

North Dakota
Department of Human Services



North Dakota Medicaid Expansion Program

2016 Annual Technical Report

Measurement Year 2015



Delmarva Foundation

A subsidiary of Quality Health Strategies

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North Dakota Medicaid Expansion Program

2016 Annual Technical Report (Measurement Year 2015)

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 2016, assessed SHP's measurement year (MY) 2015 compliance with federal and state requirements, as identified in the Code of Federal Regulations (42 CFR § 438), the SHP Managed Care Organization (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
- Focused Quality Study (FQS)

This annual technical report describes MY 2015 results of EQR activities and summarizes MCO strengths and recommendations in regard to providing quality, accessible, and timely healthcare services to the Medicaid Expansion population.

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 of the projects. The study questions and performance measures identified were applicable to and supported the PIPs. Interventions implemented addressed barriers and the MCO successfully reported improvement in its first year of remeasurement.

Performance Measure Validation

SHP had satisfactory processes for data integration, data control, and interpretation of the CMS Adult and Child Core Measures for MY 2015. Procedures and documentation used to calculate performance measures with the MCO's certified HEDIS®¹ 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 and reported demonstrated improvement in 20 of 29 measures.

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

- Some performance measures require longer than two years of enrollment. SHP was limited with two years 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 limited 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.”

Specific performance measure results are displayed in Tables 12 and 13 of the Annual Technical Report.

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Compliance Review

In general, SHP demonstrated compliance with federal and state regulations and requirements during MY 2015, 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: 100% compliant
- Grievance Systems Standard: 94% compliant
- Quality Assessment and Performance Improvement Standard: 97% compliant

Compared to MY 2014, improvement was noted in the Enrollee Rights Standard and performance slightly declined in both the Grievance Systems and Quality Assessment and Performance Improvement Standards. The decline in performance was attributed to not complying with all recommendations for improvement from MY 2015 and the introduction of several new contract requirements, such as monitoring timely access to next available appointments for specialty providers.

At the time of the site review, conducted in May 2016, SHP was already aware of noncompliant elements and was working to ensure revised member materials and policies and procedures address requirements for the next annual review.

Encounter Data Validation

By the 2015 year end, 20,601 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the 2015 measurement year of operation, 69% of the enrollees utilized health care services, up from 62% in MY 2014. There was an increase in SHP's claims volume which correlated with the increase in membership in 2015. 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 2015 was 92%. In MY 2014, the match rate was 96%. A four percentage point decline in match rate was noted. The decline may be indicative of the transition from the ICD-9 to ICD-10 coding principles. The match rate will continue to be monitored.

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 one year 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 2016 CAHPS 5.0H Member Satisfaction Survey. On January 22, 2016, 1,359 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 30% 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. Most performance measure results exceeded the national average benchmarks. Results are displayed in Table 20 of the Annual Technical Report.

Focused Quality Study

Based on Delmarva Foundation's MY 2014 EDV analysis, it was revealed that the North Dakota Medicaid Expansion population's top primary diagnosis was low back pain. The following study question was posed: Do North Dakota Medicaid Expansion network practitioners treat low back pain without ordering an imaging study within 28 days of diagnosis? The goal of the focused study is to identify the percentage of North Dakota Medicaid Expansion members with a primary diagnosis of low back pain who did *not* receive an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis. A higher rate indicates appropriate treatment of low back pain.

Due to low back pain being the most frequent diagnosis for the North Dakota Medicaid Expansion population, it is important to explore practitioner compliance with delaying the utilization of imaging studies when they are not necessary, as they are costly and do not lead to improved clinical outcomes.

Following the EQRO Protocols on (1) conducting focused studies and (2) calculating performance measures and using the HEDIS® Use of Imaging Studies for Low Back Pain performance measure specifications as a guide, Delmarva Foundation calculated the rate for MY 2015: 78.63%. SHP's rate of compliance with delaying utilization of imaging studies performed well above average and marginally exceeded the 75 percentile benchmark.

While practitioners are largely compliant, there is also opportunity for improvement. Practitioners should be reminded that imaging studies should be delayed when patients initially present with low back pain if there are no red flags and there are no signs or symptoms indicating a serious underlying condition. Practitioners are

encouraged to recommend medications, provide patient education, and refer patients for physical therapy services. Performance should continue to be monitored and trended due to (1) the frequency of the diagnosis and (2) the research that indicates costly imaging studies do not improve clinical outcomes. Should performance fall below the 75th percentile, Delmarva Foundation will recommend SHP initiate interventions to address and improve performance.

Summary of Quality, Access, and Timeliness

Quality

SHP developed a strong foundation for its quality program and completed its first remeasurement year. The MCO should continue to strengthen 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. SHP implemented interventions that address barriers and reported improvement in both projects for MY 2015.

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. Most performance measure results exceed national average benchmarks. Similarly, SHP’s CAHPS® Survey results exceed national average benchmarks in most measures.

The MCO performed well on the Quality Assessment and Performance Improvement Standard in the CR (97%), 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 the next annual audit.

SHP should continue to develop its current quality program. The program should regularly measure and monitor all activities and performance related indicators and take action 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 must increase the frequency in which stakeholders meet to discuss quality initiatives and the MCO should develop an annual Quality Program Evaluation. The MCO should trend annual results in the evaluation to facilitate an understanding of performance year over year.

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 provider 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 should address recommendations made in the CR Report that may impact access. The MCO marginally exceeds compliance with geographic access for: OB/GYN, Orthopedic Surgery, and Psychiatric providers; SHP should monitor compliance for these provider types closely. Further, the MCO should 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 primary care type providers for urgent care and routine/preventive care appointments. 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 decisions were made in a timely manner.

