days)
- Comprehensive Diabetes Care: LDL-C Screening
- Annual Monitoring for Patients on Persistent Medications: For Enrollees on ACE Inhibitors or ARBs
- Annual Monitoring for Patients on Persistent Medications: For Enrollees on Diuretics
- Annual Monitoring for Patients on Persistent Medications: Total Rate
- Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Initiation of AOD Treatment

➤ Child Performance Measures:

- Adolescent Well-Care Visit
- Percentage of Eligibles that Received Preventive Dental Services
- Percentage of Eligibles that Received Dental Treatment Services

Several measures had a denominator that was too small to calculate a reliable rate (less than 30 observations).

Reasons for small denominators include:

- Some performance measures require two years of enrollment. SHP was limited with one year of enrollment. Enrollment began January 1, 2014.
- Most pregnant women disenroll from the Medicaid Expansion Program and enroll in traditional Medicaid.
- In general, the child core measures have a small eligible population—19-20 years of age.

Lastly, measures with reported rates were found to be compliant with corresponding performance measure specifications and received “reportable” audit designations. SHP was unable to calculate a performance rate for the measure, HIV Viral Load Suppression, as the MCO does not collect the required LOINC codes. Therefore, this measure’s audit designation was assessed as “not reportable.”

Strengths

SHP demonstrated numerous strengths throughout the PMV process. Most notably the MCO:

- Demonstrated knowledge of HEDIS® and non-HEDIS performance measures via experienced quality staff.
- Applied established processes to the Medicaid Expansion product line.
- Conducted several quality outreach programs in an effort to improve member compliance for HEDIS® measures.
- Collected, processed, and reported first year performance measures in a satisfactory and timely manner given a compressed timeframe.
- In regard to benchmarking, SHP exceeded the 90th Percentile in the following adult performance measures:
 - Antidepressant Medication Management – Effective Acute Phase Treatment
 - Antidepressant Medication Management – Effective Continuation Phase Treatment

MCO Recommendations

It is recommended that SHP:

- Continue to sample with hybrid performance measures to reduce the medical record review burden.
- Consider the use of supplemental data for both HEDIS® and non-HEDIS measures to improve performance measure rates.
- Explore the use of certified HEDIS® software to calculate non-HEDIS measures in the Adult and Child Core Measure Sets. Several certified HEDIS® software vendors now offer a catalogue for the core measures.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet the NCQA Quality Compass national averages.

DHS Recommendations

It is recommended that DHS:

- Eliminate perinatal measures from the list of required performance measures, as most pregnant women disenroll with the Medicaid Expansion Program and enroll in traditional Medicaid.
- Eliminate the HIV Viral Load Suppression measure as the MCO does not capture the LOINC codes necessary to report the numerator events for the measure.
- Eliminate the Comprehensive Diabetes Care – LDL-C Screening measure. HEDIS® retired this measure.
- Eliminate the Percentage of Eligibles that Received Dental Treatment Services measure. CMS retired this measure.
- Work with the EQRO and SHP to identify replacement measures that are meaningful to the Medicaid Expansion population.

Compliance Review

Results

The CR assessed SHP's 2014 compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion population. The three key areas of regulation include the following standards: Enrollee Rights (ER), Grievance Systems (GS), and Quality Assessment and Performance Improvement (QA).

Tables 13-15 include results for each standard. Specific component scores were rolled up to the element level and the results are displayed by element within each standard.

Table 13. Enrollee Rights Results

Enrollee Rights			
Element	Met	Partially Met	Unmet
ER.1. The MCO must provide to the enrollees written information (enrollee materials and notice of written action letters) in a manner and format that may be easily understood.	X		
ER.2. The MCO must make information on providers available to the enrollees upon enrollment and annually thereafter, and give enrollees reasonable notice of any changes regarding providers.	X		
ER.3. The MCO must provide to enrollees information on enrollee rights and responsibilities.	X		
ER.4. The MCO must inform enrollees about benefits available to the enrollee upon enrollment, annually, and at least 30 days prior to any change in benefits.	X		
ER.5. The MCO must inform enrollees about after-hours and emergency coverage and do so upon enrollment, annually, and at least 30 days prior to any change.	X		
ER.6. The MCO must provide information to its enrollees on grievance, appeal, and fair hearing procedures and timeframes in a State-developed or State-approved description, upon enrollment, annually, and at least 30 days prior to any change.		X	
ER.7. The MCO must provide information to enrollees regarding advance directives.	X		
ER.8. The MCO must provide information to their enrollees regarding physician incentive plans.	Not Applicable		
ER.9. The MCO must ensure that its CHIP enrollees are not held liable for any debts of the MCO or payments for covered services.	X		
ER.10. The MCO may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.	X		
ER.11. The MCO must ensure through its provider contracts that it discloses individually identifiable health information in accordance with the privacy requirements (HIPAA provisions).	X		

Enrollee and potential enrollee materials were developed and presented in a manner and format that is easily understood. DHS requires that member written materials not exceed an eighth grade reading level; SHP uses literacy assessments to ensure compliance. The MCO offers oral interpretation services and translates written materials free of charge for enrollees. Additionally, materials can also be produced in alternative formats to meet the needs of members who, for example, are visually limited.

