North Dakota
Department of Human Services

North Dakota Medicaid Expansion Program

Annual Technical Review Report
Measurement Year (MY) 2019

Qlarant

Submitted by:
Qlarant
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North Dakota Medicaid Expansion Program

2020 Annual Technical Report

Measurement Year 2019

Executive Summary

Background

Effective January 1, 2014, the North Dakota Department of Human Services (DHS) contracted with Sanford Health Plan (SHP) to provide services to the Medicaid Expansion population.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires states contracting with managed care organizations (MCOs) to conduct annual, independent reviews of the managed care program. To meet these requirements, DHS contracts with Qlarant, an independent external quality review organization (EQRO). Qlarant evaluates the quality, accessibility, and timeliness of health care services furnished by the MCOs through various mandatory activities following Centers for Medicare and Medicaid Services (CMS)-developed EQRO protocols.[1] Qlarant completed the following external quality review (EQR) activities in 2020 to evaluate MCO performance for measurement year (MY) 2019: [2]

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review (CR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®[3]) Survey

In addition to completing federally mandated EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing the manner in which data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCOs. This document serves as Qlarant's report to DHS on the assessment of MY 2019 MCO performance.

[1] The EQRO Protocols are available for download at: www.cms.gov
[2] Measurement Year 2019 corresponds to calendar year 2019 (January 1, 2019 to December 31, 2019).
[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Key Findings

Performance Improvement Project Validation

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 2019 PIP Reports included remeasurement results and described multifaceted interventions. Sustained improvement was demonstrated in the mental health PIP's Engagement of Alcohol or Other Drug (AOD) Treatment performance measure and in the diabetes care PIP's Hemoglobin A1c (HbA1c) Control (<8%) performance measure.

Performance Measure Validation

An information systems (IS) capabilities assessment was conducted as part of PMV activities. SHP's IS capabilities were found to be appropriate to support contractual requirements.

SHP had satisfactory processes for data integration, data control, and reporting of required performance measures for MY 2019. Procedures and documentation used to calculate performance measures with the certified HEDIS®[4] software were reviewed and found to be acceptable. Program logic, source code, and test cases were reviewed for core measures not calculated with the certified software, and were found to be adequate. Sampling methodologies and medical record review activities were evaluated and met requirements. SHP successfully reported its results for all required performance measures.

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 13 exceeding the 75th percentile and two surpassing the 90th percentile.

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 2019. Qlarant reviewed the managed care standards. Recommendations were provided to SHP for guidance in policy and procedure revisions to help the MCO meet the requirements. Regarding 2019 requirements, SHP's results for each standard are displayed in Executive Summary (ES) Table 1.

ES Table 1. SHP Results for MY 2019 CR

Standards	Possible Points	Points Earned	Compliance Score
Information Requirements	28	27	96.43%
Enrollee Rights	9	9	100%
MCO Standards	67	65.5	97.76%
Quality Assessment and Performance Improvement Program	7	7	100%
Grievance and Appeal System	57	50	87.72%

[4] HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Standards	Possible Points	Points Earned	Compliance Score
Program Integrity	9	9	100%
Total	**177**	**167.5**	**94.63%**

Network Adequacy Validation

Federal standards require MCO contracted providers to provide access to members 24 hours per day, 7 days per week (24/7) as medically needed. Although providers may not be physically accessible 24/7, providers should provide their members with instruction on how to obtain care after-hours. Qlarant selected a sample of providers from SHP's online provider director and conducted telephone-based surveys to assess after-hours accessibility.

Overall, the MCO maintains a provider network that is sufficient in providing information to members regarding after-hours care.

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 33,234 unique members, 23,694 (71%) had at least one paid claim during MY 2019. For comparative purposes, this is a one percentage point decrease compared to the 72% utilization rate for MY 2018. Overall, SHP has well documented data integration and claims processing procedures. During MY 2019, SHP achieved a total match rate of 98%—meaning 98% of claims data submitted were supported by medical record documentation. Outpatient records registered the highest match rate (99%) in MY 2019, followed by Inpatient (98%) and Office Visit (97%). The match rate will continue to be monitored.

CAHPS Survey

SHP contracted with a certified CAHPS vendor to conduct the 2020 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 March 24 2020, a total of 1,350 surveys were distributed 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 199 completed surveys for a 14.90% 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 – HMOs) to gauge performance and identify opportunities for improvement. One CAHPS measure exceeded the national 75th Percentile benchmark and three surpassed the 90th Percentile benchmarks.

Conclusion

By the 2019 year end, 20,279 individuals were enrolled in the North Dakota Medicaid Expansion Program. 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. 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.

North Dakota Medicaid Expansion Program

2020 Annual Technical Report

Measurement Year 2019

Introduction

Background

The Affordable Care Act (ACA), enacted in March 2010, included a mandate, effective January 1, 2014, to expand the Medicaid program to cover individuals under the age of 65 with incomes below 133% 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, 2014.

Purpose

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)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The comprehensive assessment, conducted in 2020, assessed SHP's measurement year (MY) 2019 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 2019; 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.

Performance Improvement Project Validation

Objectives

PIPs use a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP review and validation activities provide the State with a level of confidence in results.

Methodology

The MCO is required to annually conduct PIPs designed to achieve, through ongoing measurements and interventions, significant improvement in clinical or non-clinical care areas expected to have a favorable effect on health outcomes. The two PIP topics were agreed upon by the MCO, State, and EQRO. The PIP topics are as follows:

- Comprehensive Diabetes Care
- Follow-Up for Mental Health

SHP reported on MY 2019 PIP-related activities, improvement strategies, and performance measure results in their 2020 reports. PIP measures were audited as part of the performance measure validation activity to provide confidence in reported measure rates. The MCO completed a data and barrier analysis and identified follow-up activities for each project submission. Qlarant provided MCO-specific technical assistance as requested.

Qlarant reviewed each PIP to assess the MCO's PIP methodology and to perform an overall validation of PIP results. Qlarant completed these activities in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.[5] Qlarant determined a validation rating or level of confidence in each PIP based on the validation score.[6] Validation ratings include:

- 90% - 100%: high confidence in MCO results
- 75% - 89%: moderate confidence in MCO results
- 60% - 74%: low confidence in MCO results
- ≤59%: no confidence in MCO results

[5] CMS released updated protocols in January 2020. Due to the timing of the release of the new protocol which includes assessing the early PIP planning and development process, Qlarant conducted the 2020 review and validation process using a blended approach which captured critical elements of the updated protocol, as well as earlier version. This report reflects the critical reporting elements of the new protocol.
[6] Validation rating refers to the overall confidence that a PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement (CMS EQR Protocol 1 – Validation of Performance Improvement Projects).

Results

PIP validation results for 2020 MCO-reported PIPs including MY 2019 performance measure results are included in this report. Table 1 provides an overview of each PIP followed by key improvement strategies and results.

