North Dakota
Department of Human Services

North Dakota Medicaid Expansion Program

2017 Annual Technical Report
Measurement Year (MY) 2016

Delmarva Foundation

A subsidieary of Quality Health Strategies

Submitted by:
Delmarva Foundation
September 2017

Table of Contents

Executive Summary i

Introduction and Overview 1

External Quality Review Methodology 2

Performance Improvement Project Validation 2

Performance Measure Validation 3

Compliance Review 4

Encounter Data Validation 6

CAHPS® Survey 7

Focused Quality Study 8

External Quality Review Results 9

Performance Improvement Project Validation 9

Performance Measure Validation 12

Compliance Review 21

Encounter Data Validation 39

CAHPS® Survey 42

Focused Quality Survey 45

Compliance with Previous Annual Recommendations for Improvement 47

Quality of, Access to, and Timeliness of Healthcare Services 49

Quality 49

Access 52

Timeliness 53

Conclusions 54

Recommendations 54

MCO Recommendations 54

State Recommendations 55

North Dakota Medicaid Expansion Program

2017 Annual Technical Report

Measurement Year 2016

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 2017, assessed SHP's measurement year (MY) 2016 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 2016 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

The MCO is conducting two PIPs, per requirements of the North Dakota Medicaid Expansion Quality Strategy. The PIP topics focus on the treatment of chronic conditions and follow-up for mental health. SHP's MY 2016 PIP Reports included remeasurement results and described multifaceted interventions. While performance was mixed over this last year, overall, results sustained improvement over the baseline assessments. SHP will continue with the Follow-Up After Hospitalizations for Mental Health PIP

and will replace the Prevention and Treatment of Chronic Conditions PIP with a new meaningful project that presents an opportunity for improvement.

Performance Measure Validation

SHP had satisfactory processes for data integration, data control, and interpretation of the CMS Adult and Child Core Measures for MY 2016. 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 required measures.

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

- Not enough enrollees with the required condition to be in the eligible population for the measure.
- 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. Most of the reported measures compared favorably to the national average benchmark with seven exceeding the 75th percentile and five exceeding the 90th percentile.

Compliance Review

In general, SHP demonstrated compliance with federal and state regulations and requirements during MY 2016, as it served the North Dakota Medicaid Expansion population. The key areas of regulation include the following revised Medicaid managed care standards:

- Information Requirements
- Enrollee Rights
- MCO, PIHP, and PAHP Standards
- Quality Assessment and Performance Improvement Program
- Grievance and Appeal System

Delmarva Foundation reviewed all new managed care standards – including 2016, 2017 and 2018 requirements. The 2016 requirements were scored and the 2017 and 2018 requirements include comments and recommendations. This feedback was provided to guide SHP in policy and procedure revisions to meet new requirements.

In regard to the 2016 requirements, SHP scored 94% on the Enrollee Rights Standard and scored 100% on the following elements in the MCO, PIHP, and PAHP Standards: Provider Selection, Confidentiality,

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

and Practice Guidelines. Additionally, SHP scored 100% on the MCO's Program Integrity contract requirements.

Encounter Data Validation

The Utilization Rate for SHP, measured by the number of members with at least one paid claim, was 68%. Out of a total of 34,620 unique members, 23,513 (68%) had at least one paid claim during MY 2016.[2] For comparative purposes, this is a one percentage point decrease compared to the 69% utilization rate for MY 2015. Overall, SHP has well documented data integration and claims processing procedures. During MY 2016, SHP achieved a total match rate of 93%—meaning 93% of claims data submitted was supported by medical record documentation. The increase of 1 percentage point from MY 2015 was driven by increases in both Inpatient and Outpatient match rates, which rose by 7 and 2 percentage points respectively, despite a 3 percentage point decline for Office Visits. The match rate will continue to be monitored.

SHP is advised to add a field to the encounter data file to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 365 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.

CAHPS® Survey

SHP contracted with a certified CAHPS® vendor to conduct the 2017 CAHPS® 5.0H Member Satisfaction Survey. On January 24, 2017, 1,350 surveys were mailed to a random sample of members who had been continuously enrolled in the MCO for at least five of the last six months of the measurement year. The survey, capturing member feedback about the MCO, providers, and member perception about getting needed care, getting care quickly, customer service, etc., had a 29.26% response rate. The majority of respondents indicated that they were: in good overall health and excellent/very good mental/emotional health; in 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. Four CAHPS measures exceeded the national 75th Percentile benchmark and three exceeded the 90th Percentile benchmarks. Results are displayed in Table 23 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.

[2] Unique Members were identified by social security number during the analysis of the Encounter Data Validation task completed by Delmarva Foundation. This number is based on the number of Medicaid recipients covered during the Measurement Year and is not a point in time enrollment number. For comparison purposes, at the end of MY 2016, the point in time enrollment was 18,835.

Due to low back pain being the most frequent diagnosis for the North Dakota Medicaid Expansion population, it was 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 2016: 71.21%. There was a decline in performance compared to MY 2015's result (78.63%). The decline in performance may be impacted by the smaller eligible population, which decreased by almost 500 members.

The MCO's MY 2016 performance compared favorably to the national Medicaid 25th percentile, but not the national average benchmark. Because SHP's performance does not meet the national average benchmark, North Dakota DHS should consider requiring SHP to implement interventions to improve performance.

Summary of Quality, Access, and Timeliness

Quality

SHP's North Dakota Medicaid Expansion Quality Work Plan identifies quality-related monitoring and reporting requirements. The work plan outlines quality monitoring requirements and priorities. However, while the MCO maintains a formal Medicaid Expansion Quality Work Plan, there was no evidence of a Quality Program Evaluation. Activities in the Quality Work Plan should be measured and reported in a comprehensive Quality Program Evaluation Report. A comprehensive assessment would identify each activity, goal or benchmark, result(s), assessment (including barriers, if applicable), and any follow-up action plan/intervention.

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 completed PIP activities and reported on performance.

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." 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 2017 Quality Assessment and Performance Improvement Program Standard which requires PIPs, the collection and submission of performance measures data, and mechanisms to detect both under and overutilization of services.

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 should meet with stakeholders to discuss quality initiatives. The MCO should also develop an annual Quality Program Evaluation and 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 for primary care, 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. SHP should attempt to close the provider geographic access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities, Cardiology, and Hematology and Oncology. 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 high impact and high volume specialist 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. A random sample review of grievance and appeal files was conducted during the on-site review. The grievances were all verbal and addressed immediately and all appeals were resolved in a timely manner.

During MY 2016, SHP evaluated timely access to next available appointments for multiple services. The MCO has opportunity for improvement related to timely access for the following provider types: maternity, primary care, 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 2016 year end, 18,835 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the course of the year, 68% of the enrollees utilized health care services. For comparative purposes, this is a one percentage point decrease compared to the 69% utilization rate for MY 2015. The MCO provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, 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. With three years of performance measure results, the MCO is able to trend performance and get a better idea of where SHP meets and exceeds requirements and where there is opportunity for improvement. Implementing interventions and 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 program operations and monitoring of performance.

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 for the Follow-Up for Mental Health PIP in an effort to improve performance.
- Close out the Prevention and Treatment of Chronic Conditions PIP and replace it with a new topic where there is opportunity for improvement.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet the NCQA Quality Compass national averages or measures with performance that declined between MY 2014 to MY 2016. This should also be done for the CAHPS® survey measure results.
- Review and act on specific recommendations made by the EQRO in the Compliance Review report. Ensure compliance with new Medicaid managed care standards.
- Revise member filing requirements and MCO resolution timelines for grievances and appeals to align with new standards.
- Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next available appointments.
- Continue administration of disease management programs and engage members in self-management initiatives. Focus efforts to improve participation.
- Conduct an annual Quality Program Evaluation that evaluates Quality Work Plan activities and outcomes. Trend annual results in the evaluation to facilitate an understanding of performance year over year.
- Add a field to the encounter data file submission to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 365 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.

State Recommendations

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

North Dakota Medicaid Expansion Program

2017 Annual Technical Report

Measurement Year 2016

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 2017, assessed SHP's measurement year (MY) 2016 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 2016; 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 2017 EQR activities with DHS and SHP in October 2016. Actual review and auditing activities began in March 2017 and concluded in July 2017. 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.
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.

PIP Validation Steps	
Step	Validation Requirement
8. Data Analysis/Interpretation	The study findings, or results, should be accurately and clearly stated. A comprehensive quantitative and qualitative analysis should be provided.
9. Real Improvement	Project results should be assessed as real improvement.
10. Sustained Improvement	Sustained improvement should be demonstrated through repeated measurements.