SHP communicates enrollee rights to members and also assures through its provider contracts that it discloses individually identifiable health information in accordance with privacy requirements (HIPAA provisions). The MCO communicates benefits and procedures on how to obtain benefits and services to members as required. Lastly, SHP communicates member rights to file grievances and appeals and procedures on how to do so. However, SHP did not communicate the timely filing requirement for grievances in its 2014 member materials.

Overall, SHP received a score of 99% on the Enrollee Rights Standard.

Table 14. Grievance Systems Results

Grievance Systems			
Element	Met	Partially Met	Unmet
GS.1. The MCO must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State’s fair hearing system.	X		
GS.2. The MCO’s grievance process must be timely.	X		
GS.3. The MCO must maintain written requirements regarding the filing of a grievance.		X	
GS.4. The MCO must adhere to the state’s regulations regarding the content of the notice of action.	X		
GS.5. The MCO must handle grievances and appeals according to regulations.	X		
GS.6. The MCO must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the enrollee’s health condition requires, within state-established timeframes. The MCO must comply with the state’s regulations regarding the method the MCO will use to notify an enrollee of the disposition of a grievance.	X		
GS.7. The MCO must provide an expedited review process for appeals.	X		
GS.8. The MCO must provide information about the grievance system to all providers and subcontractors at the time they enter into a contract.		X	
GS.9. The MCO must maintain records of grievances and appeals and must review the information as part of the state’s quality strategy.	X		
GS.10. The MCO must continue to provide benefits to the enrollee while the appeal and the state fair hearing are pending if the request meets requirements.	X		

Grievance Systems			
Element	Met	Partially Met	Unmet
GS.11. The MCO may recover the cost of the services furnished to the enrollee while the appeal is pending if the final resolution of the appeal is adverse to the enrollee, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR § 431.230.b.	X		
GS.12. The MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, if the MCO or the State Fair Hearing Office reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending.	X		
GS.13. The MCO or the state must pay for those services, in accordance with state policy and regulations, if the MCO or the State Fair Hearing Office reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.	X		

SHP maintains a grievance system that allows enrollees to file grievances, appeals, and request state fair hearings. In addition to communicating member rights and procedural steps on the filing process in the Member Handbook, members are also informed of procedures via Notice of Action letters. Members have 90 days from the date of the incident to file a grievance and SHP must provide resolution within 90 days of receipt of the grievance. Members have 30 days from the date of the denial of services to file an appeal, and the MCO must provide resolution within 45 days of receipt. Member requests for state fair hearings must be made within 30 days of the appeal decision date. Members must exhaust the MCO appeal process before requesting a fair hearing.

Members are informed of available assistance offered by SHP during the filing process. Members have access to toll free telephone numbers, interpretation services, etc. SHP will assist members in completing forms, as appeals are required to be documented in writing. Members are also informed that they may request the continuation of benefits during the appeals and fair hearing process and that they may be responsible for the cost of such services, if the denial is upheld.

SHP did, however, require oral grievances be documented in writing by the member, when in fact according to regulations, grievances are not required to be put in writing. Additionally, the MCO did not have evidence of communicating all requirements and timeframes for filing a grievance or an appeal to providers at the time they enter into a contract.

Overall, SHP received a score of 98% on the Grievance Systems Standard.

Table 15. Quality Assessment and Performance Improvement Results

Quality Assessment and Performance Improvement Access and Availability (AA)			
Element	Met	Partially Met	Unmet
QA.AA.1. The MCO must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	X		
QA.AA.2. Each MCO, consistent with the scope of the contracted services, must provide female enrollees with direct access to a women’s health specialist, provide a second opinion, and provide necessary services out-of-network when they cannot be provided within the provider network (at no additional cost to the enrollee).	X		
QA.AA.3. The MCO must furnish services timely.		X	
Quality Assessment and Performance Improvement Coordination of Care (CC)			
Element	Met	Partially Met	Unmet
QA.CC.1. The MCO must implement procedures to deliver primary care to and coordinate health care services for all MCO enrollees.	X		
QA.CC.2. The MCO must coordinate services for enrollees with special health care needs.	X		
QA.CC.3. The MCOs must develop a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.	X		
QA.CC.4. The MCO must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist.	X		
QA.CC.5. The MCO must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	X		
QA.CC.6. The MCO must have policies and procedures that address how it manages enrollees who are placed into the lock-in program. The MCO must provide care coordination for its enrollees in the lock-in program.	X		
Quality Assessment and Performance Improvement Utilization Management (UM)			
Element	Met	Partially Met	Unmet
QA.UM.1. The MCO must have a written procedure in place for processing requests for initial and continuing authorizations of services.	X		
QA.UM.2. The MCO must notify the requesting provider and give the enrollee written notice of any decision by the MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR § 438.404, except that the notice to the provider need not be in writing.	X		
QA.UM.3. The MCO must provide timely authorization decisions.	X		

