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External Quality Review Annual Technical Report

Review Period: January 1–December 31, 2025

North Dakota Department of Health and Human Services
Medical Services Division

Final
April 2026

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Per *Title 42 CFR § 438.364(a)(7)*, no managed care organization was exempt from the external quality review activities conducted in 2025.

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I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality of, timeliness of, and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to conduct this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare & Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO, PIHP,[1] PAHP,[2] or PCCM[3] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to healthcare services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding healthcare quality, timeliness, and access, as well as make recommendations for improvement. The annual technical report (ATR) must be submitted to CMS by April 30th of each year. In order to meet this timeline, the report generation began in September 2025 with a discussion between IPRO and the North Dakota (ND) Department of Health and Human Services (HHS) regarding the format of the report. Between the months of October and December 2025, IPRO gathered all the necessary information to produce the ATR. Any missing information was obtained as available and incorporated into the draft ATR, which was prepared from November 2025 through mid-February 2026. IPRO technical writers reviewed the draft ATR before submitting to HHS on March 11, 2026. HHS provided comments on the draft ATR on March 26, 2026. IPRO and HHS worked together to complete a final version of the ATR by April 23, 2026, for submission to CMS.

To comply with *Title 42 CFR § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, HHS contracted with IPRO, an EQRO, to conduct EQR activities for Blue Cross Blue Shield of North Dakota (BCBSND), the sole organization contracted to furnish Medicaid services to the Medicaid Expansion population in the state. Medicaid Expansion is available to individuals between 21−64 years of age with household incomes up to 138% of the federal poverty level (FPL). Through *House Bill 1012*, the 2021 ND Legislative Assembly directed DHS to continue ND Medicaid Expansion as implemented through a private carrier except for services to those individuals ages 19 and 20 years as of January 1, 2022, who receive Medicaid State Plan benefits through the fee-for-service (FFS) delivery system as administered and managed through the department. As of December 2025, the Medicaid Expansion program covers 22,874 members. This report presents MCO-level results of EQR activities for BCBSND conducted during the 2025 calendar year (CY) based on measurement year (MY) 2024 data.

[1] prepaid inpatient health plan.
[2] prepaid ambulatory health plan.
[3] primary care case management.

Scope of External Quality Review Activities Conducted

This EQR ATR focuses on the four federally required and two optional EQR activities that were conducted. IPRO utilized the *CMS External Quality Review (EQR) Protocols* published in February 2023 for this report. As set forth in *Title 42 CFR § 438.358 Activities related to external quality review(b)(1)*, these activities are:

(i) **CMS Required Protocol 1: Validation of Performance Improvement Projects** – This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services. This activity was conducted between January 2025 and February 2026.

(ii) **CMS Required Protocol 2: Validation of Performance Measures** – This activity assesses the accuracy of performance measures (PMs) reported by the MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements. This activity was conducted between June and December 2025.

(iii) **CMS Required Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations** – This activity determines MCO compliance with their contract and with state and federal regulations. This activity was conducted in 2023 and will be performed in 2026.

(iv) **CMS Required Protocol 4: Validation of Network Adequacy** – This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to their Medicaid population. This activity was conducted between August 2025 and January 2026.

(v) **CMS Optional Protocol 5: Validation of Encounter Data** – This activity is used to assess the completeness and accuracy of encounter data submitted by healthcare providers to the MCO. This activity was conducted between April 2025 and January 2026.

(vi) **CMS Optional Protocol 6: Administration or Validation of Quality-of-care Surveys** – This activity uses a member survey to measure satisfaction with care received, providers, and health plan operations. During the review period, a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) satisfaction survey was conducted by BCBS for adult members. This activity was conducted between July and December 2025.

(vii) **CMS Optional Protocol 10: Assist with the Quality Rating of Medicaid MCOs** – This activity summarizes MCO performance in a manner that allows beneficiaries to easily make comparisons and to identify strengths and weaknesses in high-priority areas. (CMS has not published an official protocol for this activity.) This activity was conducted between July and December 2025.

CMS defines "validation" in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis." **Figure 1** shows the timeline for each protocol from beginning to report finalization.

The results of these EQR activities are presented in individual activity sections of this report. Each of the activity sections includes information on:

- data collection and analysis methodologies;
- comparative findings where available; and
- BCBSND's performance strengths and opportunities for improvement.

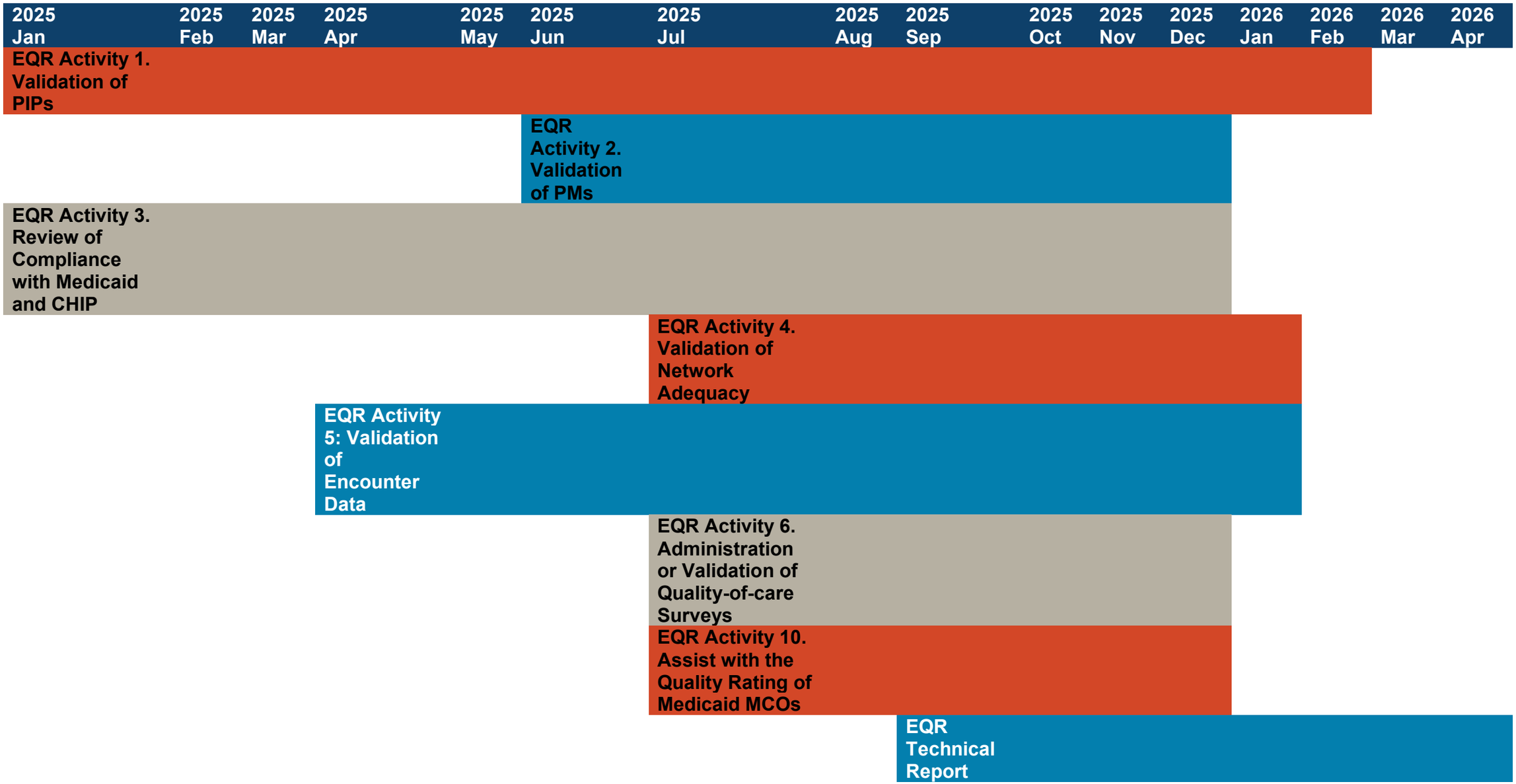

Figure 1: EQRO Protocol Timeline EQR: external quality review; PIP: performance improvement project; PM: performance measure; MCO: managed care organization; EQRO: external quality review organization.

While the *CMS External Quality Review (EQR) Protocols* states that an information systems capabilities assessment (ISCA) is a required component of the mandatory EQR activities, CMS clarified that the systems reviews conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. IPRO conducted an ISCA, as well as used the findings from the review of the MCO's HEDIS final audit report (FAR). IPRO conducted an ISCA in 2023, and the next scheduled assessment will be in 2026. This information is provided in **Section IV: Validation of Performance Measures**.

High-level Program Findings and Recommendations

IPRO used the analyses and evaluations of CY 2025 EQR activity findings to assess the performance of the ND Medicaid MCO in providing quality, timely, and accessible healthcare services to Medicaid members. BCBSND was evaluated against state and national benchmarks, where available, for measures related to the quality, access, and timeliness domains.

The following provides a high-level summary of these findings for the ND Medicaid Managed Care (MMC) Program. These MCO-level findings are discussed in each EQR activity section, as well as in **Section XI: BCBSND Strengths, Opportunities for Improvement, and EQR Recommendations**.

Quality Strategy Evaluation Summary

IPRO worked with ND HHS to develop the 2024 Quality Strategy and to review and update the 2025–2027 Quality Strategy currently in effect. As part of this effort, IPRO evaluated BCBSND's progress toward meeting the performance targets established in the 2025–2027 Quality Strategy. Findings highlight measures that demonstrated progress and identify opportunities for improvement for performance indicators that did not meet established targets.

There were 16 total ND measure rates for the quality strategy, with 12 measure rates having performance target objectives. Overall, three of the 12 ND measure rates with target objectives (25.0%) met the performance target objective for BCBSND. Under Aim 1: Healthier Populations, one of the three measures with target rates met its target objective, while the remaining measures did not achieve their respective targets or were N/A with no targets. For Aim 2: Better Outcomes, one of the five measures with target rates met the target objective. Under Aim 3: Better Experience, one of the three measures with target rates met the target objective, and for Aim 4: Smarter Spending, the single measure with a target rate did not meet the target objective.

Validation of Performance Improvement Projects

BCBSND took part in three PIP projects focusing on chronic obstructive pulmonary disease (COPD) or asthma admission rates in older adults, diabetes care, and substance use disorder (SUD). Overall, the PIPs had a focus on enhancing care coordination and primary care. BCBSND monitored progress towards goals through study indicators and tracking the implemented interventions. Indicators and progress towards the goals were measured on a quarterly basis, with feedback from IPRO to help strengthen the reliability and impact of the interventions.

The COPD PIP saw two of the three performance indicators meeting their target rates. Opportunities for improvement were noted for performance indicators across the SUD and diabetes PIPs, where target rates were not met and performance declined.

Validation of Performance Measures

Reported non-HEDIS and HEDIS measures were validated and found to be reportable. Based on a review of the HEDIS MY 2024 FAR issued by BCBSND's independent auditor and on the ISCA review, IPRO found that BCBSND was *fully compliant* with all applicable NCQA information system (IS) standards. Of the 62 measures and submeasures benchmarked against NCQA Quality

Compass® data, two performed at or above the NCQA 90th percentile, 12 performed at or above the 75th percentile but below the 90th percentile, 13 performed at or above the 50th percentile but below the 75th percentile, and 19 performed at or above the 25th percentile but below the 50th percentile. The remaining 16 measures performed below the NCQA 25th percentile.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO conducted a comprehensive administrative review of BCBSND in November 2023, consistent with *Title 42 CFR § 438* and *Title 42 CFR § 457*. The review covered the period from January 1, 2022, to December 31, 2022, and was performed in January 2023. Overall, BCBSND achieved a high rate of compliance with the standards reviewed for the comprehensive administrative review, with an overall compliance rate among the 16 domains of 95.1%. Rates of compliance for the different domains ranged from 58.8% to 100.0%. Standards for which BCBSND achieved compliance scores of 100.0% were in the following areas: Disenrollment Requirements and Limitations, Emergency and Post-stabilization Services, Coordination of Care, Confidentiality of Health Information, Practice Guidelines, and Quality Assessment and Performance Improvement (QAPI) Program. A review of compliance with Medicaid and CHIP Managed Care Regulations is performed every three years, with the next one scheduled in 2026.

Validation of Network Adequacy

Between October 2025 and January 2026, IPRO conducted a telephone survey of provider practices to evaluate the accuracy of the provider web directory and access to an adequate provider network. IPRO assessed the ability to contact providers and make office appointments using a secret shopper survey methodology.

A total of 425 providers were randomly sampled for the survey study. The project assessed the accuracy of the provider directory and the ability of providers to accommodate three types of appointments: routine, nonurgent sick, and after hours.

Overall, the survey found 226 of the 425 providers had telephone numbers that resulted in successful contact. Of these providers, 159 were accepting patients on the listed insurance provider and were practicing the primary specialty indicated in the provider directory.

These providers had the availability to schedule timely appointments at a rate of 35.8% for routine visits and 25.8% for nonurgent sick visits. After-hours access for primary care providers (PCPs) had a compliance rate of 90.9%.

The BCBSND *Top Six High-Volume Specialists Geographic Access Report* produced in July 2025 indicates that, in ND, five of the top six high-volume specialties, including behavioral health (BH), cardiology, obstetrics/gynecology (ob/gyn), orthopedic surgery, and surgery providers, met the state's requirement of 90% accessibility for BCBSND members within a 50-mile radius. However, medical oncology providers fell short of this goal, with 74.4% of members able to access these providers within a 50-mile radius. The PCP-to-member ratio was 1:4.8, which met the standard of 1:2,500.

Validation of Encounter Data

BCBSND is required to collect, maintain, and report encounter data in a manner that meets state and federal standards. The validation was conducted using an approach developed by IPRO and consistent with the CMS's *Protocol 5. Validation of Encounter Data*. BCBSND's system was reviewed for discrepancies of data elements present in the encounter types between the submitted encounter data validation (EDV) data file and the data submitted to HHS. Data elements with less than a 95% match rate were reviewed. Based upon IPRO's review of BCBSND's encounter data audit file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from BCBSND, and discussions with BCBSND and HHS during and following

the teleconference, there are fields that require further research for each of the encounter types by BCBSND, HHS, and IPRO. This is discussed further in **Section VII: Validation of Encounter Data**. While there were several fields whose value did not match, the overall claim ID match between the IPRO data warehouse and BCBSND audit file was over 95% for all claim types, a near 7% improvement from the prior study.

Validation of Quality-of-care Surveys

BCBSND is required to conduct the adult CAHPS surveys of a sample of members annually. NCQA Quality Compass tool was used to examine quality improvement and benchmark BCBSND performance through online access to health plan CAHPS performance data. The following questions performing at or above the 75th percentile were considered strengths: Got care as soon as needed when care was needed right away (Q4), Got check-up/routine care appointment as soon as needed (Q6), Personal doctor explained things in an understandable way (Q12), Personal doctor listened carefully to you (Q13), Personal doctor showed respect for what you had to say (Q14), Personal doctor spent enough time with you (Q15), Coordination of care (Q17) and Ease of filling out forms (Q27).

Utilization Review Accreditation Commission Accreditation

Utilization Review Accreditation Commission (URAC)'s accreditation standards are focused on consumer protection and quality improvement. BCBSND is URAC-accredited, and the accreditation's benefits has helped the state to focus on policies and metrics, develop long-term process and system optimization plans, implement resources to check safety, meet privacy technology requirements, and have better health outcomes by focusing on key areas such as patient access, value, and engagement. BCBSND underwent a URAC validation review in October 2023, and full accreditation was granted for Medicaid Health Plan with a Six-Month Follow-Up for two standards. Corrective action plans (CAPs) for each finding were implemented and provided to URAC. A return visit was held on 3/21/24. The URAC reviewer was satisfied with the implemented corrective actions, passed both standards, and found no new issues. BCBSND's URAC Health Plan accreditation expires on 11/1/2026. In addition to URAC Health Plan accreditation, BCBSND is one of the first two plans to obtain URAC's Mental Health and Substance Use Disorder Parity accreditation for Medicaid, Commercial-Individual, and Commercial-Large plans. BCBSND'S URAC accreditation is valid until May 1st, 2028.

Recommendations for BCBSND

Findings from this year's EQR activities highlight BCBSND's commitment to achieving the goals of the ND Medicaid quality strategy. Strengths related to goals for achieving greater effectiveness, accessibility, and quality of care were observed; however, there were also important shortcomings that can be addressed through ongoing quality measurement, reporting, and improvement activities. ATR findings regarding BCBSND's performance as measured by EQR activities highlight opportunities for improvement and are summarized in **Section II: North Dakota Medicaid Managed Care Program**. The following highlights key recommendations for BCBSND:

- Medicaid quality strategy evaluation: Consider new and expanded PIPs to address PMs that did not meet target rate objectives. For example, to drive improvement of Aim 2: Better Outcomes, consider adding the following new HEDIS measure as a both a new Quality Strategy performance measure and a new performance indicator for the diabetes management PIP: HEDIS® MY 2027 Continuous Glucose Monitoring Utilization for Patients With Diabetes (CGD-E). Consider additional core set measures for inclusion in the Quality Strategy that are consistent with the goals. To drive improvement in Aim 1: Healthier Populations, consider adding the following new HEDIS Measures to the Quality Strategy, with incorporation into a new PIP to improve mammography screening with follow-up: HEDIS® MY 2025 Documented Assessment After Mammogram (DBM-E) and Follow-Up After Abnormal Mammogram Assessment (FMA-E), as well as the HEDIS® MY 2026 Breast Cancer Screening (BCS-E)

expanded age eligibility criteria to include persons 40-74 years of age, merit consideration. In addition, the new measure for HEDIS® MY 2026 Tobacco Use Screening and Cessation Intervention (TSC-E) merits consideration for both inclusion in the Quality Strategy and as a performance indicator for a new PIP.

- PIPs: For PIPs that did not show progress, conduct barrier analysis and use findings to inform modifications to interventions. Consider additional interventions in support of rural health transformation (for example, expansion of telehealth services, increased access to continuous glucose monitoring devices, enhanced discharge planning, and increased utilization of community health workers).
- PMs: Identify drivers of and barriers to the HEDIS quality-related measures that fell below the NCQA national 25th percentile and use findings to inform modifications to interventions for improvement.
- Compliance with Medicaid standards: Focus on improving the three domains that performed poorly: Availability of Services, Assurances of Adequate Capacity and Services, and Provider Selection.
- Network adequacy: Increase timely appointment rates and enhance the accuracy of the provider directory.
- Quality-of-care member surveys: Focus on improving all measures that performed below the 50th percentile.