Table 1. SHP's PIPs

SHP	PIP 1	PIP 2
Topic	Comprehensive Diabetes Care	Follow-Up for Mental Health
Aim	Will the interventions implemented for members with diabetes increase the Comprehensive Diabetes Care rates to meet or exceed the following goals? • **Performance Measure 1:** HbA1c Testing: 94% • **Performance Measure 2:** HbA1c Poor Control >9%: 29% • **Performance Measure 3:** HbA1c Control <8%: 57% • **Performance Measure 4:** HbA1c Control <7%: 41%* • **Performance Measure 5:** Eye Exam (Retinal) Performed: 52% • **Performance Measure 6:** Medical Attention for Nephropathy: 94% • **Performance Measure 7:** Blood Pressure Control <140/90: 80%	Will the interventions implemented for the HEDIS noncompliant population impact the PIP's measures? • **Follow-Up After Hospitalization for Mental Health - Within 7 Days**: Increase the performance rate to 25%. • **Follow-Up After Hospitalization for Mental Health - Within 30 Days**: Increase the performance rate to 45%. • **Screening for Clinical Depression and Follow-Up Plan**: Increase the performance rate to at least 20% (This performance measure was discontinued in 2016). • **Engagement of Alcohol or other Drug (AOD) Treatment**: Increase the performance rate to at least 20% (This performance measure was introduced in MY 2016).
Population	Members with type 1 and type 2 diabetes	Members with mental health problems and AOD dependence
Program	Medicaid Expansion	Medicaid Expansion
Phase	2nd Remeasurement	5th Remeasurement

PIP 1: Comprehensive Diabetes Care

Interventions

Member-focused interventions:

- Provided members enrolled in the Diabetes Health Management Program, a voluntary program, with education and care coordination regarding their condition.
- Contacted members via mailings who were noncompliant with diabetes testing, reminding them to contact their provider to seek testing and exams as appropriate.

- Sent mailings to members regarding their eye exam benefits, reminding them of the importance of communication and information exchange between their eye care provider and primary care physician/practitioner, and that transportation is available for appointments.

Provider-focused interventions:

- Contacted providers using mailings which included the correct codes to submit on diabetic eye exam claims and diabetes eye exam consultation forms for notifying the member's primary care physician/practitioner of the eye exam results.
- Implemented diabetes care gap reports, sent to participating providers, to assist in identifying members with open care caps.

PIP Measure Results

Table 2 displays SHP's Comprehensive Diabetes Care PIP measure results.

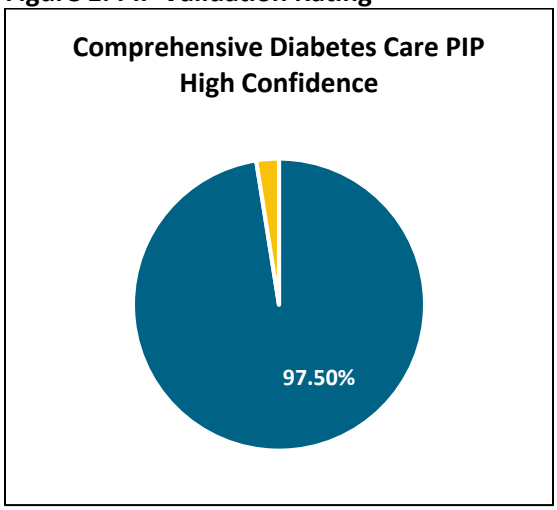
Table 2. SHP Comprehensive Diabetes Care PIP Measure Results

Performance Measure & Measure Steward	Baseline Year & Rate	Last Remeasure-ment Year & Rate	Improvement	Statistically Significant Improvement
Hemoglobin A1c (HbA1c) Testing (NCQA)	MY 2017 92.62%	MY 2019 90.27%	No	No
HbA1c Poor Control (>9%) *(lower rate is better)* (NCQA)	MY 2017 30.58%	MY 2019 28.71%	Yes	No
HbA1c Control (<8%) (NCQA)	MY 2017 55.01%	MY 2019 60.83%	Yes	No
HbA1c Control (<7%) for a Selected Population (NCQA)	MY 2017 39.66%	Discontinued in MY 2019	NA	NA
Eye Exam (Retinal) Performed (NCQA)	MY 2017 50.09%	MY 2019 49.64%	No	No
Medical Attention for Nephropathy (NCQA)	MY 2017 91.21%	MY 2019 89.05%	No	No
Blood Pressure Control (< 140/90 mm Hg) (NCQA)	MY 2017 77.86%	MY 2019 73.97%	No	No

PIP Validation Results

SHP received a validation score of 97.50% for its Comprehensive Diabetes Care PIP providing high confidence in results. Figure 1 illustrates this validation rating.

Figure 1. PIP Validation Rating



PIP 2: Follow-Up for Mental Health

Interventions

Member-focused interventions:

- Contacted members at inpatient facilities to schedule follow-up appointments prior to discharge.

MCO-focused interventions:

- Collaborated with Sanford Health's Social Workers and Emergency Department Care Managers on behavioral health issues to assist with discharge planning.
- Worked with Human Service Centers and other inpatient facilities to discuss issues and appointment workflows, and provided educated to discharge planners on health plan coverage and network coverage rules.
- Evaluated requests received for AOD treatment to ensure the most appropriate setting for members.

PIP Measure Results

Table 3 displays SHP's Follow-up for Mental Health PIP measure results.

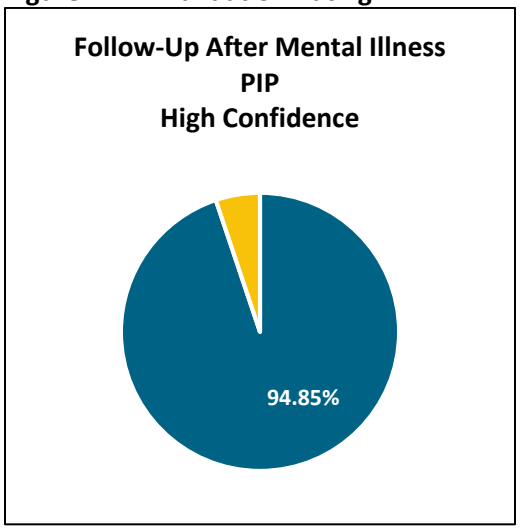
Table 3. SHP Follow-Up for Mental Health PIP Measure Results

Performance Measure & Measure Steward	Baseline Year & Rate	Last Remeasure-ment Year & Rate	Improvement	Statistically Significant Improvement
Follow-Up After Hospitalizations for Mental Health - Within 7 Days (NCQA)	MY 2014 21.88%	MY 2019 19.62%	No	No
Follow-Up After Hospitalizations for Mental Health - Within 30 Days (NCQA)	MY 2014 38.84%	MY 2019 34.45%	No	No
Screening for Clinical Depression and Follow-Up Plan (NQCA)	MY 2014 11.78%	Discontinued in MY 2016	NA	NA
Engagement of Alcohol or Other Drug (AOD) Treatment (NCQA)	MY 2016 17.32%	MY 2019 18.52%	Yes	No

PIP Validation Results

SHP received a validation score of 94.85% for its Follow-Up for Mental Health PIP providing high confidence in results. Figure 2 illustrates this validation rating.