For the first time during MY 2015, SHP evaluated timely access to next available appointments for maternity, specialty, and behavioral health services. There is opportunity for improvement for all of these provider types. 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 2015 year end, 20,601 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the course of the year, 69% of the enrollees utilized health care services. Utilization increased by seven percentage points compared to MY 2014. The MCO provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, based on the infancy of the North Dakota Medicaid Expansion Program, SHP is performing well. The MCO is actively working to address deficiencies identified during the course of the review. SHP has developed a quality program that measures and monitors performance. The MCO now has two years of data to understand current performance and opportunities for improvement. Addressing these opportunities will facilitate improvement in the areas of quality, access, and timeliness of care for the Medicaid Expansion population.

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.

Recommendations

MCO Recommendations

It is recommended that SHP:

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- Continue with current PIP interventions and explore additional opportunities that address barriers.
- 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. This should also be done for the CAHPS® measure results.
- Review and act on specific recommendations made by the EQRO in the Compliance Review report.
- Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next appointments.
- Continue administration of disease management programs and engage members in self-management initiatives.
- Continue with administration of new Fraud, Waste and Abuse Program to prevent, detect, investigate, and report suspected or actual fraud, waste and abuse.

- Participate in regular quality meetings to facilitate quality improvement discussions and initiatives.
- Conduct an annual Quality Program Evaluation that evaluates Quality Work Plan activities and outcomes. Trend annual results in the evaluation to facilitate an understanding of performance year over year.
- 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 one year of the date of service and will also aid in monitoring SHP's timeliness in paying claims.

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 review reports from SHP and provide recommendations as needed.
- Require SHP trend annual performance measure results in all reporting areas. This allows DHS to monitor performance over time and intervene should a negative trend emerge.
- Require SHP to follow up on recommendations made by the EQRO in the Compliance Review.
- Continue to have the EQRO conduct the focused study on low back pain. It was the most frequent MY 2014 diagnosis and remains in the top three diagnoses in MY 2015. Remeasurement to evaluate inappropriate imaging studies provides valuable feedback and monitors provider compliance with practice guidelines. Noncompliance may lead to unnecessary imaging studies that are costly and do not correlate to improved clinical outcomes.
- Review and revise the North Dakota Medicaid Expansion Quality Strategy annually, and:
 - Establish minimum performance thresholds for performance measures.
 - Include new requirements or shift priorities as opportunities present themselves.
 - Work with the EQRO and SHP to identify performance measures that are meaningful to the Medicaid Expansion population.

North Dakota Medicaid Expansion Program

2016 Annual Technical Report (Measurement Year 2015)

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
- Focused Quality Study (FQS)

The comprehensive assessment, conducted in 2016, assessed SHP's measurement year (MY) 2015 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 performance results for MY 2015; 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 2016 EQR activities with DHS and SHP in October 2015. Actual review and auditing activities began in March 2016 and concluded in July 2016. In addition to reviewing electronic reports, policies, data, and information systems, a two 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.

PIP Validation Steps	
Step	Validation Requirement
3. Study Indicator(s)	The study indicator(s) should be meaningful, clearly defined, and measurable.
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 PIP 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 two 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.
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 enrollees 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®² 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 valid sample frame validated by the HEDIS® Auditor according to HEDIS® protocols found in *HEDIS® 2016 Volume 3: Specifications for Survey Measures*, SHP's contracted survey vendor administered the 2016 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 22, 2016, the vendor mailed 1,359 surveys and received 406 completed surveys (via mail and phone), providing a 30% response rate for the survey.

² HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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.

Focused Quality Study

FQs target relevant areas of MCO clinical and non-clinical services in which performance is assessed to determine compliance and/or opportunities for improvement. Results provide DHS with an in depth assessment of a particular area of interest.

Delmarva Foundation uses the CMS protocol, *Conducting Focused Studies of Health Care Quality—A Voluntary Protocol for External Quality Review, Protocol 8, Version 2.0, September 2012*, as a guide in FQS activities. FQS activities are outlined in Table 5.

Table 5. FQS Activities

FQS Activities
Activity 1: Select the Study Topic
Activity 2: Define the Study Question(s)
Activity 3: Select the Study Variables
Activity 4: Study the Whole Population or Use a Representative Sample
Activity 5: Use Sound Sampling Methods
Activity 6: Reliably Collect Data
Activity 7: Analyze and Interpret Study Results
Activity 8: Report Results to the State

Delmarva Foundation tailors the FQS based on the study topic and the needs of DHS. Following the protocol, we conduct the study and report findings in a manner that is meaningful to the State. Delmarva Foundation also makes recommendations based on the FQS results.

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 2015 serves as remeasurement year 1 for the PIPs. Validation results of the project submissions are below in Tables 6 (Prevention and Treatment of Chronic Conditions PIP) and Table 8 (Follow-Up for Mental Health PIP). Respective performance measure results are displayed in Tables 7 and 9.

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 6, with one exception. Step 9, Real Improvement, was assessed as partially met as the observed improvement was not statistically significant.

Table 6. 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

Performance measure results for the Prevention and Treatment of Chronic Conditions PIP are identified in Table 7.

Table 7. 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)	91.42%
MY 2016 (remeasurement 2)	To be determined

Prevention and Treatment of Chronic Conditions PIP Performance Measure Results	
Controlling High Blood Pressure	
MY 2014 (baseline)	68.13%
MY 2015 (remeasurement 1)	68.61%
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)	91.73%
MY 2016 (remeasurement 1)	To be determined

Interventions

SHP had the following interventions in place during MY 2015 for the Prevention and Treatment of Chronic Conditions PIP:

- Diabetes and Healthy Heart (Hypertension) Health Management Programs. The programs aim to monitor and improve adherence to treatment plans by empowering members with knowledge about their condition, reinforce education, and provide support and assistance in overcoming barriers to care and lifestyle issues. The programs also monitor members who are most at risk for complications. Program components include mailing educational materials (and communicating the covered program benefit), providing practitioner education on evidence-based clinical guidelines, and educating members via telephonic contact and care coordination activities. Intervention and educational components of the health management programs include and address:

- Condition monitoring (self-monitoring and medical testing)
- Adherence to treatment plans
- Medical and behavioral health comorbidities and other health conditions
- Healthy behaviors (nutrition, exercise, weight management, etc.)
- Psychosocial issues (addressing barriers and beliefs)
- Depression screening
- Providing information to caregiver
- Encouraging communication with practitioners
- Additional external resources

Case Managers work with the complex members in the programs and educate them via telephone regarding appropriate utilization, guideline recommendations, resources, etc.