Quality Assessment and Performance Improvement Utilization Management (UM)			
Element	Met	Partially Met	Unmet
QA.UM.4. The MCO's written notice of action for termination, suspension, or reduction of previously authorized CHIP-covered service must be mailed timely.	X		
QA.UM.5. The MCO must not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	X		
QA.UM.6. The MCO must have in effect mechanisms to detect both under- and over-utilization of services.	X		
Quality Assessment and Performance Improvement Emergency Services (ES)			
Element	Met	Partially Met	Unmet
QA.ES.1. The MCO must cover and pay for emergency services and post-stabilization care services.	X		
Quality Assessment and Performance Improvement Credentialing and Recredentialing (CR)			
Element	Met	Partially Met	Unmet
QA.CR.1. The MCO must implement written policies and procedures for selection and retention of providers.	X		
QA.CR.2. The MCO's provider selection policies and procedures must not discriminate against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment.	X		
QA.CR.3. The MCO may not employ or contract with providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Balanced Budget Act of 1997. The MCO may not employ or subcontract with any federal or state sanctioned provider. Providers whose licenses have been suspended or revoked are to be disenrolled from provider services.	X		
QA.CR.4. The MCO must complete monthly queries of the System for Award Management (SAM) for excluded providers. Excluded providers should not be credentialed, or if credentialed, must be disenrolled from providing services.	X		
QA.CR.5. The MCO must report to the state when a provider is denied participating provider status. The MCO must electronically submit information relating to the non-inclusion of providers to the state within 30 calendar days of the non-inclusion action.	X		
Quality Assessment and Performance Improvement Fraud and Abuse (FA)			
Element	Met	Partially Met	Unmet
QA.FA.1. The MCO must have policies, procedures, and a mandatory compliance plan that are designed to guard against fraud and abuse and support program integrity.		X	

Quality Assessment and Performance Improvement Delegated Functions (DF)			
Element	Met	Partially Met	Unmet
QA.DF.1. The MCO must oversee and is accountable for any functions and responsibilities that it delegates to any subcontractor.	X		
Quality Assessment and Performance Improvement Disenrollment Procedures (DP)			
Element	Met	Partially Met	Unmet
QA.DP.1. The MCO must have disenrollment procedures. The procedures must specify MCO limitations.	X		
Quality Assessment and Performance Improvement Practice Guidelines (PG)			
Element	Met	Partially Met	Unmet
QA.PG.1. The MCO must maintain practice guidelines.	X		
Quality Assessment and Performance Improvement Quality Assurance and Quality Improvement (QA)			
Element	Met	Partially Met	Unmet
QA.QA.1. The MCO must maintain a Quality Assurance/Quality Improvement (QA/QI) Plan that summarizes its quality assurance system.	X		
Quality Assessment and Performance Improvement Performance Improvement (PI)			
Element	Met	Partially Met	Unmet
QA.PI.1. The MCO must conduct performance improvement projects that achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in areas of clinical and non-clinical care and are expected to have a favorable effect on health outcomes and enrollee satisfaction.	X		
Quality Assessment and Performance Improvement Performance Measurement (PM)			
Element	Met	Partially Met	Unmet
QA.PM.1. The MCO must submit performance measurement data.	X		

SHP has developed a quality program that measures and monitors quality related elements such as access and availability, utilization management functions, performance improvement, performance measures, etc. The MCO maintains a provider network that meets the requirements established by DHS. SHP monitors timely access to some, but not all, provider type appointments. The MCO needs to additionally monitor timely access for sick visits and high volume specialty appointments, as required by DHS.

The MCO appropriately coordinates care for enrollees with special needs and follows policies and requirements when making utilization management related decisions. SHP follows its credentialing and recredentialing procedures and completes related activities in a timely manner.

While SHP monitored inappropriate access or use of services and/or resources and reported suspected cases of fraud and abuse to the state in 2014, the MCO did not have a formal Fraud and Abuse Program in place to support program integrity. However, SHP has since made efforts to establish such program per state requirements.