Figure 2. PIP Validation Rating



Conclusion

SHP received an overall "high confidence" rating for both PIPs, indicating DHS and other stakeholders should have "high confidence" in the MCO's reported results. For the Comprehensive Diabetes Care PIP, there was improvement noted in two measures for MY 2019: HbA1c Poor Control (>9%) and HbA1c Control (<8%). For the Follow-Up after Mental Illness PIP, there was improvement in the Engagement of

Alcohol or Other Drug (AOD) Treatment performance measure. No improvement was statistically significant over baseline performance.

Although there was not improvement in all performance measures, SHP completed and presented a thorough barrier analysis as well as planned interventions for MY 2020, which should have a positive impact on performance measure results.

Performance Measure Validation

Objectives

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.

Methodology

Qlarant uses the *CMS EQR Protocol 2 - Validation of Performance Measures*, 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-onsite, onsite, and post-onsite. The associated PMV activities are described below in Table 4.

Table 4. PMV Activities

PMV Activities	
Audit Phase	Audit Activities
Pre-Onsite 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 onsite audit. 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 onsite audit. The pre-onsite phase ends with a conference call with the MCO to finalize the onsite review plans.
Onsite Phase*	Qlarant begins the onsite 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

PMV Activities	
Audit Phase	Audit Activities
	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-onsite activities, and provides opportunity for the MCO to respond to preliminary findings.
Post-Onsite 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.

*For MY 2019, the Onsite Phase was conducted virtually due to the COVID-19 pandemic.

Results

Validation Results

SHP completed and submitted an ISCA providing insights into their IS and processes used to produce the required CMS Adult and Child Core Quality Measures. SHP had satisfactory processes for data integration, data control, and interpretation of the performance measure specifications for MY 2019. The onsite 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 systems and processes used in claims production, member enrollment, provider management, and performance measure reporting. The interviews also provided an overview of the data warehouse and insight into quality assurance practices.

The procedures and documentation used to calculate performance measures with the MCO's certified HEDIS software were reviewed and found to be acceptable. Programming 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 onsite 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 5 below.

Table 5. Performance Measure Medical Record Over-Read Results

Medical Record Over-Read Agreement			
Measure	Record Sample Size	Compliant Records	SHP Agreement
Adult BMI Assessment	30	30	100%
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	30	30	100%

SHP's validation findings are summarized in Table 6. Documentation, denominator, numerator, and sampling validation components each received a numeric score based upon findings. An overall audit score was then applied to provide DHS with a level of confidence in reported results. Lastly, the table includes a Reporting Designation. This component may be assessed with any one of the following designations:

- **R** = Reportable; measure was compliant with the State specifications
- **DNR** = Do not report; MCO rate was materially biased and should not be reported
- **NA** = Not applicable; the MCO was not required to report the measure
- **NR** = Measure was not reported because the MCO did not offer the required benefit

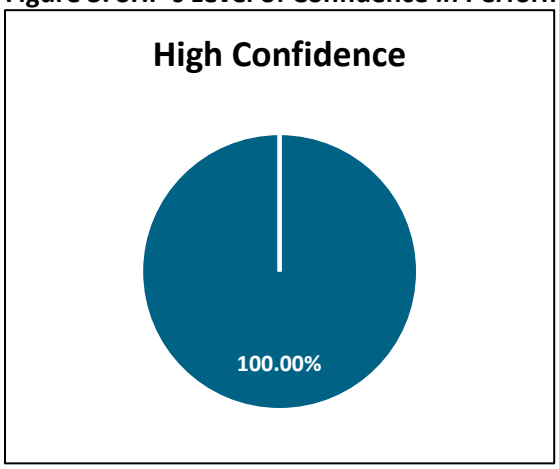
Table 6. MY 2019 Validation Results

Validation Component	Audit Element	SHP
Documentation	Data integration and control procedures are assessed to determine whether the MCO has the appropriate processes and documentation in place to extract, link, and manipulate data for accurate and reliable measure rate construction. Measurement procedures and programming specifications including data sources, programming logic, and computer source codes are documented and reviewed.	100%
Denominator	Validation of the denominator calculations for the performance measures is conducted to assess the extent to which the MCO used appropriate and complete data to identify the entire population and to the degree to which the MCO followed the measures specifications for calculating the denominator.	100%
Numerator	Validation of the numerator determines if the MCO correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and if the MCO followed the measure specifications for calculation of the numerator.	100%
Sampling	Sample size and replacement methodology specifications are reviewed to ensure the sample is not biased.	100%
Reporting	MCO followed the State specifications for reporting performance measures.	100%
Overall Audit Score	The overall audit score encompasses the MCO validation findings for Documentation, Denominator, Numerator, Sampling, and Reporting.	**100%**
Reporting Designation	Reportable; Each measure was compliant with the State specifications. The MCO reported for each measure, denominator, numerator events, and calculated final rates all in the format required by the State.	**R**

SHP received an overall audit score of 100% and all performance measures are "Reportable."

Figure 3 displays level of confidence in MCO compliance.

Figure 3. SHP's Level of Confidence in Performance Measure Results



DHS and other stakeholders should have "high confidence" in SHP's reported performance measure results.

Performance Measure Results

The 2020 (MY 2019) SHP PMV includes HEDIS and non-HEDIS measures that aligned with the 2020 North Dakota Medicaid Expansion Program Quality Strategy. Required performance measures were confirmed with DHS and the MCO in the initial steps of PMV activities. The MCO followed current 2020 HEDIS (MY 2019) with the noted exception of age differences. For non-HEDIS measures, SHP followed the most current criteria from the 2020 (MY 2019) Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications. Performance measure results are compared to benchmarks largely based on the NCQA Quality Compass 2019 National Medicaid for HMOs. Comparisons are made using a diamond rating system as shown in Table 7:

Table 7. Diamond Rating System Used to Compare SHP Performance to Benchmarks

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

The year-to-year comparison and trending pattern evaluate the past three years (MY 2017-MY 2019). **Green** and **red** represents positive and negative trends for three consecutive measurement years, respectively. Table 8 displays performance measure validation results for SHP.

