

North Dakota  
Department of Human Services



## North Dakota Medicaid Expansion Program

Annual Technical Review Report  
Measurement Year (MY) 2017

**Qlarant** 

Submitted by:  
Qlarant  
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# North Dakota Medicaid Expansion Program

## 2018 Annual Technical Report

### Measurement Year 2017

## Executive Summary

### Introduction

Effective January 1, 2015, 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 role and assurance for quality, DHS subsequently contracted with Qlarant to complete an external quality review (EQR) of the North Dakota Medicaid Expansion Program.

Qlarant conducted a 2018 comprehensive assessment of SHP's measurement year (MY) 2017 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 the MCO Program: Waiver for Managed Care Enrollment of Medicaid Expansion of the New Adult Group. Following the Centers for Medicare and Medicaid Services (CMS) EQR protocols, Qlarant evaluated the quality, access, and timeliness of services provided to the Medicaid Expansion program enrollees by assessing 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<sup>®1</sup>) Survey
- Focused Quality Study (FQS)

This annual technical report describes MY 2017 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.

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<sup>1</sup> CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

## 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 diabetes care and follow-up for mental health. SHP's MY 2017 PIP Reports included baseline and remeasurement results and described multifaceted interventions. Sustained improvement was demonstrated in the Follow-Up After Hospitalizations for Mental Health measures and SHP successfully reported baseline performance in all Comprehensive Diabetes Care performance measures.

### Performance Measure Validation

SHP had satisfactory processes for data integration, data control, and interpretation of the CMS Adult and Child Core Measures for MY 2017. Procedures and documentation used to calculate performance measures with the certified HEDIS<sup>®2</sup> software were reviewed and found to be acceptable. Programming language source code and test cases were reviewed for core measures not calculated with the certified software, and were found to be adequate. Sampling and medical record review activities were evaluated and met requirements. SHP successfully reported its results for the required performance 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 nine exceeding the 75<sup>th</sup> percentile and two surpassing the 90<sup>th</sup> percentile. Performance measure results are displayed in Tables 12 and 13 of the Annual Technical Report.

### Compliance Review

In general, SHP demonstrated compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion populations during MY 2017. Qlarant reviewed all new managed care standards – including 2017 and 2018 requirements. The 2017 requirements were scored and Qlarant provided recommendations and comments on the 2018 requirements. Feedback intentions were to provide SHP guidance in policy and procedure revisions and help the MCO meet the new requirements. Regarding 2017 requirements, SHP scored the following:

- Information Requirements: 98.21%

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

- Enrollee Rights Standard: 100%
- MCO, PIHP, and PAHP Standards: 96.94%
- Quality Assessment and Performance Improvement Program: 100%
- Grievance and Appeal System: 88.60%
- Program Integrity Contract Requirements: 100%

## Encounter Data Validation

The Utilization Rate for SHP, measured by the number of members with at least one paid claim, was 71%. Out of a total of 34,108 unique members, 24,236 (71%) had at least one paid claim during MY 2017. For comparative purposes, this is a three percentage point increase compared to the 68% utilization rate for MY 2016. Overall, SHP has well documented data integration and claims processing procedures. During MY 2017, SHP achieved a total match rate of 95%—meaning 95% of claims data submitted was supported by medical record documentation. Office Visit records registered the highest match rate (97%), followed by Outpatient records (96%), and Inpatient records had the lowest match rate (86%) which was a ten percentage point decrease from MY 2016. The match rate will continue to be monitored.

## CAHPS Survey

SHP contracted with a certified CAHPS vendor to conduct the 2018 CAHPS 5.0H Member Satisfaction Survey. The survey was designed to capture member feedback regarding the MCO, its providers, and member perception about getting needed care, getting care quickly, and customer service. On February 6, 2017, a total of 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 MCO received 315 completed surveys for a 23.35% 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. Two CAHPS measures exceeded the national 75<sup>th</sup> Percentile benchmark and four surpassed the 90<sup>th</sup> Percentile benchmarks. Results are displayed in Table 23 of the Annual Technical Report.

## Focused Quality Study

Qlarant's MY 2015 EDV analysis revealed the North Dakota Medicaid Expansion population's top primary diagnosis was low back pain. The following study question was posed: *Do North Dakota Medicaid Expansion network practitioners treat low back pain without ordering an imaging study within 28 days of diagnosis?* The goal of the focused study is to identify the percentage of North Dakota Medicaid Expansion members with a primary diagnosis of low back pain who did *not* receive an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis. A higher rate indicates appropriate treatment of low back pain.

Due to low back pain being the most frequent diagnosis for the North Dakota Medicaid Expansion population, it 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, Qlarant calculated the rate for MY 2017: 76.79%, which is a 5.58 percentage point improvement, compared to the previous annual measurement (71.21%). While improvement was noted over the last year, MY 2017 performance fell short of the baseline (MY 2015) rate of 78.63%.

While this three year study has come to a close, Qlarant recommends that North Dakota DHS and SHP be mindful of the study's findings. While performance exceeds the national average benchmark, there is still opportunity for improvement. SHP should continue to educate providers on delaying imaging studies when appropriate.

## 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 lists each activity and the associated standard (or requirement), person(s) responsible, and reporting frequency. Some of the activities include: appeals, telephone statistics, fraud and abuse, provider utilization profiling, pregnancy/deliveries, and access and availability.

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) Comprehensive Diabetes Care and (2) Follow-Up for Mental Health. The MCO successfully completed PIP activities and reported on performance.

Regarding PMV quality evaluations, CMS Adult and Child Core Measure results were found to be compliant with corresponding performance measure specifications, and therefore assessed as "reportable." Most performance measure results exceeded national average benchmarks. Similarly, SHP's CAHPS Survey results also exceeded 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 develops and implements an annual Quality Improvement Work Plan identifying key quality measures and a reporting timeline. For the first time, SHP also completed a Quality Improvement Program Evaluation for MY 2017, which included an analysis of PIPs and other key performance measures. SHP should continue to develop its current quality program. The program should regularly measure and monitor all activities with performance-related indicators and be furnished with action plans if 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.

## Access

Numerous elements within the CR assessed access to vital member information, providers and healthcare services. SHP provided members with information on available benefits and instructions in accessing such services. Member materials provide instructions in selecting and accessing providers and obtaining 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 guidance in obtaining 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 provider density within a geographic area. Additionally, 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 or non-emergency care. Transportation may be provided for members to 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. Furthermore, the MCO should actively monitor and review any access-related complaints or grievances in order 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 should compliance issues be identified.

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. All files were noted to include timely acknowledgements except for one grievance—which took the MCO 41 days to acknowledge. There were no requests for expedited appeals or state fair hearings during MY 2017.

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: behavioral health, maternity, primary care, and specialists. Additionally, the MCO should actively monitor and review any timeliness-related complaints or grievances in order to quickly identify and resolve timeliness-related issues.

## Conclusions

By the 2017 year end, 21,493 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the course of the year, 71% of enrollees utilized health care services. For comparative purposes, this is a three percentage point increase compared to the 68% utilization rate for MY 2016. 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 its performance to gauge where it meets and exceeds requirements and to identify opportunities for improvement. By implementing interventions and addressing these opportunities, the MCO 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

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- Continue to target members with diabetes using interventions aimed to improve member self-management.
- Explore value based contracting, which will likely have a positive impact on diabetic member outcomes.
- Adjust goals to ensure it is consistently facilitating quality improvement. Currently, SHP exceeds its goal for the HbA1c Poor Control (>9%) performance measure.
- SHP is encouraged to continue annual barrier analyses and also develop and implement targeted interventions.
- Consider the use of supplemental data for both HEDIS and non-HEDIS measures to improve performance measure rates.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates particularly for measures that did not meet the NCQA Quality Compass national average benchmarks.
- Review and act on specific recommendations found in the detailed CR Report in order to improve processes and obtain full compliance.
- Review annual performance and identify and prioritize opportunities for improvement.

- 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.
- Identify barriers and explore strategies to improve the three CAHPS measures that performed below the national Medicaid average:
  - Health Promotion and Education Composite
  - Rating of Health Plan
  - Rating of All Health Care
- Consider the focused study's findings on Use of Imaging Studies for Low Back Pain. While performance exceeds the national average benchmark, there is still opportunity for improvement. SHP should continue to educate providers on delaying imaging studies when appropriate.
- Continue completing an annual Quality Improvement Program Evaluation and trend annual results in the evaluation to facilitate an understanding of performance year over year.
- Attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities, Cardiology, and Hematology and Oncology.
- Monitor and review any timeliness-related complaints or grievances to quickly identify and resolve timeliness-related issues should they arise.