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

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

Performance Measure Validation

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

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

Table 2. PMV Activities

PMV Activities	
Audit Phase	Audit Activities
Pre-site Phase	Delmarva Foundation confirms measures and specifications with DHS and reviews prior audits, if available. An audit methodology is developed that is appropriate for the selected performance measures and is compliant with the CMS PMV protocol. The auditor has a conference call with the MCO to provide an overview, answer questions, and schedule an on-site visit. The MCO is asked to complete the Information Systems

PMV Activities	
	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), § 438 et seq. The key areas of regulation include the following standards:

- Information Requirements, 42 CFR § 438 Subpart A, details requirements to ensure that managed care enrollees receive information about available healthcare services, how to access services, and how to contact participating providers. Additionally, requirements to ensure that enrollees receive information on how to access auxiliary aids and services including information on alternative formats and languages are outlined.
- Enrollee Rights, 42 CFR § 438 Subpart C, includes requirements to ensure that managed care enrollees are aware of their rights and protections, including the right to make healthcare decisions.
- MCO, PIHP, and PAHP Standards, 42 CFR § 438 Subpart D, details requirements to ensure managed care enrollees have adequate and timely access to services and access to coordinated care. Services must be sufficient in the amount, duration, and scope. Authorization of services

must be consistent and based on valid and reliable clinical evidence or clinical practice guidelines. Authorization procedures must be standardized and denial of services must be made by an individual with the appropriate clinical expertise. The credentialing and recredentialing of providers must follow a uniform process and ensure providers excluded from participation in federal health care programs are not employed.

- Quality Assessment and Performance Improvement Program, 42 CFR § 438.330, Subpart E, details requirements for a comprehensive quality assessment and performance improvement program that includes performance improvement projects, collection and submission of performance measures data, and mechanisms to detect both under and overutilization of services.
- Grievance and Appeal System, 42 CFR § 438 Subpart F, 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).

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, polices, 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.

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

Assessment Procedures

Delmarva Foundation evaluates each standard by assessing compliance with all related elements and components. Standards 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 (standard)**
  - **Element 1.**
    General rule. Each MCO, PIHP, PAHP, PCCM and PCCM entity must:
    (1) have written policies regarding the enrollee rights specified in this section, and
    (2) comply with any applicable Federal and State laws that pertain to enrollee rights, and ensure that its employees and contracted providers observe and protect those rights. An enrollee has the right to:
    1.a. (component)
    Receive information in accordance with §438.10.
    1.b. (component)
    Be treated with respect and with due consideration for his or her dignity and privacy.

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 and may be 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®[3] 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.

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

Using a valid sample frame validated by the HEDIS® Auditor according to HEDIS® protocols found in *HEDIS® 2017 Volume 3: Specifications for Survey Measures*, SHP's contracted survey vendor administered the 2017 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 24, 2017, the vendor mailed 1,350 surveys and received 390 completed surveys (via mail and phone), providing a 29.26% response rate for the survey.

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

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

Focused Quality Study

FQSs 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 2016 serves as remeasurement year 2 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 Validation Results

PIP Validation Assessment				
	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

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)	91.15%
Controlling High Blood Pressure	
MY 2014 (Baseline)	68.13%

MY 2015 (Remeasurement 1)	68.61%
MY 2016 (Remeasurement 2)	72.78%
Adult Body Mass Index (BMI) Assessment	
MY 2014	NA; The measure has a two year continuous enrollment requirement
MY 2015 (Baseline)	91.73%
MY 2016 (Remeasurement 1)	94.56%

Interventions

SHP had the following interventions in place during MY 2016 for the Prevention and Treatment of Chronic Conditions PIP:

- Diabetes and Healthy Heart (Hypertension) Health Management Programs: The programs aimed 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 monitored members who were most at risk for complications. Program components included 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:
    - 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 (health risk assessment, case management screening and referral to specialists as appropriate)
    - Providing information to care giver
    - Encouraging communication with practitioners
    - Additional external resources, which may include referral to programs and services outside the plan

  Case Managers contacted complex members telephonically to provide education regarding appropriate utilization, guideline recommendations, resources, and other pertinent topics. Program members also received quarterly mailings and newsletters that provided education.

- Population Health and Patient Centered Medical Home Collaboration with other health systems to build relationships and share best practices. Staff served on committees to share information on best practices to improve health outcomes, such as ways to generate BMI awareness.

- Letters/reminders/educational materials were mailed to members who were:
    - On ACEI/ARB and noncompliant with lab level checks
    - Diabetic and noncompliant with the comprehensive diabetes care measures/standards

While no new interventions were implemented in 2016, the interventions continued from prior years address most barriers and are multifaceted—particularly the health management programs.

Strengths

- SHP sustained improvement in two performance measures: Hemoglobin A1c Testing and Controlling High Blood Pressure. The Adult BMI Assessment measure was not eligible for evaluation as two years of remeasurement data are required for assessment.
- SHP's performance results compare favorably to the HEDIS 90th percentile benchmarks for all three measures.
- SHP continued its multifaceted intervention: member engagement in its 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 should continue interventions to ensure performance is maintained.
- Based on a successful three year PIP and performance that almost meets or exceeds the HEDIS 90th percentile benchmarks, SHP should close the PIP as planned and develop a new meaningful PIP that aims to improve performance in the Comprehensive Diabetes Care measures. SHP must ensure that North Dakota DHS approves the PIP topic and performance measures before PIP implementation.

Follow-Up for Mental Health PIP Results

SHP met all applicable requirements for its Follow-up for Mental Health PIP, as identified in Table 8, with one exception. Step 9, Real Improvement, was assessed as partially met as the observed improvement was not statistically significant.

Table 8. Follow-Up for Mental Health PIP Validation Results

PIP Validation Assessment				
	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

PIP Performance Measure Results	
Follow-Up After Hospitalizations for Mental Health—Within 7 Days	
MY 2014 (Baseline)	21.88%

MY 2015 (Remeasurement 1)	27.44%
MY 2016 (Remeasurement 2)	24.52%
Follow-Up After Hospitalizations for Mental Health—Within 30 Days	
MY 2014 (Baseline)	38.84%
MY 2015 (Remeasurement 1)	49.62%
MY 2016 (Remeasurement 2)	46.82%
Screening for Clinical Depression and Follow	
MY 2014 (Baseline)	11.78%
MY 2015 (Remeasurement 1)	14.69%
MY 2016 (Remeasurement 2)	Not Applicable (Discontinued for MY 2016)
Engagement of Alcohol or Other Drug (AOD) Treatment	
MY 2016 (Baseline)	17.32%

Interventions

SHP had the following interventions in place during MY 2016 for the Follow Up for Mental Health PIP:

- Collaboration with Sanford Health on behavioral health issues. Collaboration includes regular contact between SHP's Behavioral Health Counselor and Sanford's social workers and Emergency Department's case managers. Efforts include scheduling follow-up appointments prior to discharge and understanding the member's type of mental illness and complexity.
- Behavioral Health Counselor contacting inpatient facilities to schedule 7 day follow up appointments prior to members being discharged.

Strengths

- SHP's remeasurement 2 analysis, which was both quantitative and qualitative, included a system wide barrier analysis and identified potential (or planned) interventions/opportunities for improvement.
- Remeasurement 1 and remeasurement 2 results exceed baseline performance yielding sustained improvement for the Follow-Up After Hospitalizations for Mental Health performance measures (7 days and 30 days).
- SHP introduced a new meaningful performance measure: Engagement of Alcohol or Other Drug (AOD) Treatment.

Recommendation

- SHP is encouraged to continue annual barrier analyses and develop targeted interventions. The open access appointments at the Human Services Centers have proven to be challenging for some members as they are not always seen on the day they are asked to seek services and must return the following day. SHP is working with the Human Services Centers to address this barrier and should continue discussions to improve availability and appointment access.

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 applicable 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 2016. 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
Adult BMI Assessment	30	100%
Controlling Blood Pressure	30	100%

Performance Measure Results

SHP MY 2016 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 2016 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 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 more diamonds that are displayed indicates a higher level of performance compared to the benchmarks. The performance for the past three years (MY 2014-MY 2016) is provided for trending and year-to-year comparison.