Table 8. SHP Performance Measure Validation Results

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 Comparison to Benchmarks^
Adherence to Antipsychotics for Individuals with Schizophrenia	60.22	61.36	52.29	♦
Adult Body Mass Index Assessment	93.40	93.33	94.17	♦♦♦
Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	85.43	87.81	NR	NC
Annual Monitoring for Patients on Persistent Medications: Diuretics	87.16	89.01	NR	NC
Annual Monitoring for Patients on Persistent Medications: Total Rate	86.11	88.29	NR	NC
Antidepressant Medication Management: Effective Acute Phase Treatment	62.55	64.33	61.85	♦♦♦
Antidepressant Medication Management: Effective Continuation Phase Treatment	47.20	48.17	46.72	♦♦♦
Asthma Medication Ratio: Ages 19-50	NR	NR	55.00	♦♦
Asthma Medication Ratio: Ages 51-64	NR	NR	51.72	♦
Asthma Medication Ratio: Ages 19-64 (Total)	NR	NR	53.93	♦
Breast Cancer Screening	50.35	54.97	54.69	♦
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC
Cervical Cancer Screening Ages 21-64	**42.61**	**43.60**	**44.79**	♦
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	**37.50**	**40.52**	**46.03**	♦
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg	**77.86**	**76.86**	**73.97**	♦♦♦
Comprehensive Diabetes Care: Eye Exam	50.09	51.12	49.64	♦
Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population	39.66	41.61	NR	NC
Comprehensive Diabetes Care: HbA1c Control (<8%)	**55.01**	**55.96**	**60.83**	♦♦♦♦
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) *Lower is better*	30.58	32.12	28.71	♦♦♦
Comprehensive Diabetes Care: HbA1c Testing	**92.62**	**92.57**	**90.27**	♦♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy	91.21	93.61	89.05	♦
Controlling High Blood Pressure	73.43	68.37	70.00	♦♦♦
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	NC

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 Comparison to Benchmarks^
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	81.51	85.30	85.15	♦♦♦
Flu Vaccinations for Adults, Ages 19-64	**41.75**	**38.93**	**38.60**	♦
Follow-Up After Emergency Room Visit for Mental Illness, Age 19-64: Follow-Up Within 7 days	NR	NR	24.75	♦
Follow-Up After Emergency Room Visit for Mental Illness, Age 19-64: Follow-Up Within 30 days	NR	NR	31.33	♦
Follow-Up After Hospitalization for Mental Illness, Ages 19-64: Follow-Up Within 7 Days	34.17	28.11	32.20	♦
Follow-Up After Hospitalization for Mental Illness, Ages 19-64: Follow-Up Within 30 Days	**53.61**	**51.62**	**44.49**	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Alcohol Abuse	NR	42.80	41.70	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Alcohol Abuse	NR	17.98	14.57	♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Opioid Abuse	NR	61.35	62.50	♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Opioid Abuse	NR	41.43	43.55	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Other Drug Abuse	NR	43.08	41.97	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Other Drug Abuse	NR	24.33	17.27	♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Total	**40.83**	**43.99**	**44.31**	♦♦

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 Comparison to Benchmarks^
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Total	18.03	20.82	18.52	♦♦♦
Medical Assistance With Smoking and Tobacco Use Cessation: Advised to Quit Smoking (2 year rolling average)	77.21	78.22	76.90	♦♦
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication (2 year rolling average)	52.21	54.19	52.10	♦
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (2 year rolling average)	52.77	52.33	48.10	♦♦
Plan All-Cause Readmissions Rate: Ages 18-44 *Lower is better*	NR	NR	1.5441	NC
Plan All-Cause Readmissions Rate: Ages 45-54 *Lower is better*	NR	NR	1.5655	NC
Plan All-Cause Readmissions Rate: Ages 55-64 *Lower is better*	NR	NR	1.1399	NC
Plan All-Cause Readmissions Rate: Total *Lower is better*	NR	NR	1.4182	♦
PQI 01: Diabetes Short-Term Complications Admission Rate (denominator is total member months x100,00 for ages 18-64, Rate is numerator events/100,000 member months) *Lower is better*	45.07	40.85	46.53	♦
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (denominator is total member months x100,00 for ages 40-64, Rate is numerator events/100,000 member months) *Lower is better*	45.26	28.97	48.58	♦♦♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate (denominator is total member months x100,00 for ages 18-64 and 65+, Rate is numerator events/100,000 member months) *Lower is better*	23.91	29.07	27.11	♦♦
PQI 15: Asthma Admission Rate in Younger Adults (denominator is total member months x100,00 for ages 18-39,	**8.29**	**3.47**	**2.90**	♦♦♦

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 Comparison to Benchmarks^
Rate is numerator events/100,000 member months) *Lower is better*				
Use of Opioids at High Dosage (rate is calculated per 1000 members), Ages 18 and older *Lower is better*	NR	2.79	2.75	♦♦
Use of Opioids From Multiple Providers (rate is calculated per 1000 members), Ages 18 and older: Multiple Pharmacies *Lower is better*	NR	4.75	5.02	♦♦
Use of Opioids From Multiple Providers (rate is calculated per 1000 members), Ages 18 and older: Multiple Prescribers *Lower is better*	NR	24.95	27.28	♦
Use of Opioids From Multiple Providers (rate is calculated per 1000 members), Ages 18 and older: Multiple Prescribers and Pharmacies *Lower is better*	NR	4.10	4.45	♦♦

^ *Quality Compass 2019 (Measurement Year 2018 data) National Medicaid Average for HMOs*. This is the most current benchmark source at the time of report production.
* *Quality of Care for Adults in Medicaid: Findings from the 2018 Adult Core Set Chart, September 2019*, a product of the Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, sponsored by the Centers for Medicare & Medicaid Services. This is the most current benchmark available at the time of report production.
^^ In 2020, the PCR measure reporting is based on the O/E Ratio (Observed Readmissions/Expected Readmissions) and not the Observed Readmission Rate like the previous measurement years
NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR Not Reported in previous year(s) due to new measure was added, or measure was retired.
NC No comparison made due to NA, no rate or/and benchmark available

SHP's rates for two measures met or exceeded the National Medicaid 90th Percentile:

- Comprehensive Diabetes Care: HbA1c Control (<8%)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment – Opioid Abuse

SHP's rates for twelve measures met or exceeded the National 75th Percentile but were below the 90th Percentile:

- Adult Body Mass Index Assessment
- Antidepressant Medication Management: Effective Acute Phase Treatment
- Antidepressant Medication Management: Effective Continuation Phase Treatment
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: HbA1c Poor Control (>9%) *Lower is better*
- Controlling High Blood Pressure
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment – Alcohol Abuse
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment – Opioid Abuse
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment – Other Drug Abuse
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment- Total
- PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate *Lower is better*
- PQI 15: Asthma Admission Rate in Younger Adults *Lower is better*

SHP's rates for nine measures met or exceeded the National Medicaid Average but did not meet the 75th Percentile:

- Asthma Medication Ratio: Ages 19-50
- Comprehensive Diabetes Care: HbA1c Testing
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Total
- Medical Assistance With Smoking and Tobacco Use Cessation: Advised to Quit Smoking
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
- PQI 08: Congestive Heart Failure (CHF) Admission Rate *Lower is better*
- Use of Opioids at High Dosage
- Use of Opioids From Multiple Providers: Multiple Pharmacies *Lower is better*
- Use of Opioids From Multiple Providers: Multiple Prescribers and Pharmacies *Lower is better*

SHP's rates improved year-over-year for four measures:

- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: HbA1c Control (<8%)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment – Total

SHP has the opportunity for improvement with the following measures where the MCO rate was below the National Medicaid Average or declined year-over-year:

- Adherence to Antipsychotics for Individuals with Schizophrenia
- Asthma Medication Ratio: Ages 51-64
- Asthma Medication Ratio: Ages 19-64 (Total)
- Breast Cancer Screening
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: HbA1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy

- Flu Vaccinations for Adults
- Follow-Up After Emergency Room Visit for Mental Illness: Follow-Up Within 7 days
- Follow-Up After Emergency Room Visit for Mental Illness: Follow-Up Within 30 days
- Follow-Up After Hospitalization for Mental Illness: Follow-Up Within 7 Days
- Follow-Up After Hospitalization for Mental Illness: Follow-Up Within 30 Days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment – Other Drug Abuse
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication
- Plan All-Cause Readmissions Rate: Total *Lower is better*
- PQI 01: Diabetes Short-Term Complications Admission Rate *Lower is better*
- Use of Opioids From Multiple Providers: Multiple Prescribers *Lower is better*

Conclusion

The review of SHP's IS capabilities indicates that the MCO's IS infrastructure is adequate to support its contractual requirements with DHS. Validation results revealed that SHP has appropriate systems and processes in place to calculate and report accurate performance measures. A review of performance measure results showed twenty-five measures were above the National Medicaid Average or improved year-over-year between MY 2017 and MY 2019. It also showed that opportunities for improvement existed for seventeen measures that failed to meet the National Medicaid Average or declined in performance year-over-year.

All measures provided by SHP were deemed "Reportable" and the MCO met all its PMV standards. SHP received a validation score of 100%, meaning DHS and other stakeholders can have high confidence in the reported rates.

Compliance Review

Objectives

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. These key areas of the regulations are assessed:

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

Methodology

Qlarant's review team conducts CRs in accordance with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations*[7]. The review team's systematic approach to completing the review includes three phases of activities: pre-onsite, onsite, and post-onsite. These activities were completed for SHP and are described below in Table 9.

Table 9. CR Activities

CR Activities	
Audit Phase	Audit Activities
Pre-Onsite 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-onsite survey to allow reviewers to gain organizational insight and information on any changes to the MCO within the last year. The MCO posts (uploads) its electronic documents (written plans, polices, and procedures) to Qlarant's secure web-based portal approximately 30 days prior to the onsite assessment. After this information is posted, auditors begin the document review.
Onsite Phase*	Qlarant begins the onsite review with an opening conference and reviews the purpose and objectives of the CR. Onsite review time is spent reviewing documentation, files, and records not available during the pre-onsite 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-onsite activities, and provide opportunity for the MCO to respond to preliminary findings.
Post-Onsite 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.

*For MY 2019, the Onsite Phase was conducted via telephone conference due to the COVID-19 pandemic.

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 MCO is expected to demonstrate 100% compliance with each standard, element, and component. Components for each element are assessed and receive a score based on the finding. Component assessments are then rolled up to the element level, and finally the standard level. Qlarant uses the scale displayed in Table 10 for scoring compliance.

[7] CMS released updated protocols in January 2020. Qlarant previously confirmed the 2020 review standards with DHS and provided the standards to the MCO for the MY 2019 review. Additional standards identified in the updated protocol will be reviewed and reported for baseline compliance during the 2021 (MY 2020) review.

Table 10. Scoring Scale

Assessment	Scoring	Rationale
Met	1 Point	The MCO demonstrates full compliance.
Partially Met	0.5 Point	The MCO demonstrates at least some, but not full, compliance.
Unmet	0 Points	The MCO does not demonstrate compliance on any level.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally, an overall CR compliance score is calculated.

Using the compliance scores, a level of confidence in the MCO's CR results is determined. Table 11 describes the confidence levels.

Table 11. CR Level of Confidence

Level of Confidence	Compliance Score
High Confidence in MCO compliance	95% - 100%
Confidence in MCO compliance	85% - 94%
Low Confidence in MCO compliance	75% - 84%
MCO reported results are **Not Credible**	≤74%

Results

The 2020 CR assessed SHP's MY 2019 compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion population. The 2020 CR was a comprehensive review that assessed all areas and standard requirements.

SHP's results for each standard are displayed in Table 12.

Table 12. SHP Results for MY 2019 CR

Standards	Possible Points	Points Earned	Compliance Score
Information Requirements	28	27	96.43%
Enrollee Rights	9	9	100%
MCO Standards	67	65.5	97.76%
Quality Assessment and Performance Improvement Program	7	7	100%
Grievance and Appeal System	57	50	87.72%
Program Integrity	9	9	100%
Total	**177**	**167.5**	**94.63%**

Figure 4 displays SHP's level of confidence for CR.

Figure 4. Level of Confidence for CR

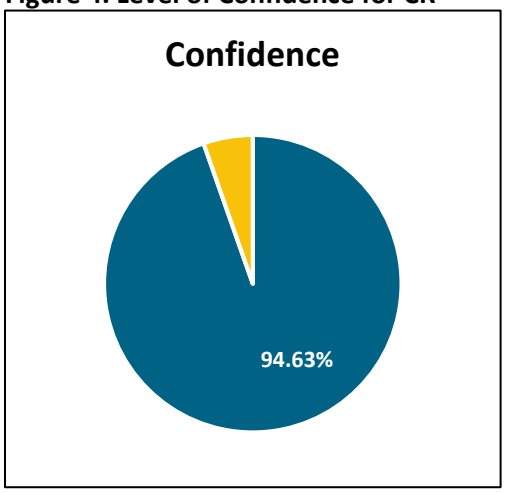


Table 13 displays SHP's results for the last four years (MY 2016-MY 2019).

Table 13. SHP Results for MYs 2016-2019

Standards	MY 2016	MY 2017	MY 2018	MY 2019
Information Requirements	N/A	98.21%	98.21%	96.43%
Enrollee Rights	94.44%	100%	100%	100%
MCO Standards	97.22%	96.94%	97.76%	97.76%
Quality Assessment and Performance Improvement Program	N/A	100%	100%	100%
Grievance and Appeal System	N/A	88.60%	91.23%	87.72%
Program Integrity	100%	100%	100%	100%
Overall Compliance Score*	**N/A**	**N/A**	**96.05%**	**94.63%**

*MY 2018 is the first time an overall compliance score is provided.