## State Recommendations

- 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.
- Continue to work with the EQRO and SHP to identify measures meaningful to the Medicaid Expansion population.
- Encourage SHP to implement interventions targeting performance measures that did not meet the NCOA Quality Compass national average benchmarks.
- Define the State's objectives and articulate measurable goals for encounter data completeness and accuracy. The industry 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.

## North Dakota Medicaid Expansion Program

### 2018 Annual Technical Report

### Measurement Year 2017

## Introduction and Overview

The Affordable Care Act (ACA), enacted in March 2010, included a mandate, effective January 1, 2015, to expand the Medicaid program to cover individuals under the age of 65 with incomes below 133% 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 2015 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, 2015.

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 Qlarant to perform such external quality review (EQR) services. Following CMS EQR Protocols, Qlarant evaluated the quality, access, and timeliness of services provided to the Medicaid Expansion program enrollees by assessing 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 2018, assessed SHP's measurement year (MY) 2017 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 2017; 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

Qlarant began planning and coordinating 2018 EQR activities with DHS and SHP in October 2017. Actual review and auditing activities began in March 2018 and concluded in July 2018. In addition to reviewing electronic reports, policies, data, and information systems, a 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.*

Qlarant 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 Qlarant’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.

PIP Validation Steps	
Step	Validation Requirement
6. Data Collection Procedures	The data collection procedures should use a systematic method of collecting valid and reliable data that represents the entire study population.
7. Improvement Strategies	The improvement strategies, or interventions, should be reasonable and address barriers on a system-level.
8. Data Analysis/Interpretation	The study findings, or results, should be accurately and clearly stated. A comprehensive quantitative and qualitative analysis should be provided.
9. Real Improvement	Project results should be assessed as real improvement.
10. Sustained Improvement	Sustained improvement should be demonstrated through repeated measurements.

Qlarant 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.*

Qlarant 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 to determine algorithmic compliance with 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	Qlarant 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 compliant with the CMS PMV protocol. The auditor has a conference call with the MCO to provide an overview, answer questions, and schedule an on-site visit. The MCO is asked to complete the Information Systems Capabilities Assessment (ISCA), and provide the source code for the selected measures. Next, the auditor reviews the completed ISCA and other supporting documents to determine areas, which need further discussion during the on-site visit. The pre-site phase ends with a conference call with the MCO to finalize the on-site review plans.
On-site Phase	Qlarant begins the on-site review with an opening conference, which provides the overall purpose and objectives of the PMV audit. The auditor interviews staff, reviews documentation, and observes key processes used by the MCO in calculating performance measures. The staff interviews not only provide insight into the accuracy and reliability of the MCO's reporting processes, but also an opportunity for the MCO to address any issues identified in the ISCA review. 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	Qlarant conducts a source code review and 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 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 42 CFR § 438 and the MCO contractual requirements with DHS. Three key areas of the regulations are assessed:

- 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 ensure that enrollees receive information on how to access auxiliary aids and services including information on alternative formats and languages.

- 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. Utilization procedures must be standardized and denial of services must be made by an individual with 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, or 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*. Qlarant’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	Qlarant develops and confirms CR standards and elements with DHS. The standards and elements are provided to the MCO and discussed during an orientation conference call. The MCO is asked to complete a pre-site survey to allow reviewers to gain organizational insight and information on any changes to the MCO within the last year. The MCO posts (uploads) its electronic documents (written plans, policies, and procedures) to Qlarant’s secure web-based portal approximately 30 days prior to the on-site assessment.

CR Activities	
Review Phase	Audit Activities
	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	Qlarant begins the 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 not available during the pre-site review. The review team also conducts staff interviews, observes processes, and follows up on Corrective Action Plans (CAPs), if necessary. Auditors are looking to make sure policies and procedures are followed and processes are consistent with requirements. A closing conference is held where auditors describe general findings, identify issues warranting follow-up, discuss post-site activities, and provide opportunity for the MCO to respond to preliminary findings.
Post-site Phase	Qlarant 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 received is reviewed and integrated into the findings, and final determinations are made.

## Assessment Procedures

Qlarant 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. Qlarant uses a three-point scale for scoring compliance: *Met—100%*, *Partially Met—50%*, and *Not Met—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.*

Qlarant conducts the EDV study 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.	Qlarant reviews contractual requirements for encounter data collection and submission to ensure the MCO follows the State’s specifications in file format and types of encounters.
2.	Qlarant assesses encounter/claims data processes and system through an Information System Capabilities Assessment (ISCA). This assessment, which includes a documentation review and interviews with key MCO staff, is conducted as part of the performance measure validation (PMV) activity.
3.	Qlarant’s analysts examine the electronic encounter data for consistency, accuracy, and completeness. This is accomplished by examining critical fields to ensure they are populated in the correct format, values are within required ranges, and volume of data is consistent with the MCO’s enrollment. To complete this activity, the MCO submits all claims for which payment is rendered in measurement year of review.
4.	Qlarant’s nurse reviewers/coders compare electronic encounter data to medical records documentation to confirm the accuracy of reported encounters. A random sample of encounters for Inpatient, Outpatient, and Office Visit claims are reviewed to evaluate if the electronic encounter is documented in the medical record and the level of documentation supported the billed service codes. The reviewers will further validate the date of service, place of service, primary and secondary diagnoses 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, which follows HEDIS<sup>3</sup> protocols. SHP contracted with a certified HEDIS survey vendor monitored by the NCQA Survey Vendor Certification Program. The certified program assures the vendor administers the survey according to HEDIS protocols and ensures all certified vendors use its standardized data collection method. As a result, the collected data can be utilized to make comparability among MCO results.

The HEDIS protocols of using a valid sample frame validated by the HEDIS Auditor are found in *HEDIS 2018 Volume 3: Specifications for Survey Measures*, and SHP's contracted survey vendor administered the 2018 CAHPS 5.0H Member Satisfaction Survey accordingly. 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 February 6, 2018, the vendor mailed 1,350 surveys and received 315 completed surveys (via mail and phone), providing a 23.35% response rate for the survey.

Rating scores are the results obtained from four health care concepts survey responses. The four health care concepts consist of All Health Care, Personal Doctor, Health Plan, and Specialist Seen Most Often categories. The respondents were asked to rate on a scale of 0-10, where 0 is the worst possible assessment and 10 is the best possible assessment. The rating scores presented in the results table are the sum of positive responses that were scored 8, 9, and 10.

Composite scores provide an insight to the areas of focus or areas of concern, and are obtained from survey responses regarding how often the respondents received care under certain conditions. Each composite focuses in a specific and unique situation, and comprises of two or more underlying questions. All questions for each composite may have the same potential responses as: *Never*, *Sometimes*, *Usually*, or *Always*. The composite scores presented in the results table are the sum of proportional averages for questions found under each composite where the response was either *Usually* or *Always*. The composite categories are made up of Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making.

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<sup>3</sup> HEDIS® - Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance.

## Focused Quality Study

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

Qlarant 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

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

## External Quality Review Results

### Performance Improvement Project Validation

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:

- Comprehensive Diabetes Care
- Follow-Up for Mental Health

MY 2017 serves as remeasurement year 3 for the mental health PIP and baseline for the diabetes care PIP. Validation results of the project submissions are below in Tables 6 (Comprehensive Diabetes Care PIP) and Table 8 (Follow-Up for Mental Health PIP). Respective performance measure results are displayed in Tables 7 and 9.

## Comprehensive Diabetes Care PIP Results

SHP met all applicable requirements for its Comprehensive Diabetes Care PIP, as identified in Table 6.

**Table 6. Comprehensive Diabetes Care 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 Comprehensive Diabetes Care PIP are identified in Table 7.