Table 12. Adult Performance Measure Results Compared to Benchmarks

Measure	SHP MY 2014 Rate	SHP MY 2015 Rate	SHP MY 2016 Rate	MY 2016 Comparison to Benchmarks*
Breast Cancer Screening	^	^	50.44%	♦
Adherence to Antipsychotics for Individuals with Schizophrenia	68.75%	70.31%	62.12%	♦♦
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%	84.44%	♦
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Enrollees on Digoxin	^	^	36.36%	♦
Annual Monitoring for Patients on Persistent Medications - Annual Monitoring for Enrollees on Diuretics	83.60%	86.73%	85.04%	♦
Annual Monitoring for Patients on Persistent Medications - Total Rate	83.38%	86.57%	84.42%	♦
Antidepressant Medication Management - Effective Acute Phase Treatment	78.07%	66.59%	61.38%	♦♦♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	71.12%	55.00%	48.17%	♦♦♦
Cervical Cancer Screening	19.77%	26.26%	31.84%	♦
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	31.91%	40.52%	38.99%	♦
Follow-Up After Hospitalization for Mental Illness, Ages 21-64 - Follow-Up Within 7 Days	21.88%	27.44%	24.91%	♦
Follow-Up After Hospitalization for Mental Illness, Ages 21-64 - Follow-Up Within 30 Days	38.84%	49.62%	47.06%	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64 - Initiated Treatment Through an	37.63%	37.44%	40.01%	♦♦

Measure	SHP MY 2014 Rate	SHP MY 2015 Rate	SHP MY 2016 Rate	MY 2016 Comparison to Benchmarks*
Inpatient Alcohol or Other Drug (AOD) Admission, Outpatient Visit, Intensive Outpatient Encounter, or Partial Hospitalization Within 14 Days of the Diagnosis (Initiation)				
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64 - Initiated Treatment and Who Had Two or More Additional Services With a Diagnosis of AOD Within 30 Days of the Initiation Visit (Engagement)	13.44%	13.15%	17.38%	♦♦♦♦
PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 18-64 ~	32.55**	33.00**	39.31**	♦♦
PQI 08 Congestive Heart Failure Admission Rate, Ages 18-64 ~	69.17**	18.19**	18.26**	♦♦
PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64 ~	264.59**	46.85**	46.59**	♦♦
PQI 15 Asthma in Younger Adults Admission Rate, Ages 18-39 ~	39.21**	8.09**	8.99**	♦♦
Plan All-Cause Readmissions Rate - Ages 18-44 ~	22.35%	18.79%	18.46%	-
Plan All-Cause Readmissions Rate - Ages 45-54 ~	17.34%	21.92%	17.25%	-
Plan All-Cause Readmissions Rate - Ages 55-64 ~	14.04%	14.50%	13.83%	-
Plan All-Cause Readmissions Rate - Total ~	18.88%	18.78%	16.92%	-
Medical Assistance With Smoking and Tobacco Use Cessation - Advising Smokers and Tobacco Users to Quit	79.22%	75.09%	73.29%	♦
Medical Assistance With Smoking and Tobacco Use Cessation - Discussing Cessation Medications	47.06%	48.11%	48.42%	♦♦
Medical Assistance With Smoking and Tobacco Use Cessation - Discussing Cessation Strategies	47.71%	47.44%	48.63%	♦♦♦
Flu Vaccinations for Adults, Ages 18-64	32.30%	37.95%	37.67%	♦

Measure	SHP MY 2014 Rate	SHP MY 2015 Rate	SHP MY 2016 Rate	MY 2016 Comparison to Benchmarks*
Adult Body Mass Index Assessment	^	91.73%	94.56%	♦♦♦♦
Comprehensive Diabetes Care: Hemoglobin A1c Testing	89.18%	91.42%	91.15%	♦♦♦
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) + ~	+	+	31.68%	♦♦♦
Comprehensive Diabetes Care: HbA1c Control (<8%) +	+	+	57.52%	♦♦♦
Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population +	+	+	42.82%	♦♦♦♦
Comprehensive Diabetes Care: Eye Exam +	+	+	48.14%	♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy +	+	+	93.27%	♦♦♦
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg +	+	+	80.35%	♦♦♦♦
Controlling High Blood Pressure	68.13%	68.61%	72.78%	♦♦♦♦
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia +	^	^	^	-
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication +	^	^	79.15%	♦
Diabetes Monitoring for People With Diabetes and Schizophrenia +	^	^	^	-

* Benchmark data source: Quality Compass 2016 (Measurement Year 2015 data) National Medicaid Average for All Lines of Business. This was the latest benchmark source at the time of report production.
** Member observations per 100,000 members.
~ A lower rate is better.
^ Denominator of less than 30 observations; too small to calculate a reliable rate.
+ New measure for North Dakota Medicaid Expansion Quality Strategy (for MY 2016).
- Rate not available; no comparison could be made to the benchmarks. Or benchmarks are not available.
♦♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.
♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.
♦ MCO rate is below the NCQA Quality Compass National Average.

Table 13. Child Performance Measure Results Compared to Benchmarks

Measure	SHP MY 2014 Rate	SHP MY 2015 Rate	SHP MY 2016 Rate	MY 2016 Comparison to Benchmarks*
Medication Management for People With Asthma, Ages 19-20 - Percentage of Children Who Remained on an Asthma Controller Medication for At Least 50% of Their Treatment Period	^	^	^	-
Medication Management for People With Asthma, Ages 19-20 - Percentage of Children Who Remained on an Asthma Controller Medication for At Least 75% of Their Treatment Period	^	^	^	-
Follow-Up After Hospitalization for Mental Illness, Ages 19-20 - Follow-Up Within 7 Days	^	^	^	-
Follow-Up After Hospitalization for Mental Illness, Ages 19-20 - Follow-Up Within 30 Days	^	^	^	-
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication - Initiation Phase	^	^	^	-
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication - Continuation and Maintenance Phase	^	^	^	-
Adolescent Well Care Visits	7.14%	10.81%	9.76%	♦
Percentage of Eligibles that Received Preventive Dental Services (PDENT)	8.14%	9.52%	8.91%	♦

^ Denominator of less than 30 observations; too small to calculate a reliable rate.
* Benchmark data source: Quality Compass 2016 (Measurement Year 2015 data) National Medicaid Average for All Lines of Business. This was the latest benchmark source at the time of report production.
- 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.

MY 2016 performance results are identified below. For most measures, performance was also compared to NCQA Quality Compass benchmarks to gauge performance and identify opportunities for improvement.

SHP performed below the national Medicaid average on the following performance measures:

- Adult Performance Measures:
  - Breast Cancer Screening
  - Flu Vaccinations for Adults
  - 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 Digoxin
  - Annual Monitoring for Patients on Persistent Medications: For Enrollees on Diuretics
  - Annual Monitoring for Patients on Persistent Medications: Total Rate
  - Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
  - Cervical Cancer Screening
  - Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
  - Comprehensive Diabetes Care: Eye Exam
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

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

The MCO performed above the national Medicaid average but was below the Medicaid 75th Percentile for the following measures:

- Adult Performance Measures:
  - Adherence to Antipsychotic for Individuals With Schizophrenia
  - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication
  - PQI 01: Diabetes Short-Term Complications Admission Rate, Ages 18-64*
  - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64*
  - PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 18-64*
  - PQI 15: Asthma in Younger Adults Admission Rate, Ages 18-39*
  - Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Initiation

- Child Performance Measures:
  - SHP did not have any child measures that met or exceeded the national Medicaid average but was below the national Medicaid 75th Percentile.

*The Prevention Quality Indicators (PQI) are Agency for Healthcare Research and Quality (AHRQ) performance measures and only have national average benchmarks. The 75th and 90th percentiles are not available for comparison.

SHP met or exceeded the national Medicaid 75th Percentile but was below the national Medicaid 90th Percentile for the following performance measures.

- Adult Performance Measures:
  - Comprehensive Diabetes Care: HbA1c Testing
  - Comprehensive Diabetes Care: HbA1c Poor Control (>9% a lower score is better)
  - Comprehensive Diabetes Care: HbA1c Control (<8%)
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Antidepressant Medication Management: Effective Acute Phase Treatment
  - Antidepressant Medication Management: Effective Continuation Phase Treatment
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

- Child Performance Measures:
  - SHP did not have any child measures that met or exceeded the national Medicaid 75th Percentile but was below the national Medicaid 90th Percentile.

SHP met or exceeded the national Medicaid 90th Percentile for the following performance measures:

- Adult Performance Measures:
  - Adult BMI Assessment
  - Comprehensive Diabetes Care: HbA1c (<7%) for a Selected Population
  - Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
  - Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Engagement
  - Controlling High Blood Pressure

- Child Performance Measures:
  - SHP did not have any child measures that met or exceeded the national Medicaid 90th Percentile.

A trend analysis was conducted on measures where data was available for all three years between MY 2014 and MY 2016. The three year trend was mixed for the majority of the Adult Performance Measures and all of the Child Performance Measures.

The following measures decreased year over year indicating a decline in SHP's performance between MY 2014 and MY 2016:

- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
- PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 18-64 (lower rate is better)

SHP's performance improved each year between MY 2014 and MY 2016 indicating a positive trend for the following measures:

- Cervical Cancer Screening
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64 (lower rate is better)
- Plan All-Cause Readmission Rate: Ages 18-44 (lower rate is better)
- Plan All-Cause Readmission Rate: Ages 18-64 Total (lower rate is better)
- Controlling High Blood Pressure

The following performance measures used denominators with less than 30 observations. In these cases, there were too few observations to produce a reliable performance rate.