- Letters/postcards are mailed to members who are noncompliant with:
 - Getting labs values checked when taking persistent medications—ACEI/ARB
 - Comprehensive diabetes performance measures
 - Controlling high blood pressure

Mailings include educational materials and encourage engagement with PCPs and compliance in monitoring and managing conditions.

- Population Health and Patient Centered Medical Home Collaboration with other health systems to build relationships and share best practices. Collaboration activities aim to improve patient outcomes and quality of care. The intervention aims to address concerns with practitioners not talking to patients about their BMIs and Best Practice Advisory in electronic medical records.

Strengths

SHP's Prevention and Treatment of Chronic Conditions PIP Report exhibited several strengths:

- The MCO provided a comprehensive project rationale indicating the need for the PIP. Individuals with chronic conditions experience 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.
- SHP exceeded its goal of 90% compliance for the Hemoglobin A1c Testing measure in its first year of remeasurement.
- SHP interventions are system-level and are expected to improve indicator performance. Most notably, SHP engages members in Diabetes and Healthy Heart health management programs. The programs aim to monitor and improve adherence to treatment plans by empowering members with knowledge about their condition, reinforce education, and provide support and assistance in overcoming barriers to care and lifestyle issues.

Recommendations

SHP is encouraged to continue with current interventions and explore additional opportunities that address barriers.

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 8 below.

Table 8. 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

Performance measure results for the Follow-Up for Mental Health PIP are identified in Table 9.

Table 9. 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)	27.44%
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)	49.62%
MY 2016 (remeasurement 2)	To be determined
Screening for Clinical Depression and Follow-Up Plan	
MY 2014	11.78%
MY 2015 (baseline)	14.69%
MY 2016 (remeasurement 1)	To be determined

Interventions

SHP had the following interventions in place during MY 2015 for the Follow Up for Mental Health PIP:

- Use of the MCO’s Life Advocates to call the inpatient facility to arrange for a 7 day follow-up appointment for members prior to discharge.
- Collaboration with Sanford Health on behavioral health issues. Collaboration includes regularly scheduled calls to discuss current behavioral health concerns and display of depression screening results.
- Collaboration with health systems to build relationships and sharing of best practices, including how to improve patient outcomes and quality of care.

Strengths

SHP’s Follow Up for Mental Health PIP Report exhibited several strengths:

- SHP provided a comprehensive project rationale indicating the need for the PIP. Not only is mental health a concern in North Dakota, but based on the MCO’s baseline performance, opportunity for improvement strongly exists within the Medicaid Expansion population as performance is well below the national average benchmarks.
- The Remeasurement 1 analysis, which was both quantitative and qualitative, included a system wide barrier analysis and identified potential interventions/opportunities for improvement to explore in the future.
- SHP demonstrated improvement in all three PIP performance measures. The MCO also exceeded its goals of 25% compliance for Follow-up after Hospitalization for Mental Health – 7 days and 45% compliance for Follow-up after Hospitalization for Mental Health – 30 days.
- Interventions are noted to be system-level and are expected to improve performance measures.

Recommendations

SHP is encouraged to continue with current interventions and explore additional opportunities that address barriers.

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 MY 2015. 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 practices; 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 10 below.

Table 10. 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	100%
Screening for Clinical Depression and Follow-Up Plan	30	100%

Performance Measure Results

SHP MY 2015 results for the CMS Adult and Child Core Quality Measures are displayed in Table 12 (adult results) and Table 13 (child results). Performance measure results are compared to benchmarks, which are largely based on the NCQA Quality Compass 2015 National Medicaid Average for All Lines of Business. Comparisons are made using a diamond rating system. The following table describes the rating system:

Table 11. 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. MY 2014 performance is also included for comparison purposes.

Table 12. Adult Performance Measure Results Compared to Benchmarks

Measure	MCO MY 2014 Rate	MCO MY 2015 Rate	Comparison to Benchmarks*
Breast Cancer Screening	^	^	-
Adherence to Antipsychotics for Individuals with Schizophrenia	68.75%	70.31%	◆◆◆
HIV Viral Load Suppression	^	^	-
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Enrollees on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	83.66%	86.46%	◆
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%	86.73%	◆
Annual Monitoring for Patients on Persistent Medications - Total Rate	83.38%	86.57%	◆
Antidepressant Medication Management - Effective Acute Phase Treatment	78.07%	66.59%	◆◆◆◆
Antidepressant Medication Management - Effective Continuation Phase Treatment	71.12%	55.00%	◆◆◆◆
Cervical Cancer Screening	19.77%	26.26%	◆
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	31.91%	40.52%	◆
Follow-Up After Hospitalization for Mental Illness, Ages 21-64 - Follow-Up Within 7 Days	21.88%	27.44%	◆
Follow-Up After Hospitalization for Mental Illness, Ages 21-64 - Follow-Up Within 30 Days	38.84%	49.62%	◆
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64 - Initiated Treatment Through an Inpatient Alcohol or Other Drug (AOD) Admission, Outpatient Visit, Intensive Outpatient Encounter, or Partial Hospitalization Within 14 Days of the Diagnosis (Initiation)	37.63%	37.44%	◆
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64 - Initiated Treatment and Who Had Two or More Additional Services With a Diagnosis of AOD Within 30 Days of the Initiation Visit (Engagement)	13.44%	13.15%	◆◆
PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 18-64~	32.55**	33.00**	-