Recommendations for HHS

HHS has developed and updated the ND Medicaid quality strategy to strengthen BCBSND's focus on population health, as measured by performance indicators for the domains of effectiveness, accessibility, quality, experience of care, and efficiency/smarter spending. The BCBSND ATR summarizes BCBSND's performance across all EQR activities in alignment with the goals of the ND Medicaid quality strategy. The findings and recommendations summarized **Section XI. BCBSND Strengths, Opportunities for Improvement**, and EQR Recommendations provide data-driven evidence to support HHS's guidance for BCBSND to implement the updated ND Medicaid quality strategy. The following Quality Strategy performance measures are highlighted as opportunities for BCBSND to meet or exceed the new performance targets by federal fiscal year (FFY) 2027:

- Breast Cancer Screening
- Colorectal Cancer Screening
- 7-day Follow-up After Emergency Department (ED) Visit for Mental Illness
- Postpartum Care
- Initiation and Engagement of Substance Use Disorder (Initiation and Engagement)
- Inpatient Hospital Admissions for Heart Failure
- Inpatient Hospital Admissions for COPD or Asthma in Older Adults
- Diabetes Short-term Complications Admission Rate
- Member Satisfaction: Rating of Health Plan and Rating of All Health Care
- Plan All-Cause Readmission

II. North Dakota Medicaid Managed Care Program

Managed Care in North Dakota

The ND Medicaid program, administered by the ND HHS Medical Services Division, has historically used an FFS or FFS with PCCM care delivery model. However, *House Bill 1362* expanded medical assistance, as authorized by the federal Patient Protection and Affordable Care Act (ACA; Pub. L. 111-148) and amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and extended coverage to adults under 65 years of age with incomes between 100% and 138% of the FPL, based on modified adjusted gross income. ND opted to enroll the Medicaid Expansion population in managed care.

On December 20, 2013, CMS granted authority through a 1915(b) waiver to allow ND to provide Medicaid Expansion as an MCO program. This allowed mandatory enrollment of individuals, including Native Americans, eligible for the Medicaid Expansion into a health plan offered by an MCO. The initial 1915(b) waiver authority ended on December 31, 2015.

On August 26, 2015, the state submitted a request to CMS for a 1115 waiver extension, as the authority initially granted was to end December 20, 2015. The state received a letter from CMS on December 18, 2015, indicating the 1115 waiver extension request was approved. The 1115 waiver was allowed to expire, as the provisions of the *2016 Medicaid Managed Care Final Rule* resulted in ND no longer having designated urban areas and being considered rural statewide and thus being exempt from having to provide a choice of MCOs and in compliance with *Section 1932(a)* of ACA and *Title 42 CFR § 438.52*.

On October 2, 2015, the state submitted a 1915(b) waiver renewal request to CMS, with authority granted on December 18, 2015. As the renewal authority ended December 31, 2017, the state submitted a 1915(b) waiver renewal request on October 2, 2017, to CMS, with authority granted on December 14, 2017. The first 1915(b) waiver renewal authority ended on December 31, 2017.

On October 2, 2017, the state submitted a 1915(b) waiver renewal request to CMS, with authority granted on December 14, 2017. ND agreed to comply with the special terms and conditions (STCs) attached to the waiver to ensure compliance with statutory and regulatory compliance. The second 1915(b) waiver renewal authority ended on December 31, 2017.

On October 8, 2019, the state submitted a 1915(b) waiver renewal request to CMS, with authority granted on December 16, 2019. This 1915(b) waiver renewal authority ended on December 31, 2021.

On October 5, 2021, the state submitted a 1915(b) waiver extension request to CMS. CMS granted the extension through April 14, 2022.

On February 17, 2022, the state submitted a 1915(b) waiver renewal request to CMS, with authority granted on February 24, 2022. This 1915(b) waiver renewal authority extended through March 31, 2024.

On January 17, 2024, the state submitted a 1915(b) waiver extension request to CMS. On February 6, 2024, CMS granted the extension through June 30, 2024. On June 7, 2024, CMS approved 1915b waiver through June 30, 2026, and on March 30, 2026, the state submitted a 1915b waiver renewal request to CMS.

As the state was only able to award one statewide MCO contract, to ensure compliance with federal MMC regulations requiring enrollees to have a choice of MCOs in the metropolitan statistical areas, the state submitted a 1115 waiver, with authority granted by CMS on February 26, 2014. This allowed

having one MCO choice for Medicaid Expansion enrollees residing in urban areas of ND. The initial 1115 waiver authority ended on December 20, 2015.

Through *Senate Bill 2012*, the 2019 ND Legislative Assembly directed HHS to continue ND Medicaid Expansion as implemented through a private carrier, except for pharmacy services, as of January 1, 2020. Thus, as of January 1, 2020, the MCO will administer and manage medical benefits to those individuals eligible for ND Medicaid Expansion; the pharmacy benefits for the ND Medicaid Expansion population will be administered and managed by the state through FFS Medicaid administration.

Through *House Bill 1012*, the 2021 ND Legislative Assembly directed HHS to change the 19- and 20-year-old Medicaid Expansion enrollees benefits to the traditional FFS benefit plan, effective January 1, 2022. Now, 19- and 20-year-old Medicaid Expansion enrollees receive the state-administered FFS benefit, which includes the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program benefits.

On January 1, 2022, Medicaid Expansion enrollees began receiving services through BCBSND as the sole MCO for the ND Medicaid Expansion program. As of December 2024, the ND Medicaid Expansion program served 22,828 individuals ages 21–64 years. The program fills historic gaps in Medicaid eligibility for low-income adults ages 21–64 years. Most Medicaid Expansion enrollees are childless adults working one or more jobs but are unable to afford health insurance. The program provides much-needed access to chronic disease management, mental health services, and addiction treatment programs.

In December 2025, ND was awarded $199 million from CMS to support the first year of a statewide Rural Health Transformation Program (RHTP). The five-year initiative aims to strengthen rural healthcare by stabilizing the workforce, expanding preventive care, improving local access to services, and enhancing data and technology connectivity, with the goal of improving access, quality, and health outcomes in rural communities

North Dakota Medicaid Quality Strategy

In accordance with *Title 42 CFR § 438.340*, ND HHS implemented a written Quality Strategy. The purpose of the ND Medicaid quality strategy is to improve the health status of North Dakotans by promoting healthy lifestyles, preventive care, disease management, and disparity elimination; improve access to quality healthcare at an affordable price to improve outcomes; increase effectiveness and efficiency in the delivery of healthcare programs and ensure value in healthcare contracts; and enhance member and provider experience. The ND 2025−2027 Quality Strategy aligns with the following four aims that are based on the Institute for Healthcare Improvement (IHI)'s quadruple aim, as well as the corresponding goals.

Aim 1: Healthier Populations

Improve the overall health of North Dakotans by increasing access to preventive services, including cancer screenings and postpartum care, and by strengthening BH follow-up and engagement. Quality Strategy goals for Aim 1 are the following: 1.1: Improve preventive health; 1.2: Improvement postpartum care; and 1.3: Improve behavioral health care.

Aim 2: Better Outcomes

Enhance health outcomes for Medicaid members with chronic conditions and SUDs through better treatment initiation, care coordination, and reduced avoidable hospitalizations. Quality Strategy goals for Aim 2 are the following: 2.1: Improve outcomes for members with SUD and 2.2: Improve health for members with chronic conditions.

Aim 3: Better Experience

Goal 3.1 aims to enhance member experience of health care by promoting timely access to care and increasing member satisfaction with both health plans and overall care received.

Aim 4: Smarter Spending

Goal 4.1 focuses on paying for value by ensuring the efficient use of public resources by reducing avoidable hospital readmissions and supporting value-based care initiatives that prioritize quality over volume.

Figure 2 depicts ND's Medicaid quality strategy, showing the conceptual linkages between healthcare needs, quality processes, and outcomes.

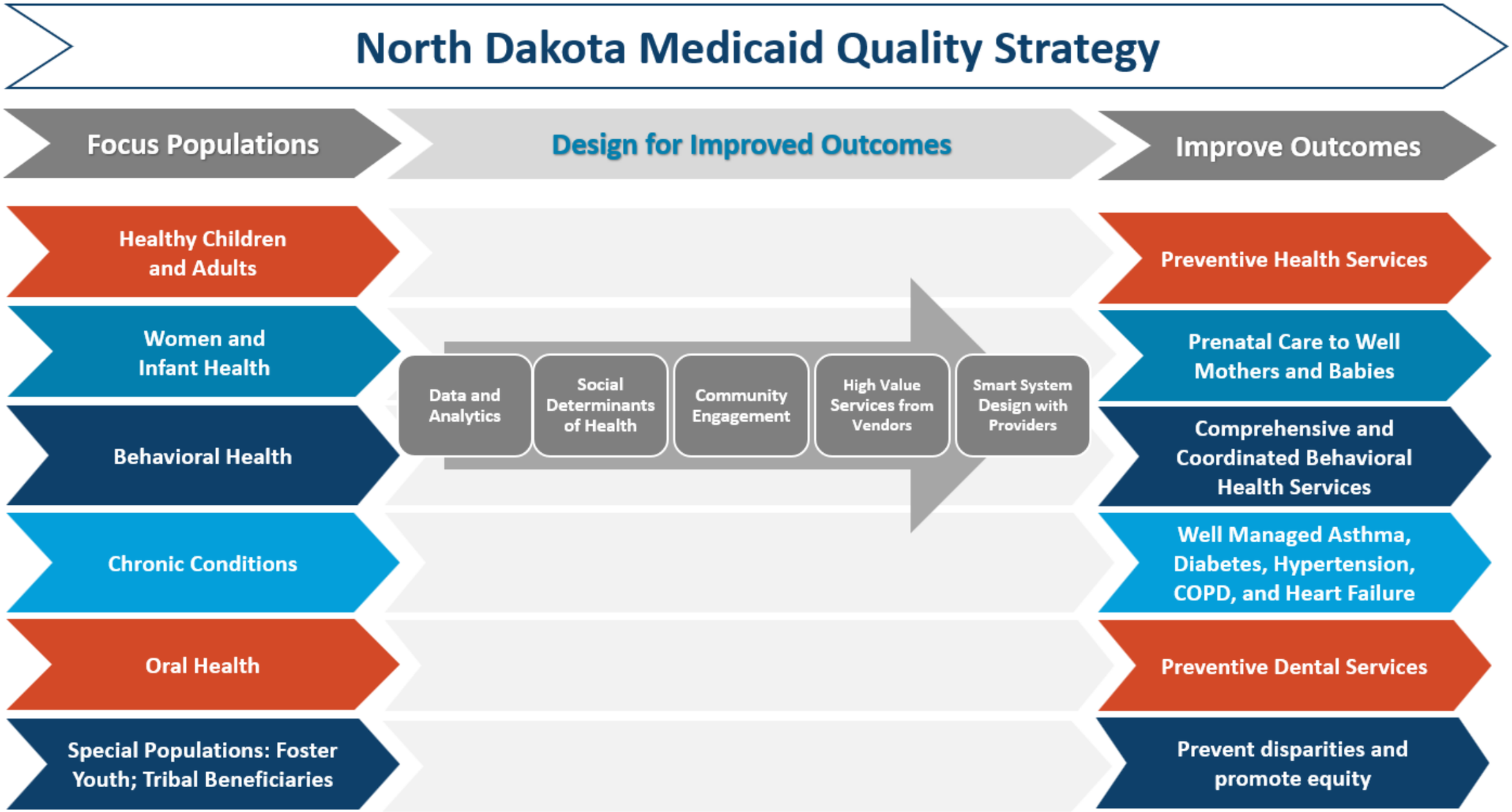

Figure 2: North Dakota Medicaid Quality Strategy COPD: chronic obstructive pulmonary disease.

IPRO's Evaluation of the North Dakota 2025−2027 Medicaid Quality Strategy

States are required by *Title 42 CFR § 438.340* to draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by each MCO, PAHP, PIHP, and PCCM entity. IPRO, the EQRO for ND, worked with HHS to update the quality strategy currently in effect as the 2025−2027 Quality Strategy and to evaluate the progress of the ND quality strategy. This section describes the quality strategy evaluation methodology and presents findings for BCBSND, specifically the PMs that showed progress and those that did not, thus representing opportunities for improvement, with corresponding recommendations.

Evaluation Methodology

- Evaluate FFY 2025 performance indicator rate percentage point (pp) change from FFY 2024 rate.
- Evaluate whether FFY 2025 performance indicator rate performed better or worse than the FFY 2024 Medicaid national median rate.
- For those PMs that neither met the FFY 2024 Medicaid median nor made progress from FFY 2024 to FFY 2025, include recommendations for BCBSND for improving the quality of healthcare services to better support the quality strategy aims of healthier populations, better outcomes, better experience, and smarter spending.

Findings and Recommendations

Table 1 and **Table 2** show BCBSND progress on meeting North Dakota Quality Strategy goals. **Table 1** summarizes performance impact on goals and objectives and **Table 2** shows measure-specific progress from FFY 2024 to FFY 2025, as well as whether the target rate was met. The following narrative summarizes progress in terms of whether target rates were met.

Overall, three of the 14 performance indicators with target rates set met the target objective.

- Aim 1 Healthier Populations: one of the five performance indicators met the target objective.
- Aim 2 Better Outcomes: one of the five performance indicator rates met the target objective.
- Aim 3 Better Experience: one of the three performance indicator rates met the target objective.
- Aim 4 Smarter Spending: the single performance indicator did not meet the target objective.

Table 1: Performance Impact on Quality Strategy Goals and Objectives

Quality Strategy Aims	Quality Strategy Goals	Finding	Met/Not Met	Performance Impact on Goals and Objectives
Aim 1: Healthier Populations	Goal 1.1: Improve Preventive Health	✗	Not Met	0/2 Medicaid rates met the target rates
Aim 1: Healthier Populations	Goal 1.1: Improve Preventive Health	✓	Met	2/2 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 1: Healthier Populations	Goal 1.1: Improve Preventive Health	✓	Met	0/2 Medicaid rates declined in performance from FFY 24 to FFY 25
Aim 1: Healthier Populations	Goal 1.2: Improve Postpartum Care	✗	Not Met	0/1 Medicaid rates met the target rates
Aim 1: Healthier Populations	Goal 1.2: Improve Postpartum Care	✗	Not Met	0/1 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 1: Healthier Populations	Goal 1.2: Improve Postpartum Care	✗	Not Met	1/1 Medicaid rates declined in performance from FFY 24 to FFY 25
Aim 1: Healthier Populations	Goal 1.3: Improve BH Care for Beneficiaries	✓	Met	1/2 Medicaid rates met the target rates
Aim 1: Healthier Populations	Goal 1.3: Improve BH Care for Beneficiaries	✓	Met	2/2 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 1: Healthier Populations	Goal 1.3: Improve BH Care for Beneficiaries	✓	Met	0/2 Medicaid rates declined in performance from FFY 24 to FFY 25
Aim 1: Healthier Populations	Conclusion	-	-	**Minimal progress was made toward meeting the target rates, as zero of two performance indicator rates met the target rates; however, both indicator rates did improve in performance from the prior year.**
Aim 1: Healthier Populations	Recommendations to drive quality strategy aims for improvement	-	-	The target rate for Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD, 30-day) should be set higher than the FFY

Quality Strategy Aims	Quality Strategy Goals	Finding	Met/Not Met	Performance Impact on Goals and Objectives
				2025 rate which surpassed the target rate. The HEDIS MY 2025 update added peer support services to the numerator; therefore, it is recommended that BCBSND monitor the utilization of peer support services in support of this measure, as well as the PIP FUA performance indicator to address follow-up for Ed visit for substance use disorder. BCBSND could consider adding the following core set measures pertinent to preventive health: Adult Immunization Status (AID-AD), Chlamydia Screening in Women (CHL-AD), Antidepressant Medication Management (AMM-AD), Cervical Cancer Screening (CCS-AD), and Ambulatory Care Sensitive Emergency Department Visits for Non-traumatic Dental Conditions in Adults (EDV-AD). The new measures for HEDIS® MY 2025 Documented Assessment After Mammogram (DBM-E) and Follow-Up After Abnormal Mammogram Assessment (FMA-E), as well as the HEDIS® MY 2026 Breast Cancer Screening (BCS-E) expanded age eligibility criteria to include persons 40-74 years of age, merit consideration. In addition, the new measure for HEDIS® MY 2026 Tobacco Use Screening and Cessation Intervention (TSC-E) merits consideration. BCBSND could consider adding the following core set measures pertinent to postpartum care: Contraceptive Care – Postpartum Women (CCP-AD), Contraceptive Care – All Women (CCW-AD) and Postpartum Depression Screening and Follow-up (PDS-AD), as well as the following measures pertinent to prenatal care: Oral Evaluation During Pregnancy (OEVP-AD), Prenatal Immunization Status (PRS-AD), and Timeliness of Prenatal Care (PPC). BCBSND could consider adding the following core set measures pertinent to BH care: Screening for

Quality Strategy Aims	Quality Strategy Goals	Finding	Met/Not Met	Performance Impact on Goals and Objectives
				Depression and Follow-up Plan (CDF-AD), Follow-up After Hospitalization for Mental Illness (FUH-AD), Follow-up After Emergency Department Visit for Mental Illness (HPCMI-AD), and Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD).
Aim 2: Better Outcomes	Goal 2.1: Improve Outcomes for Members with SUD	✗	Not Met	0/2 Medicaid rates met the target rates
Aim 2: Better Outcomes	Goal 2.1: Improve Outcomes for Members with SUD	✓	Met	1/2 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 2: Better Outcomes	Goal 2.1: Improve Outcomes for Members with SUD	✗	Not Met	1/2 Medicaid rates declined in performance from FFY 24 to FFY 25
Aim 2: Better Outcomes	Goal 2.2: Improve Health for Members with Chronic Conditions	✓	Met	1/3 Medicaid rates met the target rates
Aim 2: Better Outcomes	Goal 2.2: Improve Health for Members with Chronic Conditions	✓	Met	1/3 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 2: Better Outcomes	Goal 2.2: Improve Health for Members with Chronic Conditions	✗	Not Met	2/3 Medicaid rates declined in performance from FFY 24 to FFY 25
Aim 2: Better Outcomes	Conclusion	-	-	**Minimal progress was made toward meeting the target rates as one of five performance indicator rates met the target rate and two of the five improved in performance from the prior year.**
Aim 2: Better Outcomes	Recommendations to drive quality strategy aims for improvement	-	-	The target rate for PQI-05 Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40−64 years should be set lower than the FFY 2024 rate of 10.58. BCBSND could consider adding the following core set measures pertinent to members with SUD: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) and Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD).