- Adult Performance Measures:
  - Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
  - Diabetes Monitoring for People With Diabetes and Schizophrenia
- Child Performance Measures:
  - 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 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
  - Follow-Up After Hospitalization for Mental Illness, Ages 19-20: Follow-Up Within 7 Days
  - Follow-Up After Hospitalization for Mental Illness, Ages 19-20 Follow-Up Within 30 Days

The following measures were retired from the State's Quality Strategy and not collected by SHP for MY 2016:

- HIV Viral Load Suppression
- Care Transition - Timely Transmission of Transition Record
- Comprehensive Diabetes Care: LDL-C Screening
- PC-01 Elective Delivery
- PC-03 Antenatal Steroids
- Prenatal and Postpartum Care: Postpartum Care Rate
- Screening for Clinical Depression and Follow-Up Plan

Measures with reported rates were found to be compliant with corresponding performance measure specifications and received "reportable" audit designations.

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.
- Developed and maintains an experienced and dedicated quality team.

- Exceeded the 90th Percentile in the following adult performance measures:
  - Adult BMI Assessment
  - Comprehensive Diabetes Care: HbA1c (<7%) for a Selected Population
  - Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
  - Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Engagement
  - Controlling High Blood Pressure
- Demonstrated two years of consistent improvement between MY 2014 and MY 2016 for six measures.

MCO Recommendations

It is recommended that SHP:

- 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 average benchmarks.

DHS Recommendations

It is recommended that DHS:

- Continue to work with the EQRO and SHP to identify measures that are meaningful to the Medicaid Expansion population.
- Encourage SHP to implement interventions to target performance measures that did not meet the NCQA Quality Compass national average benchmarks.

Compliance Review

Results

The CR assessed SHP's 2016 compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion population. Delmarva Foundation reviewed all new managed care standards – including 2016, 2017, and 2018 requirements. The 2016 requirements were scored and the 2017 and 2018 requirements included comments and recommendations on how to meet requirements when applicable. This feedback was provided to guide SHP in policy and procedure revisions to meet new managed care standards.

The key areas of regulation include the following standards:

- Information Requirements
- Enrollee Rights
- MCO, PIHP, and PAHP Standards
- Quality Assessment and Performance Improvement Program

- Grievance and Appeal System
- Program Integrity Contract Requirements

Tables 14-19 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. Information Requirements Results

Information Requirements			
Element	Met	Partially Met	Unmet
Element 1. ***General Requirements***. The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.	Not scored; 2017 requirement.		
Element 2. The MCO, PIHP, PAHP, and when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in §438.3(i).	Not Applicable		
Element 3. ***Enrollee Handbook***. Each MCO, PIHP, PAHP and PCCM entity must provide each enrollee an enrollee handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).	Not scored; 2017 requirement.		
Element 4. The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program.	Not scored; 2017 requirement.		
Element 5. The enrollee handbook must include grievance, appeal, and fair hearing procedures and timeframes, consistent with Subpart F of this part, in a State-developed or State-approved description.	Not scored; 2017 requirement.		
Element 6. The enrollee handbook must include information on how to exercise an advance directive, as set forth in §438.3(j). For PAHPs, information must be provided only to the extent that the PAHP includes any of the providers described in §439.102(a) of this chapter.	Not scored; 2017 requirement.		
Element 7. The enrollee handbook must include how to access auxiliary aids and services, including additional information in alternative formats or languages.	Not scored; 2017 requirement.		
Element 8. The enrollee handbook must include the toll-free	Not scored; 2017 requirement.		

telephone number for member services, medical management, and any other unit providing services directly to enrollees.	
Element 9. The enrollee handbook must include information on how to report suspected fraud or abuse.	Not scored; 2017 requirement.
Element 10. Information required by this paragraph to be provided by a MCO, PIHP, PAHP or PCCM entity will be considered to be provided if the MCO, PIHP, PAHP or PCCM entity: (1) Mails a printed copy of the information to the enrollee's mailing address; (2) Provides the information by email after obtaining the enrollee's agreement to receive the information by email; (3) Posts the information on the Web site of the MCO, PIHP, PAHP or PCCM entity and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or (4) Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.	Not scored; 2017 requirement.
Element 11. The MCO, PIHP, PAHP, or PCCM entity must give each enrollee notice of any change that the State defines as significant in the information specified in this paragraph (g), at least 30 days before the intended effective date of the change.	Not scored; 2017 requirement.
Element 12. ***Provider Directory.*** Each MCO, PIHP, PAHP, and when appropriate, the PCCM entity, must make available in paper form upon request and electronic form, the following information about its network providers: (1) The provider's name as well as any group affiliation (2) Street address(es) (3) Telephone number(s) (4) Website URL, as appropriate (5) Specialty, as appropriate (6) Whether the provider will accept new enrollees (7) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training. (8) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment	Not scored; 2017 requirement.

Element 13. The provider directory must include the information in paragraph (h)(1) of this section for each of the following provider types covered under the contract: (1) Physicians, including specialists; (2) Hospitals; (3) Pharmacies; (4) Behavioral health providers; and (5) LTSS providers, as appropriate.	Not scored; 2017 requirement.
Element 14. Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCO, PIHP, PAHP, or PCCM entity receives updated provider information.	Not scored; 2017 requirement.
Element 15. Provider directories must be made available on the MCO's, PIHP's, PAHP's, or if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.	Not scored; 2017 requirement.
Element 16. ***Formulary.*** Each MCO, PIHP, PAHP, and when appropriate, PCCM entity, must make available in electronic or paper form, the following information about its formulary: (1) Which medications are covered (both generic and name brand). (2) What tier each medication is on. (3) Formulary drug lists must be made available on the MCO's, PIHP's PAHP's, or, if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.	Not scored; 2017 requirement.

Information Requirements, 42 CFR § 438 Subpart A, details requirements to ensure that managed care enrollees receive information about available healthcare services, how to access services, and how to contact participating providers. Additionally, requirements to ensure that enrollees receive information on how to access auxiliary aids and services including information on alternative formats and languages are outlined. SHP was largely compliant with 2017 requirements. In elements and components that were not fully compliant, the MCO is developing an action plan to ensure 2017 compliance. The MCO will be scored on the Information Requirements Standard in the next annual review that covers MY 2017.

Table 15. Enrollee Rights Results

Enrollee Rights			
Element	Met	Partially Met	Unmet
Element 1. ***General rule.*** Each MCO, PIHP, PAHP, PCCM and PCCM entity must:		X	

(1) have written policies regarding the enrollee rights specified in this section, and (2) comply with any applicable Federal and State laws that pertain to enrollee rights, and ensure that its employees and contracted providers observe and protect those rights.			
Element 2. An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§438.206 through 438.210.	X		
Element 3. ***Free exercise of rights.*** The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, PCCM or PCCM entity and its network providers or the State agency treat the enrollee.	X		
Element 4. ***Compliance with other Federal and State laws.*** The State must ensure that each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.	X		

SHP was fully compliant with three of four elements for Enrollee Rights, 42 CFR § 438 Subpart C. There was only one enrollee right that SHP was found to be partially compliant with. While member materials communicate the enrollee right to request and receive a copy of his or her medical records, and request that they be amended or corrected, this right was omitted from the MCO's policy. Subsequent to the finding, SHP addressed the deficiency and amended its policy. This revision will assist the MCO in meeting 2017 requirements. Overall, SHP scored 94% on the Enrollee Rights Standard.

Table 16. MCO, PIHP and PAHP Standards Results

Availability of Services			
Element	Met	Partially Met	Unmet

Element 1. ***Basic Rule.*** Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP, and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with §438.68. ***Delivery Network.*** The State must ensure, through its contracts, that each MCO, PIHP, and PAHP, consistent with the scope of its contracted services, meets the following delivery network requirements.	Not scored; 2018 requirement.
Element 2. ***Furnishing of Services.*** The State must ensure that each contract with an MCO, PIHP, and PAHP complies with timely access.	Not scored; 2018 requirement.
Element 3. ***Access and cultural considerations.*** Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.	Not scored; 2018 requirement.
Element 4. ***Accessibility considerations.*** Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.	Not scored; 2018 requirement.

Assurance of Adequate Capacity and Services			
Element	Met	Partially Met	Unmet
Element 5. ***Basic rule.*** The State must ensure, through its contracts, that each MCO, PIHP, and PAHP gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under this part, including the standards at §438.68 and §438.206(c)(1).	Not scored; 2018 requirement.		

Element 6. ***Timing of documentation.*** Each MCO, PIHP, and PAHP must submit the documentation: (1) at the time it enters into a contract with the State, (2) on an annual basis, (3) at any time there has been a significant change (as defined by the State) in the MCO's, PIHP's, or PAHP's operations that would affect the adequacy of capacity and services, including: changes in MCO, PIHP, or PAHP services, benefits, geographic service area, composition of or payments to its provider network; (4) or enrollment of a new population in the MCO, PIHP, or PAHP.	Not scored; 2018 requirement.