**Table 7. Comprehensive Diabetes Care PIP Performance Measure Results**

PIP Performance Measure Results	
<b>Hemoglobin A1c (HbA1c) Testing</b>	
MY 2017 (Baseline)	92.62%
<b>HbA1c Poor Control (&gt;9%)</b>	
MY 2017 (Baseline)	30.58%
<b>HbA1c Control (&lt;8%)</b>	
MY 2017 (Baseline)	55.01%
<b>HbA1c Control (&lt;7%) for a Selected Population</b>	
MY 2017 (Baseline)	39.66%
<b>Eye Exam (Retinal) Performed</b>	
MY 2017 (Baseline)	50.09%
<b>Medical Attention for Nephropathy</b>	
MY 2017 (Baseline)	91.21%
<b>Blood Pressure Control (&lt; 140/90 mm Hg)</b>	
MY 2017 (Baseline)	77.86%

## Interventions

SHP implemented the following interventions in 2017:

- **Diabetes Management Program.** The program aims to monitor and improve adherence to treatment plans by empowering members with knowledge about their condition, reinforcing

education, providing support and assistance in overcoming barriers to care and lifestyle issues, and actively monitoring those members who are most at risk for complications. Program components include educational materials, provider education on evidence-based clinical guidelines, telephonic member education, and care coordination. Educational topics covered in the program include:

- Condition monitoring
- Adherence to treatment plans
- Medical and behavioral health comorbidities and other health conditions
- Health behaviors
- Psychosocial issues
- Depression screening
- Providing information to care giver
- Encouragement for patients to communicate with their practitioner about their health conditions and treatment
- Additional external resources as appropriate

Monthly, newly eligible members are identified and receive outreach for the program. Members opting to enroll receive quarterly contact. Case managers work with the more complex members in these programs and educate them via phone regarding appropriate utilization, guideline recommendations, and resources.

- **Noncompliant Member Letters.** Members who are not compliant with the ACEI/ARB lab level checks and/or members who are not compliant with HbA1c testing, microalbuminuria testing, or eye exams receive letters to check with their providers and seek testing and exams as appropriate.
- **Eye Exam Mailings.** Members receive mailings reminding them that they do not need to pay for eye exams. The letters also remind members how to manage their condition. Providers receive mailings notifying them of the codes to submit on diabetic eye exam claims in order to waive the patient copay for the exam.
- **Value Based Contracting.** SHP is having discussions with health systems on value based contracting, which includes a focus on diabetes care performance.

## Strengths

- SHP successfully reported baseline performance in all Comprehensive Diabetes Care performance measures.
- The MCO conducted a thorough barrier analysis and implemented multiple system-level interventions to target members and providers.
- SHP maintains a robust Diabetes Health Management Program and identifies and conducts outreach to newly eligible members on a monthly basis. Enrolled members receive quarterly contact. Case Managers work directly with members deemed complex.

## MCO Recommendations

- SHP is encouraged to continue to target members with diabetes using interventions aimed to improve member self-management.
- SHP should continue to explore value based contracting which will likely have a positive impact on diabetic member outcomes.
- The MCO should also adjust goals to ensure it is consistently facilitating quality improvement. Currently, SHP exceeds its goal for the HbA1c Poor Control (>9%) performance measure.

## 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.

**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%
MY 2017 (Remeasurement 3)	32.48%

<b>PIP Performance Measure Results</b>	
<b>Follow-Up After Hospitalizations for Mental Health—Within 30 Days</b>	
MY 2014 (Baseline)	38.84%
MY 2015 (Remeasurement 1)	49.62%
MY 2016 (Remeasurement 2)	46.82%
MY 2017 (Remeasurement 3)	51.85%
<b>Screening for Clinical Depression and Follow</b>	
MY 2014 (Baseline)	11.78%
MY 2015 (Remeasurement 1)	14.69%
MY 2016 (Remeasurement 2)	Not Applicable (Discontinued for MY 2016)
<b>Engagement of Alcohol or Other Drug (AOD) Treatment</b>	
MY 2016 (Baseline)	17.32%
MY 2017 (Remeasurement 1)	18.03%

## Interventions

SHP continued or implemented the following interventions for 2017:

- 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.
- Collaboration with Human Services Centers and other inpatient facilities to discuss issues and appointment workflows. Provide education to discharge planners on health plan coverage and network coverage rules.
- Behavioral Health Counselor contacting inpatient facilities to schedule 7 day follow-up appointments prior to members being discharged.
- Closely evaluating requests received for Alcohol and Other Drug (AOD) treatment and ensuring the most appropriate setting.

## Strengths

- SHP demonstrated improvement in all three performance measures. The reported annual improvement in the Follow-Up After Hospitalizations for Mental Health – 7 Days performance measure was statistically significant.
- Sustained improvement was demonstrated in the Follow-Up After Hospitalizations for Mental Health measures.
- SHP’s Remeasurement 3 analysis, which was both quantitative and qualitative, included a system wide barrier analysis and identified multiple opportunities and interventions that should facilitate additional improvements in the performance measures.

## MCO Recommendation

- SHP is encouraged to continue annual barrier analyses and also develop and implement targeted interventions. The open access appointments at the Human Services Centers have proven to be challenging for members. The open access timeframe concept causes some members to endure long wait times to the extent of not being seen on the day services are sought and members are asked to 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. The MCO should continue to explore other opportunities to help close the gap in mental health care services. SHP is planning to discuss telemental services with a task force that involves other health systems and health plans.

## Performance Measure Validation

### Validation Results

The MCO completed and submitted an ISCA containing the MCO’s information system (IS) related to collecting and processing the required CMS Adult and applicable Child Core Quality Measures. Based on the MCO’s ISCA, SHP had satisfactory processes for data integration, data control, and interpretation of the performance measures for MY 2017. The on-site PMV audit included interviews with the MCO’s staff regarding its IS and associated procedures. These interviews enabled Qlarant’s auditor 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. Programming language source code and test cases were reviewed for core measures not calculated with the certified software, and found adequate. Microsoft Access was also utilized to calculate these measures. Samples and methodology for medical record abstraction and identifying measures requiring review were also found to be adequate and approved. Medical records were examined during the on-site visit for several measures, and two measures were selected for further medical record over-read review. 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
Comprehensive Diabetes Care HbA1c Test	30	100%
Comprehensive Diabetes Care HbA1c Control (<8%)	30	100%

### Performance Measure Results

SHP MY 2017 results for the CMS Adult and Child Core Quality Measures are respectively displayed in Tables 12 and 13. Performance measure results are compared to benchmarks largely based on the

NCQA Quality Compass 2017 National Medicaid for All Lines of Business. Comparisons are made using a diamond rating system. The following table describes the rating system:

**Table 11. Diamond Rating System Used to Compare SHP Performance to Benchmarks**

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

The more diamonds displayed indicates the higher level of performance compared to the benchmarks. The year-to-year comparison and trending pattern evaluate the past three years (MY 2015-MY 2017).

**Table 12. Adult Performance Measure Results Compared to Benchmarks**

Measure	SHP MY 2015 Rate	SHP MY 2016 Rate	SHP MY 2017 Rate	MY 2017 Comparison To Benchmarks <sup>^</sup>
Breast Cancer Screening	NA	50.44%	50.35%	◆
Adherence to Antipsychotics for Individuals with Schizophrenia	70.31%	62.12%	60.22%	◆◆
Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	86.46%	84.44%	85.43%	◆
Annual Monitoring for Patients on Persistent Medications: Digoxin <sup>#</sup>	NA	36.36%	NR <sup>2</sup>	NC
Annual Monitoring for Patients on Persistent Medications: Diuretics	86.73%	85.04%	87.16%	◆
Annual Monitoring for Patients on Persistent Medications: Total Rate	86.57%	84.42%	86.11%	◆
Antidepressant Medication Management: Effective Acute Phase Treatment	66.59%	61.38%	62.55%	◆◆◆
Antidepressant Medication Management: Effective Continuation Phase Treatment	55.00%	48.17%	47.20%	◆◆◆
Cervical Cancer Screening	26.26%	31.84%	42.61%	◆
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	40.52%	38.99%	37.50%	◆

Measure	SHP MY 2015 Rate	SHP MY 2016 Rate	SHP MY 2017 Rate	MY 2017 Comparison To Benchmarks^
Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 7 Days	27.44%	24.91%	34.17%	◆
Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 30 Days	49.62%	47.06%	53.61%	◆
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Initiated Treatment Through an Inpatient Alcohol or Other Drug (AOD) Admission, Outpatient Visit, Intensive Outpatient Encounter, or Partial Hospitalization Within 14 Days of the Diagnosis (Initiation)	37.44%	40.01%	40.83%	◆◆
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Initiated Treatment and Who Had Two or More Additional Services With a Diagnosis of AOD Within 30 Days of the Initiation Visit (Engagement)	13.15%	17.38%	18.03%	◆◆◆
PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 19-64 ~	33.00%**	39.31%**	45.07%**	◆ <sup>^^^</sup>
PQI 08 Congestive Heart Failure Admission Rate, Ages 19-64 ~	18.19%**	18.26%**	23.91%**	◆◆ <sup>^^^</sup>
PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64 ~	46.85%**	46.59%**	45.26%**	NC
PQI 15 Asthma in Younger Adults Admission Rate, Ages 19-39 ~	8.09%**	8.99%**	8.29%**	NC
Plan All-Cause Readmissions Rate: Ages 19-44 ~	18.79%	18.46%	21.73%	NC
Plan All-Cause Readmissions Rate: Ages 45-54 ~	21.92%	17.25%	19.44%	NC
Plan All-Cause Readmissions Rate: Ages 55-64 ~	14.50%	13.83%	13.14%	NC
Plan All-Cause Readmissions Rate: Total ~	18.78%	16.92%	18.83%	NC
Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	75.09%	73.29%	77.21%	◆◆
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications	48.11%	48.42%	52.21%	◆◆
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies	47.44%	48.63%	52.77%	◆◆◆
Flu Vaccinations for Adults, Ages 19-64	37.95%	37.67%	41.75%	◆◆
Adult Body Mass Index Assessment	91.73%	94.56%	93.40%	◆◆◆