The MCO completed performance measurement activities including reporting on the CMS Adult and Child Core Measure Sets, PIPs, and CAHPS Survey. SHP collected and reported baseline measurements as required which will allow for comparisons in future years.

Overall, SHP received a score of 98% on the Quality Assessment and Performance Improvement Standard.

Strengths

- SHP largely demonstrated compliance with requirements:
 - Enrollee Rights Standard: 99% compliant
 - Grievance Systems Standard: 98% compliant
 - Quality Assessment and Performance Improvement Standard: 98% compliant
- At the time of the site review, conducted in May 2015, SHP had already addressed some of its deficiencies and revised policies and member materials to meet requirements. Revisions will assist the MCO in meeting requirements for its 2015 evaluation.

Recommendations

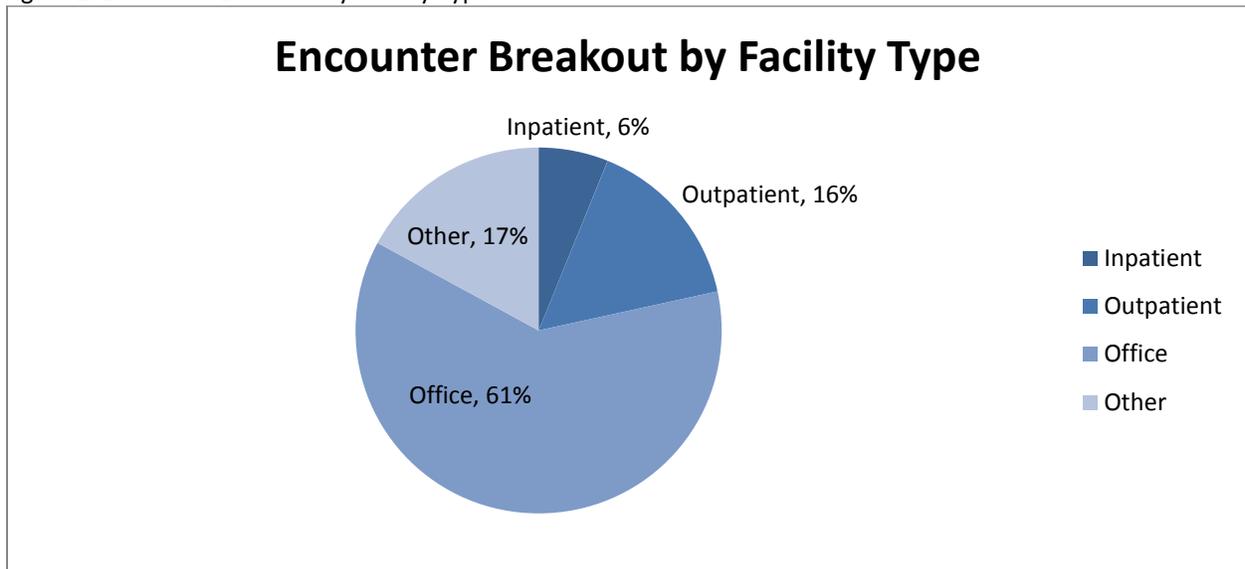
- SHP should review and implement explicit recommendations found in the detailed CR Report in order to improve processes and obtain full compliance.
- SHP should continue with efforts made in early 2015 to ensure the successful development and implementation of its Fraud and Abuse Program.

Encounter Data Validation

Claims Volume

The utilization rate for SHP, measured by the number of members with at least one paid claim, was 62%. Out of a total of 22,824 unique members, 14,187 (62%) had at least one paid claim during MY 2014. The increase in claims volume correlated with the increase in membership in 2014. Utilization by facility type is displayed in Figure 1.

Figure 1. Encounter Breakout by Facility Type



Timely Claims Submission

SHP stated that 99% of provider claims are submitted within 120 days of the date of service. This could not be verified as the encounter data file did not contain the date of claim receipt.

Data Completeness

Both the member file and the claims file were assessed for data completeness. The member file had less than 1% of cases where data were missing. Missing member data fields included dates of birth, gender, or social security numbers. The claims file also contained less than 1% of fields with missing data. Most frequently these omissions were for gender or primary diagnosis. Invalid social security numbers were found in 127 cases.

Data Accuracy

To further examine the completeness and accuracy of encounter data, a sample of SHP's members' medical records for billed claims was reviewed to examine the extent to which services billed were documented in the medical record and to confirm the accuracy and completeness of diagnosis and procedure codes submitted to SHP's encounter/claims data system.

SHP performed well on all key elements of importance to encounter data quality:

- The overall match rate (medical record documentation supporting the encounter data submitted) in MY 2014 was 96.0%.
- Inpatient records registered the highest match rate (99%), followed by outpatient records (97%), and office visit records (95%).