Coordination and Continuity of Care			
Element	Met	Partially Met	Unmet
Element 7. ***Care and coordination of services for all MCO, PIHP, and PAHP enrollees.*** Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP enrollees.	Not scored; 2017 requirement.		
Element 8. ***Additional services for enrollees with special health care needs or who need LTSS—Identification.*** The State must implement mechanisms to identify persons who need LTSS or persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. ***Assessment.*** Each MCO, PIHP and PAHP must implement mechanisms to comprehensively assess each Medicaid enrollee identified by the State and identified to the MCO, PIHP, and PAHP by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or the MCO, PIHP, or PAHP as appropriate.	Not scored; 2017 requirement.		
Element 9. ***Additional services for enrollees with special health care needs or who need LTSS—Treatment/service plans.*** MCOs, PIHPs, or PAHPs must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(i) through (v) of this section for enrollees who require LTSS and, if the State requires, must produce a treatment or service plan meeting the criteria in paragraphs (c)(3)(iii) through (v) of this section for enrollees with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.	Not scored; 2017 requirement.		

Element 10. ***Direct access to specialists.*** For enrollees with special health care needs determined through an assessment (consistent with paragraph (c)(2) of this section) to need a course of treatment or regular care monitoring, each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.	Not scored; 2017 requirement.		
Coverage and Authorization of Services			
Element	Met	Partially Met	Unmet
Element 11. ***Coverage.*** Each contract between a State and an MCO, PIHP, or PAHP must: (1) identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer, (2) require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set for in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 440 of this chapter, and (3) provide that the MCO, PIHP, or PAHP: must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished and many not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.	Not scored; 2017 requirement.		
Element 12. MCOs, PIHPs, or PAHPs may place appropriate limits on a service, on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control.	Not scored; 2017 requirement.		
Element 13. MCOs, PIHPs, or PAHPs must specify what constitutes "medically necessary services" in a manner that: (1) is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, and (2) addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services.	Not scored; 2017 requirement.		

Element 14. *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require that the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.	Not scored; 2017 requirement.
Element 15. *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.	Not scored; 2017 requirement.
Element 16. *Timeframe for decisions.* Each MCO, PIHP, or PAHP must provide decisions and notices per requirements.	Not scored; 2017 requirement.
Element 17. *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, the MCO, PIHP, or PAHP must provide notice as described in section 1927(d)(5)(A) of the Act.	Not scored; 2017 requirement.
Element 18. *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §§438.3(i), and 422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	Not scored; 2017 requirement.

Provider Selection			
Element	Met	Partially Met	Unmet
Element 19. *General rules.* Each MCO, PIHP, or PAHP must implement written policies and procedures for selection and retention of network providers and that those policies and procedures, at a minimum, meet the requirements of this section. ***Credentialing and recredentialing requirements.*** The MCO, PIHP, or PAHP must establish a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate.	X		

Confidentiality			
Element	Met	Partially Met	Unmet

Element 20. The MCO, PIHP, and PAHP must comply with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable in regard to the use and disclosure of medical records and any other health and enrollment information that identifies a particular enrollee.	X		
Grievance and Appeal System			
Element	Met	Partially Met	Unmet
Element 21. Each MCO, PIHP, and PAHP has in effect a grievance and appeal system that meets the requirements of subpart F.	X		
Subcontractual Relationships and Delegation			
Element	Met	Partially Met	Unmet
Element 22. ***General rule.*** Notwithstanding any relationship(s) that the MCO, PIHP, PAHP, or PCCM entity may have with any subcontractor, the MCO, PIHP, PAHP, or PCCM entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and all contracts or written arrangements between the MCO, PIHP, PAHP, or PCCM entity and any subcontractor must meet the requirements of paragraph (c) of this section.	Not scored; 2017 requirement.		
Practice Guidelines			
Element	Met	Partially Met	Unmet
Element 23. ***Basic rule.*** Each MCO, PIHP, and PAHP must meet the requirements of this section. ***Adoption of practice guidelines.*** Each MCO and, when applicable, each PIHP and PAHP must adopt practice guidelines.	X		
Element 24. ***Dissemination of guidelines.*** Each MCO, PIHP, and PAHP must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X		
Element 25. ***Application of guidelines.*** Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply must be consistent with the guidelines.	X		
Health Information Systems			

Element	Met	Partially Met	Unmet
Element 26. *General rule.* MCOs, PIHPs, and PAHPs must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	Not scored; 2017 requirement.		

MCO, PIHP, and PAHP Standards, 42 CFR § 438 Subpart D, details requirements to ensure managed care enrollees have adequate and timely access to services and access to coordinated care. Services must be sufficient in the amount, duration, and scope. Authorization of services must be consistent and based on valid and reliable clinical evidence or clinical practice guidelines. Authorization of services procedures must be standardized and denial of services must be made by an individual with the appropriate clinical expertise. SHP was largely compliant with 2017 and 2018 requirements. For the 2016 requirements that were scored, SHP was fully compliant with all elements under review including:

- Provider Selection
- Confidentiality
- Practice Guidelines

Overall, based on the applicable scored MCO, PIHP, and PAHP Standards, SHP scored 100%.

Table 17. Quality Assessment and Performance Improvement Program

Quality Assessment and Performance Improvement Program			
Element	Met	Partially Met	Unmet
Element 1. *General rules.* Each MCO, PIHP, and PAHP must establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees.	Not scored; 2017 requirement.		
Element 2. *Performance measurement.* Using performance measures specified by the State (as specified in § 438.330 (c)(1)(i)(ii), each MCO, PIHP, and PAHP must annually: Measure and report to the State on its performance using the standard measures, submit data to the State which enables the State to calculate the MCO's, PIHP's, or PAHP's performance and Perform a combination of the activities described in paragraphs (c)(2)(i) and (ii) of this section.	Not scored; 2017 requirement.		
Element 3. *Performance improvement projects (PIPs).* Each MCO, PIHP, and PAHP must conduct PIPs required by the State that focus on both clinical and nonclinical areas.	Not scored; 2017 requirement.		

Element 4. ***Program review by the State.*** The State must review, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2). The review must include the entity's performance on required measures, performance improvement projects, and results of efforts to support community integration for enrollees using long-term services and supports.	Not scored; 2017 requirement.

Quality Assessment and Performance Improvement Program, 42 CFR § 438.330, Subpart E, details requirements for a comprehensive quality assessment and performance improvement program that includes performance improvement projects, collection and submission of performance measures data, and mechanisms to detect both under and overutilization of services. SHP was largely compliant with 2017 requirements. However, one opportunity for improvement that remains in place includes completing an annual comprehensive quality program evaluation. The MCO will be scored on the Quality Assessment and Performance Improvement Program Standard in the next annual review that covers MY 2017.

Table 18. Grievance and Appeal System Results

General Requirements			
Element	Met	Partially Met	Unmet
Element 1. ***The grievance and appeal system.*** Each MCO, PIHP, and PAHP must have a grievance and appeal systems in place for enrollees.	Not scored; 2017 requirement.		
Element 2. ***Level of appeals.*** Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.	Not scored; 2017 requirement.		
Element 3. ***Filing requirements—authority to file.*** An enrollee may file a grievance and request an appeal with the MCO, PIHP, or PAHP. An enrollee may request a State fair hearing after receiving notice under §438.408 that the adverse benefit determination is upheld.	Not scored; 2017 requirement.		
Element 4. ***Deemed exhaustion of appeals processes.*** In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, PAHP's appeal process. The enrollee may initiate a State fair hearing.	Not scored; 2017 requirement.		
Element 5. ***Filing requirements—authority to file.*** If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee.	Not scored; 2017 requirement.		

Element 6. *Timing—Grievance.* An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.	Not scored; 2017 requirement.
Element 7. *Timing—Appeal.* Following receipt of a notification of an adverse benefit determination by an MCO, PIHP, or PAHP, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan.	Not scored; 2017 requirement.
Element 8. *Procedures—Grievance.* The enrollee may file a grievance either orally or in writing and, as determined by the State, either with the State or with the MCO, PIHP, or PAHP.	Not scored; 2017 requirement.
Element 9. *Procedures—Appeal*. The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.	Not scored; 2017 requirement.

Timely and Adequate Notice of Adverse Benefit Determinations			
Element	Met	Partially Met	Unmet
Element 10. *Notice.* The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.	Not scored; 2017 requirement.		
Element 11. *Timing of notice.* The MCO, PIHP, or PAHP must mail the notice within the following timeframes: For termination notice, suspension, or reduction of previously authorized Medicaid-covered service, within the timeframes specified in §§431.211 [at least 10 days before the date of action], 431.213, and 431.214 of this chapter, for denial of payment, at the time of any action affecting the claim and for standard service authorization decisions that deny or limit services, within the timeframe specified in §438.210(d)(1) [14 calendar days].	Not scored; 2017 requirement.		
Element 12. If the MCO, PIHP, or PAHP meets the criteria set forth for extending the timeframe for standard service authorization decisions consistent with §438.210(d)(1)(ii).	Not scored; 2017 requirement.		
Element 13. The MCO, PIHP, or PAHP must mail the notice for service authorization decisions not reached within the timeframes specified in §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.	Not scored; 2017 requirement.		
Element 14. The MCO, PIHP, or PAHP must mail the notice for expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).	Not scored; 2017 requirement.		