Measure	SHP MY 2015 Rate	SHP MY 2016 Rate	SHP MY 2017 Rate	MY 2017 Comparison To Benchmarks <sup>^</sup>
Comprehensive Diabetes Care: HbA1c Testing	91.42%	91.15%	92.62%	◆◆◆
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) + ~	NR <sup>1</sup>	31.68%	30.58%	◆◆◆
Comprehensive Diabetes Care: HbA1c Control (<8%)	NR <sup>1</sup>	57.52%	55.01%	◆◆◆
Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population	NR <sup>1</sup>	42.82%	39.66%	◆◆◆
Comprehensive Diabetes Care: Eye Exam	NR <sup>1</sup>	48.14%	50.09%	◆
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NR <sup>1</sup>	93.27%	91.21%	◆◆
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg	NR <sup>1</sup>	80.35%	77.86%	◆◆◆◆
Controlling High Blood Pressure	68.61%	72.78%	73.43%	◆◆◆◆
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	NA	79.15%	81.51%	◆◆
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	NC

<sup>^</sup> Benchmark data source: Quality Compass 2017 (Measurement Year 2016 data) National Medicaid Average for All Lines Business. This is the most current benchmark source at the time of report production.

<sup>^^</sup> Benchmark data source: The Department of Health and Human Services 2017 Annual Report on the Quality of Care for Adult in Medicaid(Mathematica’s analysis of FFY 2016, Form CMS-416 reports). This is the most current benchmark available at the time of report production.

\*\* Member observations per 100,000 members.

NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

NR<sup>1</sup> Not Reported in previous year(s) due to new measure was added.

NR<sup>2</sup> Not Reported in current MY 2017 due to measure being retired.

# Measure being retired from for MY 2017.

~ A lower rate is better.

NC No comparison made due to no rate or/and benchmark available.

**Table 13. Child Performance Measure Results Compared to Benchmarks**

Measure	SHP MY 2015 Rate	SHP MY 2015 Rate	SHP MY 2015 Rate	MY 2017 Comparison To Benchmarks <sup>^</sup>
Medication Management for People With Asthma, Ages 19-20: Percentage of Children	NA	NA	NA	NC

Measure	SHP MY 2015 Rate	SHP MY 2015 Rate	SHP MY 2015 Rate	MY 2017 Comparison To Benchmarks <sup>^</sup>
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***	NA	NA	NA	NC <sup>^^</sup>
Follow-Up After Hospitalization for Mental Illness, Ages 19-20: Follow-Up Within 7 Days***	NA	NA	15.63%	◆
Follow-Up After Hospitalization for Mental Illness, Ages 19-20: Follow-Up Within 30 Days***	NA	NA	34.38%	◆
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication: Initiation Phase***	NA	NA	NA	NC
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication: Continuation and Maintenance Phase***	NA	NA	NA	NC
Adolescent Well Care Visits	10.81%	9.76%	14.70%	◆
Percentage of Eligibles that Received Preventive Dental Services (PDENT)***	9.52%	8.91%	9.89%	◆ <sup>^^</sup>

\*\*\* Please be aware that the rates captured in this table are for ages 19-20, and some benchmarks are capturing a wider age range; therefore, caution is advised when using the rates and benchmarks to gauge performance.

<sup>^</sup> Benchmark data source: Quality Compass 2017 (Measurement Year 2016 data) National Medicaid Average for All Lines Business. This is the most current benchmark source at the time of report production.

<sup>^^</sup> Benchmark data source: The Department of Health and Human Services 2017 Annual Report on the Quality of Care for Children in Medicaid and CHIP (Mathematica's analysis of FFY 2016, Form CMS-416 reports). This is the most current benchmark available at the time of report production.

NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC No comparison made due to no rate or/and benchmark available.

MY 2017 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

- Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)
- Annual Monitoring for Patients on Persistent Medications: Diuretics
- Annual Monitoring for Patients on Persistent Medications: Total Rate
- Cervical Cancer Screening
- Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
- Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 7 Days
- Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 30 Days
- PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 18-64
- Comprehensive Diabetes Care: Eye Exam
- Child Performance Measures:
  - 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
  - Adolescent Well-Care Visit
  - Percentage of Eligibles that Received Preventive Dental Services (PDENT)

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

- Adult Performance Measures:
  - Adherence to Antipsychotic for Individuals With Schizophrenia
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Initiation
  - PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 19-64
  - Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
  - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
  - Flu Vaccinations for Adults, Ages 19-64
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- Child Performance Measures:
  - SHP did not have any child measures that met or exceeded the national Medicaid average but was below the national Medicaid 75<sup>th</sup> Percentile.

The Prevention Quality Indicators (PQI) are Agency for Healthcare Research and Quality (AHRQ) performance measures and only have national average benchmarks and 75<sup>th</sup> percentiles for PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 19-64 and PQI 08 Congestive Heart Failure Admission Rate, Ages 19-64. There are no benchmarks available for PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate or PQI 15 Asthma in Younger Adults Admission Rate.

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

- Adult Performance Measures:
  - Antidepressant Medication Management: Effective Acute Phase Treatment
  - Antidepressant Medication Management: Effective Continuation Phase Treatment
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Engagement
  - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
  - Adult Body Mass Index Assessment
  - Comprehensive Diabetes Care: HbA1c Testing
  - Comprehensive Diabetes Care: HbA1c Poor Control (>9%)
  - Comprehensive Diabetes Care: HbA1c Control (<8%)
  - Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population
- Child Performance Measures:
  - SHP did not have any child measures that met or exceeded the national Medicaid 75<sup>th</sup> Percentile but was below the national Medicaid 90<sup>th</sup> Percentile.

SHP met or exceeded the national Medicaid 90<sup>th</sup> Percentile for the following performance measures:

- Adult Performance Measures:
  - Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
  - Controlling High Blood Pressure
- Child Performance Measures:
  - SHP did not have any child measures that met or exceeded the national Medicaid 90<sup>th</sup> Percentile.

A trend analysis was conducted on measures where data was available for all three years between MY 2015 and MY 2017. 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 2015 and MY 2017:

- Adherence to Antipsychotics for Individuals with Schizophrenia Antidepressant Medication Management: Effective Continuation Phase Treatment Antidepressant Medication Management: Effective Continuation Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
- PQI 01 Diabetes Short-Term Complications Admission Rate, Ages 19-64
- PQI 08 Congestive Heart Failure Admission Rate, Ages 19-64

SHP's performance improved each year between MY 2015 and MY 2017 indicating a positive trend for the following measures:

- Cervical Cancer Screening
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Initiation
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Engagement
- PQI 05 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64
- Plan All-Cause Readmissions Rate: Ages 55-64 (lower rate is better)
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Comprehensive Diabetes Care: Eye Exam
- Controlling High Blood Pressure

The following performance measures used denominators with less than 30 observations. In these cases, too few observations existed 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

The following measures were retired from the State's Quality Strategy for MY 2017:

- Annual Monitoring for Patients on Persistent Medications: Digoxin

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

## Strengths

- The MCO's experienced quality staff demonstrated their knowledge in HEDIS and non-HEDIS performance measure and proper application of measure criteria.
- The MCO exceeded the 90<sup>th</sup> Percentile for two adult performance measures:
  - Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
  - Controlling High Blood Pressure

- The MCO demonstrated three years of consistent improvement between MY 2015 and MY 2017 for eight measures.

### **MCO Recommendations**

- Consider the use of supplemental data for both HEDIS and non-HEDIS measures to improve performance measure rates.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates particularly for measures that did not meet the NCQA Quality Compass national average benchmarks.