Measure	MCO MY 2014 Rate	MCO MY 2015 Rate	Comparison to Benchmarks*
PQI 08 Congestive Heart Failure Admission Rate, Ages 18-64~	69.17**	18.19**	-
PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64~	264.59**	46.85**	-
PQI 15 Asthma in Younger Adults Admission Rate, Ages 18-39~	39.21**	8.09**	-
Plan All-Cause Readmissions Rate - Ages 18-44~	22.35%	18.79%	-
Plan All-Cause Readmissions Rate - Ages 45-54~	17.34%	21.92%	-
Plan All-Cause Readmissions Rate - Ages 55-64~	14.04%	14.50%	-
Plan All-Cause Readmissions Rate - Total~	18.88%	18.78%	-
Medical Assistance With Smoking and Tobacco Use Cessation - Advising Smokers and Tobacco Users to Quit	79.22%	75.09%	♦
Medical Assistance With Smoking and Tobacco Use Cessation - Discussing Cessation Medications	47.06%	48.11%	♦♦
Medical Assistance With Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	47.71%	47.44%	♦♦
Flu Vaccinations for Adults, Ages 18-64	32.30%	37.95%	♦
Adult Body Mass Index Assessment	^	91.73%	♦♦♦
Care Transition - Timely Transmission of Transition Record (Discharges From an Inpatient Facility to Home/Self-Care or Any Other Site of Care)	15.82%	17.40%	-
Comprehensive Diabetes Care - Hemoglobin A1c Testing	89.18%	91.42%	♦♦♦
Comprehensive Diabetes Care - LDL-C Screening (measure retired in 2014★)	74.52%	77.55%	♦♦
Controlling High Blood Pressure	68.13%	68.61%	♦♦♦
PC-01 Elective Delivery	^	^	-
PC-03 Antenatal Steroids	^	^	-
Prenatal and Postpartum Care: Postpartum Care Rate	^	56.90%	♦
Screening for Clinical Depression and Follow-Up Plan	11.78%	14.69%	-

* Benchmark data source: Quality Compass 2015 (MY 2014 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.

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

Table 13. Child Performance Measure Results Compared to Benchmarks

Measure	MCO MY 2014 Rate	MCO MY 2015 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	^	^	-

Measure	MCO MY 2014 Rate	MCO MY 2015 Rate	Comparison to Benchmarks*
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%	10.81%	◆
Percentage of Eligibles that Received Preventive Dental Services (PDENT)	8.14%	9.52%	◆

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

* Benchmark data source: Quality Compass 2015 (MY 2014 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: Discussing Cessation Medication
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- 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
- Adult Body Mass Index Assessment
- Comprehensive Diabetes Care – LDL-C Screening
- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment

➤ 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)
 - 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
 - Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
 - Cervical Cancer Screening
 - Prenatal and Postpartum Care: Postpartum Care Rate
- Child Performance Measures:
- Adolescent Well-Care Visit
 - Percentage of Eligibles that Received Preventive Dental Services

Several measures had denominators that were too small to calculate reliable rates (less than 30 observations).

Reasons for small denominators include:

- Some performance measures require more than two years of enrollment. SHP was limited with two years 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 limited eligible population for the Medicaid Expansion population—19-20 years of age.

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.

- Conducted several quality outreach programs in an effort to improve member compliance for HEDIS® measures.
- Developed and maintains a very experienced and dedicated quality team.
- Exceeded the 90th Percentile in the following adult performance measures:
 - Antidepressant Medication Management – Effective Acute Phase Treatment
 - Antidepressant Medication Management – Effective Continuation Phase Treatment
- Demonstrated improvement in 20 of 29 measures when MY 2015 performance is compared to MY 2014 performance.

MCO Recommendations

It is recommended that SHP:

- Continue sampling 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.
- Determine if the certified HEDIS® software can be used to calculate non-HEDIS measures in the Adult and Child Core Measure Sets.
- 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. The eligible denominator population is limited, and consequently the performance measure results are not meaningful.
- 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.
- Continue to 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 2015 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 14-16 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 14. 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 Medicaid 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 are 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.

SHP received a score of 100% on the Enrollee Rights Standard for MY 2015, compared to 99% for MY 2014.

Table 15. 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			
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 offers to 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 must revise its internal complaint/grievance-related procedure to reflect the requirement that members may file grievances orally or in writing. MCO internal procedures must also require written and timely acknowledgement when appeal requests are received. Members must be informed of limited time available to present evidence and allegations of fact or law when an expedited appeal has been requested. SHP must also ensure resolution timelines reflect calendar days vs. business days. Lastly, the MCO must provide evidence of how it informs providers about the requirements and timeframes for filing a grievance or appeal at the time they enter into a contract.

Overall, SHP received a score of 94% on the Grievance Systems Standard for MY 2015. The standard was assessed as 98% compliant for MY 2014. The decline in performance is due to not complying with all

recommendations for improvement from MY 2014. While there is opportunity for improvement, achieving 94% compliance in the second annual EQR audit is commendable.

Table 16. 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		

Quality Assessment and Performance Improvement Utilization Management (UM)			
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		
QA.UM.4. The MCO's written notice of action for termination, suspension, or reduction of previously authorized Medicaid-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		

Quality Assessment and Performance Improvement Credentialing and Recredentialing (CR)			
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, in both numbers and geographic access. SHP monitors timely access to primary care, as well as specialty appointments.

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.

SHP recently established a Fraud, Waste, and Abuse program that works to identify suspect or potential incorrect, fraudulent, or abusive billing practices among other program integrity activities. The MCO contracts with two vendors to conduct pharmacy and medical Fraud, Waste, and Abuse reviews. SHP also has a designated Compliance Officer who is accountable for program integrity.

The MCO reviews data, including claims, to identify potential trends that may require investigation. Monthly claims reports are assessed for trends, practice pattern variances, adverse patterns, network system access and/or service issues, and hospital length of stay variations. Findings are reported to the Physician Quality Committee. Providers with suspect or inappropriate practices are also tracked and reported to the State.