Conclusion

SHP's overall compliance score was 94.63% for the MY 2019 CR with scores of 87.72% or greater for all standards. Qlarant found SHP had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its managed care population. Qlarant has confidence in SHP's compliance with all regulatory requirements based on its overall compliance score as shown in Figure 4.

Network Adequacy Validation

Objectives

Availability of Services (42 CFR §438.206) requires MCOs to make services included in the contract available to members 24 hours a day, 7 days a week, when medically necessary. While providers may not be accessible physically 24/7, members should be able to contact their PCP offices and seek instruction on obtaining care after-hours. Many provider offices have on-call provider contact information and/or a nurse line. At the very least, an answering machine should direct the member on

what to do in the event of an emergency–hang up and dial 911. The purpose of the NAV task is to ensure the MCO's provider network sufficiently relays after-hours care information to its members.

Methodology

CMS has not issued an EQR protocol for evaluating network adequacy. To complete the MY 2019 NAV task, Qlarant conducted telephone-based surveys to ensure provider offices were meeting this required standard. The sample was obtained from SHP's online provider directory. An experienced surveyor from Qlarant acted as a member seeking guidance after-hours. One attempt was made to contact each provider for after-hours surveys.

Results

Table 14 provides a summary of findings from the after-hours surveys.

Table 14. After-Hours Availability Results

Measurement Year	Providers having One or More Method(s) to Direct After-Hours Care* Compliance Rate
MY 2019	93%

*Methods include any one of the following: on-call provider contact information, nurse line, or answering machine with direction on what to do in the event of an emergency.

The providers were verified as having instructions on how to obtain care either through an on-call provider, nurse line, or instructions to call 911 in the event of an emergency.

Conclusion

The MCO received a compliance rate of 93%, indicating 93% of contracted providers have one or more methods to direct members on how to receive after-hours care. Analysis of the survey responses showed typically the provider's number was either answered by a recorded or automated message instructing the member to call 911 in the case of an emergency and/or providing a number to a nurse helpline, or answered by an employee of the provider or practice. Noncompliant provider office phone numbers were answered by a recorded or automated message but did not provide detail on how a member should receive after-hours care. Overall, the compliance rate shows SHP has an adequate provider network available to members 24 hours a day, 7 days a week, when medically necessary.

Encounter Data Validation

Objectives

States rely on valid and reliable encounter/claims[8] data submitted by MCOs to make key decisions. States use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. Valid and reliable encounter data is critical to states with Medicaid

[8] Encounter data consists of claims; therefore, these two terms, encounter and claims, are used interchangeably in this report.

managed care programs as states aim to reach goals of transparency and payment reform to support efforts in quality measurement and improvement. Various provisions of the Affordable Care Act demonstrate transparency of payment and delivery of care as an important part of health reform.

CMS defines encounter data as the electronic records of services provided to MCO members by both institutional and practitioner providers (regardless of how the providers were paid). Similar data is captured on standard claim forms like UB04 or CMS 1500.

CMS requires states to conduct validation studies to assess the completeness and accuracy of encounter data submitted by MCOs. States may contract with an external quality review organization (EQRO) to conduct this activity. DHS contracted with Qlarant to conduct an encounter data validation (EDV) study of the North Dakota Medicaid Expansion Program.

Validation of encounter data provides DHS a level of confidence in the completeness and accuracy of encounter data submitted by SHP.

Methodology

Qlarant conducted EDV in accordance with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*. To assess the completeness and accuracy of encounter data, Qlarant completed the following activities:

1. **Review state requirements for collecting and submitting encounter data.**
   Qlarant reviewed DHS/SHP contractual requirements for encounter data collection and submission to ensure the MCO followed the State's specifications in file format and types of encounters.

2. **Review the MCO's capability to produce accurate and complete encounter data.**
   Qlarant completed an evaluation of the MCO's Information Systems Capabilities Assessment (ISCA) to determine whether the MCO's system is able to collect and report high quality encounter data. The assessment, which included a documentation review and interviews with key MCO staff, was conducted as part of the performance measure validation (PMV) activity.

3. **Analyze MCO electronic encounter data for accuracy and completeness.**
   Qlarant's analysts examined the electronic encounter data for consistency, accuracy, and completeness. This was accomplished through activities such as examining critical fields to ensure they were populated in the correct format, data values were within required ranges, volume of data was consistent with the MCO's enrollment, and more. To complete this activity, Qlarant obtained an encounter/claims file from SHP, which reflected payment made from January 1, 2019 to December 31, 2019.

4. **Review medical records for confirmation of findings of analysis of encounter data.**
   Qlarant's certified coders/nurse reviewers compared 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 were reviewed to evaluate if the electronic encounter was documented in the medical record and whether the level of documentation supported the billed service codes. Reviewers further validated the date of service, place of service, primary and secondary diagnoses and procedure codes, and, if applicable, revenue codes.

5. **Submitted findings to the State.**
   Qlarant prepared this report for submission to DHS, which includes results, strengths, and recommendations.

Results

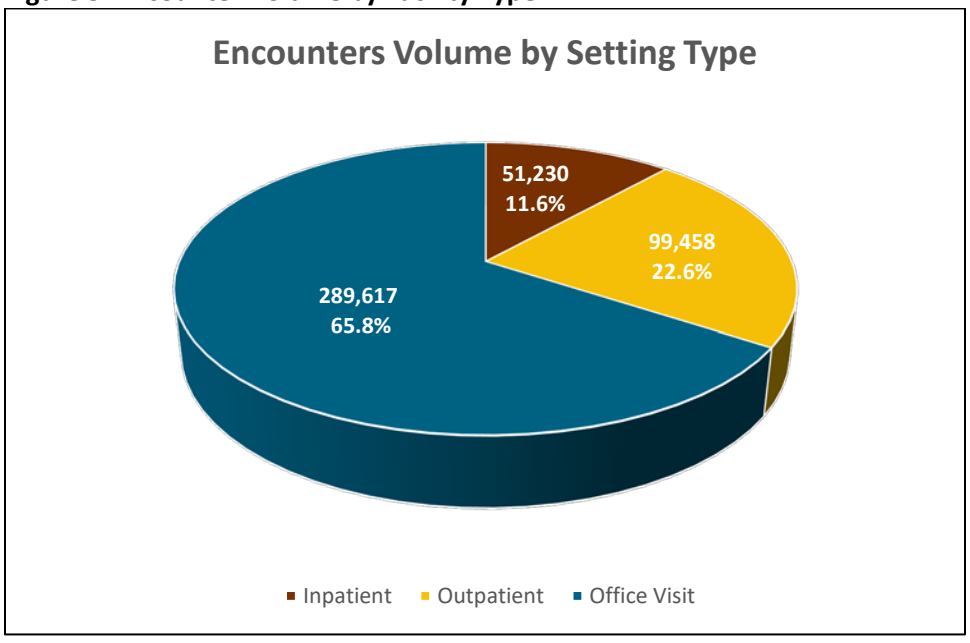
This section includes EDV results for SHP, and is based on an assessment of encounters/claims paid during MY 2019 (January 1, 2019 – December 31, 2019).