Quality Strategy Aims	Quality Strategy Goals	Finding	Met/Not Met	Performance Impact on Goals and Objectives
				BCBSND could consider adding the following core set measures pertinent to members with chronic conditions: Asthma Medication Ratio (AMR-AD), HIV Viral Load Suppression (HVL-AD), and Controlling Blood Pressure (CBP-AD), and Glycemic Status Assessment for Patients with Diabetes (GSD-AD). Pending final approval by NCQA of the proposed new measure for HEDIS® MY 2027 Continuous Glucose Monitoring Utilization for Patients With Diabetes (CGD-E).
Aim 3: Better Experience	Goal 3.1: Enhance Member Experience	✓	Met	1/3 Medicaid rates met the target rates
Aim 3: Better Experience	Goal 3.1: Enhance Member Experience	✗	Not Met	0/3 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 3: Better Experience	Goal 3.1: Enhance Member Experience	✗	Not Met	3/3 Medicaid rates declined in performance from FFY 24 to FFY 25
Aim 3: Better Experience	Conclusion	-	-	**Progress was not demonstrated for meeting the target rates nor for improving the indicator rates.**
Aim 3: Better Experience	Recommendations to drive quality strategy aims for improvement	-	-	The target rate for CPA-AD, Getting Care Quickly (CAHPS; usually/always) should be set higher, as the FFY 2025 rate surpassed the target rate. To drive improvement in the Quality Strategy aim to enhance member experience, ND HHS can recommend that BCBSND beneficiary focus groups be conducted to identify the reasons for beneficiary dissatisfaction with the health plan, as well as with all health care, and ask beneficiaries how satisfaction might be improved.
Aim 4: Smarter Spending	Goal 4.1: Focus on Paying for Value	✗	Not Met	0/1 Medicaid rates met the target rates
Aim 4: Smarter Spending	Goal 4.1: Focus on Paying for Value	✗	Not Met	0/1 Medicaid rates improved in performance from FFY 24 to FFY 25
Aim 4: Smarter Spending	Goal 4.1: Focus on Paying for Value	✗	Not Met	1/1 Medicaid rates declined in performance from FFY 24 to FFY 25

Quality Strategy Aims	Quality Strategy Goals	Finding	Met/Not Met	Performance Impact on Goals and Objectives
Aim 4: Smarter Spending	Conclusion	-	-	**Progress was not demonstrated for meeting the target rates nor for improving the indicator rates.**
Aim 4: Smarter Spending	Recommendations to drive quality strategy aims for improvement	-	-	To drive improvement in the Quality Strategy aim to focus on paying for value, ND HHS can recommend that BCBSND enhance collaboration with hospitals for discharge planning. For example, interventions might include improved processes for notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge. The plan should consider adding discharge planning interventions for all PIPs to drive improvements in follow-up after hospital encounters for enrollees with chronic conditions and to reduce hospitalizations for these enrollees.

BH: behavioral health; BCBSND: Blue Cross Blue Shield of North Dakota; SUD: substance use disorder.
N/A: not applicable.

Table 2 shows BCBSND progress for each performance indicator from FFY 2024 to FFY 2025. The following narrative summarizes progress in terms of whether percentage point improvement was shown from FFY 2024 to FFY 2025. Overall, four of the 12 performance indicators with rates for both FFY 2024 to FFY 2025 showed progress from FFY 2024 to FFY 2025. Three of the four performance indicators for Aim 1: Healthier Populations showed progress from FFY 2024 to FFY 2025. For Aim 2: Better Outcomes, two of the five performance indicator rates showed progress from FFY 2024 to FFY 2025. For Aim 3: Better Experience, none of the three performance indicator rates showed progress from FFY 2024 to FFY 2025. For Aim 4: Smarter Spending, the single performance indicator did not show progress from FFY 2024 to FFY 2025.

Performance Measures that Showed Progress

The BCBSND PMs that showed progress are summarized in the following narrative (**Table 2**).

Aim 1: Healthier Populations

Goal 1.3: Improve BH Care for Beneficiaries

- **Follow-up After ED Visit for Mental Illness (FUM-AD, 30-day follow-up, ages 18−64 years):** BCBSND FFY 2025 rate for beneficiaries ages 18−64 years increased by 2.75 pp from FFY 2024 and met the Medicaid median FFY 2024 rate.
- **Follow-up After ED Visit for Mental Illness (FUM-AD, 7-day follow-up, ages 18−64 years):** BCBSND FFY 2025 rate for beneficiaries ages 18−64 years increased by 4.88 pp from FFY 2024 but did not meet the Medicaid median FFY 2024 rate.

Aim 2: Better Outcomes

Goal 2.1: Improve Outcomes for Members with SUD

- **Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD):** BCBSND FFY 2025 rate increased by 0.39 pp but did not meet the Medicaid median FFY 2024 rate.

Goal 2.2: Improve Health for Members with Chronic Conditions

- **Inpatient Hospital Admissions for COPD (lower rate is better; PQI05-AD):** BCBSND FFY 2025 rate increased by 3.67 pp from FFY 2024; however, the rate still fell below the Medicaid median FFY 2024 rate (lower is better).
- **Inpatient Hospital Admissions for Diabetes Short-term Complications (lower rate is better; PQI01-AD):** BCBSND FFY 2025 rate decreased by 4.07 pp from FFY 2024; however, the rate was still above the Medicaid median FFY 2024 rate (lower is better).

Opportunities for Improvement

Findings and recommendations for performance indicators that did not show progress are summarized in the following narrative (**Table 2**).

Aim 1: Healthier Populations

Goal 1.2: Improve Postpartum Care

- **Timely Postpartum Care (PPC-AD):** To improve this measure, BCBSND could consider conducting a PIP aimed at increasing timely postpartum visits among MMC recipients. An intervention for consideration would be using provider performance incentives for postpartum visits conducted according to the schedule recommended in the American College of Obstetricians and Gynecologists (ACOG) clinical practice guidelines, “Optimizing Postpartum Care.”

Aim 2: Better Outcomes

Goal 2.2: Improve Health for Members with Chronic Conditions

- **Inpatient Hospital Admissions for Diabetes Short-term Complications (lower rate is better; PQI01-AD):** While this rate did decrease by 4.07 pp, the rate was still above the Medicaid median (lower is better). To improve this measure, BCBSND could build on their current diabetes PIP, specifically Indicator 2: annually decrease the number of hospital admissions with a principal diagnosis of diabetes with short-term complications, with the goal to reach 17.2 admissions or fewer. Interventions for consideration include ensuring beneficiary linkage with PCPs within 30 days following discharge, as well as with endocrinologists for enrollees with poor diabetic control, and improving access to continuous glucose monitoring devices.
- **Inpatient Hospital Admissions for Heart Failure (lower rate is better; PQI08-AD):** To improve this measure, BCBSND could consider conducting a PIP aimed at decreasing avoidable hospital admissions for heart failure among ND MMC recipients. Interventions could focus on improving outpatient management and care coordination for members with chronic heart failure. For example, interventions might include enhanced processes for early identification of members at risk of decompensation, improved care transitions between inpatient and outpatient settings, increased collaboration with cardiologists and PCPs, and the use of remote monitoring or home-based follow-up to support medication adherence, symptom monitoring, and weight management.

Aim 3: Experience of Care

Goal 3.1: Enhance Member Experience

- **Getting Care Quickly, Rating of Health Plan, and Rating of All Health Care (CPA-AD):** Beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved.

Aim 4: Smarter Spending

Goal 4.1: Focus on Paying for Value

- **Ratio of Observed All-Cause Readmissions to Expected Readmissions (lower rate is better; O/E ratio):** This rate continues to increase year after year (lower is better). To improve this measure, BCBSND could consider conducting a PIP aimed at decreasing hospital readmissions among ND MMC recipients. Interventions for MCO collaboration with hospitals for discharge planning can be conducted to improve transitions in care. For example, interventions might include improved processes for notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge.

Table 2: BCBSND Progress on Meeting North Dakota Quality Strategy Goals

Aim/Goal	Rate Definition	BCBSND FFY 2023[1]	BCBSND FFY 2024[2]	BCBSND FFY 2025[3]	BCBSND Progress by pp[4]	Performance Target (by FFY 2027)[5]	Met Target Objective
Aim 1: Healthier Populations – Goal 1.1: Improve Preventive Health	Breast Cancer Screening (BCS-AD)[6]	30.40%	44.19%	49.38%	+5.19	52.68%[7]	No
Aim 1: Healthier Populations – Goal 1.1: Improve Preventive Health	Colorectal Cancer Screening, ages 50−64 years (COL-AD)[8]	14.00%	21.26%	37.84%	+16.58	41.72%[9]	No
Aim 1: Healthier Populations – Goal 1.2: Improve Postpartum Care	Prenatal and Postpartum Care, Timely Postpartum Care	39.50%	38.92%	37.78%	-1.14	80.23%	No
Aim 1: Healthier Populations – Goal 1.3: Improve BH Care for Beneficiaries	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD, 30-day)	51.50%	51.94%	54.69%	+2.75	53.82%	Yes
Aim 1: Healthier Populations – Goal 1.3: Improve BH	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD, 7-day)	35.90%	27.16%	32.04%	+4.88	38.62%	No

Aim/Goal	Rate Definition	BCBSND FFY 2023[1]	BCBSND FFY 2024[2]	BCBSND FFY 2025[3]	BCBSND Progress by pp[4]	Performance Target (by FFY 2027)[5]	Met Target Objective
Care for Beneficiaries							
Aim 2: Better Outcomes – Goal 2.1: Improve Outcomes for Members with SUD	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD), Initiation	51.10%	44.73%	45.12%	**+0.39**	54.68%	No
Aim 2: Better Outcomes – Goal 2.1: Improve Outcomes for Members with SUD	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD), Engagement	28.00%	21.06%	18.29%	**-2.77**	> 29.94%	No
Aim 2: Better Outcomes – Goal 2.2: Improve Health for Members with Chronic Conditions	Inpatient Hospital Admissions for Heart Failure, ages 18−64 years (lower is better)	25.94%	22.92%	30.12%	**+7.20**	23.9%	No
Aim 2: Better Outcomes – Goal 2.2: Improve Health for Members with Chronic Conditions	Inpatient Hospital Admissions for Diabetes Short-term Complications, ages 18−64 years (lower is better)	24.41%	30.47%	26.40%	**-4.07**	17.2%	No
Aim 2: Better Outcomes – Goal 2.2:	Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40−64 years (lower is better)	25.41%	10.58%	14.25%	**+3.67**	23.2%	Yes

Aim/Goal	Rate Definition	BCBSND FFY 2023[1]	BCBSND FFY 2024[2]	BCBSND FFY 2025[3]	BCBSND Progress by pp[4]	Performance Target (by FFY 2027)[5]	Met Target Objective
Improve Health for Members with Chronic Conditions							
Aim 3: Better Experience – Goal 3.1: Enhance Member Experience	CPA-AD, Getting Care Quickly (CAHPS; usually/always)	79.5%	89.5%	89.3%	**-0.2**	81.1%	Yes
Aim 3: Better Experience – Goal 3.1: Enhance Member Experience	CPA-AD, Rating of Health Plan (CAHPS; 8,9,10)	71.4%	73.5%	70.0%	**-3.5**	77.7%	No
Aim 3: Better Experience – Goal 3.1: Enhance Member Experience	CPA-AD, Rating of All Health Care (CAHPS; 8,9,10)	82.1%	73.0%	69.4%	**-3.6**	> 82.6%	No
Aim 4: Smarter Spending – Goal 4.1: Focus on Paying for Value	Plan All-Cause Readmission, O/E Ratio (lower is better)	1.0213	1.024	1.12	**+0.096**	0.9853	No

[1] Federal fiscal year (FFY) 2023 (calendar year [CY] 2022) data.
[2] FFY 2024 (CY 2023) data.
[3] FFY 2025 (CY 2024) data.
[4] Percentage point difference (pp) indicates absolute percentage point change from FFY 2024 to CY 2024, where plus (+) shows an increase in percentage, and minus (–) shows a decrease in percentage. Plus (+) represents better performance, and minus (–)

represents worse performance from FFY 2024 to FFY 2025, except for measures indicated by “lower is better,” for which minus (–) represents better performance.
[5] Target rates for HEDIS and CAHPS measures were set as the rate of the 50th MY 2023 Medicaid Quality Compass percentile.
[6] The BCS-AD measure collection method was changed to ECDS. Trending should be interpreted with caution.
[7] The BCS-AD measure was used for the Medicaid median benchmark.
[8] The COL-E measure collection method was changed to ECDS. Trending from the baseline FFY 2023 COL-AD rate should be interpreted with caution.
[9] The COL-AD measure was used for the Medicaid median benchmark.
BCBSND: Blue Cross Blue Shield of North Dakota; N/A: not applicable; FUM-AD: Follow-up After Emergency Department Visit for Mental Illness; IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment. COPD: chronic obstructive pulmonary disease; CPA-AD: CAHPS Health Plan Survey, Adult Version; CAHPS: Consumer Assessment of Healthcare Providers and Systems; BH: behavioral health; SUD: substance use disorder; O/E: observed-to-expected.

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies contracting with MMC plans must conduct PIPs that focus on both clinical and nonclinical areas. According to CMS, the purpose of a PIP is to assess and improve the processes and outcomes of healthcare provided by MCOs. *Title 42 CFR § 438.356(a)(1)* and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, HHS contracted with IPRO to validate the PIPs that were underway in CY 2025. PIP topics are displayed in **Table 3.**

Table 3: PIP Topics

PIP Topics
PIP 1: COPD or Asthma in Older Adults Admission Rate: The aim of this PIP is to reduce inpatient admissions associated with chronic obstructive pulmonary disease (COPD) or asthma by building a connection with a healthcare provider.
PIP 2: Diabetes Care: The aim of this PIP is to reduce inpatient admissions associated with diabetes complications by establishing a connection with a healthcare provider.
PIP 3: Substance Use Disorder: The aim of this PIP is to reduce inpatient admissions associated with substance use disorder (SUD) for individuals enrolled in Medicaid Expansion by establishing a connection with a healthcare provider.

COPD: chronic obstructive pulmonary disease; PIP: performance improvement project.

Technical Methods of Data Collection and Analysis

IPRO's review and validation of PIPs included assessing the methodological soundness of the design, conduct, and reporting to ensure real improvement in care has occurred. IPRO's validation process began at the PIP proposal phase and continues through the life of the PIP. During the conduct of the PIPs, IPRO provided technical assistance to the BCBSND to help them progress.

IPRO used CMS's *Protocol 1. Validation of Performance Improvement Projects* as the framework to assess the quality of each PIP, as well as to score the compliance of each PIP with both federal and state requirements. IPRO's assessment involves the following 10 elements:

1. Review of the selected study topic(s) for relevance of focus and the MCO's enrollment.
2. Review of the PIP aim statement for clarity.
3. Review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population.
4. Review of selected performance indicators, which should be objective, clear, unambiguous, and meaningful to the focus of the PIP.
5. Review of sampling methods (if sampling is used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement (e.g., observed changes were likely to be attributable to the PIP intervention).
10. Assessment of whether the MCO achieved sustained improvement.

IPRO provides PIP report templates for the submission of project proposals, baseline and interim updates, and results. All data needed to conduct the validation are obtained through these report submissions. The validation protocol begins with an assessment of the methodology for conducting the PIP, which is evaluated for the PIP baseline proposal.

Interim PIP validation findings are assessed as one of the following:

- Met: all items reviewed for the element are deemed to be acceptable.
- Partially met: one or more of the items reviewed for the element are not acceptable and require revisions.
- Not met: all the items reviewed for the element are not acceptable, and each needs to be revised.

IPRO performs quarterly PIP coaching reviews with BCBSND, where the MCO is given the opportunity to speak on their latest updates and receive feedback from IPRO. Following the quarterly calls, IPRO sends BCBSND written evaluations to assist in tracking their performance, whereby BCBSND can implement the feedback into their work.

A determination is made as to the overall credibility of the results of each PIP, with an assignment of one of three categories, as shown in **Table 4,** with results shown in **Table 5**.

Table 4: Overall Credibility of Results

Validation Level	Definition
High confidence	The PIP was methodologically sound and produced evidence of significant improvement; the demonstrated improvement was clearly linked to the quality improvement processes implemented.
Moderate confidence	The PIP was methodologically sound and produced some evidence of improvement; some of the quality improvement processes were clearly linked to the demonstrated improvement.
Low confidence	a) The PIP was methodologically sound; however, no evidence of improvement was produced; or b) The quality improvement processes and interventions were poorly executed and could not be linked to any improvement that may have occurred.

PIP: performance improvement project.

Three BCBSND PIPs concluded their third interim year on December 31, 2025. Findings will be final when the PIPs conclude on December 31, 2026. The following findings are preliminary.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates, methods for PM calculations, targets, benchmarks, interventions (planned and executed), intervention tracking measures (ITMs), and rates, barriers, and limitations.

PIP 1: COPD or Asthma in Older Adults Admission Rate

Goal: Reduce inpatient admissions associated with COPD or asthma by building a connection with a healthcare provider.

The following key interventions were implemented by BCBSND:

- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND.
- *CHAMPION your health* flyer sent out to encourage members to access PCPs and address all healthcare needs including medical and mental health.
- Case management made engagement calls to initiate case management interventions including help with medical appointment scheduling and assisting with social or community needs. In their third quarter 2025 report, BCBSND proposed a new intervention to conduct care management outreach to link enrollees with their PCP, including an offer of assistance

with care management, scheduling appointments with their PCP, transportation or social needs of the enrollee.
- Utilization management sent daily reports to case management with enrollees who were discharged from inpatient or observational settings. Case management then initiated engagement with members to address their healthcare and social determinants of health (SDoH) needs. In their third quarter 2025 report, BCBSND proposed a new intervention to engage enrollees with a COPD admission in care management services.

There were three study indicators for this PIP:
- Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of COPD or asthma during the CY. This indicator was also stratified by American Indian and Alaska Native and White populations.
- Retired Indicator 2 as of third quarter 2025: The percentage of acute inpatient and observation stay discharges for a principal diagnosis of COPD or asthma who also had a visit with a health care provider for a principal diagnosis of COPD or asthma during the CY.
- Replacement Indicator 2: The percentage of enrollees discharged from acute inpatient or observation stay for a principal diagnosis of COPD or asthma who also had a visit with a health care provider with a diagnosis of COPD or asthma within 30 days of discharge. BCBSND replaced the original Indicator 2 with this indicator in response to IPRO's recommendations to address validity and to incorporate a timeframe for meaningful improvement.
- Indicator 3: The number of discharges with a principal diagnosis of COPD or asthma per 100,000 member months, ages 40–64 years.

PIP 2: Diabetes Care

Goal: Reduce inpatient admissions associated with diabetes complications by establishing a connection with a healthcare provider.

The following key interventions were implemented by BCBSND:
- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND.
- *CHAMPION your health* flyer sent out to encourage members to access PCP and address all healthcare needs including medical and mental health.
- Case management made outbound engagement calls to reach members for start of case management interventions, medical needs including appointments with PCP and/or specialty care, and social/community needs. In their third quarter PDSA worksheet, BCBSND indicated plans for a new intervention for care managers to receive a report on members with a hospital admission for diabetes and address follow-up appointment with their PCP or specialty provider, as well as community support.
- Case management performed in-home hemoglobin A1c (HbA1c) labs for enrollees with diagnosis of diabetes.
- BCBSND sent monthly reports including members with multiple admissions to case management for follow-up for medical interventions, follow-up appointment needs with PCP or specialty provider and community support.
- In their fourth quarter PIP report, BCBSND indicated plans to focus with providers on improving access to continuous glucose monitors (CGMs), and to incorporate member education on CGM benefits and how to access.

There were four study indicators for this PIP:

- Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of diabetes during the CY. This indicator was also stratified by American Indian and Alaska Native and White populations.
- Indicator 2: The rate of diabetic admissions with short term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months.
- Retired Indicator 3 as of third quarter2025: The percentage of enrollees discharged from acute inpatient and observation stay discharges for a principal diagnosis of diabetes who also had a visit with a health care provider for a principal diagnosis of diabetes during the CY.
- Replacement Indicator 3: BCBSND is working on replacing retired Indicator 3 with a performance indicator that measures 30-day follow-up after hospitalization for diabetes.
- Indicator 4: The percentage of enrollees with diabetes (types 1 and 2) whose HbA1c was in control (HbA1c < 8.0%)

PIP 3: Substance Use Disorder

Goal: Reduce inpatient admissions associated with SUD for individuals enrolled in Medicaid Expansion by establishing a connection with a healthcare provider.