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 remeasurement 1 results (MY 2015) which allows for comparison to baseline performance rates (MY 2014).

In an effort to achieve full compliance, SHP must improve timely access to the following provider type appointments: maternity, specialists, and behavioral health providers. The MCO must explicitly state in its

Provider Access Policy that network providers are prohibited from offering reduced hours of operation to the Medicaid Expansion population. SHP must also revise language in its Utilization Review Policy to explicitly state that notices of action to terminate, suspend, or reduce previously authorized services must be mailed at least 10 days before the date of action. Lastly, SHP must provide evidence of more frequent quality meetings and must produce an annual Quality Program Evaluation.

SHP received a score of 97% on the Quality Assessment and Performance Improvement Standard for MY 2015. Performance was 98% for MY 2014. The marginal decline in performance is due to the implementation of additional requirements that were not fully met by the MCO, such as next available appointment standards for all provider types—not just primary care providers. Also, the MCO is still developing its Quality Program which includes regular quality meetings and evaluating the success of the quality program. A Quality Program Evaluation should also identify opportunities for improvement. Achieving 97% compliance in the second annual EQR audit is commendable.

Strengths

- SHP largely demonstrated compliance with requirements:
 - Enrollee Rights Standard: 100% compliant
 - Grievance Systems Standard: 94% compliant
 - Quality Assessment and Performance Improvement Standard: 97% compliant
- At the time of the site review, conducted in May 2016, SHP was already aware of some of its deficiencies and was in the process of addressing them to meet requirements. Revisions will assist the MCO in meeting requirements for its 2017 evaluation that assesses 2016 performance.

Recommendations

- SHP should review and act on specific recommendations found in the detailed CR Report in order to improve processes and obtain full compliance.
- SHP should continue with the administration of its new Fraud, Waste and Abuse Program to prevent, detect, investigate, and report suspected or actual fraud, waste and abuse.
- Review annual performance and identify and prioritize opportunities for improvement.

Encounter Data Validation

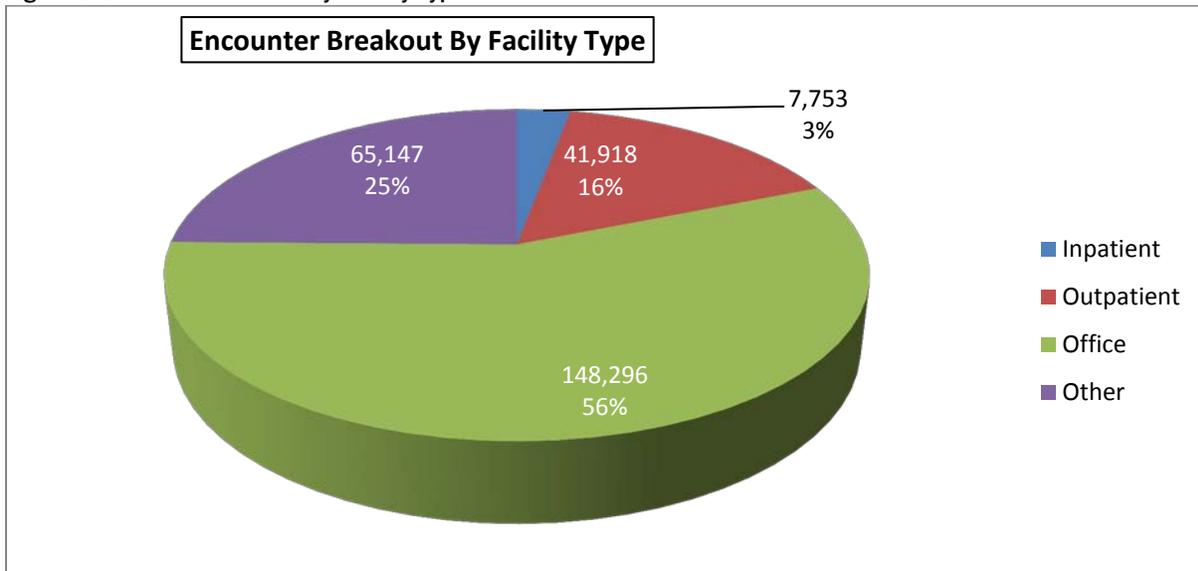
Claims Volume

The utilization rate for SHP, measured by the number of members with at least one paid claim, was 69%. Out of a total of 31,658 unique members³, 21,745 (69%) had at least one paid claim during MY 2015. For comparative purposes, this is a seven percentage point increase over the 62% utilization rate for MY 2014.

³ Unique Members were identified by social security number.

For MY 2015, approximately 62% of members had an Office Visit encounter, 53% had an Outpatient encounter, 9% of members had an Inpatient encounter, and 44% had an encounter classified as “Other.” Overall, there were approximately 263,114 encounters for MY 2015. An encounter analysis by facility type is displayed in Figure 1. Approximately 56% of encounters were for Office Visits, 16% for Outpatient, 3% for Inpatient, and 25% for Other.

Figure 1. Encounter Breakout by Facility Type



Timely Claims Submission

SHP stated that 99% of provider claims are submitted within 90 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 social security numbers. Invalid social security numbers were found in 59 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:

- In MY 2015, the overall match rate (medical record documentation supporting the encounter data submitted) was 92%. In MY 2014, the match rate was 96%. A four percentage point decline in match rate was noted.
- In MY 2015, Outpatient records registered the highest match rate, 95%; followed by Office Visit records, 92%; and trailed by Inpatient records, 89%. By contrast in MY 2014, Inpatient records registered the highest rate, 99%; compared to Outpatient records, 97%; and Office Visit records, 95%.

