North Dakota
Department of Human Services

North Dakota Medicaid Expansion Program

Annual Technical Review Report
Measurement Year (MY) 2018

Qlarant

Submitted by:
Qlarant
September 2019

Table of Contents

North Dakota Medicaid Expansion Program

2019 Annual Technical Report

Measurement Year 2018

Executive Summary

Introduction

Effective January 1, 2014, the North Dakota Department of Human Services (DHS) contracted with Sanford Health Plan (SHP) to provide services to the Medicaid Expansion population. In its oversight 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 2019 comprehensive assessment of SHP's measurement year (MY) 2018 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®[1]) Survey

This annual technical report describes MY 2018 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.

[1] CAHPS® 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 2018 PIP Reports included remeasurement results and described multifaceted interventions. Sustained improvement was demonstrated in the Follow-Up After Hospitalizations for Mental Health measures and SHP successfully reported year one remeasurement 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 2018. Procedures and documentation used to calculate performance measures with the certified HEDIS®[2] 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.

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 15 exceeding the 75th percentile and four surpassing the 90th percentile. Performance measure results are displayed in Tables 15 and 16 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 2018. 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 2018 requirements, SHP's results for each standard are displayed in Executive Summary (ES) Table 1.

ES Table 1. SHP Results for MY 2018 CR

Standards	Possible Points	Points Earned	Compliance Score
Information Requirements	28	27.5	98.21%
Enrollee Rights	9	9	100%
MCO Standards	67	65.5	97.76%
Quality Assessment and Performance Improvement Program	7	7	100%

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

Standards	Possible Points	Points Earned	Compliance Score
Grievance and Appeal System	57	52	91.23%
Program Integrity	9	9	100%
Total	**177**	**170**	**96.05%**

Encounter Data Validation

The Utilization Rate for SHP, measured by the number of members with at least one paid claim, was 72%. Out of a total of 33,595 unique members, 24,114 (72%) had at least one paid claim during MY 2018. For comparative purposes, this is a one percentage point increase compared to the 71% utilization rate for MY 2017. Overall, SHP has well documented data integration and claims processing procedures. During MY 2018, SHP achieved a total match rate of 98%—meaning 98% of claims data submitted was supported by medical record documentation. Outpatient records registered the highest match rate (99%) in MY 2018, followed by Inpatient (97%) and Office Visit (97%). The match rate will continue to be monitored.

CAHPS Survey

SHP contracted with a certified CAHPS vendor to conduct the 2019 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 5, 2019, 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 253 completed surveys for a 19.01% 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. One CAHPS measure exceeded the national 75th Percentile benchmark and one surpassed the 90th Percentile benchmarks. Results are displayed in Table 22 of the Annual Technical Report.

Conclusions

By the 2018 year end, 20,173 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.

Recommendations

MCO Recommendations

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- SHP should adjust PIP performance measure goals to ensure it is consistently facilitating quality improvement. Although one goal was adjusted to meet this recommendation, SHP also exceeds its goal for the HbA1c Control (<7%) for a Selected Population performance measure.
- 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 Human Services Centers to address this barrier and should continue discussions to improve availability and appointment access as well as to clarify services offered.
- The MCO should continue to explore other opportunities to help close the gap in mental health care services. SHP is planning to discuss telemental and teletherapy services with a task force that involves other health systems and health plans.
- Consider the use of supplemental data to improve performance measure rates.
- 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.
- Review and act on specific recommendations found in the detailed CR Report in order to improve processes. Minor revisions to policies and procedures should be made to ensure compliance with the Medicaid managed care standards.
- 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.
- SHP should attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities and Hematology and Oncology.
- Monitor and review any access and/or timeliness-related complaints or grievances to quickly identify and resolve access-related issues should they arise.
- 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.
- SHP should ensure that all grievances are acknowledged 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.
- 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.

North Dakota Medicaid Expansion Program

2019 Annual Technical Report

Measurement Year 2018

Introduction and Overview

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

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

The comprehensive assessment, conducted in 2019, assessed SHP's measurement year (MY) 2018 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 2018; 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 2019 EQR activities with DHS and SHP in October 2018. Actual review and auditing activities began in March 2019 and concluded in July 2019. 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.

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

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. 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

Qlarant's review team conducts CRs in accordance with the CMS EQR protocol, *Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review, Protocol 1, Version 2.0, September 2012*. The review team's systematic approach to completing the review includes three phases of activities: pre-site review, on-site review, and post-site review. These activities were completed for SHP and 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, polices, and procedures) to Qlarant's secure web-based portal approximately 30 days prior to the on-site assessment. After this information is posted, auditors begin the document review.
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. Table 4 provides an example of the standard, element, and component structure.