### **State Recommendations**

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

## **Compliance Review**

### **Results**

The CR assessed SHP's 2017 compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion population. Qlarant reviewed all new managed care standards – including 2017 and 2018 requirements. The 2017 requirements were scored and Qlarant provided recommendations and comments on how the MCO fared in meeting 2018 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	Not Met
<b>Element 1. General Requirements.</b> 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.	X		
<b>Element 2.</b> 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.		
<b>Element 3. Enrollee Handbook.</b> 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).	X		
<b>Element 4.</b> The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program.	X		
<b>Element 5.</b> 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.	X		
<b>Element 6.</b> 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.	X		
<b>Element 7.</b> The enrollee handbook must include how to access auxiliary aids and services, including additional information in alternative formats or languages.	X		
<b>Element 8.</b> The enrollee handbook must include the toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees.	X		

Information Requirements			
Element	Met	Partially Met	Not Met
<b>Element 9.</b> The enrollee handbook must include information on how to report suspected fraud or abuse.	X		
<b>Element 10.</b> 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.	X		
<b>Element 11.</b> 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.	X		
<b>Element 12. Provider Directory.</b> 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		X	

Information Requirements			
Element	Met	Partially Met	Not Met
(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.			
<b>Element 13.</b> 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.	X		
<b>Element 14.</b> 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.	X		
<b>Element 15.</b> 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.	X		
<b>Element 16. Formulary.</b> 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.	X		

Information Requirements, 42 CFR § 438 Subpart A, ensures that managed care enrollees receive information about available healthcare services, how to access services, and how to contact participating providers. Additionally, requirements ensure enrollees receive information on accessing auxiliary aids and services and outlining information on alternative formats and languages. The MCO scored 98.21% on the Information Requirements Standard for MY 2017.

The MCO is developing an action plan to ensure 2018 compliance for elements and components that were not fully compliant.

**Table 15. Enrollee Rights Results**

Enrollee Rights			
Element	Met	Partially Met	Not Met
<p><b>Element 1. General rule.</b> Each MCO, PIHP, PAHP, PCCM and PCCM entity must:</p> <p>(1) have written policies regarding the enrollee rights specified in this section, and</p> <p>(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.</p>	X		
<p><b>Element 2.</b> 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.</p>	X		
<p><b>Element 3. Free exercise of rights.</b> 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.</p>	X		
<p><b>Element 4. Compliance with other Federal and State laws.</b> 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.</p>	X		

Enrollee Rights, 42 CFR § 438.100 Subpart C, ensures managed care enrollees have rights. SHP was 100% compliant with all elements in this section.

**Table 16. MCO, PIHP, and PAHP Standards Results**

Availability of Services			
Element	Met	Partially Met	Not Met
<p><b>Element 1. Basic Rule.</b> 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.</p> <p><b>Delivery Network.</b> 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.</p>			Not scored; 2018 requirement.
<p><b>Element 2. Furnishing of Services.</b> The State must ensure that each contract with an MCO, PIHP, and PAHP complies with timely access.</p>			Not scored; 2018 requirement.
<p><b>Element 3. Access and cultural considerations.</b> 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.</p>			Not scored; 2018 requirement.
<p><b>Element 4. Accessibility considerations.</b> 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.</p>			Not scored; 2018 requirement.
Assurance of Adequate Capacity and Services			
Element	Met	Partially Met	Not Met
<p><b>Element 5. Basic rule.</b> 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).</p>			Not scored; 2018 requirement.

Assurance of Adequate Capacity and Services			
Element	Met	Partially Met	Not Met
<p><b>Element 6. Timing of documentation.</b> Each MCO, PIHP, and PAHP must submit the documentation:</p> <ul style="list-style-type: none"> <li>(1) at the time it enters into a contract with the State,</li> <li>(2) on an annual basis,</li> <li>(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,</li> <li>(4) or enrollment of a new population in the MCO, PIHP, or PAHP.</li> </ul>	Not scored; 2018 requirement.		
Coordination and Continuity of Care			
Element	Met	Partially Met	Not Met
<p><b>Element 7. Care and coordination of services for all MCO, PIHP, and PAHP enrollees.</b> Each MCO, PIHP, and PAHP must implement procedures to deliver care to and coordinate services for all MCO, PIHP, and PAHP enrollees.</p>	X		
<p><b>Element 8. Additional services for enrollees with special health care needs or who need LTSS—Identification.</b> 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.</p> <p><b>Assessment.</b> 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.</p>	X		

Coordination and Continuity of Care			
Element	Met	Partially Met	Not Met
<b>Element 9. Additional services for enrollees with special health care needs or who need LTSS—Treatment/service plans.</b> 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.	X		
<b>Element 10. Direct access to specialists.</b> 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.	X		
Coverage and Authorization of Services			
Element	Met	Partially Met	Not Met
<b>Element 11. Coverage.</b> 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.	X		

Coverage and Authorization of Services			
Element	Met	Partially Met	Not Met
<b>Element 12.</b> 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.	X		
<b>Element 13.</b> 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.	X		
<b>Element 14. Authorization of services.</b> 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.	X		
<b>Element 15. Notice of adverse benefit determination.</b> 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.	X		
<b>Element 16. Timeframe for decisions.</b> Each MCO, PIHP, or PAHP must provide decisions and notices per requirements.		X	
<b>Element 17. Covered outpatient drug decisions.</b> 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.			X
<b>Element 18. Compensation for utilization management activities.</b> 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.	X		

Provider Selection			
Element	Met	Partially Met	Not Met
<p><b>Element 19. General rules.</b> 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.</p> <p><b>Credentialing and recredentialing requirements.</b> 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.</p>	X		
Confidentiality			
Element	Met	Partially Met	Not Met
<p><b>Element 20.</b> 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.</p>	X		
Grievance and Appeal System			
Element	Met	Partially Met	Not Met
<p><b>Element 21.</b> Each MCO, PIHP, and PAHP has in effect a grievance and appeal system that meets the requirements of subpart F.</p>	X		
Subcontractual Relationships and Delegation			
Element	Met	Partially Met	Not Met
<p><b>Element 22. General rule.</b> 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.</p>	X		

Practice Guidelines			
Element	Met	Partially Met	Not Met
<b>Element 23. Basic rule.</b> Each MCO, PIHP, and PAHP must meet the requirements of this section. <b>Adoption of practice guidelines.</b> Each MCO and, when applicable, each PIHP and PAHP must adopt practice guidelines.	X		
<b>Element 24. Dissemination of guidelines.</b> Each MCO, PIHP, and PAHP must disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees.	X		
<b>Element 25. Application of guidelines.</b> 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	Not Met
<b>Element 26. General rule.</b> 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.	X		

MCO, PIHP, and PAHP Standards, 42 CFR § 438 Subpart D, ensure managed care enrollees have adequate and timely access to services and 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 service procedures must be standardized and denial of service must be made by an individual with the appropriate clinical expertise. Overall, based on the applicable scored MCO, PIHP, and PAHP Standards, SHP scored 96.94%.

**Table 17. Quality Assessment and Performance Improvement Program Results**

Quality Assessment and Performance Improvement Program			
Element	Met	Partially Met	Not Met
<b>Element 1. General rules.</b> 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.	X		

Quality Assessment and Performance Improvement Program			
Element	Met	Partially Met	Not Met
<b>Element 2. Performance measurement.</b> 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.	X		
<b>Element 3. Performance improvement projects (PIPs).</b> Each MCO, PIHP, and PAHP must conduct PIPs required by the State that focus on both clinical and nonclinical areas.	X		
<b>Element 4. Program review by the State.</b> 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.	X		

Quality Assessment and Performance Improvement Program, 42 CFR § 438.330 Subpart E, ensures a comprehensive quality assessment and performance improvement program includes performance improvement projects, collection and submission of performance measures data, and mechanisms to detect both under- and overutilization of services. SHP was 100% compliant with 2017 requirements.