Tables 17-19 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 17. North Dakota EDV Results by Element for Inpatient Encounter Type, MY 2015

Inpatient Encounter Type	Diagnosis Codes		Revenue Codes		Procedure Codes		Total	
	MY 2014	MY 2015	MY 2014	MY 2015	MY 2014	MY 2015	MY 2014	MY 2015
Match	105	107	82	71	37	26	224	204
No Match	1	21	0	3	2	0	3	24
Total Elements	106	128	82	74	39	26	227	228
Match Percent	99%	84%	100%	96%	95%	100%	99%	89%

Table 18. North Dakota EDV Results by Element for Outpatient Encounter Type, MY 2015

Outpatient Encounter Type	Diagnosis Codes		Revenue Codes		Procedure Codes		Total	
	MY 2014	MY 2015	MY 2014	MY 2015	MY 2014	MY 2015	MY 2014	MY 2015
Match	150	150	87	101	98	128	335	379
No Match	3	12	1	4	8	5	12	21
Total Elements	153	162	88	105	106	133	347	400
Match Percent	98%	93%	99%	96%	92%	96%	97%	95%

Table 19. North Dakota EDV Results by Element for Office Visit Encounter Type, MY 2015

Office Visit Encounter Type	Diagnosis Codes		Revenue Codes		Procedure Codes		Total	
	MY 2014	MY 2015	MY 2014	MY 2015	MY 2014	MY 2015	MY 2014	MY 2015
Match	387	360	NA	NA	288	268	675	628
No Match	22	53	NA	NA	12	3	34	56
Total Elements	409	413	NA	NA	300	271	709	684
Match Percent	95%	87%	NA	NA	96%	99%	95%	92%

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

Strengths

- SHP continues to strengthen their data intake and information systems.
- SHP has well documented data integration and claims processing procedures.

MCO Recommendations

- Add a field to encounter data to document date claim is received. This will make it easier to assess if providers are submitting claims within one year of the date of service and will also aid in monitoring SHP’s timeliness in paying claims.
- Continue to conduct on-site visits to providers to explain the State’s data reporting requirements and to provide technical assistance to providers in meeting ICD-10 reporting requirements.
- Conduct provider audits to ascertain the extent to which providers are adherent to ICD-10 coding principles. The decline in rates may be indicative of the transition from the ICD-9 to ICD-10 system of coding during MY 2015.
- 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 nonconformities and focus areas for further education. During MY 2015, match rates across all settings declined, primarily due to a higher volume of mismatches in diagnostic codes.
- SHP should be mindful of additional codes reported which could not be confirmed in the medical records and explore this further, in addition to the accuracy of codes reported. Analysis reveals that the majority of “no match” cases occurred from missing diagnosis and procedure codes following primary codes. Some of the codes reported in the claims file could not be confirmed in the medical record received.
- Conduct targeted analyses when anomalies or irregularities are noted in data.

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.

SHP’s overall rate was 92% compared to 96% in MY 2014 with diagnosis code mismatches accounting for the majority of the decline in performance. The most significant rate decline occurred in the Inpatient setting.

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.

CAHPS® Survey

SHP contracted with a certified CAHPS® vendor to conduct the 2016 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 22, 2015, 1,359 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 406 surveys were completed via mail or phone, providing a response rate of 30%. 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 20.

Table 20. CAHPS Survey Results Compared to Benchmarks

Measure	MCO 2015 Rate	MCO 2016 Rate	2016 MCO Rate Compared to Benchmarks*
Customer Service Composite	91.7%	88.4%	♦♦
Getting Needed Care Composite	85.2%	82.8%	♦♦
Getting Care Quickly Composite	84.6%	81.0%	♦♦
How Well Doctors Communicate Composite	93.3%	93.1%	♦♦♦
Shared Decision Making Composite	79.0%	81.8%	♦♦♦
Health Promotion and Education Composite	65.3%	69.2%	♦
Coordination of Care Composite	81.6%	85.6%	♦♦
Rating of Health Plan (8+9+10)	71.7%	73.8%	♦
Rating of All Health Care (8+9+10)	70.3%	74.6%	♦♦
Rating of Personal Doctor (8+9+10)	84.7%	84.6%	♦♦♦♦
Rating of Specialist Seen Most often (8+9+10)	78.2%	82.1%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (2 year rolling average for 2016)	79.2%	75.1%	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (2 year rolling average for 2016)	47.1%	48.1%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (2 year rolling average for 2016)	47.7%	47.4%	♦♦

Measure	MCO 2015 Rate	MCO 2016 Rate	2016 MCO Rate Compared to Benchmarks*
Aspirin Use and Discussion: Take daily aspirin/ every other day	NA	NA	--
Aspirin Use and Discussion: Discussed risks and benefits of using aspirin	39.0%	NA	--
Flu vaccination: Had flu shot or spray in the nose since July 1, 2015	32.3%	38.0%	◆
Phoned plan to get help with transportation	2.9%	3.3%	--
Received help with transportation	NR	NR	--
Help with transportation met your needs	NR	NR	--

* Benchmark Source: 2015 (MY 2014) NCQA Quality Compass National Medicaid.

-- National benchmark not available.

NA Response rate <100.

NR Not Reportable; Less than 13 responses for MCO 2015 and less than 11 responses for MCO 2016.

◆ 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
- Shared Decision Making Composite
- Coordination of Care Composite
- Rating of All Health Care (8+9+10)
- Rating of Personal Doctor (8+9+10)
- Rating of Specialist Seen Most Often (8+9+10)
- 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)
- Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Flu Vaccination: Had flu shot or spray in the nose since July 1, 2015

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 13 responses to the questions.

Strengths

- In regard to benchmarking, SHP exceeded the 90th Percentile in the following CAHPS® measure:
 - Rating of Personal Doctor (8+9+10)

Recommendations

- 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.

Focused Quality Study

Background

Based on Delmarva Foundation's MY 2014 EDV analysis, it was revealed that the North Dakota Medicaid Expansion population's top primary diagnosis was low back pain (lumbago). Due to the frequency of the diagnosis, Delmarva Foundation and DHS decided to further explore and analyze findings through a focused study.