Table 4. Example of Standard, Element, and Component Structure

Standard	Enrollee Rights
Element 1	General rule. Each MCO 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:
Component 1.a	Receive information in accordance with §438.10.
Component 1.b	Be treated with respect and with due consideration for his or her dignity and privacy.

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 5 for scoring compliance.

Table 5. 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 6 describes the confidence levels.

Table 6. 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%

The 2019 CR, which assessed MY 2018 compliance, was a comprehensive review that assessed *all* areas and standard requirements.

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 7.

Table 7. 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 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 2019 Volume 3: Specifications for Survey Measures*, and SHP's contracted survey vendor administered the 2019 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 5, 2019, the vendor mailed 1,350 surveys and received 253 completed surveys (via mail and phone), providing a 19.01% 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*.

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 2018 serves as remeasurement year 4 for the mental health PIP and remeasurement year 1 for the diabetes care PIP. Validation results of the project submissions are below in Tables 8 (Comprehensive Diabetes Care PIP) and Table 10 (Follow-Up for Mental Health PIP). Respective performance measure results are displayed in Tables 9 and 11.

Comprehensive Diabetes Care PIP Results

Validation assessment results for the Comprehensive Diabetes Care PIP are identified in Table 8.

Table 8. 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 9.

Table 9. Comprehensive Diabetes Care PIP Performance Measure Results

PIP Performance Measure Results	
Hemoglobin A1c (HbA1c) Testing	
MY 2017 (Baseline)	92.62%
MY 2018 (Remeasurement 1)	92.57%
HbA1c Poor Control (>9%) (lower rate is better)	
MY 2017 (Baseline)	30.58%
MY 2018 (Remeasurement 1)	32.12%
HbA1c Control (<8%)	
MY 2017 (Baseline)	55.01%
MY 2018 (Remeasurement 1)	55.96%
HbA1c Control (<7%) for a Selected Population	
MY 2017 (Baseline)	39.66%
MY 2018 (Remeasurement 1)	41.61%
Eye Exam (Retinal) Performed	
MY 2017 (Baseline)	50.09%
MY 2018 (Remeasurement 1)	51.12%
Medical Attention for Nephropathy	
MY 2017 (Baseline)	91.21%
MY 2018 (Remeasurement 1)	93.61%

PIP Performance Measure Results	
Blood Pressure Control (< 140/90 mm Hg)	
MY 2017 (Baseline)	77.86%
MY 2018 (Remeasurement 1)	76.86%

Interventions

SHP implemented the following interventions in 2018:

- **Diabetes Health 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, resources, etc.
- **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 completed a thorough analysis of seven performance measures relating to comprehensive diabetes care.
- SHP demonstrated improvement in four performance measures as compared to baseline rates, two of which exceeded MCO goals.
- SHP adjusted the goal for the Medical Attention for Nephropathy performance measure by two percentage points (94%) for MY 2019 due to the MCO's achieved rate for MY 2018 (93.61%) exceeding the set goal (92%).
- SHP 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.
- SHP should adjust goals to ensure it is consistently facilitating quality improvement. Although one goal was adjusted to meet this recommendation, SHP also exceeds its goal for the HbA1c Control (<7%) for a Selected Population performance measure.
- In order to receive full compliance for Step 9, Real Improvement, SHP must demonstrate statistically significant improvement in at least one performance measure.

Follow-Up for Mental Health PIP Results

Validation assessment results for the Follow-Up for Mental Health PIP are identified in Table 10.

Table 10. 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			

PIP Validation Assessment				
	Met	Partially Met	Not Met	Not Applicable
Step 10. Sustained Improvement	X			

Performance measure results for the Follow-Up for Mental Health PIP are identified in Table 11.

Table 11. 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%
MY 2018 (Remeasurement 4)	28.09%
Follow-Up After Hospitalizations for Mental Health—Within 30 Days	
MY 2014 (Baseline)	38.84%
MY 2015 (Remeasurement 1)	49.62%
MY 2016 (Remeasurement 2)	46.82%
MY 2017 (Remeasurement 3)	51.85%
MY 2018 (Remeasurement 4)	50.85%
Screening for Clinical Depression and Follow-Up Plan	
MY 2014 (Baseline)	11.78%
MY 2015 (Remeasurement 1)	14.69%
MY 2016 (Remeasurement 2)	Not Applicable (Discontinued for MY 2016)
Engagement of Alcohol or Other Drug (AOD) Treatment	
MY 2016 (Baseline)	17.32%
MY 2017 (Remeasurement 1)	18.03%
MY 2018 (Remeasurement 2)	20.82%

Interventions

SHP continued or implemented the following interventions for 2018:

- 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 AOD treatment and ensuring the most appropriate setting.
- Collaboration between Population Health and Patient Centered Medical Home Committee and health systems to help improve patient outcomes and quality of care.