The following key interventions were implemented by BCBSND:

- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND.
- *CHAMPION your health* flyer sent out to encourage members to access PCP and address all healthcare needs including medical and mental health.
- Case management outbound engagement calls made to reach members for the start of case management interventions, medical appt needs including appointments with PCP and/or specialty care, and social/community needs.
- Case management received alerts from BCBSND, local ED and HIN on members that have been treated in the ED or were admitted to acute inpatient. Case management addressed healthcare needs following receiving alerts, such as follow-up appointments, gaps in care, health education needs, home visits and social supports.
- BCBSND provided case management vendor with a list of enrollees that fell into the denominator for the FUA and FUI measure. Case management reviewed the list to determine additional outreach and case management needs. In their third quarter 2025 report, BCBSND indicated they are working with care management to outreach members with an ED visit for SUD and schedule follow-up within 30 days of the ED visit. In their fourth quarter 2025 report, BCBSND anticipated that data for the corresponding ITM would be forthcoming in 2026.
- In their fourth quarter 2025 report, BCBSND stated that the implementation of peer support services covered by BCBSND would be discontinued “as UM no longer requires preauthorization for peer support.”.
- Enrolled members into the coordinated services program, to ensure close monitoring and care from an established PCP.

There were five study indicators for this PIP:

- Indicator 1: The percentage of Medicaid Expansion enrollees who have had at least one ambulatory or preventive care visit with a healthcare provider for a principal diagnosis of SUD or any diagnosis of drug overdose. This indicator was also stratified by American Indian and Alaska Native and White populations.
- Indicator 2: The percentage of ED visits for which the enrollee received follow-up within 7 days of the ED visit.
- Indicator 3: The percentage of ED visits for which the enrollee received follow-up within 30 days of the ED visit.

- Indicator 4: The percentage of follow-up for High-Intensity Care for Substance Use Disorder – Within 7 Days of visits or discharges for which the member received follow-up for SUD after the visit or discharge.
- Indicator 5: The percentage of follow-up for After High-Intensity Care for Substance Use Disorder – Within 30 Days of visits or discharges for which the member received follow-up for SUD after the visit or discharge.

Findings

BCBSND submitted three third-year interim PIP reports. These projects focused on:

- COPD or asthma admissions in older adults,
- diabetes care, and
- SUD.

IPRO reviewed each PIP using eight validation criteria. **Table 5** summarizes PIP validation results; findings were the following:

- **COPD/Asthma PIP**: 7 out of 8 validation elements were met.
- **Diabetes Care PIP**: 5 out of 8 validation elements were met.
- **SUD PIP**: 7 out of 8 validation elements were met.

Each PIP's performance results are summarized in **Tables 6–8**, along with narrative explanations of the most important findings. **Table 9** provides a summary of IPRO's assessment of improvement for each performance indicator across all three PIPs.

Table 5: PIP Validation Results for PIP Elements – Quarter 4, 2025

Validation Element[1,2]	PIP 1: COPD/Asthma	PIP 2: Diabetes Care	PIP 3: SUD
Topic/Rationale	Met	Met	Met
Aim	Met	Met	Met
Methodology	Met	Met	Met
Population analysis and stratification	Met	Met	Met
Barrier analysis	Met	Met	Met
Robust interventions	Partially met	Partially met	Partially met
Results table	Met	Partially met	Met
Discussion and validity	Met	Partially met	Met
Overall credibility of results[3]	Moderate confidence	Moderate confidence	Moderate confidence

[1] Interim Year 3 results for the COPD/Asthma, Diabetes Care, and SUD PIPs.
[2] There are three levels of validation results: met, partially met, and not met.
[3] There are three levels of overall credibility of results: high confidence, moderate confidence, and low confidence.
PIP: performance improvement project; COPD: chronic obstructive pulmonary disease; SUD: substance use disorder.

Table 6: BCBSND COPD or Asthma in Older Adults Admission Rate PIP Interim Results

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	Interim Period CY 2025	Target Rate
Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of COPD or asthma during the CY.	66.85% (357/534)	68.52% (283/413)	64.86% (216/333)	87.45% (467/ 534)	72.00%
Indicator 1: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	American Indian and Alaska Native 71.05% (54/76) White 65.91% (261/396)	American Indian and Alaska Native 64.38% (47/73) White 68.77% (240/349)	American Indian and Alaska Native 61.67% (37/60) White 65.76% (169/257)	American Indian and Alaska Native 76.67% (69/90) White 89.93% (375/ 417)	72.00%

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	Interim Period CY 2025	Target Rate
Retired Indicator 2: The percentage of acute inpatient and observation stay discharges for a principal diagnosis of COPD or asthma who also had a visit with a healthcare provider for a principal diagnosis of COPD or asthma during the CY.	50.00% (15/30)	71.43% (15/21)	53.33% (8/15)	Retired	60.00%
Indicator 2: The percentage of enrollees discharged from acute inpatient or observation stay for a principal diagnosis of COPD or asthma who also had a visit with a healthcare provider for diagnosis of COPD or asthma within 30 days of discharge.	N/A	N/A	35.29% (6/17)	16.67% (2/12)	41.29%
Indicator 3: The number of discharges with a principal diagnosis of COPD or asthma per 100,000 member months (MM), ages 40–64 years.	13.96 (24 discharges/ 171,937 MM)	11.02 (20 discharges/ 181,442 MM)	14.16 (20 discharges/ 141,221 MM)	13.61 (19 discharges/ 139,634 MM)	< 20 discharges/ 100,000 MM

BCBSND: Blue Cross Blue Shield of North Dakota; COPD: chronic obstructive pulmonary disease; PIP: performance improvement project; CY: calendar year; Q3: third quarter; MM: member months.

COPD/Asthma PIP: The results below are for the COPD/Asthma Performance Improvement Project.
Indicator 1 (annual visits): BCBSND met the target for the overall population, the American Indian/Alaska Native (AIAN) population, and the White population (**Table 6**). From baseline CY 2022 to interim CY 2025, the rate increased by 20.60 percentage points overall, by 5.62 percentage points for the AIAN population, and by 24.02 percentage points for the White population.

Indicator 2 (30-day follow-up after discharge): BCBSND began tracking this new indicator in CY 2024 and did not meet the target. From CY 2024 to CY 2025, the rate decreased by 18.62 percentage points.

Indicator 3 (COPD admissions; lower is better): BCBSND met the target. From CY 2022 to CY 2025, the rate decreased by 0.35 discharges per 100,000 member months.

Recommendations
Implement discharge planning interventions to improve performance on Indicator 2.

Table 7: BCBSND Diabetes Care PIP Interim Results

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	Interim Period CY 2025	Target Rate
Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of diabetes during the CY.	81.26% (1,609/1,980)	81.58% (1,422/1,743)	80.83% (1075/1330)	77.49% (1298/ 1675)	88.00%
Indicator 1: Stratification for American Indian or Alaskan Native and White (non-Hispanic).	American Indian and Alaska Native 75.93% (328/432) White 81.87% (971/1186)	American Indian and Alaska Native 76.77% (314/409) White 82.65% (872/1055)	American Indian and Alaska Native 77.53% (245/316) White 77.18% (619/802)	American Indian and Alaska Native 66.52% (302/454) White 80.67% (864/1071)	85.00%
Indicator 2: The rate of diabetic admissions with short term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months.	New measure baseline 2023	30.92 (124/ 401,010 MM)	20.46 (46/ 224,843 MM)	29.07 (85/ 292,413 MM)	<17.2 discharges/ 100,000 MM
Retired Indicator 3: The percentage of enrollees discharged from acute inpatient and observation stay discharges for a principal diagnosis of diabetes who also had a visit with a healthcare provider for a principal diagnosis of diabetes during the CY.	81.94% (59/72)	83.12% (64/77)	80.00% (40/50)	N/A	88.00%
Indicator 3: % The percentage of enrollees with diabetes (types 1 and 2) whose HbA1c was in control (HbA1c < 8.0%).	29.44% (121/411)	40.88% (157/411)	47.45% (222/411)	Not Reported	60.83%

BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; Q3: third quarter; CY: calendar year; MM: member month; HbA1c: hemoglobin A1c.

Diabetes Care PIP: BCBSND did not meet the target rates for any Diabetes Care PIP indicators (**Table 7**).

Indicator 1 (annual visits): From baseline CY 2022 to interim CY 2025, the annual visit rate decreased by 3.77 percentage points for the total population, 9.41 percentage points for the AIAN population, and 1.2 percentage points for the White population.

Indicator 2 (diabetic admissions; lower is better): Measurement began in CY 2023. From interim CY 2023 to interim CY 2025, the diabetic admission rate decreased by 1.85 discharges per 100,000 member months.

Recommendations

- Prioritize discharge planning.
- Provide member education on how to access CGMs.
- Provide member education on transportation benefits.
- Provide provider education on the new nutrition continuing education requirements.

Table 8: BCBSND Substance Use Disorder PIP Interim Results

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	Interim Period CY 2025	Target Rate
Indicator 1: The percentage of Medicaid Expansion enrollees who have had at least one ambulatory or preventive care visit with a healthcare provider for a principal diagnosis of SUD or any diagnosis of drug overdose.	37.74% (1,175/3,113)	40.50% (1,766/4,361)	44.26% (956/2160)	42.29% (1,114/ 2,634)	49.26%
Indicator 1: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	Not Reported	American Indian and Alaska Native 37.01% (356/962) White 39.62% (735/1859)	American Indian and Alaska Native 41.15% (321/780) White 41.56% (527/1268)	American Indian and Alaska Native 37.02% (348/ 940) White 45.90% (717/ 1,562)	42.00%

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	Interim Period CY 2025	Target Rate
Indicator 2: The percentage of ED visits for which the enrollee received follow-up within 7 days of the ED visit.	35.79% (446/1,246)	31.70% (471/1486)	29.98% (268/894)	25.31% (245/ 968)	40.79%
Indicator 2: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued
Indicator 3: The percentage of ED visits for which the enrollee received follow-up within 30 days of the ED visit.	49.28% (614/1246)	45.36% (674/1486)	43.96% (393/894)	39.46% (382/ 968)	54.28%.
Indicator 3: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	Discontinued	Discontinued	Discontinued	Discontinued	Discontinued
Indicator 4: The percentage of follow-up for High-Intensity Care for Substance Use Disorder – Within 7 Days, of visits or discharges for which the member received follow-up for SUD after the visit or discharge.	Not Reported	41.01% (497/1,212)	51.70% (609/1178)	48.59% (741/ 1,525)	56.70%
Indicator 5: The percentage of follow-up for After High-Intensity Care for Substance Use Disorder – Within 30 Days, of visits or discharges for which the member received follow-up for SUD after the visit or discharge.	Not Reported	59.82% (725/1,212)	65.45% (771/1178)	63.15% (963/ 1,525)	70.45%

BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; Q3: third quarter; SUD: substance use disorder; ED: emergency department; N/A: not applicable.

SUD PIP: BCBSND met the target rate for one measure in the SUD PIP: **Indicator 1 (annual visits)** for the White population (**Table 8**).

Indicator 1 (annual visits): From baseline CY 2022 to interim CY 2025, the rate increased by 4.55 percentage points for the total population, by 0.01 percentage points for the AIAN population, and by 6.28 percentage points for the White population.

Indicator 2 (7-day follow-up after an ED visit): From baseline CY 2022 to interim CY 2025, the rate decreased by 10.48 percentage points.

Indicator 3 (30-day follow-up after an ED visit): From baseline CY 2022 to interim CY 2025, the rate decreased by 9.82 percentage points.

Indicator 4 (7-day follow-up after high-intensity care): From CY 2023 to interim CY 2025, the rate increased by 7.58 percentage points.

Indicator 5 (30-day follow-up after high-intensity care): From CY 2023 to interim CY 2025, the rate increased by 3.33 percentage points.

Recommendations

- Conduct a barrier analysis focused on the AIAN population to better understand barriers to preventive visits for enrollees with SUD and to inform improvement for Indicator 1.
- Implement discharge planning interventions to help improve follow-up performance for Indicators 2, 3, 4, and 5.

Table 9 displays a summary of IPRO's improvement assessment for each project indicator by PIP topic for BCBSND. This table displays results through the third interim year for the COPD/Asthma in Older Adults Admission Rate, Diabetes Care, and Substance Use Disorder PIPs. Final assessments will be made after final data is received, when the PIPs conclude on December 31, 2026. Assessment of indicator performance was based on the following four categories:

- Target met (or exceeded), and performance improvement demonstrated (denoted by green highlight).
- Target not met, but performance improvement demonstrated (denoted by yellow highlight).
- Target not met, and performance decline demonstrated (denoted by red highlight).
- Unable to evaluate performance at this time (denoted by gray highlight).

Table 9: Assessment of BCBSND PIP Indicator Performance

Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim
COPD/Asthma in Older Adults Admission Rate PIP		
Indicator 1	% of enrollees with at least one annual visit for COPD/asthma	Target exceeded, and performance improvement demonstrated. (Green)
Indicator 1: Stratification	American Indian and Alaska Native	Target exceeded, and performance improvement demonstrated. (Green)
Indicator 1: Stratification	White	Target exceeded, and performance improvement demonstrated. (Green)
Retired: Indicator 2	% of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma	Unable to evaluate performance at this time. (Gray)
Indicator 2	Percent of enrollees discharged from acute inpatient or observation stay for a principal diagnosis of COPD or asthma who also had a visit with a health care provider for diagnosis of COPD or asthma within 30 days of discharge	Target not met, and performance decline demonstrated (from CY 2024 to CY 2025). (Red)
Indicator 3	Rate of admissions with a principal diagnosis of COPD or asthma per 100,000 member months	Target exceeded, and performance improvement demonstrated. (Green)
Diabetes Care PIP		
Indicator 1	% of enrollees with at least one annual visit for diabetes	Target not met, and performance decline demonstrated. (Red)
Indicator 1: Stratification	American Indian and Alaska Native	Target not met, and performance decline demonstrated. (Red)
Indicator 1: Stratification	White	Target not met, and performance decline demonstrated. (Red)
Indicator 2	Diabetic admissions with short term complications per 100,000 member months	Target not met, but performance improvement demonstrated from CY 2023 to CY 2025. (Yellow)
Retired Indicator 3	% of enrollees discharged for diabetes with a healthcare provider visit for diabetes	Unable to evaluate performance at this time. (Gray)
Indicator 3	% of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (< 8.0%)	Unable to evaluate performance at this time. (Gray)

Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim
Substance Use Disorder PIP		
Indicator 1	% of Medicaid Expansion enrollees who have had at least one preventive care visit for a principal diagnosis of SUD or drug overdose	Target not met, but performance improvement demonstrated. (Yellow)
Indicator 1: Stratification	American Indian and Alaska Native	Target not met, and performance improvement was not demonstrated. (Red)
Indicator 1: Stratification	White	Target exceeded, and performance improvement demonstrated. (Green)
Indicator 2	% of ED visits for which enrollee received follow-up within 7 days	Target not met, and performance decline demonstrated. (Red)
Indicator 3	% of ED visits for which enrollee received follow-up within 30 days	Target not met, and performance decline demonstrated. (Red)
Indicator 4	% of follow up for High-Intensity Care for Substance Use Disorder – Within 7 Days, of visits or discharges for which the member received follow-up for substance use disorder after the visit or discharge.	Target not met, but performance improvement demonstrated from CY 2023 to CY 2025. (Yellow)
Indicator 5	% of follow up, After High-Intensity Care for Substance Use Disorder - Within 30 Days, of visits or discharges for which the member received follow-up for substance use disorder after the visit or discharge	Target not met, but performance improvement demonstrated from CY 2023 to CY 2025. (Yellow)

BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; COPD: chronic obstructive pulmonary disease; PCP: primary care provider; BP: blood pressure SUD: substance use disorder; ED: emergency department.

Strengths and Opportunities for Improvement

Strengths

For the COPD/Asthma PIP, BCBSND met the target rate for indicator one (annual visits), for the entire population, the American Indian/ Alaska Native population, and for the White population (**Table 6**). The target rate for indicator three (rate of COPD admissions) was also met. For the SUD PIP, BCBSND met the target rate for indicator one stratified for the White population (**Table 8**).

Opportunities for Improvement

None of the target rates were met for the Diabetes Care PIP (**Table 7**), and only one indicator, which was stratified for the White population only, was met for the SUD PIP (**Table 8**). The plan should consider adding discharge planning interventions for all PIPs to help drive improvements in the indicators tracking follow-up after hospital encounters and to reduce hospitalizations for complications. IPRO also recommended BCBSND conduct barrier analysis for the American Indian/ Alaska Native population to better understand the barriers faced by this population to receiving care, to drive performance for indicator 1 across all PIPs. The plan should also consider

additional interventions in support of Rural Health Transformation (RHT) and in collaboration with RHT teams. For example, expansion of telehealth services and increased utilization of community health workers. Further, improving access to continuous glucose monitoring can drive improvement in glycemic status for BCBSND enrollees with diabetes, as well as drive improvement for the proposed new measure for HEDIS® MY 2027: Continuous Glucose Monitoring Utilization for Patients With Diabetes (CGD-E), pending finalization of this measure.

IV. Validation of Performance Measures

Objectives

Title 42 CFR § 438.330(c) Performance measurement establishes that the state must identify standard PMs relating to the performance of managed care plans and that the state requires each managed care plan to annually measure and report to the state on their performance using the standard measures required by the state.

Medicaid MCOs calculate PMs to monitor and improve processes of care. As per CMS regulations, validation of PMs is one of the mandatory EQR activities. The methodology for validation of PMs is based on CMS's *Protocol 2. Validation of Performance Measures* from *CMS's External Quality Review (EQR) Protocols*. The primary objectives of the PM validation process are to assess the following:

- structure and integrity of the MCO's underlying IS;
- MCO ability to collect valid data from various internal and external sources;
- vendor (or subcontractor) data and processes, as well as the relationship of these data sources to those of the MCO;
- MCO ability to integrate different types of information from varied data sources (e.g., member enrollment, claims, and pharmacy data) into a data repository or set of consolidated files for use in constructing MCO PMs; and
- documentation of the MCO's processes to collect appropriate and accurate data, manipulate the data through programmed queries, internally validate results of the operations performed on the data sets, follow specified procedures for calculating the specified PMs, and report the measures appropriately.

Technical Methods of Data Collection and Analysis

MCO-calculated Non-HEDIS Performance Measures

In addition to the HEDIS measures, BCBSND calculated rates for non-HEDIS measures that were validated as one of the contracted tasks between IPRO and HHS. PM validation activities included but were not limited to:

- confirmation that rates were produced with certified software or with logic approved by NCQA automated source code review;
- medical record review (MRR) validation;
- review of supplemental data sources;
- review of system conversions/upgrades, if applicable;
- review of vendor data, if applicable; and
- follow-up on issues identified during documentation review or previous audits.