Approximately eighty percent of people experience back pain at least once in their lifetimes.⁴ Acute low back pain is one of the most common reasons adults seek a physician office visit. An accurate history and physical examination are essential for evaluating acute low back pain. Frequently, patients report pain after minor forward bending, twisting, or lifting. It is also key to note whether the reported low back pain is a first episode or a recurrent episode. Reports of certain red flags should prompt initiation of aggressive treatment or referral to a spine specialist. Red flags may include significant trauma from a fall, motor vehicle crash, heavy lifting in a patient with osteoporosis, etc. Without signs and symptoms indicating a serious underlying condition, imaging studies are *not* warranted or recommended, as costly imaging studies (X-ray, MRI, CT scans, etc.) do not lead to improved clinical outcomes in these patients.⁵ Research describes that the increased use of unnecessary imaging leads to less than favorable results. Specifically, the research indicates that overuse of MRIs for patients with low back pain is related to an increased rate of surgical procedures that have not consistently been shown to significantly reduce painful symptoms and improve daily functions.⁶

The goals of treatment for acute low back pain are to relieve pain, improve function, reduce missed days at work, and develop coping strategies through education. Optimizing treatment may minimize the development of chronic pain, which accounts for most of the health care costs associated with low back pain. Acceptable and recommended treatment includes:⁷

⁴ Journal of Orthopaedic & Sports Physical Therapy, Volume 41, Number 11, November 2011

^{5,7} <http://www.aafp.org/afp/2012/0215/p343.html>

⁶ Journal of Orthopaedic & Sports Physical Therapy, Volume 41, Number 11, November 2011

- Medications. Nonsteroidal anti-inflammatory drugs (NSAIDs) are often first-line therapy for low back pain. Non-benzodiazepine muscle relaxants are also beneficial in treatment. Opioids are commonly prescribed for patients with severe acute low back pain; however, there is little evidence of their benefit.
- Patient education. Patient education involves a discussion of the often benign nature of acute back pain and reassurance that most patients need little intervention for significant improvement in pain. Patients should be educated to stay active, within limits, and to avoid twisting, bending, and lifting. Patients should return to normal activities as soon as possible. The goal of patient education is to reduce worry about back pain and to provide insight on how to avoid worsening the pain and how to prevent recurrence.
- Physical therapy. Physical therapist directed exercise programs for acute back pain can reduce the rate of recurrence, increase the time between episodes of back pain, and decrease the need for healthcare services. As a result, the exercise programs are cost-effective treatments for acute low back pain.

Purpose and Study Question

The study question is simple: Do North Dakota Medicaid Expansion network practitioners treat low back pain without ordering an imaging study within 28 days of diagnosis? The goal of the focused study is to identify the percentage of North Dakota Medicaid Expansion members with a primary diagnosis of low back pain who did *not* receive an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis. A higher rate indicates appropriate treatment of low back pain.

Due to low back pain being the most frequent diagnosis for the North Dakota Medicaid Expansion population, it is important to explore practitioner compliance with delaying the utilization of imaging studies when they are not necessary, as they are costly and do not lead to improved clinical outcomes.

Findings

Following the EQRO Protocols on (1) conducting focused studies and (2) calculating performance measures and using the HEDIS® Use of Imaging Studies for Low Back Pain performance measure specifications as a guide, Delmarva Foundation calculated the rate for MY 2015: 78.63%. SHP's rate of compliance with delaying utilization of imaging studies performed well above average and marginally exceeded the 75th percentile benchmark (NCQA Quality Compass National Medicaid All Lines of Business – HEDIS 2015 (MY 2014)).

Strengths

North Dakota Medicaid Expansion network providers are largely compliant with guidelines to delay imaging studies when members present with a primary diagnosis of low back pain.

Recommendations

Delmarva Foundation recommends that the performance measure continue to be measured, monitored, and trended due to (1) the frequency of the diagnosis and (2) the research that indicates costly imaging studies do not improve clinical outcomes. Should performance fall below the 75th percentile, Delmarva Foundation will recommend SHP initiate interventions to address and improve performance.

Results of the focused study should also be shared with SHP’s network practitioners. While practitioners are largely compliant, there is also opportunity for improvement. Practitioners should be reminded that imaging studies should be delayed when patients initially present with low back pain if there are no red flags and there are no signs or symptoms indicating a serious underlying condition. Practitioners are encouraged to recommend medications, provide patient education, and refer patients for physical therapy services.

Compliance with Previous Annual Recommendations for Improvement

The following table identifies recommendations made in the previous Annual Technical Report (MY 2014) and the follow-up activities completed by SHP in 2015.

Table 21. 2015 Compliance with 2014 Recommendations

2015 Compliance with 2014 Recommendations	
2014 Recommendation	2015 Compliance Assessment
Review and act on explicit recommendations made by the EQRO in the separate, detailed Compliance Review report.	SHP revised numerous policies and procedures to address requirements. In some instances, member materials were not approved expeditiously enough to meet the 2015 year-end deadline. In these instances, compliance should be achieved in the 2016 review. There were a few occasions in which recommended changes were not implemented; however, the MCO has since initiated actions to address such deficiencies.
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.	SHP developed a formal Fraud, Waste and Abuse (FWA) Program. The MCO uses a number of system edits and programmatic reviews of data designed to detect potential FWA. Further, SHP contracts with two vendors to conduct pharmacy and medical FWA reviews. Contracted services include a review and analysis to identify suspect or potential incorrect, fraudulent, or abusive billing practices. SHP also developed a policy and procedure that addresses program integrity requirements. The policy identifies processes for investigating provider and member FWA, and mandates the reporting of suspected cases to ND DHS. SHP also has a designated Compliance Officer who is accountable for Program Integrity.
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.	SHP expanded its timely access to appointment surveys beyond primary care providers. The MY 2015 survey also assessed timely access to specialists, maternity care, and behavioral health services.