Strengths

- SHP demonstrated improvement in one performance measure: Engagement of Alcohol and Other Drug (AOD) Treatment. The reported annual improvement in this performance measure was statistically significant.
- The Engagement of AOD Treatment performance measure exceed the MCO's goal (20%), so SHP has increased the goal to 25% for MY 2019.
- All performance measures demonstrated sustained improvement, as they all continue to exceed baseline rates.
- SHP's Remeasurement 4 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 Recommendations

- 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 Human Services Centers to address this barrier and should continue discussions to improve availability and appointment access as well as to clarify services offered.
- The MCO should continue to explore other opportunities to help close the gap in mental health care services. SHP is planning to discuss telemental and teletherapy 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 providing insights into the MCO's information system (IS) and processes used to produce the required CMS Adult and Child Core Quality Measures. Based on MCO's ISCA, SHP had satisfactory processes for data integration, data control, and interpretation of the performance measure specifications for MY 2018. 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, provider systems 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 12 below.

Table 12. 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%

SHP validation findings are summarized in Table 13. The Documentation, Denominator, Numerator, and Sampling components were determined to be Met. SHP's rates for all performance measures from the North Dakota Medicaid Expansion Quality Strategy Plan received the audit designation of Reportable (R).

Table 13. PMV Audit Designation 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.	Met
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 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.	Met

Validation Component	Audit Element	SHP
Numerator	The 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 followed the measure specifications for calculation of the numerator.	Met
Sampling	The sample size and replacement methodology met specifications and the sample is unbiased.	Met
Reporting Designation: R The reporting designation includes an assessment of whether the MCO followed the State's requirements for reporting the measures' rates and followed specifications for the measure. The State requires the MCOs to report the denominator, specific numerator events, and calculated final rates.		

Performance Measure Results

SHP MY 2018 results for the CMS Adult and Child Core Quality Measures are respectively displayed in Tables 15 and 16. Performance measure results are compared to benchmarks largely based on the NCQA Quality Compass 2018 National Medicaid for HMOs. Comparisons are made using a diamond rating system. The following table describes the rating system:

Table 14. Diamond Rating System Used to Compare SHP Performance to Benchmarks

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

The more diamonds 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 2016-MY 2018).

Table 15. Adult Performance Measure Results Compared to Benchmarks

Measure	SHP MY 2016 Rate	SHP MY 2017 Rate	SHP MY 2018 Rate	MY 2018 Comparison To Benchmarks^
Adherence to Antipsychotics for Individuals with Schizophrenia	62.12%	60.22%	61.36%	♦♦
Adult Body Mass Index Assessment	94.56%	93.40%	93.33%	♦♦♦
Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	84.44%	85.43%	87.81%	♦
Annual Monitoring for Patients on Persistent Medications: Diuretics	85.04%	87.16%	89.01%	♦♦
Annual Monitoring for Patients on Persistent Medications: Total Rate	84.42%	86.11%	88.29%	♦♦
Antidepressant Medication Management: Effective Acute Phase Treatment	61.38%	62.55%	64.33%	♦♦♦
Antidepressant Medication Management: Effective Continuation Phase Treatment	48.17%	47.20%	48.17%	♦♦♦
Breast Cancer Screening	50.44%	50.35%	54.97%	♦
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NBM
Cervical Cancer Screening	31.84%	42.61%	43.60%	♦
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	38.99%	37.50%	40.52%	♦
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg	80.35%	77.86%	76.86%	♦♦♦
Comprehensive Diabetes Care: Eye Exam	48.14%	50.09%	51.12%	♦
Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population	42.82%	39.66%	41.61%	♦♦♦
Comprehensive Diabetes Care: HbA1c Control (<8%)	57.52%	55.01%	55.96%	♦♦♦
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) *Lower is Better*	31.68%	30.58%	32.12%	♦♦♦
Comprehensive Diabetes Care: HbA1c Testing	91.15%	92.62%	92.57%	♦♦♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy	93.27%	91.21%	93.61%	♦♦♦♦
Controlling High Blood Pressure	72.78%	73.43%	68.37%	♦♦♦

Measure	SHP MY 2016 Rate	SHP MY 2017 Rate	SHP MY 2018 Rate	MY 2018 Comparison To Benchmarks^
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	NBM
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	79.15%	81.51%	85.30%	♦♦♦
Flu Vaccinations for Adults, Ages 18-64	37.67%	41.75%	38.93%	♦
Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 7 Days	24.91%	34.17%	28.11%	♦
Follow-Up After Hospitalization for Mental Illness, Ages 21-64: Follow-Up Within 30 Days	47.06%	53.61%	51.62%	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Alcohol Abuse	NR	NR[1]	42.80%	♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Alcohol Abuse	NR	NR	17.98%	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Opioid Abuse	NR	NR	61.35%	♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment-Opioid Abuse	NR	NR	41.43%	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Other Drug Abuse	NR	NR	43.08%	♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Other Drug Abuse	NR	NR	24.33%	♦♦♦♦