Handling of Grievances and Appeals			
Element	Met	Partially Met	Unmet
Element 15. ***General requirements.*** In handling grievances and appeals, each MCO, PIHP, and PAHP must give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	Not scored; 2017 requirement.		
Element 16. ***Special requirements.*** An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations.	Not scored; 2017 requirement.		
Resolution and Notification: Grievances and Appeals			
Element	Met	Partially Met	Unmet
Element 17. ***Basic rule.*** Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.	Not scored; 2017 requirement.		
Element 18. ***Format of notice—Grievances.*** The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at §438.10.	Not scored; 2017 requirement.		
Element 19. ***Format of notice—Appeals.*** For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at §438.10.	Not scored; 2017 requirement.		
Element 20. ***Format of notice—Expedited Appeals.*** For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.	Not scored; 2017 requirement.		

Element 21. ***Content of notice of appeal resolution.*** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed and for appeals not resolved wholly in favor of the enrollees— (1) the rights to request a State fair hearing, and how to do so; (2) the right to request and receive benefits while the hearing is pending, and how to make the request; (3) that the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.	Not scored; 2017 requirement.
Element 22. ***Requirements for State fair hearings—Availability.*** An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.	Not scored; 2017 requirement.
Element 23. ***Deemed exhaustion of appeals processes.*** In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.	Not Applicable; duplication in the CFR standards (previously addressed under Element 4)
Element 24. ***State fair hearing.*** The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.	Not scored; 2017 requirement.
Element 25. ***Parties to the State fair hearing.*** The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.	Not scored; 2017 requirement.

Expedited Resolution of Appeals			
Element	Met	Partially Met	Unmet
Element 26. ***General rule.*** Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.	Not scored; 2017 requirement.		

Element 27. ***Punitive action.*** The MCO, PIHP, or PAHP must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.	Not scored; 2017 requirement.		
Element 28. ***Action following denial of a request for expedited resolution.*** If the MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it must: (1) transfer the appeal to the timeframe for standard resolution in accordance with §438.408(b)(2); and (2) follow the requirements in §438.408(c)(2).	Not scored; 2017 requirement.		
Information About the Grievances and Appeal System to Providers and Subcontractors			
Element	Met	Partially Met	Unmet
Element 29. The MCO, PIHP, or PAHP must provide information specified in §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.	Not scored; 2017 requirement.		
Recordkeeping Requirements			
Element	Met	Partially Met	Unmet
Element 30. MCOs, PIHPs and PAHPs must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.	Not scored; 2017 requirement.		
Element 31. The record of each grievance or appeal must contain, at a minimum, all of the following information: (1) a general description of the reason for the appeal or grievance, (2) the date received, (3) the date of each review or, if applicable, review meeting, (4) resolution at each level of the appeal or grievance, if applicable, (5) date of resolution at each level, if applicable, (6) name of the covered person for whom the appeal or grievance was filed.	Not scored; 2017 requirement.		
Element 32. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.	Not scored; 2017 requirement.		
Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending			
Element	Met	Partially Met	Unmet

Element 33. ***Continuation of benefits.*** The MCO, PIHP, or PAHP must continue the enrollee's benefits if all of the following occur: (1) the enrollee files the request for an appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii); (2) the appeal involves the termination, suspension, or reduction of previously authorized services; (3) the services were ordered by an authorized provider; (4) the period covered by the original authorization has not expired; and (5) the enrollee timely files for continuation of benefits.	Not scored; 2017 requirement.
Element 34. ***Duration of continued or reinstated benefits.*** If at the enrollee's request, the MCO, PIHP, or PAHP continues or reinstates the enrollee's benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: (1) the enrollee withdraws the appeal or request for State fair hearing; (2) the enrollee fails to request a State fair hearing and continuation of benefits within 10 calendar days after the MCO, PIHP, or PAHP sends the notice of an adverse resolution to the enrollee's appeal under §438.408(d)(2); (3) a State fair hearing office issues a hearing decision adverse to the enrollee.	Not scored; 2017 requirement.
Element 35. ***Enrollee responsibility for services furnished while the appeal or State fair hearing is pending.*** If the final resolution of the appeal or State fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under §431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and State fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.	Not scored; 2017 requirement.

Effectuation of Reversed Appeal Resolutions			
Element	Met	Partially Met	Unmet

Element 36. ***Services not furnished while the appeal is pending.*** If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.	Not scored; 2017 requirement.
Element 37. ***Services furnished while the appeal is pending.*** If the MCO, PIHP, or PAHP, or the State fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO, PIHP, or PAHP, or the State must pay for those services, in accordance with State policy and regulations.	Not scored; 2017 requirement.

Grievance and Appeal System, 42 CFR § 438 Subpart F, 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). SHP is largely compliant with 2017 requirements; however, some adjustments need to be made regarding the grievances and appeals member filing and MCO resolution timelines to meet the new requirements. The Grievance and Appeal System Standard will be scored for the next annual review that covers MY 2017.

Table 19. Program Integrity (based on MCO contract requirements) Results

Program Integrity Contract Requirements			
Element	Met	Partially Met	Unmet
Element 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		

SHP maintains a 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 has 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 North Dakota DHS. SHP scored 100% on the Program Integrity Standard.

Strengths

- SHP largely demonstrated compliance with the new Medicaid managed care standards—many of which are not required until 2017 or 2018.

- Overall, SHP scored well on the new 2016 requirements:
  - Enrollee Rights Standard: 94% compliant
  - MCO, PIHP, and PAHP Standards: 100% compliant for Elements encompassing Provider Selection, Confidentiality, and Practice Guidelines
  - Program Integrity: 100%
- At the time of the site review, conducted in May 2017, 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 the next annual review which will occur in 2018 and cover MY 2017.

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 make required adjustments in its grievance and appeal procedures to ensure compliance with timelines related to member filing and MCO resolution requirements.
- SHP should complete an annual comprehensive quality program evaluation.
- SHP should review annual performance and identify and prioritize opportunities for improvement.

Encounter Data Validation

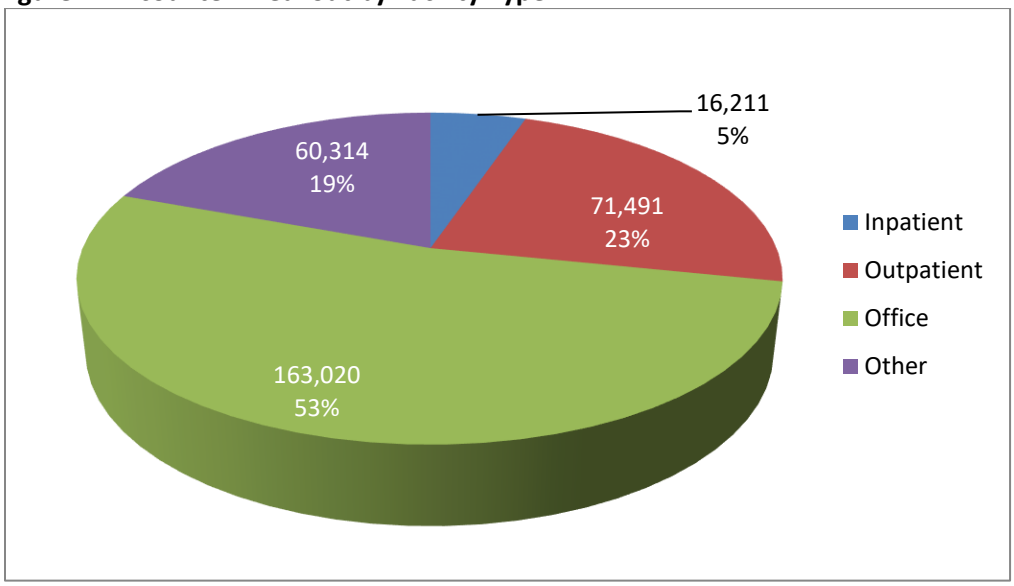
Claims Volume

The Utilization Rate for SHP, measured by the number of members with at least one paid claim, was 68%. Out of a total of 34,620 unique members, 23,513 (68%) had at least one paid claim during MY 2016.[4] For comparative purposes, this is a one percentage point decrease compared to the 69% utilization rate for MY 2015.

Analysts evaluated the volume of encounters submitted to the MCO throughout the year which provides useful information on the completeness of encounter data. This evaluation examined the number of encounters by encounter type (i.e., Inpatient, Outpatient and Office Visit). Figure 1 shows the volume and percentage of encounters by facility type for those members who had an encounter. Most encounters occurred in the Physician Office setting (53%). Only 5% of encounters occurred via the Inpatient setting.