Tables 16-18 illustrate EDV results by review element for each encounter type. The elements reviewed for each encounter type were diagnosis codes, procedure codes, and revenue codes (not applicable for office visit encounters).

Table 16. North Dakota EDV Results by Element for Inpatient Encounter Type, MY 2014

Encounter Type	MY 2014			
	Diagnosis Codes	Revenue Codes	Procedure Codes	Total
Match	105	82	37	224
No Match	1	0	2	3
Total Elements	106	82	39	227
Match Percent	99%	100%	95%	99%

Table 17. North Dakota EDV Results by Element for Outpatient Encounter Type, MY 2014

Encounter Type	MY 2014			
	Diagnosis Codes	Revenue Codes	Procedure Codes	Total
Match	150	87	98	335
No Match	3	1	8	12
Total Elements	153	88	106	347
Match Percent	98%	99%	92%	97%

Table 18. North Dakota EDV Results by Element for Office Visit Encounter Type, MY 2014

Encounter Type	MY 2014			
	Diagnosis Codes	Revenue Codes	Procedure Codes	Total
Match	387	NA	288	675
No Match	22	NA	12	34
Total Elements	409	NA	300	709
Match Percent	95%	NA	96%	95%

“No Match” errors were due to lack of medical record documentation and incorrect principal diagnosis (inpatient encounters) or incorrect diagnosis codes.

Strengths

- SHP has well documented data integration and claims processing procedures.
- Member files and claims files were largely complete. Each file type had less than 1% missing data.
- In regard to accuracy, the overall match rate (medical record documentation supporting the encounter data submitted) in MY 2014 was 96.0%.

MCO Recommendations

- Add a field to encounter data to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 120 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.
- Conduct on-site visits to providers to explain state data reporting requirements and to provide technical assistance to providers in meeting ICD-10 reporting requirements.
- With the transition to ICD-10, review a stratified sample of medical records to ensure the integrity of claims submitted from providers and to identify non-conformities and focus areas for further education.
- Conduct targeted analyses when anomalies or irregularities are noted in data.
- Conduct provider audits to ascertain the extent to which providers are adherent to ICD-10 coding principles.

State Recommendations

As data and the Medicaid Expansion Program mature, it will be important to monitor encounter data for completeness and accuracy. Trending over time will help DHS to set realistic data goals and standards. In general, MCOs should strive to achieve a rate of 95% for completeness and accuracy. The SHP contract clearly defines encounters, file formats, and timeframes for submitting encounter data. DHS should:

- Clearly define the state's objectives and articulate measurable goals for encounter data completeness and accuracy. The usual standard is 95%.
- Include encounter data completeness and accuracy goals and monitoring processes as a component of North Dakota's overall Quality Strategy for the Medicaid Expansion Program.
- Beginning in October 2015, it will be important to monitor encounter data closely to ensure that the transition to ICD-10 coding does not impact the completeness and accuracy of MCO data. If DHS has not already done so, request that SHP submit an ICD-10 test file for review.

CAHPS® Survey

SHP contracted with a certified CAHPS® vendor to conduct the 2015 CAHPS 5.0H Member Satisfaction Survey. The survey captures member feedback about the MCO, providers, and member perception about getting needed care, getting care quickly, customer service, etc.

On January 19, 2015, 1,350 surveys were mailed to a random sample of members who had been continuously enrolled in the MCO for at least five of the last six months of the measurement year. A total of 412 surveys were completed via mail or phone, providing a response rate of 31%. The majority of respondents indicated that they were: in excellent/very good overall health and mental/emotional health; in the 18-34 age range (very closely followed by the 55 and older range); female; with an education of high school or less; and white.

SHP’s CAHPS® results were compared to NCQA Quality Compass benchmarks (Medicaid – All Lines of Business) to gauge performance and identify opportunities for improvement. Results are displayed in Table 19.

Table 19. CAHPS Survey Results Compared to Benchmarks

CAHPS Survey Results Compared to Benchmarks		
Measure	MCO 2015 Rate	MCO Rate Compared to Benchmarks*
Customer Service Composite	91.7%	◆◆◆◆
Getting Needed Care Composite	85.2%	◆◆◆
Getting Care Quickly Composite	84.6%	◆◆◆
How Well Doctors Communicate Composite	93.3%	◆◆◆◆
Shared Decision Making Composite [^]	79.0%	--
Health Promotion and Education Composite	65.3%	◆
Coordination of Care Composite	81.6%	◆◆
Rating of Health Plan (8+9+10)	71.7%	◆
Rating of All Health Care (8+9+10)	70.3%	◆
Rating of Personal Doctor (8+9+10)	84.7%	◆◆◆◆
Rating of Specialist Seen Most often (8+9+10)	78.3%	◆
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit	79.2%	◆◆
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications	47.1%	◆◆
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	47.7%	◆◆◆
Aspirin Use and Discussion: Take daily aspirin/ every other day	NA	--
Aspirin Use and Discussion: Discussed risks and benefits of using aspirin	39.0%	--
Flu vaccination: Had flu shot or spray in the nose since July 1, 2014	32.3%	--
Phoned plan to get help with transportation	2.89%	--
Received help with transportation	NR	--
Help with transportation met your needs	NR	--

* Benchmark Source: 2014 (MY 2013) NCQA Quality Compass National Medicaid, All Lines of Business.