Measure	SHP MY 2016 Rate	SHP MY 2017 Rate	SHP MY 2018 Rate	MY 2018 Comparison To Benchmarks^
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment- Total	40.01%	40.83%	43.99%	♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment- Total	17.38%	18.03%	20.82%	♦♦♦
Medical Assistance With Smoking and Tobacco Use Cessation: Advised to Quit Smoking (2 year rolling average)	73.29%	77.21%	78.22%	♦♦
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication (2 year rolling average)	48.42%	52.21%	54.19%	♦♦
Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (2 year rolling average)	48.63%	52.77%	52.23%	♦♦♦
Plan All-Cause Readmissions Rate: Ages 18-44 *Lower is Better*	18.46%	21.73%	19.58%	NBM
Plan All-Cause Readmissions Rate: Ages 45-54 *Lower is Better*	17.25%	19.44%	21.23%	NBM
Plan All-Cause Readmissions Rate: Ages 55-64 *Lower is Better*	13.83%	13.14%	17.33%	NBM
Plan All-Cause Readmissions Rate: Total *Lower is Better*	16.92%	18.83%	19.48%	NBM
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*	39.31	45.07	40.85	♦
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*	46.59	45.26	28.97	♦♦♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate (denominator is total	18.26	23.91	29.07	♦

Measure	SHP MY 2016 Rate	SHP MY 2017 Rate	SHP MY 2018 Rate	MY 2018 Comparison To Benchmarks^
member months x100,00 for ages 18-64 and 65+, Rate is numerator events/100,000 member months) *Lower is Better*				
PQI 15: Asthma Admission Rate in Younger Adults (denominator is total member months x100,00 for ages 18-39, Rate is numerator events/100,000 member months) *Lower is Better*	8.99	8.29	3.47	♦♦♦
Use of Opioids at High Dosage (rate is calculated per 1000 members), Ages 18 and older *Lower is Better*	NR	NR	2.79%	NBM
Use of Opioids From Multiple Providers (rate is calculated per 1000 members), Ages 18 and older: Multiple Prescribers *Lower is Better*	NR	NR	24.95%	NBM
Use of Opioids From Multiple Providers (rate is calculated per 1000 members), Ages 18 and older: Multiple Pharmacies *Lower is Better*	NR	NR	4.75%	NBM
Use of Opioids From Multiple Providers (rate is calculated per 1000 members), Ages 18 and older: Multiple Prescribers and Pharmacies *Lower is Better*	NR	NR	4.10%	NBM

^ Benchmark data source: *Quality Compass 2018 (Measurement Year 2017 data) National Medicaid Average for HMOs*. This is the most current benchmark source at the time of report production.
* Benchmark data source: *Quality of Care for Adults in Medicaid: Findings from the 2017 Adult Core Set Chart, December2018*, 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.
NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR Not Reported.
NBM No Benchmark available/ no comparison made due to no rate or/and benchmark available, NA, or NC.
Green Positive trend for three consecutive measurement years.
Red Negative trend for three consecutive measurement years.

Table 16. Child Performance Measure Results Compared to Benchmarks

Measure	SHP MY 2016 Rate	SHP MY 2017 Rate	SHP MY 2018 Rate	MY 2018 Comparison To Benchmarks^
Adolescent Well Care Visits	9.76%	14.70%	NC	NBM
Follow-Up After Hospitalization for Mental Illness, Ages 19-20: Follow-Up Within 7 Days	NA	15.63%	27.91%	♦

Measure	SHP MY 2016 Rate	SHP MY 2017 Rate	SHP MY 2018 Rate	MY 2018 Comparison To Benchmarks^
Follow-Up After Hospitalization for Mental Illness, Ages 19-20: Follow-Up Within 30 Days	NA	34.38%	44.19%	♦
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	NA	NA	NA	NBM
Medication Management for People With Asthma, Ages 19-20: 75% Compliance	NA	NA	NA	NBM

Please be aware that the rates captured in this table are for ages 19-20, and these benchmarks are capturing a wider age range; therefore, caution is advised when using the rate and benchmarks to gauge performance.
^ Benchmark data source: *Quality Compass 2018 (Measurement Year 2017 data) National Medicaid Average for HMOs*. This is the most current benchmark source at the time of report production.
* Benchmark data source: *Quality of Care for Children in Medicaid and CHIP: Findings for the 2017 Child Core Set Chart Pack*, December 2018, 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.
NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC Not Collected.
NBM No Benchmark available/ no comparison made due to no rate or/and benchmark available, NA, or NC.