MCO-calculated HEDIS Performance Measures

To ensure compliance with reporting requirements, BCBSND contracted with an NCQA-certified HEDIS vendor and an NCQA-licensed HEDIS compliance organization. The NCQA-licensed audit organization assessed compliance with NCQA standards in the four designated IS standards, as follows:

- IS A: Administrative Data;
- IS C: Clinical and Care Delivery Data;
- IS M: Medical Record Review; and
- IS R: Data Management and Reporting.

In addition, the following two HEDIS measure determination (HD) standards were assessed:

- HD 4.0: Algorithmic Compliance; and
- HD 5.0: Outsourced or Delegated Reporting Functions.

The HEDIS Compliance Audit results in audited rates or calculations at the measure level and indicate if the measures can be publicly reported. The auditor approves the rate or report status of each measure and survey included in the audit, as follows:

- Reportable (R) – a rate or numeric result; the organization followed the specifications and produced a reportable rate or result for the measure.
- Small denominator (N/A) – the organization followed the specifications, but the denominator was too small (< 30 members) to report a valid rate.
- Benefit not offered (NB) – the organization did not offer the health benefit required by the measure.
- Not reportable (NR) – the organization calculated the measure, but the rate was materially biased, or the organization chose not to report the measure or was not required to report the measure.

Information System Capabilities Assessment

An ISCA should be conducted every three years. IPRO conducted an ISCA review of BCBSND in January 2023, and as such, an ISCA review was not completed during this past year and will be conducted in 2026. The purpose of the ISCA review was to provide IPRO with a baseline assessment of the BCBSND encounter data submission processes and the completeness and accuracy of encounter data submitted by BCBSND to the state. IPRO conducted the ISCA in accordance with Appendix A of the *CMS External Quality Review (EQR) Protocols* published in October 2019, which were the latest protocols at the time of the ISCA. This assessment posed standard questions to assess BCBSND's strengths with respect to the aforementioned tasks. Responses to these questions assisted IPRO in assessing the extent to which BCBSND's IS were capable of producing and tracking valid encounter data, PMs, and other data necessary to support quality assessment and improvement, as well as of managing the care delivered to their enrollees.

The remote meeting and the ISCA completed by BCBSND were organized into five sections:

1. Data Integration and Systems Architecture
2. Enrollment System(s) and Processes
3. Claim/Encounter System(s) and Processes
4. Provider Data System(s) and Processes
5. Oversight of Contracted Vendor(s)

ISCA Findings and Recommendations

Based on the responses provided from the ISCA and the remote meeting interviews and discussions, IPRO found the following strengths, opportunities for improvement, and corrective action requests. During the remote meeting, BCBSND demonstrated their enrollment system screens and enrollment history and demographic screens, and they showed that the enrollment elements and information from the daily and monthly 834 files were captured in the enrollment system. They also demonstrated their claims and provider system screens. IPRO's assessment determined that BCBSND met or exceeded the standards reviewed.

IPRO noted the following findings of the ISCA review, as presented in **Table 10**.

Table 10: ISCA Findings

Category	Result	Comments
Completeness and accuracy of encounter data collected and submitted to the state	Met	BCBSND's information systems have a process in place that generates and submits encounter data to ND HHS, Medical Services Division. BCBSND includes up to 25 ICD-10 diagnosis codes for institutional encounters and 12 ICD-10 diagnosis codes for professional encounters, including the primary diagnosis codes.
Validation and/or calculation PMs	N/A	BCBSND has been enrolling members into the Medicaid Expansion contract since January 1, 2022. BCBSND has not received any requirements from state for MY 2022 reporting. BCBSND plans to use Cotiviti® for PM and HEDIS MY 2022 reporting.
Utility of the information systems to conduct MCO quality assessment and improvement initiatives	Met	BCBSND's information systems support various data reporting requests, both internally and externally.
Ability of the information systems to conduct MCO quality assessment and improvement initiatives	Met	BCBSND's information systems can conduct quality assessments and conduct improvement initiatives.
Ability of the information systems to oversee and manage the delivery of healthcare to the MCO's enrollees	Met	BCBSND receives and processes the daily 834 files. The daily 834 enrollment roster files identify enrollees who have been re-enrolled for the current month. The member eligibility segment records are imported and processed into BCBSND's Enrollment Communication System (ECS), and the member tables are populated and loaded into the EDW, which is maintained by BCBSND's third-party vendor, enGen. BCBSND assigns every member a unique enterprise consumer identifier (ECI) in BCBSND's enrollment system, which remains the same for a member through all product changes.
Ability of the information systems to generate complete, accurate, and timely T-MSIS data	N/A	BCBSND does not submit encounter data directly to T-MSIS. BCBSND submits institutional and professional encounter data files to ND HHS, Medical Services Division on a weekly basis.
Utility of the information systems for review of provider network adequacy	Met	BCBSND utilizes Quest Analytics® for assessing and reporting network adequacy.

Category	Result	Comments
Utility of the MCO's information systems for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, vital statistics, public health data)	Met	BCBSND's information systems have processes in place to receive, validate, and incorporate claims data and produce internal and regulatory reports.

ISCA: information systems capabilities assessment; BCBSND: Blue Cross Blue Shield of North Dakota; ND: North Dakota; HHS: Department of Health and Human Services; ICD-10: International Classification of Diseases, 10th Revision; PM: performance measure; N/A: not applicable; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; MCO: managed care organization; EDW: enterprise data warehouse; T-MSIS: Transformed Medicaid Statistical Information System.

Description of Data Obtained

In addition to the ISCA, IPRO reviewed BCBSND's HEDIS MY 2024 FAR from Attest Health Care Advisors, their licensed HEDIS auditor, to determine compliance with ISCA standards. The FAR revealed BCBSND met all standards for successful reporting (**Table 11**).

Table 11: BCBSND Compliance with Information Systems Standards – MY 2024

IS Standard	Results
IS A: Administrative Data	Met
IS C: Clinical and Care Delivery Data	Met
IS M: Medical Record Review	Met
IS R: Data Management and Reporting	Met
HD 4.0: Algorithmic Compliance	Met
HD 5.0: Outsourced or Delegated Reporting Functions	Met

BCBSND: Blue Cross Blue Shield North Dakota; MY: measurement year; IS: information systems.

Non HEDIS Data

BCBSND was required to submit member-level detail files and source code for each of the non-HEDIS measures being validated. IPRO received these files and validated their contents. Any discrepancies were discussed and resolved with BCBSND. In addition to the member-level files, IPRO received source code from BCBSND's software vendor, Cotiviti, which was also validated against the measure specifications. BCBSND also submitted their rates for the measures being validated by IPRO. These rates were reviewed, and questions were provided to BCBSND for response and resolution.

HEDIS Data

IPRO also received BCBSND's NCQA IDSS and FAR from their independent NCQA HEDIS auditor, Attest Health Care Advisors, as well as the audited HEDIS rates. IPRO compared the HEDIS rates to the NCQA Medicaid HMO national benchmarks and are shown in **Table 15**.

Conclusions and Findings

BCBSND's independent auditors determined that the HEDIS rates reported by BCBSND were calculated in accordance with NCQA's defined specifications, and there were no data collection or reporting issues identified.

Table 12 displays the color key for CMS 2024 CMS Core Set Data Dashboard quartile comparisons, and **Table 13** displays the IPRO-validated non-HEDIS PMs for MY 2024 for BCBSND.

Table 12: Color Key for IPRO-validated Non-HEDIS PM Comparisons to CMS Benchmarks

Color Key[1]	How Rate Compares to the CMS 2024 Core Set Dashboard Quartiles
Orange	Less than (<) the minimum.
Light Orange	Greater than or equal to (≥) the minimum and (<) the first quartile.
Light Gray	Greater than or equal to (≥) the first quartile and (<) the median.
Gray	Greater than or equal to (≥) the median and (<) the third quartile.
Light Blue	Greater than or equal to (≥) the third quartile and (<) the maximum.
Blue	Greater than or equal (≥) the maximum.
White	No benchmark.

[1] There were no rates that were ≥ the maximum.
HEDIS: Healthcare Effectiveness Data and Information Set; PM: performance measure; CMS: Centers for Medicare & Medicaid Services.

Table 13: IPRO-Validated Non-HEDIS Performance Measures – MY 2024

Measure	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate	Change from MY 2023 – MY 2024	MY 2024 Compared to CMS 2024 Core Set Data Dashboard
Screening for Depression and Follow-up Plan: Ages 18 Years and Older (CDF-AD)					
Ages 18–64 years	0.00%	0.00%	1.00%	1.00	Greater than or equal to (≥) the first quartile and (<) the median
Concurrent Use of Opioids and Benzodiazepines (COB-AD)[1]					
Ages 18–64 years	10.08 %	9.27%	12.79 %	3.52	Greater than or equal to (≥) the first quartile and (<) the median (lower is better)
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[1]					
Ages 18–64 years	0.00%	0.00%	0.89%	0.89	Greater than or equal to (≥) the minimum and (<) the first quartile (lower is better)
Use of Pharmacotherapy for Opioid Use (OUD-AD)					
Total	64.44 %	59.22 %	60.89 %	1.67	Greater than or equal to (≥) the median and (<) the third quartile
Buprenorphine	46.03 %	23.73 %	23.58 %	-0.15	Greater than or equal to (≥) the minimum and (<) the first quartile
Oral naltrexone	2.86%	2.50%	1.90%	-0.60	Greater than or equal to (≥) the first quartile and (<) the median
Long-acting, injectable naltrexone	1.27%	0.74%	0.89%	0.15	Greater than or equal to (≥) the first quartile and (<) the median
Methadone	18.41 %	35.40 %	38.10 %	2.70	Greater than or equal to (≥) the third quartile and (<) the maximum.
Diabetes Short-term Complications Admission Rate (PQI01-AD)[1]					
Ages 18–64 years	24.41 %	30.47 %	26.40 %	-4.07	Greater than or equal to (≥) the third quartile and (<) the maximum (lower is better)

Measure	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate	Change from MY 2023 – MY 2024	MY 2024 Compared to CMS 2024 Core Set Data Dashboard
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate (PQI05-AD)[1]					
Ages 40–64 years	25.41 %	10.58 %	14.25 %	3.67	Greater than or equal to (≥) the minimum and (<) the first quartile (lower is better)
Heart Failure Admission Rate (PQI08-AD)[1]					
Ages 18–64 years	25.94 %	22.92 %	30.12 %	7.20	Greater than or equal to (≥) the median and (<) the third quartile (lower is better)
Asthma in Younger Adults Admission Rate (PQI15-AD)[1]					
Ages 18–39 years	1.36%	0.46%	0.64%	0.18	Less than (<) the minimum (lower is better)
Contraceptive Care – Postpartum Women Ages 21–44 Years (CCP-AD)					
Most or moderately effective contraception – 3 days	7.36%	6.56%	1.67%	-4.89	Greater than or equal to (≥) the minimum and (<) the first quartile
Most or moderately effective contraception – 90 days	25.15 %	31.15 %	31.67 %	0.52	Greater than or equal to (≥) the minimum and (<) the first quartile
LARC – 3 days	0.00%	0.00%	0.00%	0.00	Less than (<) the minimum
LARC – 90 days	5.52%	12.30 %	6.67%	-5.63	Less than (<) the minimum
Contraceptive Care – All Women Ages 21–44 Years (CCW-AD)					
Provision of most or moderately effective contraception	15.89 %	15.58 %	16.86 %	1.28	Greater than or equal to (≥) the minimum and (<) the first quartile
Provision of LARC	2.96%	2.98%	3.47%	0.49	Greater than or equal to (≥) the minimum and (<) the first quartile
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (> 9.0%; HPCMI-AD)[1,2]					
Ages 18–64 years	100.00%	93.14 %	75.00 %	-18.14	No benchmark
HIV Viral Load Suppression (HVL-AD)					
Ages 18–64 years	0.00%	0.00%	0.00%	0.00	No benchmark

[1] Lower rate is better. HEDIS: Healthcare Effectiveness Data and Information Set; CY: calendar year; MY: measurement year; LARC: long-acting reversible contraception.

[2] For the 2025 Core set, the Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (BbA1c) Poor Control (>9.0%) measure was modified by the measure steward and is now Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (> 9.0%; HPCMI-AD) measure.

Non-HEDIS Measure Findings

Of the 18 elements that had benchmarks available, lower is better for six measures: one was less than (<) the minimum, two were greater than or equal to (≥) the minimum and (<) the first quartile, one was greater than or equal to (≥) the median and (<) the third quartile, and one was greater than or equal to (≥) the third quartile and (<) the maximum.

Higher is better for 12 measures: two were less than (<) the minimum, five were greater than or equal to (≥) the minimum and (<) the first quartile, three were greater than or equal to (≥) the first quartile and (<) the median, one was greater than or equal to (≥) the median and (<) the third quartile, and one was greater than or equal to (≥) the third quartile and (<) the maximum (**Table 13**).

Table 14 shows the color key for HEDIS PM comparisons for NCQA HEDIS MY 2024 Quality Compass national percentiles. **Table 15** shows the HEDIS PMs for MY 2024 for BCBSND along with this comparison.

Table 14: Color Key for HEDIS PM Comparisons to HEDIS MY 2024 Medicaid HMO QC National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2024 QC National Medicaid Percentiles
Orange	Below the national Medicaid 25th percentile.
Light Orange	At or above the national Medicaid 25th percentile but below the 50th percentile.
Gray	At or above the national Medicaid 50th percentile but below the 75th percentile.
Light Blue	At or above the national Medicaid 75th percentile but below the 90th percentile.
Blue	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; MY: measurement year; QC: Quality Compass.

Table 15: BCBSND NCQA-Certified Audited HEDIS PMs − MY 2024

Measure	MY 2023 Rate	MY 2024 Rate	Change From MY 2023 to 2024	MY 2024 Compared to MY 2024 Quality Compass
Effectiveness of Care				
Chlamydia Screening in Women (CHL)				
CHL: Ages 21−24 years	37.97%	46.79%	8.82	< 25th
CHL: Total rate	37.97%	46.79%	8.82	< 25th
Cervical Cancer Screening (CCS)				
CCS: Cervical Cancer Screening	24.80%	30.83%	6.03	< 25th
Effectiveness of Care: Respiratory Conditions				
Asthma Medication Ratio (AMR)				
AMR: Ages 19−50 years	98.51%	86.11%	-12.40	≥ 90th
AMR: Total rate	98.97%	90.00%	-8.97	≥ 90th
Effectiveness of Care: Cardiovascular Conditions				
Controlling High Blood Pressure (CBP)				
CBP: Total rate	53.28%	56.69%	3.41	< 25th
Effectiveness of Care: Diabetes				
Glycemic Status Assessment for Patients with Diabetes (GSD)				
GSD: Glycemic Status (>9%)[1]	48.91%	45.26%	-3.65	< 25th
GSD: Glycemic Status (<8%)	40.88%	47.45%	6.57	< 25th

Measure	MY 2023 Rate	MY 2024 Rate	Change From MY 2023 to 2024	MY 2024 Compared to MY 2024 Quality Compass
Effectiveness of Care: Behavioral Health				
Antidepressant Medication Management (AMM)				
AMM: Effect acute phase treatment	63.36%	64.25%	0.89	≥ 25th and < 50th
AMM: Effect continuation phase treatment	44.78%	47.83%	3.05	≥ 50th and < 75th
Follow-up after Hospitalization for Mental Illness (FUH)				
FUH: Ages 18−64 years, 30-day follow-up	41.85%	54.86%	13.01	≥ 25th and < 50th
FUH: Ages 18−64 years, 7-day follow-up	24.81%	34.29%	9.48	≥ 25th and < 50th
FUH: Total rate 30-day follow-up	41.85%	54.86%	13.01	≥ 25th and < 50th
FUH: Total rate 7-day follow-up	24.81%	34.29%	9.48	≥ 25th and < 50th
Follow-up after Emergency Department Visit for Mental Illness (FUM)				
FUM: Ages 18−64 years, 30-day follow-up	51.94%	54.69%	2.75	≥ 50th and < 75th
FUM: Ages 18−64 years, 7-day follow-up	27.16%	32.04%	4.88	≥ 25th and < 50th
FUM: Total rate 30-day follow-up	51.94%	54.69%	2.75	≥ 25th and < 50th
FUM: Total rate 7-day follow-up	27.16%	32.04%	4.88	< 25th
Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)				
FUA: 30-day follow-up, ages 18+ years	44.51%	45.66%	1.15	≥ 75th and < 90th
FUA: 7-day follow-up, ages 18+ years	29.97%	30.91%	0.94	≥ 50th and < 75th
FUA: 30-day follow-up, total	44.51%	45.66%	1.15	≥ 50th and < 75th
FUA: 7-day follow-up, total	29.97%	30.91%	0.94	≥ 50th and < 75th
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
SSD: Total rate	79.13%	81.07%	1.94	≥ 25th and < 50th
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
SAA: Total rate	45.32%	50.55%	5.23	< 25th
Medication Management				
Avoidance of Antibiotic Treatment in Adults for Acute Bronchitis/Bronchiolitis (AAB)				
AAB: Ages 18−64 years	59.36%	56.45%	-2.91	≥ 75th and < 90th
AAB: Total rate	59.36%	56.45%	-2.91	≥ 25th and < 50th

Measure	MY 2023 Rate	MY 2024 Rate	Change From MY 2023 to 2024	MY 2024 Compared to MY 2024 Quality Compass
Access/Availability of Care				
Initiation and Engagement of Alcohol and Other Drug (IET)				
IET: Alcohol abuse – initiation, ages 18–64 years	40.58%	43.18%	2.60	≥ 25th and < 50th
IET: Alcohol abuse – initiation, total	40.58%	43.18%	2.60	≥ 50th and < 75th
IET: Opioid abuse – initiation, ages 18–64 years	61.36%	65.34%	3.98	≥ 50th and < 75th
IET: Opioid abuse – initiation, total	61.36%	65.34%	3.98	≥ 50th and < 75th
IET: Other drug abuse – initiation, ages 18–64 years	44.78%	45.12%	0.34	≥ 50th and < 75th
IET: Other drug abuse – initiation, total	44.78%	45.12%	0.34	≥ 50th and < 75th
IET: Total - initiation – ages 18–64 years	44.73%	46.95%	2.22	≥ 50th and < 75th
IET: Total - initiation – total	44.73%	46.95%	2.22	≥ 50th and < 75th
IET: Alcohol abuse – engagement, ages 18–64 years	17.23%	18.29%	1.06	≥ 75th and < 90th
IET: Alcohol abuse – engagement, total	17.23%	18.29%	1.06	≥ 75th and < 90th
IET: Opioid abuse – engagement, ages 18–64 years	41.19%	47.29%	6.10	≥ 75th and < 90th
IET: Opioid abuse – engagement, total	41.19%	47.29%	6.10	≥ 75th and < 90th
IET: Other drug abuse – engagement, ages 18–64 years	19.87%	21.20%	1.33	≥ 75th and < 90th
IET: Other drug abuse – engagement, total	19.87%	21.20%	1.33	≥ 75th and < 90th
IET: Total - engagement – ages 18–64 years	21.06%	23.38%	2.32	≥ 75th and < 90th
IET: Total - engagement − total	21.06%	23.38%	2.32	≥ 75th and < 90th
Prenatal and Postpartum Care (PPC)				
PPC: Timeliness of prenatal care	48.65%	48.89%	0.24	< 25th
PPC: Postpartum care	38.92%	37.78%	-1.14	< 25th
Utilization and Risk-adjusted Utilization				
Plan All-Cause Readmissions (PCR) Observed/Expected Ratio[1]				
PCR: Observed/Expected ratio, ages 18–64 years	1.02	1.12	0.10	≥ 50th and < 75th
PCR: Observed/Expected ratio, ages 55–64 years	0.90	1.00	0.10	≥ 75th and < 90th
PCR: Observed/Expected ratio, ages 45–54 years	1.10	0.95	-0.15	≥ 75th and < 90th
PCR: Observed/Expected ratio, ages 18–44 years	1.05	1.34	0.29	≥ 25th and < 50th
ECDS Measures				
Breast Cancer Screening (BCS-E)				
BCS-E: Total rate	44.19%	49.38%	5.19	< 25th
Colorectal Cancer Screening (COL-E)				
COL-E: Ages 46–50 years	N/A	27.79%	N/A	≥ 25th and < 50th
COL-E: Ages 51–75 years	N/A	36.34%	N/A	< 25th
COL-E: Total Rate	N/A	34.24%	N/A	< 25th

Measure	MY 2023 Rate	MY 2024 Rate	Change From MY 2023 to 2024	MY 2024 Compared to MY 2024 Quality Compass
Adult Immunization Status (AIS-E)				
AIS-E: Influenza, ages 19−65 years	N/A	13.15%	N/A	≥ 25th and < 50th
AIS-E: Influenza, total	N/A	13.15%	N/A	≥ 25th and < 50th
AIS-E: Td/Tdap, ages 19−65 years	N/A	16.74%	N/A	< 25th
AIS-E: Td/Tdap, total	N/A	16.74%	N/A	< 25th
AIS-E: Zoster, ages 50−65 years	N/A	7.56%	N/A	≥ 25th and < 50th
AIS-E: Zoster, total	N/A	7.56%	N/A	≥ 25th and < 50th
Prenatal Immunization Status (PRS-E)				
PRS-E: Influenza	N/A	18.97%	N/A	≥ 25th and < 50th
PRS-E: Tdap	N/A	57.76%	N/A	≥ 25th and < 50th
PRS-E: Combination	N/A	16.38%	N/A	≥ 25th and < 50th
Postpartum Depression Screening and Follow-Up (PDS-E)				
PDS-E: Total rate	N/A	0.00%	N/A	< 25th

[1] Lower rate is better.