[4] Unique Members were identified by social security number during the analysis of the Encounter Data Validation task completed by Delmarva Foundation. This number is based on the number of Medicaid recipients covered during the Measurement Year and is not a point in time enrollment number. For comparison purposes, at the end of MY 2016, the point in time enrollment was 18,835.

Figure 1. Encounter Breakout by Facility Type



Timely Claims Submission

Another aspect of incomplete data involves situations in which encounters are not submitted to the MCO within a reasonable time after a provider conducts the service. To evaluate how timely the providers submitted encounters to the MCO, analysts attempted calculating the number of days between the date of service and receipt of the claim. However, SHP's encounter data file did not contain the date of receipt of a claim. Therefore, although SHP stated that 99% of provider claims are submitted within 30 days of the date of service, Delmarva Foundation could not verify this based on the data received.

Data Completeness

Delmarva Foundation examined both the member file and the claims file to assess data completeness. The member file had less than 1% of cases where data was 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 74 cases in the unduplicated member file and in 109 cases in the unduplicated claims file.

Data Accuracy

The review of members' medical records offers another method to examine the completeness and accuracy of encounter data. For this study, Delmarva Foundation pulled a sample of SHP's members' medical records for billed claims 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.

Upon receipt of the medical records, the record was verified against the sample listing and data from the database were used to analyze the consistency between submitted encounter data and corresponding medical records. Cases where a match between the medical record and encounter data

could not be verified by date of birth, gender, or name were excluded from analysis. Claims with no payment or negative payment balances were excluded from the analysis.

Tables 20-22 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). MY 2015 results are included for purposes of comparison to MY 2016.

Table 20. North Dakota EDV Results by Element for Inpatient Encounter Type

Encounter Type	Diagnosis Codes		Revenue Codes		Procedure Codes		Total	
	MY 2015	MY 2016	MY 2015	MY 2016	MY 2015	MY 2016	MY 2015	MY 2016
Match	107	106	71	103	26	31	204	240
No Match	21	11	3	0	0	0	24	11
Total Elements	128	117	74	103	26	31	228	251
Match Percent	84%	91%	96%	100%	100%	100%	89%	96%

Table 21. North Dakota EDV Results by Element for Outpatient Encounter Type

Encounter Type	Diagnosis Codes		Revenue Codes		Procedure Codes		Total	
	MY 2015	MY 2016	MY 2015	MY 2016	MY 2015	MY 2016	MY 2015	MY 2016
Match	150	148	101	155	128	174	379	477
No Match	12	10	4	2	5	3	21	15
Total Elements	162	158	105	157	133	177	400	492
Match Percent	93%	94%	96%	99%	96%	98%	95%	97%

Table 22. North Dakota EDV Results by Element for Office Visit Encounter Type

Encounter Type	Diagnosis Codes		Revenue Codes		Procedure Codes		Total	
	MY 2015	MY 2016	MY 2015	MY 2016	MY 2015	MY 2016	MY 2015	MY 2016
Match	360	435	NA	NA	268	288	628	723
No Match	53	80	NA	NA	3	8	56	88
Total Elements	413	515	NA	NA	271	296	684	811
Match Percent	87%	84%	NA	NA	99%	97%	92%	89%

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

MCO Strengths

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

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 365 days 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 State data reporting requirements and to provide technical assistance to providers in meeting ICD-10 reporting requirements.
- 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.
- Conduct provider audits to ascertain the extent to which providers are adherent to coding principles.

State Recommendations

As data and the Medicaid Expansion program continue to mature, it is 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 93% for MY 2016, compared to 92% in MY 2015. The most significant rate decline occurred in diagnosis codes for the Office Visit 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 2017 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 24, 2017, 1,350 surveys were mailed to a random sample of members who had been continuously enrolled in the MCO for at least five of the last six months of the measurement year. A total of 390 surveys were completed via mail or phone, providing a response rate of 29%. The majority of respondents indicated that they were: overall in good health and excellent/very good mental/emotional health; in the 55 or older age range; female; with an education of high school or less; and white.

SHP's CAHPS® Survey results were compared to NCQA Quality Compass benchmarks (Medicaid – All Lines of Business) to gauge performance and identify opportunities for improvement. Results are displayed in Table 23.

Table 23. CAHPS Survey Results Compared to Benchmarks

Measure	SHP 2015 Rate	SHP 2016 Rate	SHP 2017 Rate	2017 SHP Rate Compared to Benchmarks*
Customer Service Composite	91.7%	88.4%	92.7%	♦♦♦♦
Getting Needed Care Composite	85.2%	82.8%	83.0%	♦♦
Getting Care Quickly Composite	84.6%	81.0%	83.9%	♦♦♦
How Well Doctors Communicate Composite	93.3%	93.1%	92.8%	♦♦♦
Shared Decision Making Composite	79.0%	81.8%	83.0%	♦♦♦♦
Health Promotion and Education Composite	65.3%	69.2%	73.4%	♦♦
Coordination of Care Composite	81.6%	85.6%	85.4%	♦♦♦
Rating of Health Plan (8+9+10)	71.7%	73.8%	75.1%	♦♦
Rating of All Health Care (8+9+10)	70.3%	74.6%	72.5%	♦
Rating of Personal Doctor (8+9+10)	84.7%	84.6%	85.8%	♦♦♦♦
Rating of Specialist Seen Most often (8+9+10)	78.2%	82.1%	79.1%	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (2 year rolling average for 2016)	79.2%	75.1%	73.3%	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (2 year rolling average for 2016)	47.1%	48.1%	48.5%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (2 year rolling average for 2016)	47.7%	47.4%	48.6%	♦♦♦
Aspirin Use and Discussion: Take daily aspirin/ every other day	NA	NA	28.4%	-
Aspirin Use and Discussion: Discussed risks and benefits of using aspirin	39.0%	NA	35.0%	-
Flu vaccination: Had flu shot or spray in the nose since July 1, 2016	32.3%	38.0%	37.7%	♦
Phoned plan to get help with transportation	2.9%	3.3%	5.1%	-

Measure	SHP 2015 Rate	SHP 2016 Rate	SHP 2017 Rate	2017 SHP Rate Compared to Benchmarks*
Received help with transportation	NR	NR	NR	-
Help with transportation met your needs	NR	NR	NR	-

* Benchmark Source: 2016 (MY 2015) NCQA Quality Compass National Medicaid. This was the latest benchmark source at the time of report production.
- National benchmark not available.
NA Response rate <100.
NR Not Reportable; less than 30 responses.
♦ the rate is below the NCQA Quality Compass National Medicaid Average.
♦♦ the rate is equal to or exceeds the NCQA Quality Compass National Medicaid Average, but does not meet the 75th Percentile.
♦♦♦ the rate is equal to or exceeds the NCQA Quality Compass 75th, but does not meet the 90th Percentile.
♦♦♦♦ the rate is equal to or exceeds the NCQA Quality Compass 90th Percentile for Medicaid.

SHP performed below the national Medicaid average for the following CAHPS® measures:

- Rating of All Health Care
- Rating of Specialist Seen Most Often
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Had the Flu Shot or Spray in the Nose

The MCO met or exceeded the national Medicaid average but was below the national Medicaid 75th Percentile for the following CAHPS® measures:

- Getting Needed Care Composite
- Health Promotion and Education Composite
- Rating of Health Plan
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications

SHP met or exceeded the national Medicaid 75th Percentile but was below the national Medicaid 90th Percentile for the following CAHPS® measures:

- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Coordination of Care Composite
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

SHP met or exceeded the national 90th Percentile in the following CAHPS® measures:

- Customer Service Composite
- Shared Decision Making Composite
- Rating of Personal Doctor

A trend analysis was conducted and the following conclusions were made after reviewing three consecutive years of performance (MY 2014-MY 2016):

- Performance in most measures was mixed year over year.
- A decline in performance year over year was identified in two measures:
  - How Well Doctors Communicate Composite
  - Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- A positive trend (improvement year over year) was identified in the following measures:
  - Shared Decision Making Composite
  - Health Promotion and Education Composite
  - Rating of Health Plan
  - Supplemental Question: Phoned Plan to Get Help with Transportation
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications

Strengths

- In regard to benchmarking, SHP exceeded the 90th Percentile in the following CAHPS® measure:
  - Customer Service Composite
  - Shared Decision Making Composite
  - Rating of Personal Doctor

- SHP also showed strength with improving rates between MY 2014 and MY 2016 for the following measures:
  - Shared Decision Making Composite
  - Health Promotion and Education Composite
  - Rating of Health Plan
  - Supplemental Question: Phoned Plan to Get Help with Transportation
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications

Recommendations

- SHP is encouraged to identify barriers and explore strategies to improve the four CAHPS® measures that performed below the national Medicaid average:
  - Rating of All Health Care
  - Rating of Specialist Seen Most Often
  - Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
  - Had the Flu Shot or Spray in the Nose

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.[5] 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.[6] 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.[7]

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:[8]

- 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.