MY 2018 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:
  - Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
  - Comprehensive Diabetes Care: Eye Exam
  - Flu Vaccinations for Adults, Ages 18-64
  - 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
  - PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 18-64 and 65 plus

- 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

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

- Adult Performance Measures:
  - Adherence to Antipsychotics for Individuals with Schizophrenia
  - Annual Monitoring for Patients on Persistent Medications: Diuretics
  - Annual Monitoring for Patients on Persistent Medications: Total Rate
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Alcohol Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Other Drug Abuse
  - 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

- Child Performance Measures:
  - SHP did not have any child measures that met criteria for this category.

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:
  - 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 Control (<7%) for a Selected Population
  - Comprehensive Diabetes Care: HbA1c Control (<8%)
  - Comprehensive Diabetes Care: HbA1c Poor Control (>9%)
  - Comprehensive Diabetes Care: HbA1c Testing
  - 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, Ages 18-64: Initiation of AOD Treatment – Opioid Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Total
  - Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
  - PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64
  - PQI 15: Asthma Admission Rate in Younger Adults, Ages 18-39

- Child Performance Measures:
  - SHP did not have any child measures that met criteria for this category.

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

- Adult Performance Measures:
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Alcohol Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment- Opioid Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Other Drug Abuse

- Child Performance Measures:
  - SHP did not have any child measures that met criteria for this category.

A trend analysis was conducted on measures where data was available for all three years between MY 2016 and MY 2018. 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 2016 and MY 2018:

- Adult Body Mass Index Assessment
- Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg
- Plan All-Cause Readmissions Rate: Ages 45-54
- Plan All-Cause Readmissions Rate: Total
- PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 18-64 and 65 plus

SHP's performance improved each year between MY 2016 and MY 2018 indicating a positive trend for the following measures:

- 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
- Antidepressant Medication Management: Effective Acute Phase Treatment
- Cervical Cancer Screening
- Comprehensive Diabetes Care: Eye Exam
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Initiation of AOD Treatment – Total

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement 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 Medication
- PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, Ages 40-64
- PQI 15: Asthma Admission Rate in Younger Adults, Ages 18-39

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

- Adult Performance Measures:
  - Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
  - Diabetes Monitoring for People With Diabetes and Schizophrenia

- Child Performance Measures:
  - Medication Management for People With Asthma, Ages 19-20: Percentage of Children Who Remained on an Asthma Controller Medication for At Least 50% of Their Treatment Period
  - Medication Management for People With Asthma, Ages 19-20: 75% Compliance

Measures with reported rates were found to be compliant with corresponding performance measure specifications and received "reportable" audit designations. The full Performance Measure Results Report is included in Appendix III.

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 90th Percentile for four adult performance measures:
  - Comprehensive Diabetes Care: Medical Attention for Nephropathy
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Alcohol Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment- Opioid Abuse
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Other Drug Abuse
- The MCO demonstrated three years of consistent improvement between MY 2016 and MY 2018 for 13 measures.

MCO Recommendations

- Consider the use of supplemental data to improve performance measure rates.
- Review the performance measure results and focus on identifying and implementing strategies to improve performance particularly for measures that did not meet the 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 national average benchmarks.

Compliance Review

Results

The CR assessed SHP's 2018 compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion population. Qlarant reviewed all 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

SHP's results for each standard are displayed in Table 17. A detailed assessment including results of all elements and components are included with the narrative that follows. Specific recommendations on how to meet requirements are also included for any element or component that did not achieve full compliance for the MY 2018 CR.

Table 17. SHP Results for MY 2018 CR

Standards	Possible Points	Points Earned	Compliance Score
Information Requirements	28	27.5	98.21%
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	52	91.23%
Program Integrity	9	9	100%
Total	**177**	**170**	**96.05%**

Table 18 displays SHP's results for the last three years (MY 2016-MY 2018).

Table 18. SHP Results for MYs 2016-2018

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

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

Strengths

- SHP was fully compliant with almost all requirements. The MCO achieved an outstanding score of 96.05%.
- Improvement was demonstrated in the MCO Standards and the Grievance and Appeal System.
- SHP maintained 100% compliance in Enrollee Rights, Quality Assessment and Performance Improvement Program, and Program Integrity.
- SHP was cooperative and open to feedback from Qlarant reviewers during the on-site audit.