BCBSND: Blue Cross Blue Shield of North Dakota; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; PM: performance measure; MY: measurement year; HbA1c: hemoglobin A1c; Td/Tdap: tetanus, diphtheria, and pertussis; N/A: not applicable; some measures were not able to be reported for MY2023.

HEDIS Measures Findings

Of the 62 measures and submeasures reported by BCBSND, two were above the NCQA 90th percentile, 12 were between the NCQA 75th and 90th percentiles, 13 were between the 50th and 75th percentiles, 19 were between the 25th and 50th percentiles, and 16 fell below the NCQA 25th percentile (**Table 15**).

Strengths, Opportunities for Improvement, and Recommendations

Focusing on the HEDIS quality-related measures that fell below the NCQA national 25th percentile, BCBSND should continue to identify barriers and consider interventions to improve performance to improve quality, timeliness and access.

V. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

Title 42 CFR § 438.358 Activities related to external quality review(b)(1)(iii) establishes that a review of a MCO's compliance with federal Medicaid and CHIP standards is a mandatory external quality activity. Further, the state, its agent, or the EQRO must conduct this review within the previous three-year period.

As required by Section 2.1 of the Compliance of the *North Dakota Medicaid Expansion Managed Care Organization Contract*, BCBSND is required to meet all regulations specified in *Title 42 CFR Part 438 Managed Care*.

Title 42 CFR § 438.358 Activities related to external quality review(a)(1) mandates that the state or an EQRO must perform the review to determine managed care compliance with federal Medicaid and CHIP standards. Per *Title 42 CFR § 438.360 Nonduplication of mandatory activities with Medicare or accreditation review*, in place of a review by the state, its agent, or the EQRO, states can use information obtained from a national accrediting organization review for the EQR activities. Through this authority, the Office of Health and Human Services uses the results of each managed care plans' NCQA Accreditation Survey to verify managed care plan compliance with state and federal standards.

This section summarizes the 2023 compliance results. The next comprehensive review will be conducted in 2026, as the compliance validation process is conducted triennially. In November 2023, BCBSND participated in a compliance review for the review period January 1−December 31, 2022.

Technical Methods of Data Collection and Analysis

Data collected from BCBSND and submitted to IPRO were considered in determining the extent to which BCBSND was in compliance with the standards.

In developing its review protocols, IPRO followed a detailed and defined process, consistent with the CMS EQRO protocols for monitoring regulatory compliance of MCOs. For each set of standards reviewed, IPRO prepared standard-specific tools with standard-specific elements (i.e., substandards). The tools included the following:

- statement of federal, state, and MCO contract requirements and applicable state regulations;
- prior results and follow-up;
- NCQA-deemable citation and NCQA determination;
- reviewer compliance determination;
- descriptive reviewer findings and recommendations related to the findings;
- overall compliance determinations and scoring grid; and
- suggested evidence.

In addition, where applicable (e.g., Grievance and Appeals Systems), file review worksheets were created to facilitate complete and consistent file review. Reviewer findings on the tools formed the basis for assigning preliminary and final determinations.

The 2023 compliance review consisted of three phases: 1) a pre-interview desk review of MCO documentation and case file review, 2) remote review interviews, and 3) post-interview report preparation.

Pre-review Activities

Prior to the remote visit, the review was initiated with an introduction letter, documentation request, and request for eligible populations for all file reviews. The documentation request was a list of pertinent documents for the review period, such as policies and procedures, sample contracts, program descriptions, work plans, and various program reports. The eligible population request required BCBSND to submit case lists for file reviews (e.g., for member grievances, a list of grievances for a selected quarter of the year; for care coordination, a list of members enrolled in care management during a selected period of the year). From these lists, IPRO selected a random sample of files for review.

IPRO began its "desk review" when the pre-review documentation was received from BCBSND. Prior to the review, a notice was sent to BCBSND including a confirmation of the remote review dates, an introduction to the review team members, a review agenda, and a list of files selected for review.

Review Activities

Beginning with the 2019 novel coronavirus (COVID-19) restrictions and supported by positive feedback and efficient results for reviews conducted in 2020 and 2021, the review took the form of remote online meetings and offsite reviews. This part of the review commenced with an opening conference, where staff members were introduced and an overview of the purpose and process for the review and agenda was provided. Following this, IPRO conducted a review of additional documentation provided by BCBSND, as well as of the file reviews. Staff interviews were conducted to clarify and confirm findings. When appropriate, walkthroughs or demonstrations of work processes were conducted. The remote review concluded with a closing conference, during which IPRO provided feedback regarding the preliminary findings, follow-up items needed, and the next steps in the review process.

Post-interview Report Preparation

Following the remote interviews, review tools were updated. These post-interview tools included an initial review determination for each element reviewed and identified the specific evidence used to assess MCO compliance with the standard or the rationale for why an MCO was partially compliant or noncompliant. For each element that was deemed less than fully compliant, IPRO provided a recommendation for MCOs to consider in order to attain full compliance.

In order to make a compliance determination for each domain, IPRO assigned a point value to each element based on the determination assigned by the reviewer. The numerical score for each domain was calculated by adding the points achieved for each element and dividing the total by the number of applicable elements reviewed in the domain. The compliance determination was displayed as a percentage.

The standard determinations and assigned point values are shown in **Table 16.**

Table 16: ND MMC Compliance Monitoring Standard Designations

Standard Designations	Interpretation	Points
Met	BCBSND has met or exceeded requirements.	1.0
Partially met	BCBSND has met most requirements but may be deficient in a small number of areas.	0.5
Not met	BCBSND has not met the requirements.	0.0
Deemed	BCBSND fully met requirements in NCQA's accreditation review.	1.0
Not applicable (N/A)[1]	Contractual element does not require a review decision; for reviewer information purposes.	-

[1] Elements determined to be not applicable were not included in the overall determination calculation.
ND: North Dakota; MMC: Medicaid managed care; BCBSND: Blue Cross Blue Shield of North Dakota; NCQA: National Committee for Quality Assurance.

Description of Data Obtained

To assess BCBSND's compliance with federal and state regulations and contract requirements, IPRO reviewed documents relevant to each standard, such as policies and procedures; sample contracts; the annual quality improvement program description, work plan, and annual evaluation; member and provider handbooks; access reports; committee descriptions and minutes; case files; program monitoring reports; and evidence of monitoring, evaluation, analysis, and follow-up. Supplemental documentation was requested for areas where IPRO deemed it necessary to support compliance.

The review determination was based on IPRO's assessment and analysis of the evidence presented by BCBSND. For elements where BCBSND was less than fully compliant, IPRO provided a narrative description of the evidence reviewed and reason for the determination. BCBSND was provided preliminary findings and had 20 business days to submit a response and clarification of information for consideration. BCBSND could only clarify documentation that had been previously submitted; no new documentation was accepted. IPRO/HHS reviewed BCBSND responses and prepared the final compliance determinations.

Findings and Conclusions

There were three categories that underperformed and had scores less than 90%: Availability of Services, Assurances of Adequate Capacity and Services, and Provider Selection (**Table 17**). The Availability of Services domain had 18 of 33 elements that were fully met and 15 partially met (data not shown). The majority of the issues were related to not including all providers in the GeoAccess report, provider manual deficiencies, and policies lacking adequate information. The Assurances of Adequate Capacity and Services domain contained 6 of 24 fully met and four partially met contractual elements (data not shown). Issues included lack of providers on the GeoAccess reporting, a missing policy, and insufficient providers in several locations. The Provider Selection domain had 24 of 32 elements that were fully met and four partially met (data not shown). The majority of elements were not fully met because of a lack of documentation. Overall, compliance rate was 95.1% (**Table 17**).

Recommendations

BCBSND should focus on the three domains that performed poorly: Availability of Services, Assurances of Adequate Capacity and Services, and Provider Selection.

Table 17: Compliance Review Findings

CFR Topic	Total Points	Applicable Elements	BCBSND Compliance Score
438.56 Disenrollment Requirements and Limitations	13	13	100.0%
438.100 Enrollee Rights and Protections	108	109	99.1%
438.114 Emergency and Post-stabilization Services	9	9	100.0%
438.206 Availability of Services	25.5	33	77.3%
438.207 Assurances of Adequate Capacity and Services	10	17	58.8%
438.208 Coordination of Care	113	113	100.0%
438.210 Coverage and Authorization	68	71	95.8%
438.214 Provider Selection	26	32	81.3%
438.224 Confidentiality of Health Information	6	6	100.0%
438.228 Grievance and Appeals	69.5	72	95.2%
438.230 Subcontractual Relationships and Delegations	22	24	91.7%
438.236 Practice Guidelines	8	8	100.0%
438.242 Health Information Systems	61	62	98.4%
438.330 QAPI	34	34	100.0%
438.608 Program Integrity	52	53	98.1%
Overall	**625**	**657**	**95.1%**

CFR: Code of Federal Regulations; BCBSND: Blue Cross Blue Shield of North Dakota; QAPI: Quality Assurance and Performance Improvement.

VI. Validation of Network Adequacy

Objectives

Title 42 CFR § 438.68 Network adequacy standards requires states that contract with an MCO to deliver services must develop and enforce network adequacy standards consistent with the CFR. At a minimum, states must develop time and distance standards for the following provider types: adult and pediatric primary care, ob/gyn, adult and pediatric BH (for mental health and SUD), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support (LTSS), as per *Title 42 CFR § 438.68(b)*. ND has developed access standards based on the requirements, which are described in the *North Dakota Medicaid Expansion Managed Care Organization Contract*.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)(iv)* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, ND contracted with IPRO to perform the validation of network adequacy for BCBSND. The most current CMS protocols available in 2023 did not include a network adequacy protocol. However, IPRO and ND developed a methodology involving a telephone survey of PCPs and specialists and a review of network adequacy standards reported by BCBSND.

Technical Methods of Data Collection and Analysis

Provider Access Survey Study

Between October 2025 and January 2026, IPRO conducted a telephone survey of provider practices to evaluate the accuracy of the provider web directory and access to an adequate provider network. IPRO assessed the ability to contact providers and make office appointments using a secret shopper survey methodology.

A total of 425 providers were randomly sampled for the survey study. The project assessed the accuracy of the provider directory and the ability of providers to accommodate three types of appointments: routine, nonurgent sick, and after-hours.

Survey responses were used to assess both access to providers and the accuracy of BCBSND provider directory data across two domains:

- Patient access: information on whether the provider could be contacted via telephone, was still contracted with BCBSND, and was accepting new patients; information on the soonest-available appointment with any provider at the location for routine visits and nonurgent sick Medicaid members.
- Provider web directory accuracy: the degree to which survey responses aligned with web directory data for providers' telephone number, office location, BCBSND contract status, and new patient acceptance status.

Survey calls took place Monday–Friday, 8:00 a.m.–4:30 p.m. CST. Up to four attempts were made to reach a live respondent for each provider sampled. The four attempts to reach office personnel were generally made on different days and/or different times of the day. The after-hours calls were made after 7:00 p.m. CST and on weekends.

A "secret shopper" methodology was used to conduct the phone call survey. Surveyors were instructed to role-play as MMC members seeking care. Using scripted scenarios with clinical indicators that were developed by IPRO and approved by ND Medicaid, surveyors attempted to obtain appointments for care.

Provider Inclusion

For providers to be included in the survey, four criteria had to be met during the phone call:

1. Successful contact was made with the provider's office.
2. Provider was participating in BCBSND.
3. Provider was accepting new patients.
4. Provider was practicing as a PCP, ob/gyn, cardiologist, substance abuse counselor, or BH provider.

Overall, the survey found 226 of the 425 providers had telephone numbers that resulted in successful contact (**Figure 3**). Of these providers, 159 were accepting patients on the listed insurance provider and were practicing the primary specialty indicated in the provider directory.

These providers had the availability to schedule timely appointments at a rate of 35.8% for routine visits and 25.8% for nonurgent sick visits (**Table 21**). After-hours access for PCPs had a compliance rate of 90.9%.

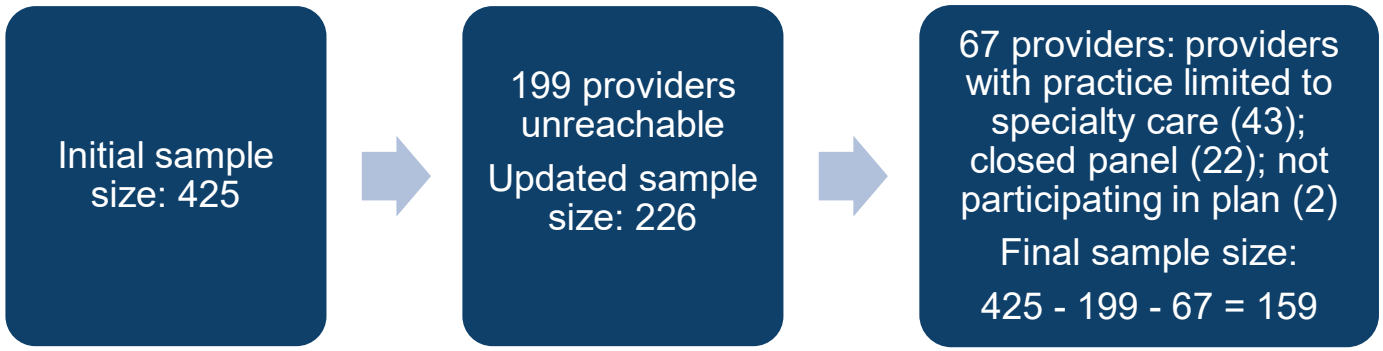

Figure 3: Web Directory Sample Size

Description of Data Obtained

For the provider access survey study, IPRO obtained provider information from the provider web directory. For the review of network adequacy standards, IPRO analyzed data from the *PCP Geographic-Access Repor*t, the *PCP-to-Enrollee Ratio Report*, the *Top Six High-Volume Specialists Geographic Access Report*, and the annual *Summary Access and Availability Analysis Report*.

Conclusions and Findings

Directory Accuracy Findings

Directory accuracy findings are presented in **Table 18**.

Table 18: Web Provider Directory Accuracy by Provider Specialty

Provider Specialty	Total Providers Surveyed	Total Providers Who Verified the Accuracy of Their Data in the Provider Network Data System[1]	Provider Directory Access Rate by Specialty
Family practice/Internal medicine	217	89	41.0%
Obstetrics/Gynecology	50	23	46.0%
Cardiology	48	23	47.9%
Behavioral health (MD, PhD)	50	13	26.0%
Substance abuse counseling	60	19	31.7%
Total	**425**	**159**	**37.4%**

[1] Providers who are participating in Medicaid and accepting new patients for the reported specialty.

Directory Access failures are presented in **Table 19**.

Table 19: Managed Care Plan Provider Directory Access Failure Summary

Failure Reason[1]	Total Failed Providers	Percent of Total Failures[2]
Provider not at site	137	51.5%
Answering machine/Voicemail system	51	19.2%
Provider practice is restricted to specialty care	43	16.2%
Provider not accepting new patients (closed panel)	22	8.3%
Telephone company message indicating phone out of order	4	1.5%
No answer	3	1.1%
Provider not a plan participant	2	0.8%
Put on hold > 10 min	2	0.8%
Wrong telephone number	2	0.8%
Total	**266**	**100.0%**

[1] Failure reason is based on the final call attempt.
[2] Percentages may not add up to 100.0% due to rounding.

Access and Availability Secret Shopper Survey Findings

The following results pertain to the 159 providers participating in the plan that were confirmed to be accepting new patients. **Table 20** shows the number of providers offering appointments to new patients for routine well-check visits and nonurgent sick visits.

Table 20: Appointment Availability and After-Hours Access Rates

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	Family practice/Internal medicine	28	21	75.0%
Routine	Obstetrician/Gynecologist	12	10	83.3%
Routine	Cardiologist	23	10	43.5%
Routine	Behavioral health provider (MD, PhD)	13	5	38.5%
Routine	Licensed substance abuse counselor	19	6	31.6%

Call Type	Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate[1]
Routine	**Total routine**	**95**	**52**	**54.7%**
Nonurgent sick	Family practice/Internal medicine	20	16	80.0%
Nonurgent sick	Obstetrician/Gynecologist	11	8	72.7%
Nonurgent sick	Cardiologist	0	0	-
Nonurgent sick	Behavioral health provider (MD, PhD)	0	0	-
Nonurgent sick	**Total nonurgent sick**	**31**	**24**	**77.4%**
After-hours access[2]	Family practice/Internal medicine	33	30	90.9%
After-hours access[2]	Obstetrician/Gynecologist	0	0	-
After-hours access[2]	Cardiologist	0	0	-
After-hours access[2]	Behavioral health provider (MD, PhD)	0	0	-
After-hours access[2]	**Total after-hours access**	**33**	**30**	**90.9%**

[1] Timeliness was not considered when determining appointment availability rates.
[2] After-hours access does not require an appointment.