**Table 18. Grievance and Appeal System Results**

General Requirements			
Element	Met	Partially Met	Not Met
<b>Element 1. The grievance and appeal system.</b> Each MCO, PIHP, and PAHP must have a grievance and appeal systems in place for enrollees.	X		
<b>Element 2. Level of appeals.</b> Each MCO, PIHP, and PAHP may have only one level of appeal for enrollees.	X		

General Requirements			
Element	Met	Partially Met	Not Met
<b>Element 3. Filing requirements—authority to file.</b> 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.	X		
<b>Element 4. Deemed exhaustion of appeals processes.</b> 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.	X		
<b>Element 5. Filing requirements—authority to file.</b> 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.	X		
<b>Element 6. Timing—Grievance.</b> An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.	X		
<b>Element 7. Timing—Appeal.</b> 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.		X	
<b>Element 8. Procedures—Grievance.</b> 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.	X		
<b>Element 9. Procedures—Appeal.</b> 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.		X	
Timely and Adequate Notice of Adverse Benefit Determinations			
Element	Met	Partially Met	Not Met
<b>Element 10. Notice.</b> 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.	X		

Timely and Adequate Notice of Adverse Benefit Determinations			
Element	Met	Partially Met	Not Met
<b>Element 11. Timing of notice.</b> 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].	X		
<b>Element 12.</b> 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).	X		
<b>Element 13.</b> 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.	X		
<b>Element 14.</b> The MCO, PIHP, or PAHP must mail the notice for expedited service authorization decisions, within the timeframes specified in §438.210(d)(2).	X		
Handling of Grievances and Appeals			
Element	Met	Partially Met	Not Met
<b>Element 15. General requirements.</b> 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.	X		
<b>Element 16. Special requirements.</b> An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations.		X	

Resolution and Notification: Grievances and Appeals			
Element	Met	Partially Met	Not Met
<b>Element 17. Basic rule.</b> 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.		X	
<b>Element 18. Format of notice—Grievances.</b> 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.	X		
<b>Element 19. Format of notice—Appeals.</b> 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.	X		
<b>Element 20. Format of notice—Expedited Appeals.</b> For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.	X		
<b>Element 21. Content of notice of appeal resolution.</b> 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— <ul style="list-style-type: none"> <li>(1) the rights to request a State fair hearing, and how to do so;</li> <li>(2) the right to request and receive benefits while the hearing is pending, and how to make the request;</li> <li>(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.</li> </ul>	X		
<b>Element 22. Requirements for State fair hearings—Availability.</b> An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.	X		

Resolution and Notification: Grievances and Appeals			
Element	Met	Partially Met	Not Met
<b>Element 23. Deemed exhaustion of appeals processes.</b> 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.		
<b>Element 24. State fair hearing.</b> 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.		X	
<b>Element 25. Parties to the State fair hearing.</b> 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.		X	
Expedited Resolution of Appeals			
Element	Met	Partially Met	Not Met
<b>Element 26. General rule.</b> 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.	X		
<b>Element 27. Punitive action.</b> 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.	X		
<b>Element 28. Action following denial of a request for expedited resolution.</b> 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).	X		

Information About the Grievances and Appeal System to Providers and Subcontractors			
Element	Met	Partially Met	Not Met
<b>Element 29.</b> 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.		X	
Recordkeeping Requirements			
Element	Met	Partially Met	Not Met
<b>Element 30.</b> 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.	X		
<b>Element 31.</b> 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.	X		
<b>Element 32.</b> The record must be accurately maintained in a manner accessible to the state and available upon request to CMS.	X		
Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending			
Element	Met	Partially Met	Not Met
<b>Element 33. Continuation of benefits.</b> 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;	X		

Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending			
Element	Met	Partially Met	Not Met
(4) the period covered by the original authorization has not expired; and (5) the enrollee timely files for continuation of benefits.			
<b>Element 34. Duration of continued or reinstated benefits.</b> 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.	X		
<b>Element 35. Enrollee responsibility for services furnished while the appeal or State fair hearing is pending.</b> 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.	X		
Effectuation of Reversed Appeal Resolutions			
Element	Met	Partially Met	Not Met
<b>Element 36. Services not furnished while the appeal is pending.</b> 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	X		

Effectuation of Reversed Appeal Resolutions			
Element	Met	Partially Met	Not Met
reversing the determination.			
<b>Element 37. Services furnished while the appeal is pending.</b> 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.	X		

Grievance and Appeal System, 42 CFR § 438 Subpart F, mandates 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 equips 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). For MY 2017, SHP scored 88.60% in this section. SHP is developing an action plan to meet requirements.

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

Program Integrity Contract Requirements			
Element	Met	Partially Met	Not Met
<b>Element 1.</b> 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 data reviews designed to detect potential FWA. Furthermore, 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 Medicaid managed care standards.
- Overall, SHP scored well on the 2017 requirements:
  - Information Requirements: 98.21%
  - Enrollee Rights Standard: 100%
  - MCO, PIHP and PAHP Standards: 96.94%

- Quality Assessment and Performance Improvement Program: 100%
- Grievance and Appeal System: 88.60%
- Program Integrity: 100%

### MCO 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 review annual performance and identify and prioritize opportunities for improvement.

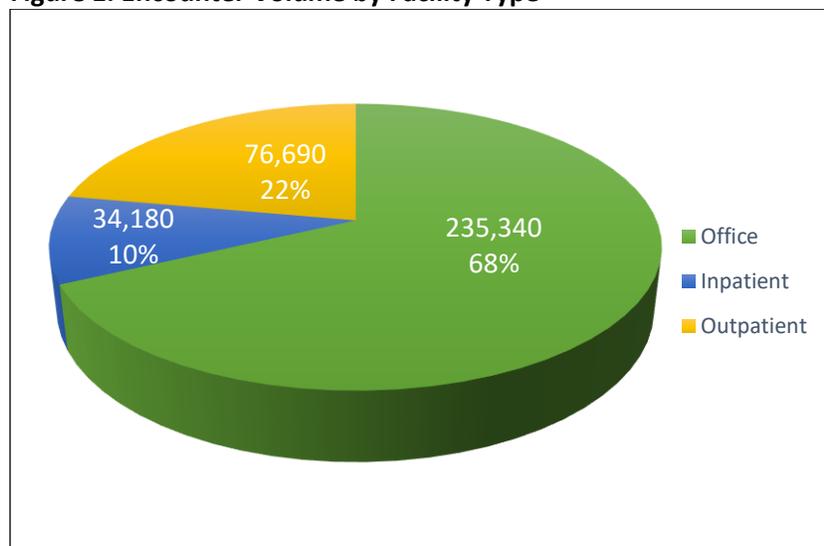
## Encounter Data Validation

### Claims Volume

The Utilization Rate for SHP, measured by the number of members with at least one paid claim, was 71%. Out of a total of 34,108 unique members, 24,236 (71%) had at least one paid claim during MY 2017. For comparative purposes, this is a three percentage point increase compared to the 68% utilization rate for MY 2016.

Qlarant analysts evaluated the volume of claims submitted to the MCO throughout the year, which provides useful information on the completeness of encounter data. This evaluation examined the number of claims by facility type selected for the EDV study, which included Inpatient, Outpatient, and Office Visit. Figure 1 shows the volume and percentage of claims by facility type for those members who had an encounter. Most encounters occurred in the Physician Office setting (68%). Only 10% of encounters occurred via the Inpatient setting.

**Figure 1. Encounter Volume 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 providers conduct the services. In order to evaluate how timely providers are in claims submission, the number of days between date of service and date of claims receipt are calculated. SHP stated 99% of provider claims were submitted within 30 days from the date of service. Qlarant, however, could not verify this information as SHP's encounter data file did not contain date of receipt of claim.

## Data Completeness and Appropriateness

Qlarant's initial evaluation focused on evaluating key data fields contained in SHP's encounter data system, including member ID, provider ID, date of service, primary diagnosis and procedure, and member gender. Since these fields are required in SHP's submission of encounter data to DHS, Qlarant analysts examined the percentage of professional and institutional encounters that contained values in these data fields (percentage present). The analysts then assessed if the submitted values were in the correct format and contained expected values (percentage valid values). For example, an encounter where the member ID field was populated with a value of "0000000" would be considered to have a value present and in correct format, but not with a valid value.

## Data Accuracy

The review of members' medical records offers another method to examine the completeness and accuracy of encounter data. Using the encounter data file prepared by SHP, Qlarant identified all members with an Inpatient, Outpatient, or Office Visit service claim. Analysts then used stratified random sampling to select a sample size to ensure a 90% confidence interval with a 5% +/- error rate for sampling. The sample was stratified based on the percentage of Inpatient (coded 21), Outpatient (coded 22), and Office Visit (coded 11) claims submitted in proportion to the total encounters with an oversample to ensure adequate numbers of records were received.

Upon receipt of the medical records, the record was verified against the sample listing and member demographics from the data file 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 as well.

Tables 20-22 illustrate EDV results by encounter type and review element. The elements reviewed for each encounter type were diagnosis codes, procedure codes, and revenue codes (not applicable for Office Visit encounters). MY 2015, 2016, and 2017 results are included for purposes of comparison.