Opportunities for Improvement

- Opportunities exist in the following CR standards: Information Requirements, MCO Standards, and Grievance and Appeal System. Examples include:
    - Revise the hard copy Provider Directory to include: website URL, whether the provider has completed cultural competence training, and whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam rooms, and equipment. The electronic version of the Provider Directory needs to include: website URL (provider offices), whether the provider has completed cultural competence training, and whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam rooms, and equipment.
    - Demonstrate improvement in provider access and timeliness survey results. A 90% compliance rating is recommended.
    - Achieve at least 85% compliance in meeting the 50 mile standard for geographic distribution of each provider group. Attempt to close the provider geographic access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities and Hematology and Oncology. Continue to focus on providing transportation services, as needed, to meet the needs of the population.
    - Remove or clarify the statement within the "Independent, External Review of Final Adverse Determinations (Denials)" section of the Medical Management Program Policy and Procedure that states that North Dakota Medicaid Expansion Members do not have the right to an external review for expedited authorization decisions.
    - Revise all appeals related documentation to specify that oral appeals must be followed by written, signed appeals, as required per the federal regulation.

- Ensure that all grievances and appeals are acknowledged within a timely manner.
- Indicate in policy language that the MCO ensures individuals who make decisions on grievances and appeals are individuals who, if deciding a grievance regarding denial of expedited resolution of an appeal, have the appropriate clinical expertise in treating the enrollee's condition or disease.
- Revise materials and indicate that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution, as required per federal regulation.
- Ensure that all grievances are resolved within the 90 day timeframe.
- Consistently communicate that members have 120 calendar days from the date of the MCO's notice of appeal resolution to file a State fair hearing.
- Update the Provider Manual with information on the fair hearing process.

MCO Recommendations

- SHP should review the detailed CR Report for all specific recommendations that will enhance compliance. Revise policies and procedures accordingly.

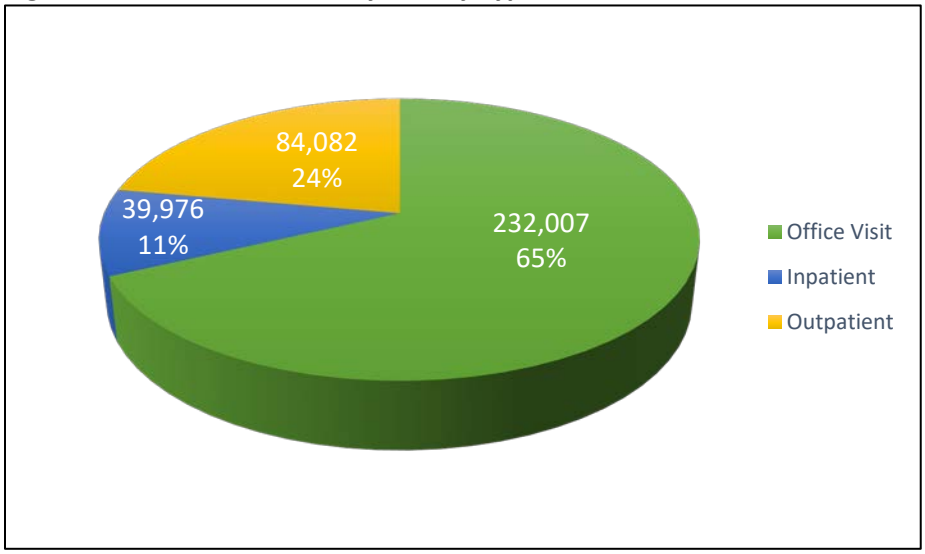
Encounter Data Validation

Claims Volume

The utilization rate for SHP, measured by the number of unique members with at least one paid claim, was 72%. Out of 33,595 unique members, 24,114 (72%) had at least one paid claim during MY 2018. For comparative purposes, this is a one percentage point increase compared to the 71% utilization rate for MY 2017.

Qlarant analysts further evaluated SHP's submitted 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 Office Visit setting (65%), and followed by Outpatient setting (24%). Only 11% 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 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 99.69% 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. 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 19-21 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 2016, 2017, and 2018 results are included for purposes of comparison.

Table 19. EDV Results by Element for Inpatient Encounter Type

Inpatient Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018
Match %	91%	81%	96%	100%	100%	100%	100%	89%	98%	96%	86%	97%

Table 20. EDV Results by Element for Outpatient Encounter Type

Outpatient Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018
Match %	94%	90%	98%	99%	100%	100%	98%	99%	100%	97%	96%	99%

Table 21. EDV Results by Element for Office Visit Encounter Type

Office Visit Encounter	Diagnosis Codes			Revenue Codes			Procedure Codes			Total		
	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018	MY 2016	MY 2017	MY 2018
Match %	84%	96%	95%	NA	NA	NA	97%	99%	99%	89%	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

Strengths

- SHP has well documented data integration and claims processing procedures.
- At 80%, SHP’s auto-adjudication rate is relatively high.