Claims Volume

The utilization rate for SHP, measured by the number of unique members with at least one paid claim, was 71%. Out of 33,264 unique members, 23,694 (71%) had at least one paid claim during MY 2019. For comparative purposes, this is a one percentage point decrease compared to the 72% utilization rate for MY 2018.

Qlarant analysts further evaluated SHP's submitted claims by facility type selected for the EDV study, which included Inpatient, Outpatient, and Office Visit. Figure 5 shows the volume and percentage of claims by facility type for those members who had an encounter. Most encounters occurred in the Office Visit setting (65.8%), and followed by Outpatient setting (22.6%). Only 11.6% of encounters occurred via the Inpatient setting.

Figure 5. 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 amount of 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. During the PMV audit, SHP stated 99.37% 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.

The SHP member data contained 41,144 records for MY 2019. Once duplicates were removed, Qlarant was able to identify 33,264 unique members. Of those members, 22,547 were further determined to have received services in inpatient, outpatient, and office visit settings after evaluating data completeness and appropriateness.[9]

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. The sample size was selected to ensure a 90% confidence interval with a 5% +/- error rate for sampling. The sample was divided between Inpatient (coded 21), Outpatient (coded 22), and Office Visit (coded 11) claims submitted 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.

Tables 15-17 illustrate MY 2019 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 2017 and MY 2018 results are included for purposes of comparison.

[9] Qlarant found 29 had no social security number, nine had an invalid value, and 103 members were in the claims data under two different member ID numbers.

Table 15. EDV Results by Element for Inpatient Encounter Type

Inpatient Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019
Match	79	90	111	16	46	26	41	39	42	136	175	179
No Match	18	4	3	0	0	0	5	1	0	23	5	3
Total Elements	97	94	114	16	46	26	46	40	42	159	180	182
Match %	**81%**	**96%**	**97%**	**100%**	**100%**	**100%**	**89%**	**98%**	**100%**	**86%**	**97%**	**98%**

Table 16. EDV Results by Element for Outpatient Encounter Type

Outpatient Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019
Match	142	146	154	134	145	255	134	152	225	410	443	634
No Match	15	3	2	0	0	0	1	0	2	16	3	4
Total Elements	157	149	156	134	145	255	135	152	227	426	446	638
Match %	**90%**	**98%**	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**99%**	**96%**	**99%**	**99%**

Table 17. EDV Results by Element for Office Visit Encounter Type

Office Visit Encounter	Diagnosis Codes			Procedure Codes			Total		
	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019	MY 2017	MY 2018	MY 2019
Match	398	448	476	275	251	334	673	699	810
No Match	18	23	16	1	1	5	19	24	21
Total Elements	416	471	492	276	252	339	692	723	831
Match %	**96%**	**95%**	**97%**	**99%**	**99%**	**99%**	**97%**	**97%**	**97%**

Reasons for determining a "no match" element include:

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

Conclusion

Qlarant found the MCO has the capability to produce accurate and complete encounter data. An analysis of 440,305 encounters submitted revealed 22,547 members obtained services for inpatient, outpatient, and office visit settings.

Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters to confirm the accuracy of codes. SHP achieved a match rate of 98%, meaning 98% of claims submitted were supported by medical record documentation. SHP achieved a high match rate for each encounter setting: 98% for inpatient, 99% for outpatient, and 97% for office visit.

CAHPS

Objectives

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.

Methodology

The Adult CAHPS survey is part of the CMS Adult Core Set of Measures that follows HEDIS protocols, a methodology that meets the requirements for CMS EQR Protocol 6 – Administration or Validation of Quality of Care Surveys. 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 2020 Volume 3: Specifications for Survey Measures*, and SHP's contracted survey vendor administered the 2020 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 March 24, 2020, the vendor distributed a total of 1,350 surveys (11 surveys were ineligible) and received 199 completed surveys (via mail, phone, and internet), providing a 14.09% 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 Coordination of Care Composite. Share Decision and Health Education and Promotion Composites were retired for 2020 CAHPS.

Results

Table 18 displays CAHPS Survey results for SHP.

Table 18. CAHPS Survey Results Compared to Benchmarks

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Getting Care Quickly Composite (Always + Usually)	87.34	78.94	NA	NC
Getting Needed Care Composite (Always + Usually)	86.88	80.46	89.60	♦♦♦♦
How Well Doctors Communicate Composite (Always + Usually)	94.82	92.28	96.50	♦♦♦♦
Customer Service Composite (Always + Usually)	NA	NA	NA	NC
Coordination of Care Composite (Always + Usually)	83.33	NA	NA	NC
Health Promotion and Education Composite* (Always + Usually)	73.01	61.59	NR	NC
Shared Decision Making Composite* (Always + Usually)	82.83	NA	NR	NC
Rating of All Health Care (8+9+10)	**73.66**	**75.61**	**81.00**	♦♦♦
Rating of Personal Doctor (8+9+10)	**85.58**	**85.71**	**90.30**	♦♦♦♦
Rating of Specialist Seen Most often (8+9+10)	82.01	NA	NA	NC
Rating of Health Plan (8+9+10)	75.17	74.38	80.30	♦♦
Flu vaccination: Had flu shot or spray in the nose since July 1, 2018	**41.75**	**38.93**	**38.60**	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (rolling 2 year average reported for 2018)	77.21	78.22	76.90	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (rolling 2 year average reported for 2018)	52.21	54.19	52.10	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (rolling 2 year average reported for 2018)	**52.77**	**52.23**	**48.10**	♦♦

^ Benchmark data source: Quality Compass 2019 (MY 2018 data) National Medicaid Average for HMOs. This is the most current benchmark source at the time of report production.
* These CAHPS measures have been removed for 2020 surveys.
NA Response rate of less than 100 observations; too small to calculate a reliable rate.
NC No comparison made due to no rate or/and benchmark available.
NR Not reported. Measure was retried.

SHP's rates for three measures met or exceeded the 90th Percentile:

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

Rating of All Health Care met or exceeded the 75th Percentile but did not meet the 90th Percentile.

Another three measures met or exceeded the National Medicaid Average but were below the 75th Percentile:

- Rating of Health Plan
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies

SHP's rates for Flu Vaccination and Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications did not meet the National Medicaid Average.