[^] Shared Decision Making Composite measures were revised significantly between 2014 and 2015; therefore benchmarks are not available.

-- National benchmark not available.

NA Response rate <100.

NR Not Reportable; <11 responses.

◆ The rate is below the NCQA Quality Compass National Medicaid Average.

◆◆ The rate is equal to or exceeds the NCQA Quality Compass National Medicaid Average, but does not meet the 75th Percentile.

◆◆◆ The rate is equal to or exceeds the NCQA Quality Compass National Medicaid Average, but does not meet the 90th Percentile.

◆◆◆◆ The rate is equal to or exceeds the NCQA Quality Compass 90th Percentile for Medicaid.

The MCO performed above average on the following CAHPS® Survey measures:

- Customer Service Composite
- Getting Needed Care Composite
- Getting Care Quickly Composite

- How Well Doctors Communicate Composite
- Coordination of Care Composite
- Rating of Personal Doctor (8+9+10)
- Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

SHP performed below average on the following CAHPS® measures:

- Health Promotion and Education Composite
- Rating of Health Plan (8+9+10)
- Rating of All Health Care (8+9+10)
- Rating of Specialist Seen Most Often (8+9+10)

DHS required SHP add the transportation related questions to the survey to assess whether or not transportation services were meeting the needs of members. However, results were not reportable as there were less than 11 responses to the questions.

Strengths

- In regard to benchmarking, SHP exceeded the 90th Percentile in the following CAHPS® measures:
 - Customer Service Composite
 - How Well Doctors Communicate Composite
 - Rating of Personal Doctor (8+9+10)

Recommendation

- SHP should review the CAHPS® Survey report and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet the NCQA Quality Compass national averages.

Quality of, Access to, and Timeliness of Healthcare Services

Quality

Quality health care, as defined by the Institute of Medicine (IOM), is safe, effective, patient-centered, timely, efficient, and equitable (Crossing the Quality Chasm: A New Health System for the 21st Century, IOM, 2001). As it pertains to external quality review, it is defined as "the degree to which a Managed Care Organization (MCO)...increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." (Centers for Medicare & Medicaid Services, Final Rule: External Quality Review, 2003).

Quality Strengths

SHP developed a strong foundation for its quality program and completed baseline measurements for 2014. The MCO should be able to expand its quality program, measure and monitor performance, and implement interventions and quality initiatives in order to improve enrollee health related outcomes.

In compliance with the North Dakota Medicaid Quality Strategy, SHP implemented two PIPs, one of which has a behavioral health focus. The PIPs topics are (1) Prevention and Treatment of Chronic Conditions and (2) Follow-Up for Mental Health. The MCO successfully developed and reported on the PIPs. The project submissions included comprehensive project rationales and identified appropriate study questions and indicators. SHP completed barrier analyses for each project and identified interventions that will be implemented during MY 2015. SHP's PIP submissions met all applicable requirements.

SHP has established satisfactory processes for data integration, data control, and interpretation of the performance measures for 2014. Procedures and documentation used to calculate performance rates were found to be acceptable. Medical record over-read agreement rates exceeded minimum requirements. The MCO successfully reported baseline results for the CMS Adult (and applicable Child) Core Set of Measures. When rates are compared to the Quality Compass 2014 National Medicaid Average for All Lines of Business, SHP exceeded the national average for the following measures:

- Adult Performance Measures:
 - Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
 - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication
 - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
 - Controlling High Blood Pressure
 - Comprehensive Diabetes Care: Hemoglobin A1c Testing

- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Adherence to Antipsychotics for Individuals with Schizophrenia
- Initiation and Engagement of Alcohol and Other Drug Dependence(AOD) Treatment: Engagement of AOD Treatment
- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
- PQI 08: Congestive Heart Failure (CHF) Admission Rate
- PQI 15: Adult Asthma Admission Rate

➤ Child Performance Measures:

- SHP did not perform above average for any child performance measures.