- During MY 2018, SHP achieved a total match rate of 98%—meaning 98% of claims data submitted were supported by medical record documentation. This is an increase of three percentage points from MY 2017 (95%).
- Outpatient records registered the highest match rate (99%) in MY 2018, followed by Inpatient (97%) and Office Visit (97%). Inpatient matched rate registered an 11 percentage point increase from MY 2017 (86%).

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 2019 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 5, 2019, 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 253 surveys were completed via mail, internet, or phone with a response rate of 19.01%. 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 2018 benchmarks to gauge performance and identify opportunities for improvement. Results are displayed in Table 22.

Table 22. CAHPS Survey Results Compared to Benchmarks

Measure	SHP 2017 Rate	SHP 2018 Rate	SHP 2019 Rate	SHP 2019 Rate Compared to Benchmarks^
Coordination of Care Composite	85.40%	83.33%	NA	NC
Customer Service Composite	NA	NA	NA	NC
Flu vaccination: Had flu shot or spray in the nose since July 1, 2018	37.67%	41.75%	38.93%	♦
Getting Care Quickly Composite	83.94%	87.34%	78.94%	♦
Getting Needed Care Composite	83.02%	86.88%	80.46%	♦
Health Promotion and Education Composite	73.38%	73.01%	61.59%	♦
How Well Doctors Communicate Composite	92.79%	94.82%	92.28%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (rolling 2 year average reported for 2018)	73.29%	77.21%	78.22%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (rolling 2 year average reported for 2018)	48.45%	52.21%	54.19%	♦♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (rolling 2 year average reported for 2018)	48.63%	52.77%	52.23%	♦♦♦
Rating of All Health Care (8+9+10)	72.50%	73.66%	75.61%	♦♦
Rating of Health Plan (8+9+10)	75.14%	75.17%	74.38%	♦
Rating of Personal Doctor (8+9+10)	85.82%	85.58%	85.71%	♦♦♦♦
Rating of Specialist Seen Most often (8+9+10)	79.10%	82.01%	NA	NC
Shared Decision Making Composite	82.87%	82.83%	NA	NC

^ Benchmark data source: Quality Compass 2018 (MY 2017 data). 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.
NC No comparison made due to no rate or/and benchmark available.
Green Positive trend for three consecutive measurement years.
Red Negative trend for three consecutive measurement years.

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

- Flu vaccination: Had flu shot or spray in the nose since July 1, 2018

- Getting Care Quickly Composite
- Getting Needed Care Composite
- Health Promotion and Education Composite
- Rating of Health Plan (8+9+10)

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

- How Well Doctors Communicate Composite
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit
- Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
- Rating of All Health Care (8+9+10)

SHP met or exceeded the national Medicaid 75th Percentile but was below the national Medicaid 90th Percentile for Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies measure and met or exceeded the national 90th Percentile for Rating of Personal Doctor (8+9+10) measure.

A trend analysis was conducted and the following conclusions were made after reviewing three consecutive years of performance (MY 2016-MY 2018):

- Performance for most measures was mixed year over year.
- A decline in performance year over year was identified in one measure, Health Promotion and Education Composite.
- A positive trend (improvement year over year) was identified in the following measures:
    - Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit
    - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
    - Rating of All Health Care (8+9+10)

Strengths

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

- SHP also showed improved performance between MY 2016 and MY 2018 for the following measures:
    - Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit
    - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications
    - Rating of All Health Care (8+9+10)

MCO Recommendations

- SHP is encouraged to identify barriers and explore strategies to improve the CAHPS measures that performed below the national Medicaid average:
  - Flu vaccination: Had flu shot or spray in the nose since July 1, 2018
  - Getting Care Quickly Composite
  - Getting Needed Care Composite
  - Health Promotion and Education Composite
  - Rating of Health Plan (8+9+10)

Compliance with Previous Annual Recommendations for Improvement

The following table identifies recommendations made in the previous Annual Technical Report (MY 2017) and the follow-up activities completed by SHP in 2018.

Table 23. 2018 Compliance with 2017 Recommendations

2018 Compliance with 2017 Recommendations	
2017 Recommendation	2018 Compliance Assessment
Continue to target members with diabetes using interventions aimed to improve member self-management.	**Compliant.** SHP implemented several interventions: Diabetes Health Management Program, sending letters to noncompliant members, and eye exam mailings.
Explore value based contracting, which will likely have a positive impact on diabetic member outcomes.	**Compliant.** SHP is having discussions with healthy systems on value based contracting which includes a focus on diabetes care performance.
Adjust goals to ensure SHP is consistently facilitating quality improvement. Currently, SHP exceeds its goal for the HbA1c Poor Control (>9%) performance measure.	**Continues to be an opportunity improvement.** Although one goal was adjusted to meet this recommendation, SHP also exceeds its goal for the HbA1c Control (<7%) for a Selected Population performance measure.
Consider the use of supplemental data for both HEDIS and non-HEDIS measures to improve performance measure rates.	**Compliant.** SHP uses sources of data allowable by measure specifications.
Review the performance measures 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.	**Continues to be an opportunity for 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 2018, 12 measures performed below the national average benchmarks.