**Table 20. EDV Results by Element for Inpatient Encounter Type**

Inpatient Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017
Match %	84%	91%	81%	96%	100%	100%	100%	100%	89%	89%	96%	86%

**Table 21. EDV Results by Element for Outpatient Encounter Type**

Outpatient Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017
Match %	93%	94%	90%	96%	99%	100%	96%	98%	100%	95%	97%	96%

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

Office Visit Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017	MY 2015	MY 2016	MY 2017
Match %	87%	84%	96%	NA	NA	NA	99%	97%	99%	92%	89%	97%

Reasons for determining a “no match” element include:

- Lack of medical record documentation
- Incorrect principal diagnosis or incorrect diagnosis codes
- Incorrect revenue codes
- Incorrect procedure codes

## Strengths

- SHP has well documented data integration and claims processing procedures.
- At 83%, SHP’s auto-adjudication rate is relatively high.
- During MY 2017, SHP achieved a total match rate of 95%—meaning 95% of claims data submitted was supported by medical record documentation. This is an increase of 2 percentage points from MY 2016.

## 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.
- Conduct provider audits to ascertain the extent to which providers are adherent to coding principles.

## State Recommendations

- Clearly define the State’s objectives and articulate measurable goals for encounter data completeness and accuracy. The industry 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 2018 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, and customer service.

On February 6, 2018, 1,350 surveys were mailed to a random sample of members who had been continuously enrolled in the MCO for at least five out of the last six months of the measurement year. A total of 315 surveys were completed via mail, internet, or phone with a response rate of 23.35%. 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 2017 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 <sup>^</sup>
Customer Service Composite	88.35%	NA	NA	NC
Getting Needed Care Composite	82.81%	83.02%	86.88%	◆◆◆◆
Getting Care Quickly Composite	81.01%	83.94%	87.34%	◆◆◆◆
How Well Doctors Communicate Composite	93.14%	92.79%	94.82%	◆◆◆◆
Shared Decision Making Composite	81.75%	82.87%	82.83%	◆◆◆
Health Promotion and Education Composite	69.18%	73.38%	73.01%	◆
Coordination of Care Composite	85.59%	85.40%	83.33%	◆◆
Rating of Health Plan (8+9+10)	73.79%	75.14%	75.17%	◆
Rating of All Health Care (8+9+10)	74.56%	72.50%	73.66%	◆

Measure	SHP 2015 Rate	SHP 2016 Rate	SHP 2017 Rate	2017 SHP Rate Compared to Benchmarks <sup>^</sup>
Rating of Personal Doctor (8+9+10)	84.56%	85.82%	85.58%	◆◆◆◆
Rating of Specialist Seen Most often (8+9+10)	82.09%	79.10%	82.01%	◆◆
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (2 year rolling average for 2017)	75.09%	73.29%	77.21%	◆◆
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (2 year rolling average for 2017)	48.11%	48.45%	52.21%	◆◆
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (2 year rolling average for 2017)	47.44%	48.63%	52.77%	◆◆◆
Aspirin Use and Discussion: Take daily aspirin/every other day <sup>+</sup>	NA	28.42%	NR <sup>2</sup>	NC
Aspirin Use and Discussion: Discussed risks and benefits of using aspirin	NA	35.03%	NR <sup>2</sup>	NC
Flu vaccination: Had flu shot or spray in the nose since July 1, 2017	37.95%	37.67%	41.75%	◆◆
Phoned plan to get help with transportation	3.28%	5.09%	NR	NC
Received help with transportation	NA	NA	NR	NC
Help with transportation met your needs	NA	NA	NR	NC

<sup>^</sup> Benchmark data source: Quality Compass 2017 (MY 2016 data) National Medicaid Average for All Lines Business. This is the most current benchmark source at the time of report production.

NA Response rate of less than 100 observations; too small to calculate a reliable rate.

NR Not Reported. The organization chose not to report the measure

NR<sup>2</sup> Not Reported in current MY 2017 due to measure being retired.

+ Measure being retired for MY 2017.

NC No comparison made due to no rate or/and benchmark available.

◆ 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 75<sup>th</sup> Percentile.

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

◆◆◆◆ the rate is equal to or exceeds the NCQA Quality Compass 90<sup>th</sup> Percentile for Medicaid.

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

- Health Promotion and Education Composite
- Rating of Health Plan
- Rating of All Health Care

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

- Coordination of Care Composite
- Rating of Specialist Seen Most often (8+9+10)
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Flu vaccination: Had flu shot or spray in the nose since July 1, 2017

SHP met or exceeded the national Medicaid 75<sup>th</sup> Percentile but was below the national Medicaid 90<sup>th</sup> Percentile for the following CAHPS measures:

- Share Decision Making Composite
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (2 year rolling average for 2017)

SHP met or exceeded the national 90<sup>th</sup> Percentile in the following CAHPS measures:

- Getting Needed Care Composite
- Getting Care Quickly Composite
- How Well Doctors Communicate Composite
- Rating of Personal Doctor

A trend analysis was conducted and the following conclusions were made after reviewing three consecutive years of performance (MY 2015-MY 2017):

- Performance in most measures was mixed year over year.
- A decline in performance year over year was identified in one measure:
  - Coordination of Care Composite
- A positive trend (improvement year over year between MY 2015 and MY 2017) was identified in the following measures:
  - Getting Needed Care Composite
  - Getting Care Quickly Composite
  - Rating of Health Plan

- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

## Strengths

- In regard to benchmarking, SHP exceeded the 90<sup>th</sup> Percentile in the following CAHPS measure:
  - Getting Needed Care Composite
  - Getting Care Quickly Composite
  - How Well Doctors Communicate Composite
  - Rating of Personal Doctor
- SHP also showed improved performance between MY 2015 and MY 2017 for the following measures:
  - Getting Needed Care Composite
  - Getting Care Quickly Composite
  - Rating of Health Plan
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

## MCO Recommendations

- SHP is encouraged to identify barriers and explore strategies to improve the three CAHPS measures that performed below the national Medicaid average:
  - Health Promotion and Education Composite
  - Rating of Health Plan
  - Rating of All Health Care

## Focused Quality Study

### Background

Qlarant's MY 2014 EDV analysis revealed that the North Dakota Medicaid Expansion population's top primary diagnosis was low back pain (lumbago). Due to the frequency of the diagnosis, Qlarant 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.<sup>4</sup> 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, or other injuries. Without signs and symptoms indicating a serious underlying condition, imaging studies are *not* warranted or recommended, as costly imaging studies (X-ray, MRI, or CT scans) do not lead to improved clinical outcomes in these patients.<sup>5</sup> Research describes that the increased use of unnecessary imaging leads to less than favorable results. Specifically, research indicates that MRI overuse for patients with low back pain relates to an increased rate of surgical procedures that have not consistently shown significantly reduced painful symptoms and improved daily functions.<sup>6</sup>

Treatment goals 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:<sup>7</sup>

- **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.

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.

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<sup>4</sup> Journal of Orthopaedic & Sports Physical Therapy, Volume 41, Number 11, November 2011

<sup>5</sup> <http://www.aafp.org/afp/2012/0215/p343.html>

<sup>6</sup> Journal of Orthopaedic & Sports Physical Therapy, Volume 41, Number 11, November 2011

<sup>7</sup> <http://www.aafp.org/afp/2012/0215/p343.html>

## 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, Qlarant calculated the rate for MY 2017: 76.79%, which is a 5.58 percentage point improvement, compared to the previous annual measurement (71.21%). While improvement was noted over the last year, MY 2017 performance fell short of the baseline (MY 2015) rate of 78.63%.

## Strengths

SHP exceeds the national average (73.57%) by 3.22 percentage points.

## MCO & State Recommendations

While this three-year study has come to a close, Qlarant recommends that North Dakota DHS and SHP be mindful of the study's findings. While performance exceeds the national average benchmark, there is still opportunity for improvement. SHP should continue to educate providers on delaying imaging studies when appropriate.

Low back pain is a frequent diagnosis and research indicates costly imaging studies do not improve clinical outcomes. 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 2016) and the follow-up activities completed by SHP in 2017.

**Table 24. 2017 Compliance with 2016 Recommendations**

2017 Compliance with 2016 Recommendations	
2016 Recommendation	2017 Compliance Assessment
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.	<b>Compliant.</b> SHP's Remeasurement 3 analysis, which was both quantitative and qualitative, included a system-wide barrier analysis and identified multiple opportunities and interventions that should facilitate additional improvements in the performance measures.
Close out the Prevention and Treatment of Chronic Conditions PIP and replace it with a new topic where there is opportunity for improvement.	<b>Compliant.</b> The Prevention and Treatment of Chronic Conditions PIP was closed out. SHP began reporting on a Comprehensive Diabetes Care PIP. MY 2017 will be baseline.