[5] Journal of Orthopaedic & Sports Physical Therapy, Volume 41, Number 11, November 2011
[6] http://www.aafp.org/afp/2012/0215/p343.html
[7] Journal of Orthopaedic & Sports Physical Therapy, Volume 41, Number 11, November 2011
[8] http://www.aafp.org/afp/2012/0215/p343.html

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 2016: 71.21%. There was a decline in performance compared to MY 2015's result (78.63%). The decline in performance may be impacted by the smaller eligible population, which decreased by almost 500 members.
The MCO's MY 2016 performance compared favorably to the national Medicaid 25th percentile, but not the national average benchmark. Because SHP's performance does not meet the national average benchmark, North Dakota DHS should consider requiring SHP to implement interventions to improve performance.

Strengths

No strengths were noted due to performance that does not meet the national average benchmark.

Recommendations

Delmarva Foundation recommends that the North Dakota DHS consider requiring SHP to implement interventions or strategies to improve performance.

Results of the focused study should also be shared with SHP's network practitioners due to the 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 2015) and the follow-up activities completed by SHP in 2016.

Table 24. 2016 Compliance with 2015 Recommendations

2016 Compliance with 2015 Recommendations	
2015 Recommendation	2016 Compliance Assessment
Review and act on specific recommendations made by the EQRO in the Compliance Review report.	**Unable to evaluate due to changes in the standards.** SHP continued efforts to improve compliance with recommendations in the Compliance Review report; however, a new set of standards were introduced for the MY 2016 Compliance Review audit. Due to changes within the standards, it is difficult to gauge compliance year over year. The MY 2016 assessment will serve as a new baseline.
Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next available appointments.	**Continues to be an opportunity for improvement.** Ensuring timely access to provider appointments continues to be a challenge for SHP. There is opportunity for improvement in the following provider types: behavioral health, OB, and primary care.
Continue with administration of new Fraud, Waste and Abuse Program to prevent, detect, investigate, and report suspected or actual fraud, waste, and abuse.	**Compliant.** SHP maintains a Fraud, Waste, and Abuse (FWA) Plan that uses a number of system edits and programmatic reviews of data designed to detect potential FWA. SHP contracts with two vendors to conduct pharmacy and medical FWA reviews. The pharmacy vendor submits quarterly reports that identify members with excessive high dollar/high risk prescriptions and providers with excessive prescriptions. The medical claims vendor completes retrospective annual reviews to identify suspect or potential incorrect, fraudulent, or abusive billing practices. SHP reported no suspected cases were identified for 2016.
Conduct an annual Quality Program Evaluation that evaluates Quality Work Plan activities and outcomes.	**Continues to be an opportunity for improvement.** SHP has not completed an annual Quality Program Evaluation.
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.	**Continues to be an opportunity for improvement.** 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 second remeasurement year. The MCO should continue to expand its quality program, measure and monitor performance, and implement interventions and quality initiatives in order to improve enrollee health related outcomes.

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 addressed barriers and reported sustained improvement in both projects for MY 2016 when performance is compared to baseline results.

SHP has a satisfactory process for data integration, data control, and interpretation of the performance measures. 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 2016 National Medicaid Average for All Lines of Business, SHP exceeded the national average but was below the Medicaid 75th Percentile for the following measures:

- Adult Performance Measures:
  - Adherence to Antipsychotic for Individuals With Schizophrenia
  - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
  - PQI 01: Diabetes Short-Term Complications Admission Rate, Ages 18-64*
  - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64*
  - PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 18-64*
  - PQI 15: Asthma in Younger Adults Admission Rate, Ages 18-39*
  - Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Initiation

SHP met or exceeded the national Medicaid 75th Percentile but was below the national Medicaid 90th Percentile for the following performance measures.

- Adult Performance Measures:
  - Comprehensive Diabetes Care: HbA1c Testing
  - Comprehensive Diabetes Care: HbA1c Poor Control (>9% a lower score is better)
  - Comprehensive Diabetes Care: HbA1c Control (<8%)
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Antidepressant Medication Management: Effective Acute Phase Treatment
  - Antidepressant Medication Management: Effective Continuation Phase Treatment
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

SHP met or exceeded the national Medicaid 90th Percentile for the following performance measures:

- Adult Performance Measures:
  - Adult BMI Assessment
  - Comprehensive Diabetes Care: HbA1c (<7%) for a Selected Population
  - Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
  - Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment: Engagement
  - Controlling High Blood Pressure

SHP largely demonstrated compliance with the new Medicaid managed care standards—many of which are not required until 2017 or 2018. Overall, SHP scored well on the new 2016 requirements:

- Enrollee Rights Standard: 94% compliant
- MCO, PIHP and PAHP Standards: 100% compliant for Elements encompassing Provider Selection, Confidentiality, and Practice Guidelines
- Program Integrity: 100%

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 93% 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 2017 member satisfaction via a CAHPS® Survey. Compared to the NCQA Quality Compass National Medicaid All Lines of Business benchmarks, SHP scored above the national Medicaid average but below the national Medicaid 75th Percentile for the following CAHPS® measures:

- Getting Needed Care Composite
- Health Promotion and Education Composite

- Rating of Health Plan
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications

SHP met or exceeded the national Medicaid 75th Percentile but was below the national Medicaid 90th Percentile for the following CAHPS® measures:

- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Coordination of Care Composite
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

SHP met or exceeded the national 90th Percentile in the following CAHPS® measures:

- Customer Service Composite
- Shared Decision Making Composite
- Rating of Personal Doctor

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 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 conduct two PIPs, as required in the North Dakota Medicaid Expansion Quality Strategy. The MCO should monitor barriers and gauge effectiveness of interventions. As new barriers are identified, new strategies should be developed. It is expected that SHP will close its Prevention and Treatment of Chronic Conditions PIP. The MCO should replace the PIP with a new meaningful PIP topic and performance measures that offer opportunity for improvement.

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:
  - Breast Cancer Screening
  - Flu Vaccinations for Adults
  - 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 Digoxin
  - Annual Monitoring for Patients on Persistent Medications: For Enrollees on Diuretics
  - Annual Monitoring for Patients on Persistent Medications: Total Rate
  - Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit

  - Cervical Cancer Screening
  - Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
  - Comprehensive Diabetes Care: Eye Exam
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

- 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. The MCO should ensure that it is ready for the new standards that are effective in 2017 and 2018.

To ensure timely receipt of provider claims analysis, 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 365 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.
For CAHPS® Survey measures not meeting the national averages, SHP should develop and implement initiatives that aim to improve performance. SHP performed below average on the following measures:

- Rating of All Health Care
- Rating of Specialist Seen Most Often
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Had the Flu Shot or Spray in the Nose

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. Even taking into account the many rural geographic areas of North Dakota, SHP exceeded the minimum requirements for access to primary care services. 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 Medicaid average for the CAHPS® composite Getting Needed Care. The Coordination of Care composite exceeded the national Medicaid 75th Percentile. 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. SHP should attempt to close the provider geographic access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities, Cardiology, and Hematology and Oncology. 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 high impact and high volume specialist 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 maintains 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 75th percentile benchmark.

Timeliness Recommendations

SHP has opportunity for improvement related to timely access to next available appointments for the following provider types: maternity, primary care, and behavioral health. 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 2016 year end, 18,835 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the course of the year, 68% of the enrollees utilized health care services. For comparative purposes, this is a one percentage point decrease compared to the 69% utilization rate for MY 2015. The MCO provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, 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. With three years of performance measure results, the MCO is able to trend performance and get a better idea of where SHP meets and exceeds requirements and where there is opportunity for improvement. Implementing interventions and 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 program operations and monitoring of performance.

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 for the Follow-Up for Mental Health PIP in an effort to improve performance.
- Close out the Prevention and Treatment of Chronic Conditions PIP and replace it with a new topic where there is opportunity for improvement.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates, particularly for the measures that did not meet the NCQA Quality Compass national averages or measures with performance that declined between MY 2014 to MY 2016. This should also be done for the CAHPS® survey measure results.
- Review and act on specific recommendations made by the EQRO in the Compliance Review report. Ensure compliance with new Medicaid managed care standards.
- Revise member filing requirements and MCO resolution timelines for grievances and appeals to align with new standards.

- Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next available appointments.
- Continue administration of disease management programs and engage members in self-management initiatives. Focus efforts to improve participation.
- Conduct an annual Quality Program Evaluation that evaluates Quality Work Plan activities and outcomes. Trend annual results in the evaluation to facilitate an understanding of performance year over year.
- Add a field to the encounter data file submission to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 365 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.

State Recommendations

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