2018 Compliance with 2017 Recommendations	
2017 Recommendation	2018 Compliance Assessment
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 2018 was 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.
Identify barriers and explore strategies to improve the three CAHPS measures that performed below the national Medicaid average: o Health Promotion and Education Composite o Rating of Health Plan o Rating of All Health Care	**Continues to be an opportunity for improvement.** The results for Rating of All Health Care exceeded the national average. However Health Promotion and Education Composite and Rating of Health Plan results were below the national averages. SHP should continue to research barriers and develop strategies to improve performance for the two CAHPS measures.
Attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities, Cardiology, and Hematology and Oncology.	**Continues to be an opportunity for improvement.** Ensuring timely access to provider appointments continues to be a challenge for SHP.

Quality of, Access to, and Timeliness of Healthcare Services

Quality

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

Quality Strengths

SHP successfully developed and reported on two PIPs. For the Comprehensive Diabetes Care PIP, the MCO demonstrated improvement in four performance measures, two of which exceeded MCO goals. 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. For the Follow-Up After Hospitalization for Mental Health PIP, SHP exceeded its goal and reported statistically significant improvement in the Engagement of Alcohol and Other Drug (AOD) Treatment performance measure. The MCO sustained improvement in all performance 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 2017 National Medicaid Average for All Lines of Business, 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: Medical Attention for Nephropathy
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Alcohol Abuse
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment- Opioid Abuse
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Ages 18-64: Engagement of AOD Treatment – Other Drug Abuse

SHP largely demonstrated compliance with the Medicaid managed care standards. Overall, SHP scored well on the 2018 requirements:

- Information Requirements: 98.21%
- Enrollee Rights Standard: 100%
- MCO, PIHP and PAHP Standards: 97.76%
- Quality Assessment and Performance Improvement Program: 100%
- Grievance and Appeal System: 91.23%
- 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 is an increase of three percentage points from MY 2017 (95%).

Lastly, SHP measured MY 2018 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 on most measures. SHP met or exceeded the national 90th Percentile in the Rating of Personal Doctor (8+9+10) measure.

Quality 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, 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:
  - Annual Monitoring for Patients on Persistent Medications: Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24
  - Comprehensive Diabetes Care: Eye Exam
  - Flu Vaccinations for Adults, Ages 18-64
  - 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
  - PQI 08: Congestive Heart Failure (CHF) Admission Rate, Ages 18-64 and 65 plus

- 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

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:

- Flu vaccination: Had flu shot or spray in the nose since July 1, 2018
- Getting Care Quickly Composite
- Getting Needed Care Composite
- Health Promotion and Education Composite
- Rating of Health Plan (8+9+10)

Access

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

Access Strengths

Numerous elements within the CR assessed access to vital member information, 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.

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 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.

Based on survey results, SHP's rate scored below the Quality Compass National Average benchmark for the CAHPS composite Getting Needed Care. Due to the response rate was less than 100 observations, Coordination of Care composite's rate was considered non-applicable (NA).

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.

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. 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 one occurrence of untimely resolution.

CAHPS Survey results revealed SHP's Getting Care Quickly composite rate registered below the Quality Compass National Average benchmark.

Conclusions

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.

Recommendations

MCO Recommendations

- Continue to work collaboratively with the State and the EQRO and work to meet all requirements.
- SHP should adjust PIP performance measure goals to ensure it is consistently facilitating quality improvement. Although one goal was adjusted to meet this recommendation, SHP also exceeds its goal for the HbA1c Control (<7%) for a Selected Population performance measure.
- 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 Human Services Centers to address this barrier and should continue discussions to improve availability and appointment access as well as to clarify services offered.
- The MCO should continue to explore other opportunities to help close the gap in mental health care services. SHP is planning to discuss telemental and teletherapy services with a task force that involves other health systems and health plans.
- Consider the use of supplemental data to improve performance measure rates.
- 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.

- Review and act on specific recommendations found in the detailed CR Report in order to improve processes. Minor revisions to policies and procedures should be made to ensure compliance with the Medicaid managed care standards.
- 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.
- SHP should attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities and Hematology and Oncology.
- Monitor and review any access and/or timeliness-related complaints or grievances to quickly identify and resolve access-related issues should they arise.
- 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.
- SHP should ensure that all grievances are acknowledged 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.
- 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.