2017 Compliance with 2016 Recommendations	
2016 Recommendation	2017 Compliance Assessment
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.	<b>Continues to be an opportunity for improvement.</b> SHP completed a Quality Improvement Program Evaluation for MY 2017, which included key performance measures. The MCO aims to improve performance where there are opportunities for improvement.
Review and act on specific recommendations made by the EQRO in the Compliance Review report. Ensure compliance with new Medicaid managed care standards.	<b>Continues to be an opportunity for improvement.</b> While improvement has been made with following the new Medicaid managed care standards, SHP still has opportunity for improvement and should follow recommendations outlined in the Compliance Review Report.
Revise member filing requirements and MCO resolution timelines for grievances and appeals to align with new standards.	<b>Continues to be an opportunity for improvement.</b> SHP should follow recommendations outlined in the Compliance Review Report.
Implement initiatives and/or corrective actions to ensure enrollees are able to obtain timely next available appointments.	<b>Continues to be an opportunity for improvement.</b> 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, maternity, primary care, and specialists.
Continue administration of disease management programs and engage members in self-management initiatives. Focus efforts to improve participation.	<b>Compliant. SHP should continue efforts to engage members.</b> SHP maintained its disease management programs. To expand efforts to identify qualifying enrollees, beginning in 2017, SHP began distributing a New Member Survey that asks about enrollee health history. Returned surveys are screened and members who qualify are enrolled in the MCO's health management programs.
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.	<b>Compliant.</b> SHP completed a Quality Improvement Program Evaluation for the Medicaid Expansion program for MY 2017, which included an analysis of PIPs and other key performance measures.

2017 Compliance with 2016 Recommendations	
2016 Recommendation	2017 Compliance Assessment
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.	<b>Continues to be an opportunity for improvement.</b> SHP did not add a field to the encounter data to document date 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 21<sup>st</sup> 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 third 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) Comprehensive Diabetes Care 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 successfully reported baseline performance in all Comprehensive Diabetes Care performance measures and conducted a thorough barrier analysis while implementing interventions to target members and providers. Sustained improvement was demonstrated in the Follow-Up After Hospitalization for Mental Health measures.

PMV findings indicated that SHP has appropriate processes for data integration, data control, and performance measure interpretation. The MCO's procedures and documentation used in calculating performance rates were found to be acceptable. Medical record over-read agreement rates were 100% for both selected measures. The MCO successfully reported results for the CMS Adult (and applicable Child) Core Set of Measures. When rates are compared to the Quality Compass MY 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
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 19-64: Initiation
  - PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 19-64
  - Medical Assistance With Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit
  - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medications
  - Flu Vaccinations for Adults, Ages 19-64
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

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: HbA1c Control (<7%) for a Selected Population
  - 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
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement Ages 19-64
  - Adult BMI Assessment

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

- Adult Performance Measures:
  - Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
  - Controlling High Blood Pressure

SHP largely demonstrated compliance with the Medicaid managed care standards. Overall, SHP scored well on the 2017 requirements:

- Information Requirements: 98.21%
- Enrollee Rights Standard: 100%
- MCO, PIHP and PAHP Standards: 96.94%
- Quality Assessment and Performance Improvement Program: 100%
- Grievance and Appeal System: 88.60%
- Program Integrity: 100%

The MCO's quality program measures and monitors quality-related elements such as access and availability, utilization management functions, performance improvement, and performance measurement. 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.

Regarding encounter data, SHP achieved a total match rate of 95% - meaning 95% of claims data submitted was supported by medical record documentation. This is an increase of 2 percentage points from MY 2016. At 83%, SHP's auto-adjudication rate is relatively high. SHP has well documented data integration and claims processing procedures.

Lastly, SHP measured MY 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 75<sup>th</sup> Percentile for the following CAHPS measures:

- Coordination of Care
- Rating of Specialist Seen Most Often (8+9+10)
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smoker to Quit
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Flu Vaccination: Had a flu shot or spray in the nose since July 1, 2017

SHP met or exceeded the national Medicaid 75<sup>th</sup> Percentile but was below the national Medicaid 90<sup>th</sup> Percentile for the following CAHPS measures:

- Share Decision Making Composite
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

SHP met or exceeded the national 90<sup>th</sup> Percentile in the following CAHPS measures:

- Getting Need Care Composite
- Getting Care Quickly Composite
- How Well Doctors Communicate 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 should continue completing an annual Quality Improvement Program Evaluation. The MCO should trend annual results in the evaluation to facilitate an understanding of performance year over year.

SHP conducts two PIPs, as required in the North Dakota Medicaid Expansion Quality Strategy. The MCO should continuously monitor barriers and gauge effectiveness of interventions. As new barriers are identified, new strategies should be developed.

For PMV, the MCO should review its core measure results and identify and implement strategies to improve performance on rates that failed to meet the national average benchmarks. These measures include:

- Adult Performance Measures:
  - Breast Cancer Screening
  - Follow-Up After Hospitalization for Mental Illness, Ages 21-62: Follow-Up Within 7 Days
  - Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 30 Days
  - Annual Monitoring for Patients on Persistent Medications: For Enrollees on ACE Inhibitors or ARBs
  - Annual Monitoring for Patients on Persistent Medications: For Enrollees on Diuretics
  - Annual Monitoring for Patients on Persistent Medications: Total Rate
  - Cervical Cancer Screening
  - Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
  - PQI 01 Diabetes Short-Term Complications Admission Rate: Ages 19-64
  - Comprehensive Diabetes Care: Eye Exam
  
- Child Performance Measures:
  - Adolescent Well-Care Visit
  - Percentage of Eligibles that Received Preventive Dental Services
  - Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 7 Days)
  - Follow-Up After Hospitalization for Mental Illness (Follow-Up Within 30 Days)

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.

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:

- Health Promotion and Education Composite
- Rating of Health Plan
- Rating of All Health Care

## 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, providers, and healthcare services. SHP provided members with information on available benefits and instructions on how to access such services. Member materials communicated 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 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. 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 90<sup>th</sup> Percentile for the CAHPS composite Getting Needed Care. The Coordination of Care composite exceeded the national Medicaid average. 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. 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 availability 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 were 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 90<sup>th</sup> percentile benchmark.

### Timeliness Recommendations

SHP has opportunity for improvement related to timely access to next available appointments for the following provider types: behavioral health, maternity, primary care, and specialists. There is opportunity for improvement for all of these provider types. The MCO should actively monitor and review any timeliness-related complaints or grievances to quickly identify and resolve timeliness-related issues. Additionally, SHP should ensure that all grievances are acknowledged in a timely manner. A sample file review revealed an occurrence of untimely acknowledgement.

## Conclusions

By the 2017 year end, 21,493 individuals were enrolled in the North Dakota Medicaid Expansion Program. During the course of the year, 71% of the enrollees utilized health care services. For comparative purposes, this is a three percentage point decrease compared to the 68% utilization rate for MY 2016. The MCO provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, SHP is performing well. SHP 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 to gauge where it meets and exceeds requirements and to identify opportunity for improvement. By implementing interventions and addressing these opportunities, the MCO 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

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- Continue to target members with diabetes using interventions aimed to improve member self-management.
- Explore value based contracting, which will likely have a positive impact on diabetic member outcomes.
- Adjust goals to ensure it is consistently facilitating quality improvement. Currently, SHP exceeds its goal for the HbA1c Poor Control (>9%) performance measure.
- SHP is encouraged to continue annual barrier analyses and also develop and implement targeted interventions.
- Consider the use of supplemental data for both HEDIS and non-HEDIS measures to improve performance measure rates.
- Review the performance measure report and focus on identifying and implementing strategies to improve performance rates particularly for measures that did not meet the NCQA Quality Compass national average benchmarks.
- Review and act on specific recommendations found in the detailed CR Report in order to improve processes and obtain full compliance.
- Review annual performance and identify and prioritize opportunities for improvement.
- 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.
- Identify barriers and explore strategies to improve the three CAHPS measures that performed below the national Medicaid average:
  - Health Promotion and Education Composite
  - Rating of Health Plan
  - Rating of All Health Care
- Consider the focused study's findings on Use of Imaging Studies for Low Back Pain. While performance exceeds the national average benchmark, there is still opportunity for improvement. SHP should continue to educate providers on delaying imaging studies when appropriate.
- Continue completing an annual Quality Improvement Program Evaluation and trend annual results in the evaluation to facilitate an understanding of performance year over year.
- Attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities, Cardiology, and Hematology and Oncology.
- Monitor and review any timeliness-related complaints or grievances to quickly identify and resolve timeliness-related issues should they arise.

## State Recommendations

- 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.
- Continue to work with the EQRO and SHP to identify measures meaningful to the Medicaid Expansion population.
- Encourage SHP to implement interventions targeting performance measures that did not meet the NCQA Quality Compass national average benchmarks.
- Define the State's objectives and articulate measurable goals for encounter data completeness and accuracy. The industry 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.