Overall, based on the CR, SHP demonstrated a high level of compliance with federal regulations and contract requirements (including requirements outlined in the quality strategy). The MCO was 99% compliant with the Enrollee Rights Standard, 98% compliant with the Grievance Systems Standard, and 98% compliant with the Quality Assessment and Performance Improvement Standard. Specifically, in regard to quality, the MCO's quality program measures and monitors quality related elements such as access and availability, utilization management functions, performance improvement, performance measurement, etc. The MCO's Complex Case Management Program requires the MCO to identify and assess members with special health care needs. The program is based on evidence-based guidelines and NCQA requirements. SHP's credentialing and recredentialing policies and procedures also meet requirements; a random sample file review found that the MCO was compliant in its credentialing activities.

In regard to the SHP's encounter data, less than 1% of member file cases had missing data and less than 1% of claims files had fields with missing data. Data accuracy, based on a medical record review, was assessed at a 96% match rate where medical record documentation supported the encounter data submitted. In 2014, the MCO had well documented data integration and claims processing procedures.

Lastly, SHP measured 2014 member satisfaction via a CAHPS® Survey. Compared to the NCQA Quality Compass National Medicaid, All Lines of Business benchmarks, SHP scored above average in the following measures:

- Customer Service Composite
- Getting Needed Care Composite
- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Coordination of Care Composite
- Rating of Personal Doctor (8+9+10)

- Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

Quality Recommendations

SHP should expand upon its current quality framework in an effort to develop a comprehensive program that measures and monitors all activities and performance related indicators. The MCO should identify benchmarks, goals, and/or thresholds in which to measure itself against. When performance does not meet an acceptable goal or threshold, the MCO should identify barriers and develop and implement activities that aim to improve performance.

SHP is encouraged to continue with the development of its two PIPs. The MCO must implement interventions, monitor performance, and assess effectiveness of interventions. SHP should continue to evaluate barriers and ensure that interventions target barriers.

The MCO should review its core measure results and identify and implement strategies to improve performance on rates that did not meet the national benchmark average. These measures include:

- Adult Performance Measures:
 - Flu Vaccinations for Adults
 - Chlamydia Screening in Women
 - Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 7 Days)
 - Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 30 Days)
 - Comprehensive Diabetes Care: LDL-C Screening
 - Annual Monitoring for Patients on Persistent Medications: For Enrollees on ACE Inhibitors or ARBs
 - Annual Monitoring for Patients on Persistent Medications: For Enrollees on Diuretics
 - Annual Monitoring for Patients on Persistent Medications: Total Rate
 - Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Initiation of AOD Treatment

- Child Performance Measures:
 - Adolescent Well-Care Visit
 - Percentage of Eligibles that Received Preventive Dental Services
 - Percentage of Eligibles that Received Dental Treatment Services

In regard to the CR, SHP should review the CR Report and its detailed findings and recommendations. Specific recommendations are made, that if implemented, should demonstrate compliance with requirements and positively impact member outcomes. Most notably, the MCO needs to fully implement a formal Fraud

and Abuse Program to support program integrity. While SHP's program was not officially in effect in 2014, the MCO has been working to develop a Fraud and Abuse Program in 2015.

To ensure timely receipt of provider claims, SHP should add a field to its encounter data to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 120 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.

For CAHPS® Survey measures not meeting the national averages, SHP should develop and implement initiatives that aim to improve performance. SHP performed below average on the following measures:

- Health Promotion and Education Composite
- Rating of Health Plan (8+9+10)
- Rating of All Health Care (8+9+10)
- Rating of Specialist Seen Most Often (8+9+10)

Access

An assessment of access considers the degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the healthcare system. Access (or accessibility), as defined by NCQA, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." Access to healthcare is the foundation of good health outcomes.

Access Strengths

Numerous elements within the CR assessed access to vital member information and access to providers and healthcare services. SHP provided members with information on available benefits and instructions on how to access such services. Member materials communicate how to select and access providers and how to obtain after hours and emergency services. In an effort to promote the delivery of healthcare in a culturally competent manner, the MCO communicated the availability of oral interpretation services and how to obtain written translated materials. Additionally, SHP explained members' rights to access and utilize the grievance system.

SHP provides members with access to an adequate primary care provider (PCP) network in terms of numbers and geography. DHS requires the MCO have at least 1 PCP for every 2,500 members. SHP more than adequately meets the state's requirement in terms of numbers of providers. 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 PCPs; all members have access to primary care within 50 miles. Additionally, in regard to access, female enrollees have direct access to women's health specialists, all

members have access to second opinions, and members may obtain necessary healthcare services outside of the provider network should SHP providers not be able to adequately provide them.

The MCO also provides transportation services to members requiring the service. SHP can arrange to transport members to provider offices for routine, non-emergency care. Members may also pick up prescriptions or durable medical equipment on the day of appointments.