In comparing rates year-over-year, Rating of All Health Care and Rating of Personal Doctor improved each year between MY 2017 and MY 2019. Flu Vaccinations and Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies declined each year between MY 2017 and MY 2019.

Conclusion

Overall, SHP enrollees are satisfied with their health care. There are opportunities for improvement for Flu Vaccination and Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications.

MCO Quality, Access, Timeliness Assessment

Quality

Quality health care, as defined by the CMS EQR Protocol, is "the degree to which an MCO, PIHP, PAHP, or PCCM entity (described at 42 C.F.R. §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement."

Strengths

SHP successfully implemented and reported on two PIPs. For the Comprehensive Diabetes Care PIP, the MCO demonstrated improvement in two performance measures, both of which exceeded MCO goals. One of these performance measures showed sustained improvement over baseline performance for two consecutive years. SHP maintains a robust Diabetes Health Management Program where enrolled members receive diabetes focused educational materials, quarterly contact, and care coordination. In addition, Case Managers work directly with enrolled members who are deemed complex. For the Follow-Up for Mental Health PIP, SHP's Engagement of Alcohol or Other Drug (AOD) Treatment performance measure scored above baseline for the third year in a row.

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 all performance measures. When rates are compared to the NCQA Quality Compass benchmarks (Medicaid – HMOs), SHP exceeded the national average in most performance measures. The MCO exceeded the national Medicaid 90th Percentile for the following adult performance measures:

- Comprehensive Diabetes Care: HbA1c Control (<8%)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement of AOD Treatment – Opioid Abuse

SHP largely demonstrated compliance with the Medicaid managed care standards. Overall, SHP scored well on the 2019 requirements:

- Information Requirements: 96.43%
- Enrollee Rights Standard: 100%
- MCO, PIHP and PAHP Standards: 97.76%
- Quality Assessment and Performance Improvement Program: 100%
- Grievance and Appeal System: 87.72%
- 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 98%—meaning 98% of claims data submitted were supported by medical record documentation. This match rate is consistent with the MY 2018 match rate, also 98%.

Lastly, SHP measured MY 2019 member satisfaction via a CAHPS Survey. Compared to the NCQA Quality Compass benchmarks (Medicaid – HMOs), SHP scored above the national Medicaid average on most measures. SHP met or exceeded the national 90th Percentile the following measures:

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

Weaknesses and Recommendations

SHP should continue to refine 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, SHP should review its results and identify strategies to improve performance for the following measures that did not meet the National Medicaid Average or decline in performance year-over-year:

- Adherence to Antipsychotics for Individuals with Schizophrenia
- Asthma Medication Ratio: Ages 51-64
- Asthma Medication Ratio: Ages 19-64 (Total)
- Breast Cancer Screening
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: HbA1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Flu Vaccinations for Adults
- Follow-Up After Emergency Room Visit for Mental Illness: Follow-Up Within 7 days
- Follow-Up After Emergency Room Visit for Mental Illness: Follow-Up Within 30 days
- Follow-Up After Hospitalization for Mental Illness: Follow-Up Within 7 Days
- Follow-Up After Hospitalization for Mental Illness: Follow-Up Within 30 Days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation of AOD Treatment – Other Drug Abuse
- Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication
- Plan All-Cause Readmissions Rate: Total *Lower is better*
- PQI 01: Diabetes Short-Term Complications Admission Rate *Lower is better*
- Use of Opioids From Multiple Providers: Multiple Prescribers *Lower is better*

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.

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.

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 member, as needed. 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.

Weaknesses and 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: Cardiology and

Hematology and Oncology. SHP should continue to focus on providing transportation and telehealth services, as needed, to meet the needs of the population.

Further, the MCO should actively monitor and review any access-related complaints or grievances to quickly identify and resolve access-related issues.

Timeliness

The Institute of Medicine (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.

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. The MCO received a compliance rate of 93% for the NAV activity, indicating 93% of contracted providers have one or more methods to direct members on how to access after-hours care. The compliance rate shows SHP has an adequate provider network available to members 24 hours a day, 7 days a week, when medically necessary. 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.

Weaknesses and 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. 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 appeals and grievances are acknowledged in a timely manner. A sample file review revealed one grievance and four appeal occurrences of untimely resolution.

Assessment of Previous Recommendations

The following table identifies recommendations made in the previous Annual Technical Report (MY 2018) and the follow-up activities completed by SHP in 2019.

Table 19. 2019 Compliance with 2018 Recommendations

2019 Compliance with 2018 Recommendations	
2018 Recommendation	2019 Compliance Assessment
Explore opportunities to help close the gap in mental health care services.	**Continues to be an opportunity improvement.** There was no improvement in the MY 2019 Follow-Up for Mental Health PIP for any performance measure. SHP should develop additional interventions to help close the gap, such as utilizing telehealth and teletherapy services.
Adjust goals to ensure SHP is consistently facilitating quality improvement. Currently, SHP exceeds its goal for the HbA1c Control (<7%) for a Selected Population performance measure.	**Continues to be an opportunity improvement.** Although one goal was adjusted to meet this recommendation, SHP also exceeded its goal for the HbA1c Control (<8%) performance measure by nearly 4 percentage points.
Consider the use of supplemental data to improve performance measure rates.	**Compliant.** SHP uses qualified supplemental data for performance measures.
Review the performance measure and CAHPS survey results and focus on identifying and implementing strategies to improve performance particularly for measures that did not meet the national average benchmarks	**Continues to be an opportunity improvement.** SHP should continue to review performance measure results and develop strategies to improve rates that did not meet the national average benchmarks. For MY 2019, 17 measures performed below the national average benchmarks.
Review and act on specific recommendations found in the detailed CR Report in order to improve processes and obtain full compliance.	**Continues to be an opportunity for improvement.** While improvement has been made with following the Medicaid managed care standards, SHP still has opportunity for improvement and should follow recommendations outlined in the Compliance Review Report. Overall compliance for MY 2019 was 94.63%, a decrease from MY 2018 (96.05%).
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.	**Continues to be an opportunity for improvement.** SHP did not add a field to the encounter data to document date claim is received.
Attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities and Hematology and Oncology.	**Continues to be an opportunity for improvement.** Ensuring timely access to provider appointments continues to be a challenge for SHP.
Ensure that all grievances are acknowledged in a timely manner	**Continues to be an opportunity for improvement.** For MY 2019, out of the sample reviewed, one grievance was not resolved in a timely manner. Additionally, the appeals sample

2019 Compliance with 2018 Recommendations	
2018 Recommendation	2019 Compliance Assessment
	indicated that SHP did not resolve four appeals in a timely manner.

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 national average benchmarks.
- Consider removing retired HEDIS measures from the Quality Strategy including Adult BMI Assessment and Comprehensive Diabetes Care – Medical Attention to Nephropathy.
- 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.

Conclusion

SHP 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 a maturing program, 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.