Timely Appointment Availability Findings

Table 21 shows the number of providers offering appointments to new patients for timely routine well-check visits and sick visits.

Table 21: Timely Appointment Rates

Call Type	Provider Type	Total Providers Surveyed	Timely Appointments[1]	Appointment Rate
Routine	Family practice/Internal medicine	28	15	53.6%
Routine	Obstetrician/Gynecologist	12	4	33.3%
Routine	Cardiologist	23	5	21.7%
Routine	Behavioral health provider (MD, PhD)	13	4	30.8%
Routine	Licensed substance abuse counselor	19	6	31.6%
Routine	**Total routine**	**95**	**34**	**35.8%**
Nonurgent sick	Family practice/Internal medicine	20	7	35.0%
Nonurgent sick	Obstetrician/Gynecologist	11	1	9.1%
Nonurgent sick	Cardiologist	0	N/A	N/A
Nonurgent sick	Behavioral health provider (MD, PhD)	0	N/A	N/A
Nonurgent sick	Licensed substance abuse counselor	0	N/A	N/A

Call Type	Provider Type	Total Providers Surveyed	Timely Appointments[1]	Appointment Rate
Nonurgent sick	**Total nonurgent sick**	**31**	**8**	**25.8%**
After-hours access[2]	Family practice/Internal medicine	33	30	90.9%
After-hours access[2]	Obstetrician/Gynecologist	0	N/A	N/A
After-hours access[2]	Cardiologist	0	N/A	N/A
After-hours access[2]	Behavioral health provider (MD, PhD)	0	N/A	N/A
After-hours access[2]	Licensed substance abuse counselor	0	N/A	N/A
After-hours access[2]	**Total after-hours access**	**33**	**30**	**90.9%**

[1] Timely is within 72 hours for nonurgent sick and within six weeks for routine-type calls.
[2] After-hours access does not require an appointment.
N/A not applicable

Provider Directory Accuracy

Only 37.4% of providers had accurate directory information (**Table 18**), while 266 out of 425 providers (62.6%) failed the directory access check (**Table 19**). Of the 425 providers sampled, 199 (46.8%) were unreachable (**Figure 3**).

Appointment Rates

Compared to the prior year, overall appointment rates decreased slightly for routine appointments from 55.6% to 54.7% (**Table 20**). Nonurgent sick appointment rates also decreased slightly from 80.6% to 77.4%. For routine appointment rates, the following areas increased from the prior year: family practice/internal medicine; BH provider, and cardiologist (data not shown). For nonurgent appointment rates, the family practice/internal medicine category increased slightly (data not shown).

Timely Appointment Rates

Compared to the prior year, overall appointment rates decreased for routine appointments from 42.9% to 35.8% (**Table 21**). Nonurgent sick appointment rates increased from 16.1% to 25.8%. For routine appointment rates, the following areas increased from the prior year: BH provider and cardiologist (data not shown). For nonurgent appointment rates, the family practice/internal medicine category increased slightly (data not shown).

After-hours Appointment Rates

After hour compliance rates increased from the prior year from 52.1% to 90.9% (**Table 21**).

Review of Network Adequacy Standards

Provider-to-member Ratio Findings

Each quarter, BCBSND is required to calculate and report the PCP-to-member ratio to HHS. IPRO validated the BCBSND-calculated ratios for July 2025. **Table 22** displays the validated BCBSND ratio for CY 2025. BCBSND met the PCP-to-member ratio standard for CY 2025 of 1 PCP to 2,500 members.

Table 22: BCBSND Provider-to-member Ratio, CY 2025

Specialty[1]	Number of Providers-to-members	Ratio of Providers-to-members
PCP	6,431:21,933	1:3.4

[1] Source: PCP to Enrollee Ratio Report, Medicaid Expansion, July 2025.
BCBSND: Blue Cross Blue Shield of North Dakota; CY: calendar year; PCP: primary care provider.

Network Adequacy Distance Standards Findings

ND requires that every BCBSND member have access to providers within the established distance standards. IPRO analyzed *Top Six High-Volume Specialists Geographic Access Report* produced in July 2025 by BCBSND to determine if they were compliant with the HHS distance requirements (**Table 23**).

Table 23: BCBSND Adherence to Distance Standards – Top Six High-volume Specialties

Specialty[1]	Standard	% with Access
Behavioral health providers	1 in 50 miles	100.0%
Cardiology providers	1 in 50 miles	96.9%
Medical oncology providers	1 in 50 miles	74.4%
Ob/Gyn providers	1 in 50 miles	97.8%
Orthopedic surgery providers	1 in 50 miles	97.7%
Surgery providers	1 in 50 miles	99.8%

[1] Provider types that were top six high-volume specialties in the second quarter of 2025.
BCBSND: Blue Cross Blue Shield of North Dakota; ob/gyn: obstetrician/gynecologist.

Network Information Systems Validation

The network IS validation will be conducted as part of the ISCA in 2026, as the ISCA is to be conducted at least once every three years. The following describes the validation performed in 2024.

The network IS validation is a component of the network validation EQR activity, during which IPRO evaluated the integrity of the systems used to collect, store, and process provider network data.

IPRO developed a survey in Research Electronic Data Capture (REDCap®) to support this effort. The survey questions addressed topics such as the systems used to collect and store provider data for network analysis; methods of data entry; the roles of staff involved in collecting, storing, and analyzing data; the frequency of data collection and updates; the extent of missing data; and the quality assurance measures in place to prevent and correct errors.

The survey was distributed to BCBSND on October 18, 2024, and closed on November 11, 2024. A two-hour virtual meeting was held on December 4, 2024, to discuss BCBSND's responses to the network adequacy validation ISCA and to conduct a review of BCBSND's IS. BCBSND and IPRO staff attended the virtual meeting.

The Provider Data Systems and Processes review included a detailed review of the BCBSND's provider network systems and credentialing processes and a discussion of maintenance of provider directories for their Medicaid Expansion program. The discussion also included access and availability of the provider portal.

BCBSND was found to be compliant with the utility of the IS for collection and maintenance of BCBSND's provider network, as well as their IS ability to review and calculate provider network adequacy.

Recommendations

The following summarizes IPRO's recommendations to BCBSND based on the validation of network adequacy findings:

- BCBSND should increase timely appointment rates for providers to ensure members are able to access care and obtain appointments in a timely manner.
- BCBSND should undertake measures to enhance the accuracy and accessibility of their PCP directory.
- BCBSND should include additional information needed to demonstrate compliance with the time, distance, and ratio standards detailed in the MCO Contract § 2.9.1. For instance, the MCO should provide separate data on distance to PCPs for non-rural and rural enrollees.
- The state imposed Liquidated Damages on BCBS due to the findings of this network adequacy section and BCBS should provide detailed information on how they will rectify the deficiencies going forward.

VII. Validation of Encounter Data

Objectives

Title 42 CFR § 438.242 Health information systems(c) requires that states hold managed care plans contractually responsible for the collection, maintenance, and reporting of encounter data in a manner that meets state and federal standards. These standards are intended to ensure that the encounter data provide a complete and accurate representation of services provided to enrollees.

As required by section 2.15.9 Encounter Data of the *North Dakota Medicaid Expansion Managed Care Organization Contract*, MCOs must submit encounter data monthly to the state that are accurate and complete. Managed care plan encounter submissions must include all paid lines associated with a claim and those denied claims or lines for which Medicare or a third party has paid in full.

Title 42 CFR § 438.358 Activities related to external quality review(c)(1) encourages states to validate encounter data reported by managed care plans during the preceding 12 months. In 2025, IPRO conducted this activity. IPRO aimed to verify the completeness and accuracy of encounters with service dates between January 1 and December 31, 2024, and submitted to the state between January 1, 2024, and March 31, 2025, for all professional, institutional inpatient, and institutional outpatient encounter types and fields.

Technical Methods of Data Collection and Analysis

The encounter data submitted to HHS were reconciled to the corresponding source claims data from the originally adjudicated claims in the BCBSBD claim systems and with the Health Insurance Portability and Accountability Act (HIPAA) 837 encounter data extract strings submitted to HHS. IPRO requested the claims data residing in the MCO's claims systems.

BCBSND was requested to select all claims adjudicated by the MCO; the claims provided to IPRO contained encounter submissions including all paid (original, corrected, adjusted/voided, and paid at $0) encounter data and partial payments denied at the line level and paid at the header level. IPRO provided BCBSND documentation outlining the logic to be utilized in identifying the claims to be selected and documentation outlining the identifying data elements used to compare to the claims that IPRO receives and stores in the monthly vendor extracts. BCBSND submitted the claims by claim type to IPRO. IPRO imported and compared the records submitted by BCBSND to the IPRO data warehouse and reviewed discrepant records (< 95.00% match). IPRO selected a sample of 1,000 records for each encounter type and data element discrepancy category identified. IPRO provided percentages of all discrepancies by discrepancy category to ND HHS and BCBSND.

BCBSND submitted data using the layouts developed by IPRO. File layouts were provided for the following encounter types:

- professional claims;
- institutional inpatient claims; and
- institutional outpatient claims.

The validation was conducted using an approach developed by IPRO and consistent with CMS's *Protocol 5. Validation of Encounter Data*. The encounter data validation study was conducted utilizing the following methodology:

1. BCBSND submitted specified data elements obtained from their adjudicated source claims that correspond to the selected audit period. To verify the source claims data, IPRO requested that include the internal control number when available. The internal control number is obtained when the encounter is adjudicated in the state's Medicaid Management Information System.

2. IPRO imported BCBSND's files and generated separate data tables per encounter type per managed care plan. Analyses were conducted using SAS®.
3. To identify discrepancies, IPRO compared the values of each data element from BCBSND's source data to values of the corresponding data element from the HHS source data housed in the IPRO data warehouse.
4. The percentage of records with discrepant values were calculated for each data element, and those with less than a 95.00% match rate were investigated.
5. IPRO reviewed discrepancies and categorized the data element discrepancies for each encounter type, where applicable.
6. Among data elements with less than a 95.00% match rate, IPRO selected a random sample of 1,000 discrepant records for each encounter type and discrepancy category for BCBSND. IPRO provided counts of all discrepant records by discrepancy category to HHS. The sample size was determined based on the number of discrepancies.
7. For BCBSND, IPRO identified omitted and surplus internal control numbers. The omitted internal control numbers were identified as the encounters in BCBSND's claims files that were not present in IPRO's data warehouse. The surplus internal control numbers were identified in IPRO's data warehouse that were included in BCBSND's claims files.

A teleconference was held to discuss preliminary findings and conduct staff interviews. BCBSND's system was reviewed for discrepancies of data elements present in the encounter types between the submitted encounter data validation data file and the data submitted to HHS. The attendees of the encounter data validation study call included HHS, BCBSND, and IPRO. Data elements with less than a 95.00% match rate were reviewed.

Following the teleconference with BCBSND, IPRO worked with BCBSND and HHS to identify any inconsistencies between the values and/or information provided by BCBSND and confirmed the information HHS received for each data element by encounter type.

Description of Data Obtained

IPRO requested and received from BCBSND all electronic encounters residing in their claims transaction system, with dates of service from January 1 to December 31, 2024, and submitted to the state between January 1, 2024, and March 31, 2025, for professional, institutional inpatient, and institutional outpatient claim types. BCBSND was requested to select all claims adjudicated by the MCO. The claims provided to IPRO contained encounter submissions including all paid (original, corrected, adjusted/voided, and paid at $0) encounter data and partial payments denied at the line level and paid at the header level. The claims data used for this study to compare to the BCBSND encounter data were based on the data in the IPRO data warehouse as obtained monthly from HHS. In addition to the claims data validation, in accordance with Protocol 5, IPRO requested and received medical records for a sample of providers, which were compared to the claims data to determine accuracy of the claims file.

Conclusions and Findings

Based upon IPRO's review of BCBSND's encounter data audit file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from BCBSND, and discussions with BCBSND and HHS during and following the teleconference, there are areas that require further research by encounter type by BCBSND, HHS, and IPRO.

Table 24 shows the match rates by encounter type.

Table 24: Match Rates by Encounter Data Type

Encounter Data Type	CY 2025 Total Encounters (n)	CY 2025 Matched Encounters (n)	CY 2025 Match Rate (%)	CY 2024 Match Rate (%)	Change CY 2024 to CY 2026
Professional	900,375	890,375	98.89	94.86	4.03
Institutional inpatient	112,353	109,544	97.50	64.68	32.82
Institutional outpatient	741,093	732,877	98.89	90.54	8.35
Total	1,753,821	1,732,796	98.80	91.95	6.85

FY: fiscal year.

Data elements with less than a 95.00% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type. Findings are summarized in **Tables 25–27.**

Table 25: Professional Data Element Discrepancies and Findings

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Unique Medicaid number assigned to the recipient (MMIS_ID)	890,328	99.99	47	0.01	-
Date on which the statement period on the claim began, start date of service on the header (START_DT)	890,375	100	0	0.00	-
Date on which the statement period on the claim ended, end date of service on the header (END_DT)	890,375	100	0	0.00	-
Date on which the statement period on the claim for the detailed line item (SVC_DT)	890,375	100	0	0.00	-
A code to indicate where the service was provided – place of service (PLACE_CD)	887,968	99.73	2,407	0.27	-
The first or principal diagnosis code (DX_CD)	890,374	100	1	0.00	-
Second diagnosis (DX_CD_02)	890,375	100	0	0.00	-

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Third diagnosis (DX_CD_03)	890,374	100	1	0.00	-
Fourth diagnosis (DX_CD_04)	890,375	100	0	0.00	-
Fifth diagnosis (DX_CD_05)	890,375	100	0	0.00	-
Sixth diagnosis (DX_CD_06)	890,375	100	0	0.00	-
Seventh diagnosis (DX_CD_07)	890,375	100	0	0.00	-
Eighth diagnosis (DX_CD_08)	890,375	100	0	0.00	-
Ninth diagnosis (DX_CD_09)	890,375	100	0	0.00	-
Tenth diagnosis (DX_CD_10)	890,375	100	0	0.00	-
Eleventh diagnosis (DX_CD_11)	890,375	100	0	0.00	-
Twelfth diagnosis (DX_CD_12)	890,375	100	0	0.00	-
Procedure/supplies/service code, i.e., CPT-4, CPT-CAT-II, and/or HCPCS (PROC_CD)	890,374	100	1	0.00	-
The units of service billed at the detail level (UNIT_COUNT_CLAIM)	860,037	96.59	30,338	3.41	-
The first of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_1)	725,612	81.50	164,763	18.50	Three issues were noted regarding procedure modifier codes: 1. BCBSND reported that, prior to January 1, 2026, certain modifiers were excluded from files submitted to ND HHS; 2. BCBSND advised that certain modifiers are designated for internal administrative and financial use only and are therefore not transmitted externally, including in the EDV study file; 3. During the study period, BCBSND identified system issues related to its process for extracting modifier codes submitted to ND HHS.
The second of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_2)	869,471	97.65	20,904	2.35	
The third of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_3)	888,247	99.76	2,128	0.24	
The fourth of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_4)	890,268	99.99	107	0.01	
The national drug code for the drug dispensed on the claim if present (NDC_NBR_J_CD)	890,375	100	0	0.00	-
Billing Provider Medicaid ID (BILLING_PROV_ID)	774,380	86.97	115,995	13.03	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file and their claims system.

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
					IPRO discussed this discrepancy with ND HHS and a BCBSND provider NPI submission issue was identified related to BCBSND's provider master file.
Rendering Provider Medicaid ID (RENDERING_PROV_ID)	779,048	87.50	111,327	12.50	In two of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. The third example reviewed did not match the 837 file or their claims system. IPRO to discuss this discrepancy with ND HHS.
Referring Provider Medicaid ID (REFERRING_PROV_ID)	804,526	90.36	85,849	9.64	In two of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. The other example reviewed did not match. IPRO discussed this discrepancy with ND HHS and a BCBSND provider NPI submission issue was identified related to BCBSND's provider master file.

[1] Total professional encounters = 890,375.
BCBSND: Blue Cross Blue Shield of North Dakota; EDV: encounter data validation; ND: North Dakota; HHS: Department of Health and Human Services; ID: identification; MMIS: Medicaid Management Information System; CPT®: Current Procedural Terminology. HCPCS: Healthcare Common Procedure Coding System.

Table 26: Institutional Inpatient Data Element Discrepancies and Findings

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Unique Medicaid number assigned to the recipient (MMIS_ID)	109,485	99.95	59	0.05	-
Date that the recipient was admitted to a facility (FAC_ADM_DT)	109,544	100	0	0.00	-
Date on which the statement period on the claim began, start date of service on the header (START_DT)	109,544	100	0	0.00	-
Date on which the statement period on the claim ended, end date of service on the header (END_DT)	109,544	100	0	0.00	-

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Date on which the statement period on the claim for the detailed line item (DTL_SVC_DT)	109,544	100	0	0.00	-
Admit Type Code UB is the standard UB code for the type of admission, indicating the priority of the admission or visit on a facility claim (FAC_ADMIT_TYPE_CD)	109,544	100	0	0.00	-
Discharge status (FAC_DSCHRG_STAT_CD)	109,544	100	0	0.00	-
Type of bill (FAC_BILL_TYPE_CD)	109,544	100	0	0.00	-
Type of bill frequency code (FAC_BILL_TYPE_FREQ)	90,406	82.53	19,138	17.47	For the three examples that BCBSND reviewed, BCBSND submitted two records on the study file. For two examples, the value of one record on the study file matched the DW and the 837. The value of the other record matched their claims system. For one example, the value of one record on the study file matched the 837 and their claims system. This appears to be due to timing issues. BCBSND reported that voided encounters that were denied by the state are sent to enGen but not to ND HHS.
DRG code (three-digit field; please submit value in this field only if it is an inpatient claim paid on a DRG rate as reported on the encounter); DRG code submitted by the provider (DRG_CD_SUBMIT)	89,964	82.13	19,580	17.87	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file and their claims system. In the 2024 EDV study report, IPRO requested that ND HHS provide the MCO-submitted DRG. The IPRO DW is populated with the state calculated/ computed DRG. For future EDV studies, IPRO to update the data request file layout instructions to remove the comparison of DRG values.
DRG code (three-digit field; please submit value in this field only if it is an inpatient claim paid on a DRG rate as reported on the encounter); (DRG_CD_CALC) DRG code calculated by the plan's grouper	31,446	28.71	78,098	71.29	BCBSND does not have a grouper that calculates/computes a DRG. Matches were based on blank values.