2015 Compliance with 2014 Recommendations	
2014 Recommendation	2015 Compliance Assessment
Implement new disease management programs as planned. Encourage participation and engagement in new and existing programs.	SHP has the following disease management programs in place: <ul style="list-style-type: none"> ➤ Congestive Heart Failure ➤ Hypertension ➤ Diabetes ➤ Coronary Artery Disease (new in 2015) ➤ Asthma (new in 2015)
Implement interventions for PIPs that aim to improve member outcomes.	SHP implemented multiple interventions that address barriers. Improvement was documented in both PIPs.
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.	As part of SHP's Quality Program, the MCO aims to continuously monitor and improve the quality and safety of patient care and health delivery services. Additionally, the MCO's goal is to implement improvement interventions as necessary. It is expected that the MCO will provide evidence of such activities as the quality program matures. Currently, the MCO is working to improve measures in its PIPs and it also conducts activities such as reaching out to members at risk based on health risk assessments. The MCO is working toward minimizing gaps in care and enrolling members in disease and health management programs.
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.	The MCO did not add an additional field to document the date a claim is received.

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 its first remeasurement year. The MCO should be able to continue 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 implemented interventions that address barriers and reported improvement in both projects for MY 2015.

SHP has established satisfactory processes for data integration, data control, and interpretation of the performance measures for 2015. 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 results for the CMS Adult (and applicable Child) Core Set of Measures. When rates are compared to the Quality Compass 2015 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: Discussing Cessation Medication
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
- Controlling High Blood Pressure
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- 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
- Adult Body Mass Index Assessment
- Comprehensive Diabetes Care – LDL-C Screening
- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment

➤ 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 100% compliant with the Enrollee Rights Standard, 94% compliant with the Grievance Systems Standard, and 97% 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 92% match rate where medical record documentation supported the encounter data submitted. The MCO had well documented data integration and claims processing procedures.

Lastly, SHP measured 2015 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
- Shared Decision Making Composite
- Coordination of Care Composite
- Rating of All Health Care (8+9+10)
- Rating of Personal Doctor (8+9+10)
- Rating of Specialist Seen Most Often (8+9+10)
- 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 continue to develop its current quality program. The program should regularly measure and monitor all activities and performance related indicators and take action 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 must increase the frequency in which stakeholders meet to discuss quality initiatives and the MCO should develop an annual Quality Program Evaluation. The MCO should trend annual results in the evaluation to facilitate an understanding of performance year over year.

SHP is encouraged to continue with the development of its two PIPs. The MCO should monitor barriers and gauge effectiveness of interventions. As new barriers are identified, new strategies should be developed.

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)
- 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
- Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
- Cervical Cancer Screening
- Prenatal and Postpartum Care: Postpartum Care Rate
- Child Performance Measures:
 - Adolescent Well-Care Visit
 - Percentage of Eligibles that Received Preventive Dental 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 implemented a formal Fraud and Abuse Program to support program integrity. SHP should continue to refine the program as the MCO aims to reduce fraud, waste, and abuse.

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 one year 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)
- Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Flu Vaccination: Had flu shot or spray in the nose since July 1, 2015.

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 and 1 specialty provider for every 3,000 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 and other provider types, including specialty providers. Even taking into account the many rural geographic areas of North Dakota, SHP exceeded the minimum requirements; all members have access to providers 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. The MCO marginally exceeds compliance with geographic access for: OB/GYN, Orthopedic Surgery, and Psychiatric providers; SHP should monitor compliance for these provider types closely. 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 primary care type providers for urgent care and routine/preventive care appointments. 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 decisions were made in a timely manner.

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

Timeliness Recommendations

For the first time during MY 2015, SHP evaluated timely access to next available appointments for maternity, specialty, and behavioral health services. There is opportunity for improvement for all of these provider types. 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 2015 year end, 20,601 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the course of the year, 69% of the enrollees utilized health care services. Utilization increased by seven percentage points compared to MY 2014. The MCO provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, based on the infancy of the North Dakota Medicaid Expansion Program, SHP is performing well. The MCO is actively working to address deficiencies identified during the course of the review. SHP has developed a quality program that measures and monitors performance. The MCO now has two years of data to understand current performance and opportunities for improvement. Addressing these opportunities will facilitate improvement in the areas of quality, access, and timeliness of care for the Medicaid Expansion population.

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.

Recommendations

MCO Recommendations

It is recommended that SHP:

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- Continue with current PIP interventions and explore additional opportunities that address barriers.
- 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. This should also be done for the CAHPS® measure results.
- Review and act on specific recommendations made by the EQRO in the Compliance Review report.
- Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next appointments.
- Continue administration of disease management programs and engage members in self-management initiatives.
- Continue with administration of new Fraud, Waste and Abuse Program to prevent, detect, investigate, and report suspected or actual fraud, waste and abuse.
- Participate in regular quality meetings to facilitate quality improvement discussions and initiatives.
- Conduct an annual Quality Program Evaluation that evaluates Quality Work Plan activities and outcomes. Trend annual results in the evaluation to facilitate an understanding of performance year over year.

- 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 one year of the date of service and will also aid in monitoring SHP's timeliness in paying claims.

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 review reports from SHP and provide recommendations as needed.
- Require SHP trend annual performance measure results in all reporting areas. This allows DHS to monitor performance over time and intervene should a negative trend emerge.
- Require SHP to follow up on recommendations made by the EQRO in the Compliance Review.
- Continue to have the EQRO conduct the focused study on low back pain. It was the most frequent MY 2014 diagnosis and remains in the top three diagnoses in MY 2015. Remeasurement to evaluate inappropriate imaging studies provides valuable feedback and monitors provider compliance with practice guidelines. Noncompliance may lead to unnecessary imaging studies that are costly and do not correlate to improved clinical outcomes.
- Review and revise the North Dakota Medicaid Expansion Quality Strategy annually, and:
 - Establish minimum performance thresholds for performance measures.
 - Include new requirements or shift priorities as opportunities present themselves.
 - Work with the EQRO and SHP to identify performance measures that are meaningful to the Medicaid Expansion population.