Based on survey results, SHP compares favorably to the national average benchmarks for the CAHPS® Survey composites: Getting Needed Care and Coordination of Care. Both composites provide evidence of member satisfaction with access to care.

Access Recommendations

SHP should address recommendations made in the CR Report that may impact access. Further, the MCO should actively monitor and review any access related complaints or grievances to quickly identify and resolve access related issues.

Timeliness

The IOM defines timeliness as “reducing waits and sometimes harmful delays.” Standards for timeliness are incorporated into the MCO contract and define the length of time in which an enrollee would be able to schedule or receive an appointment. Timeframes are based on the urgency of need and the presence or absence of health symptoms.

Timeliness Strengths

SHP maintains a policy and procedure that addresses timely access to provider appointments. Based on the CR, it was determined that members have timely access to urgent care and routine/preventive care appointments 95% of the time. In the event of an emergency, members are instructed to access emergency services immediately. Members may go to the closest emergency room or call 911. The MCO’s Provider Access and Availability Standards require providers to be available 24 hours a day, 7 days a week. SHP has developed procedures to monitor timely access and is able to take corrective action if there is failure to comply.

Members also have rights to timely resolution for grievances and appeals and timely utilization management decisions. During the CR, a random sample of appeals was reviewed and all were resolved timely.

CAHPS® Survey results revealed favorable scoring on the Getting Care Quickly composite. Results exceeded the national average benchmark.

Timeliness Recommendations

In addition to monitoring timely access to urgent care and routine/preventive care visits, SHP should also monitor timely access for sick visits and timely access to specialty providers. Additionally, the MCO should actively monitor and review any timeliness related complaints or grievances to quickly identify and resolve timeliness related issues.

Conclusions

By the 2014 year end, 17,212 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the first year, 62% of the enrollees utilized health care services. North Dakota DHS has effectively managed oversight and collaboratively worked with SHP and the EQRO to ensure successful implementation, monitoring, and evaluation of the program.

SHP provided evidence of meeting almost all federal, state, and quality strategy requirements. In the few instances where the MCO did not meet requirements in its first year of operation, it has since demonstrated that it is actively working to develop plans and policies to meet requirements. SHP has developed a quality program that measures and monitors performance. The MCO has established baseline performance and will be able to compare future performance to the 2014 measurement year. As the program matures and collects additional data and performance results, SHP and DHS will easily be able to identify opportunities for improvement in an effort to improve the health outcomes of the Medicaid Expansion population.

The EQRO will evaluate MCO progress in the next annual report. Performance will be compared to baseline results.

Recommendations

MCO Recommendations

It is recommended that SHP:

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- Review and act on explicit recommendations made by the EQRO in the separate, detailed Compliance Review report.
- Revise enrollee materials to clearly communicate the grievance timely filing requirement of 90 days from the date of incident. Revise policies to eliminate the requirement for written grievances.
- Continue with efforts to develop a formal Fraud and Abuse Program supported by relevant policies that outline procedures to prevent, detect, investigate, and report suspected or actual fraud, waste, and abuse.

- Ensure that timely access surveys include all provider types and situations, including consultations with specialists, as the MCO did not monitor access to all provider types during 2014.
- Implement new disease management programs as planned: Coronary Artery Disease, Attention Deficit Hyperactivity Disorder, and Asthma. Encourage participation and engagement in new and existing programs.
- Implement interventions for PIPs that aim to improve member outcomes.
- Review the CMS Adult and Child Core Measure Set performance measure results and the CAHPS® Survey results and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet the national Medicaid averages.
- Add a field to encounter data to document the date a claim is received to monitor provider claim submission timeliness and SHP claim payment timeliness.

State Recommendations

It is recommended that ND DHS:

- Continue to support, provide guidance, and work collaboratively with SHP as the organization works to meet all requirements.
- Continue to work with the EQRO to develop acceptable standards and to identify opportunities for improvement.
- Continue to review reports from SHP and provide recommendations as needed. Monitor results for trends and intervene early should concerns arise.
- Require SHP to follow up on recommendations made by the EQRO in the Compliance Review.
- Define high volume specialists to member ratios to assure adequate provider access.
- Define geographic access requirements for high volume specialists.
- Review the list of measures that the EQRO recommends to eliminate based on pregnant women disenrollment, the MCO not capturing necessary LOINC codes, and measure retirement.
- Work with the EQRO and MCO to identify new replacement measures that are meaningful to the Medicaid Expansion population.
- Define measureable goals for encounter data completeness and accuracy; 95% is recommended.
- Review and revise the North Dakota Medicaid Expansion Quality Strategy annually, and:
 - Establish minimum performance thresholds for performance measures; national Medicaid average is recommended.
 - Include new requirements or shift priorities as opportunities present themselves.