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
					The IPRO DW is populated with the state calculated/computed DRG. For future EDV studies, IPRO to update the data request file layout instructions to remove the comparison of DRG values.
The first or principal diagnosis code (DX_CD)	109,544	100	0	0.00	-
Second diagnosis (DX_CD_02)	31,605	28.85	77,939	71.15	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file and their claims system. In the 2024 EDV study report, IPRO requested that ND HHS populate the DW monthly extracts provided to IPRO with the diagnosis codes found in Loop 2300, with the qualifier code "ABF," in the order they appear on BCBSND's 837 file. ND HHS is working with their data warehouse vendor to address the issue.
Third diagnosis (DX_CD_03)	26,666	24.34	82,878	75.66	See finding for Second diagnosis (DX_CD_02)
Fourth diagnosis (DX_CD_04)	26,857	24.52	82,687	75.48	See finding for Second diagnosis (DX_CD_02)
Fifth diagnosis (DX_CD_05)	27,858	25.43	81,686	74.57	See finding for Second diagnosis (DX_CD_02)
Sixth diagnosis (DX_CD_06)	28,910	26.39	80,634	73.61	See finding for Second diagnosis (DX_CD_02)
Seventh diagnosis (DX_CD_07)	30,734	28.06	78,810	71.94	See finding for Second diagnosis (DX_CD_02)
Eighth diagnosis (DX_CD_08)	32,722	29.87	76,822	70.13	See finding for Second diagnosis (DX_CD_02)
Ninth diagnosis (DX_CD_09)	35,327	32.25	74,217	67.75	See finding for Second diagnosis (DX_CD_02)
Tenth diagnosis (DX_CD_10)	38,400	35.05	71,144	64.95	See finding for Second diagnosis (DX_CD_02)
Eleventh diagnosis (DX_CD_11)	41,675	38.04	67,869	61.96	See finding for Second diagnosis (DX_CD_02)
Twelfth diagnosis (DX_CD_12)	45,526	41.56	64,018	58.44	See finding for Second diagnosis (DX_CD_02)
Thirteenth diagnosis (DX_CD_13)	49,446	45.14	60,098	54.86	See finding for Second diagnosis (DX_CD_02)
Fourteenth diagnosis (DX_CD_14)	56,044	51.16	53,500	48.84	See finding for Second diagnosis (DX_CD_02)
Fifteenth diagnosis (DX_CD_15)	60,000	54.77	49,544	45.23	See finding for Second diagnosis (DX_CD_02)
Sixteenth diagnosis (DX_CD_16)	63,866	58.30	45,678	41.70	See finding for Second diagnosis (DX_CD_02)
Seventeenth diagnosis (DX_CD_17)	67,429	61.55	42,115	38.45	See finding for Second diagnosis (DX_CD_02)
Eighteenth diagnosis (DX_CD_18)	70,532	64.39	39,012	35.61	See finding for Second diagnosis (DX_CD_02)

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Nineteenth diagnosis (DX_CD_19)	73,784	67.36	35,760	32.64	See finding for Second diagnosis (DX_CD_02)
Twentieth diagnosis (DX_CD_20)	77,262	70.53	32,282	29.47	See finding for Second diagnosis (DX_CD_02)
Twenty-first diagnosis (DX_CD_21)	80,560	73.54	28,984	26.46	See finding for Second diagnosis (DX_CD_02)
Twenty-second diagnosis (DX_CD_22)	83,008	75.78	26,536	24.22	See finding for Second diagnosis (DX_CD_02)
Twenty-third diagnosis (DX_CD_23)	85,191	77.77	24,353	22.23	See finding for Second diagnosis (DX_CD_02)
Twenty-fourth diagnosis (DX_CD_24)	86,852	79.29	22,692	20.71	See finding for Second diagnosis (DX_CD_02)
Twenty-fifth diagnosis (DX_CD_25)	89,732	81.91	19,812	18.09	See finding for Second diagnosis (DX_CD_02)
Admitting diagnosis code (DX_ADMIT)	109,544	100	0	0.00	-
Patient Reason for Visit diagnosis Code 1 (DX_REASN)	109,544	100	0	0.00	-
External (E) diagnosis code 1 (DX_EXT)	102,788	93.83	6,756	6.17	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file and their claims system. ND HHS is working with their data warehouse vendor to address the issue.
The principal ICD surgical procedure code on the facility claim (PROC_CD_01)	109,544	100	0	0.00	-
Surgical code 2 (PROC_CD_02)	109,544	100	0	0.00	-
Surgical code 3 (PROC_CD_03)	109,544	100	0	0.00	-
Surgical code 4 (PROC_CD_04)	109,544	100	0	0.00	-
Surgical code 5 (PROC_CD_05)	109,544	100	0	0.00	-
Surgical code 6 (PROC_CD_06)	109,544	100	0	0.00	-
Surgical code 7 (PROC_CD_07)	109,544	100	0	0.00	-
The principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)	91,434	83.47	18,110	16.53	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file and their claims system. ND HHS is working with their data warehouse vendor to address the issue.
Surgical code 2 date (PROC_CD_02_DT)	92,619	84.55	16,925	15.45	See finding for the principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)
Surgical code 3 date (PROC_CD_03_DT)	95,136	86.85	14,408	13.15	See finding for the principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Surgical code 4 date (PROC_CD_04_DT)	97,835	89.31	11,709	10.69	See finding for the principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)
Surgical code 5 date (PROC_CD_05_DT)	100,302	91.56	9,242	8.44	See finding for the principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)
Surgical code 6 date (PROC_CD_06_DT)	102,169	93.27	7,375	6.73	See finding for the principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)
Surgical code 7 date (PROC_CD_07_DT)	98,970	90.35	10,574	9.65	See finding for the principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)
Procedure code if applicable (PROC_CD)	109,544	100	0	0.00	-
The units of service billed at the detail (UNIT_COUNT_CLAIM)	92,670	84.60	16,874	15.40	The issue appears to be associated with voids, where BCBSND did not submit these values as negative values as expected. For future EDV studies, IPRO to update the data request file layout instructions to indicate negative values be reflected for voids.
The first of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_1)	106,782	97.48	2,762	2.52	-
The second of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_2)	109,544	100	0	0.00	-
The third of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_CD_3)	109,544	100	0	0.00	-
The fourth of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_CD_4)	109,544	100	0	0.00	-
The CMS standard revenue code from the UB facility claim (FAC_REVENUE_CD)	109,506	99.97	38	0.03	-
The national drug code for the drug dispensed on the institutional claim if present (NDC_NBR_J_CD)	109,544	100	0	0.00	-
Billing Provider Medicaid ID (BILLING_PROV_ID)	97,318	88.84	12,226	11.16	In two of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. In another encounter example that BCBSND reviewed, the value in the IPRO DW matched the values

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
					in the 837 file. The EDV study file included the Medicaid Provider ID instead of the Provider NPI. IPRO discussed this discrepancy with ND HHS and a BCBSND provider NPI submission issue was identified related to BCBSND's provider master file.
Attending Provider Medicaid ID (ATTENDING_PROV_ID)	105,593	96.39	3,951	3.61	-
Operating Provider Medicaid ID (OPERATING_PROV_ID)	105,141	95.98	4,403	4.02	-

[1] Total institutional inpatient encounters = 109,544.

BCBSND: Blue Cross Blue Shield of North Dakota; EDV: encounter data validation; ND: North Dakota; HHS: Department of Health and Human Services; ID: identification; DW: data warehouse; MMIS: Medicaid Management Information System; MCO: managed care organization; ICD: International Classification of Diseases; NPI: National Provider Identifier; DRG: diagnosis-related group; UB: uniform bill; CMS: Centers of Medicare & Medicaid Services.

Table 27: Institutional Outpatient Data Element Discrepancies and Findings

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Unique Medicaid number assigned to the recipient (MMIS_ID)	732,776	99.99	101	0.01	-
Date that the recipient was admitted to a facility (FAC_ADM_DT)	732,877	100	0	0.00	-
Date on which the statement period on the claim began, start date of service on the header (START_DT)	732,877	100	0	0.00	-
Date on which the statement period on the claim ended, end date of service on the header (END_DT)	732,877	100	0	0.00	-
Date on which the statement period on the claim for the detailed line item (DTL_SVC_DT)	732,877	100	0	0.00	-
Admit Type Code UB is the standard UB code for the type of admission, indicating the priority of the admission or visit on a facility claim (FAC_ADMIT_TYPE_CD)	732,877	100	0	0.00	-
Discharge status (FAC_DSCHRG_STAT_CD)	732,877	100	0	0.00	-

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Type of bill (FAC_BILL_TYPE_CD)	732,877	100	0	0.00	-
Type of bill (FAC_BILL_TYPE_FREQ)	586,093	79.97	146,784	20.03	For one example that BCBSND reviewed, BCBSND submitted two records on the study file. The numeric value of one record matched the DW and the 837. The numeric value of the second record matched the claims system. The issue also appears to be a timing issue. For example, BCBSND reported that voided encounters that were denied by ND HHS are sent to enGen but not to ND DHS.
The first or principal diagnosis code (DX_CD)	732,875	100	2	0.00	-
Second diagnosis (DX_CD_02)	114,878	15.67	617,999	84.33	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file. In the 2024 EDV study report, IPRO requested that ND HHS populate the DW monthly extracts provided to IPRO with the diagnosis codes found in Loop 2300, with the qualifier code “ABF,” in the order they appear on BCBSND’s 837 file. ND HHS is working with their data warehouse vendor to address the issue.
Third diagnosis (DX_CD_03)	162,722	22.20	570,155	77.80	See finding for Second diagnosis (DX_CD_02)
Fourth diagnosis (DX_CD_04)	241,571	32.96	491,306	67.04	See finding for Second diagnosis (DX_CD_02)
Fifth diagnosis (DX_CD_05)	319,054	43.53	413,823	56.47	See finding for Second diagnosis (DX_CD_02)
Sixth diagnosis (DX_CD_06)	389,320	53.12	343,557	46.88	See finding for Second diagnosis (DX_CD_02)
Seventh diagnosis (DX_CD_07)	447,763	61.10	285,114	38.90	See finding for Second diagnosis (DX_CD_02)
Eighth diagnosis (DX_CD_08)	495,420	67.60	237,457	32.40	See finding for Second diagnosis (DX_CD_02)
Ninth diagnosis (DX_CD_09)	536,009	73.14	196,868	26.86	See finding for Second diagnosis (DX_CD_02)
Tenth diagnosis (DX_CD_10)	570,341	77.82	162,536	22.18	See finding for Second diagnosis (DX_CD_02)
Eleventh diagnosis (DX_CD_11)	597,686	81.55	135,191	18.45	See finding for Second diagnosis (DX_CD_02)
Twelfth diagnosis (DX_CD_12)	618,742	84.43	114,135	15.57	See finding for Second diagnosis (DX_CD_02)
Thirteenth diagnosis (DX_CD_13)	636,827	86.89	96,050	13.11	See finding for Second diagnosis (DX_CD_02)
Fourteenth diagnosis (DX_CD_14)	656,363	89.56	76,514	10.44	See finding for Second diagnosis (DX_CD_02)
Fifteenth diagnosis (DX_CD_15)	669,287	91.32	63,590	8.68	See finding for Second diagnosis (DX_CD_02)
Sixteenth diagnosis (DX_CD_16)	681,378	92.97	51,499	7.03	See finding for Second diagnosis (DX_CD_02)

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Seventeenth diagnosis (DX_CD_17)	690,502	94.22	42,375	5.78	See finding for Second diagnosis (DX_CD_02)
Eighteenth diagnosis (DX_CD_18)	699,115	95.39	33,762	4.61	See finding for Second diagnosis (DX_CD_02)
Nineteenth diagnosis (DX_CD_19)	704,875	96.18	28,002	3.82	See finding for Second diagnosis (DX_CD_02)
Twentieth diagnosis (DX_CD_20)	711,366	97.06	21,511	2.94	See finding for Second diagnosis (DX_CD_02)
Twenty-first diagnosis (DX_CD_21)	715,055	97.57	17,822	2.43	See finding for Second diagnosis (DX_CD_02)
Twenty-second diagnosis (DX_CD_22)	718,709	98.07	14,168	1.93	See finding for Second diagnosis (DX_CD_02)
Twenty-third diagnosis (DX_CD_23)	720,948	98.37	11,929	1.63	See finding for Second diagnosis (DX_CD_02)
Twenty-fourth diagnosis (DX_CD_24)	721,976	98.51	10,901	1.49	See finding for Second diagnosis (DX_CD_02)
Twenty-fifth diagnosis (DX_CD_25)	723,943	98.78	8,934	1.22	See finding for Second diagnosis (DX_CD_02)
Admitting Diagnosis Code (DX_ADMIT)	732,877	100	0	0.00	-
Patient Reason for Visit diagnosis code 1 (DX_REASN)	732,877	100	0	0.00	-
External (E) diagnosis code 1 (DX_EXT)	718,139	97.99	14,738	2.01	-
The principal ICD surgical procedure code on the facility claim (PROC_CD_01)	732,877	100	0	0.00	-
Surgical code 2 (PROC_CD_02)	732,877	100	0	0.00	-
Surgical code 3 (PROC_CD_03)	732,877	100	0	0.00	-
Surgical code 4 (PROC_CD_04)	732,877	100	0	0.00	-
Surgical code 5 (PROC_CD_05)	732,877	100	0	0.00	-
Surgical code 6 (PROC_CD_06)	732,877	100	0	0.00	-
Surgical code 7 (PROC_CD_07)	732,877	100	0	0.00	-
The principal ICD surgical procedure code date on the facility claim (PROC_CD_01_DT)	732,877	100	0	0.00	-
Surgical code 2 date (PROC_CD_02_DT)	732,877	100	0	0.00	-
Surgical code 3 date (PROC_CD_03_DT)	732,877	100	0	0.00	-
Surgical code 4 date (PROC_CD_04_DT)	732,877	100	0	0.00	-
Surgical code 5 date (PROC_CD_05_DT)	732,877	100	0	0.00	-
Surgical code 6 date (PROC_CD_06_DT)	732,877	100	0	0.00	-
Surgical code 7 date (PROC_CD_07_DT)	732,877	100	0	0.00	-
Procedure code if applicable (PROC_CD)	732,876	100	1	0.00	-

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
The units of service billed at the detail (UNIT_COUNT_CLAIM)	594,429	81.11	138,448	18.89	The issue appears to be associated with voids, where BCBSND did not submit these values as negative values as expected. For future EDV studies, IPRO to update the data request file layout instructions to indicate negative values be reflected for voids.
The first of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_1)	620,241	84.63	112,636	15.37	Three issues were noted regarding procedure modifier codes: 1. BCBSND reported that, prior to January 1, 2026, certain modifiers were excluded from files submitted to ND HHS; 2. BCBSND advised that certain modifiers are designated for internal administrative and financial use only and are therefore not transmitted externally, including in the EDV study file; 3. During the study period, BCBSND identified system issues related to its process for extracting modifier codes submitted to ND HHS.
The second of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_2)	716,667	97.79	16,210	2.21	See finding for the first of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_1)
The third of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_3)	732,151	99.90	726	0.10	See finding for the first of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_1)
The fourth of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_4)	732,875	100	2	0.00	See finding for the first of up to four procedures/services/supplies modifiers if applicable (PROC_MOD_CD_1)
The CMS standard revenue code from the UB facility claim (FAC_REVENUE_CD)	732,870	100	7	0.00	-
The national drug code for the drug dispensed on the institutional claim if present (NDC_NBR_J_CD)	732,471	99.94	406	0.06	-
Billing Provider Medicaid ID (BILLING_PROV_ID)	608,778	83.07	124,099	16.93	In one of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. In the second encounter example that BCBSND reviewed, the value in the IPRO DW matched the values

Data Element Description/Name[1]	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
					in the 837 file. The EDV study file included the Medicaid Provider ID instead of the Provider NPI. IPRO discussed this discrepancy with ND HHS and a BCBSND provider NPI submission issue was identified related to BCBSND's provider master file.
Attending Provider Medicaid ID (ATTENDING_PROV_ID)	708,068	96.61	24,809	3.39	-
Referring Provider Medicaid ID (REFERRING_PROV_ID)	680,020	92.79	52,857	7.21	BCBSND confirmed the values provided on the EDV study matched the values in the 837 file and their claims system. IPRO discussed this discrepancy with ND HHS and a BCBSND provider NPI submission issue was identified related to BCBSND's provider master file.
Operating Provider Medicaid ID (OPERATING_PROV_ID)	717,910	97.96	14,967	2.04	-

[1] Total institutional outpatient encounters = 732,877.

BCBSND: Blue Cross Blue Shield of North Dakota; EDV: encounter data validation; ND: North Dakota; HHS: Department of Health and Human Services; ID: identification; DW: data warehouse; MMIS: Medicaid Management Information System; ICD: International Classification of Diseases; NPI: National Provider Identifier; UB: uniform bill; CMS: Centers for Medicare & Medicaid Services.

Interviews with BCBSND

IPRO held a teleconference with HHS and BCBSND to discuss and review claim discrepancies and claims that were not able to be matched to the IPRO data warehouse. It was noted that no changes to the BCBSND claims system were made since the February 2023 ISCA review. During this meeting, a review of discrepant records included reviewing the BCBSND claims screen, as well as their 837 file submissions to ND HHS. Any items that BCBSND was not able to provide during the meeting were addressed in the following weeks.

Analysis of Medical Records

IPRO used the following methodology to conduct the MMR:

1. IPRO pulled a random sample of 273 BCNSND encounters and an oversample of 546 encounters from all electronic encounters in the study period that were in the data warehouse.
2. IPRO mailed providers the information from a sampled encounter asking them to provide documentation about the visit associated with the encounter.
3. Providers submitted the requested medical records to IPRO.
4. IPRO reviewed the medical records submitted by providers.

The sample size was selected to achieve a 90% confidence interval and a 5% +/- error rate for sampling. An oversample was added to ensure that an adequate number of records were reviewed, as shown in **Table 28**.

Table 28: Medical Record Review Sample Information by Encounter Data Type

Encounter Data Type	Electronic Encounters Matched (n)	Sample Size (n)	Oversample Size (n)[1]	Reviews Completed (n)	Reviews Completed for Verified Records[2]
Professional	890,375	162	324	103	96
Institutional inpatient	109,544	12	24	5	5
Institutional outpatient	732,877	99	198	50	45
Total	1,732,796	273	546	158	146

[1] An oversample of 200% was selected to provide the number of adequate reviews for each encounter data type to meet the required sample size.
[2] Excluding records where the member's demographic information and/or date(s) of service on the medical record did not match what was on the encounter.

Tables 29–31 presents the results of the MRR.

Table 29: Medical Record Review Results – Professional Encounters

Professional Encounters	Data Elements Examined	Match (n)	Match Rate (%)
Principal diagnosis code	94	88	93.6
Procedure code	94	89	94.7
Total	188	177	94.2

Table 30: Medical Record Review Results – Institutional Inpatient Encounters

Institutional Inpatient Encounters	Data Elements Examined	Match (n)	Match Rate (%)
Principal diagnosis code	5	5	100.0
Procedure code	5	5	100.0
Revenue code	5	5	100.0
Total	15	15	100.0

Table 31: Medical Record Review Results – Institutional Outpatient Encounters

Institutional Outpatient Encounters	Data Elements Examined	Match (n)	Match Rate (%)
Principal diagnosis code	45	42	93.3
Procedure code	45	42	93.3
Revenue code	45	45	100.0
Total	135	129	95.6

IPRO finds there to be no material electronic encounter data issues. The completeness, timeliness, and accuracy of electronic encounter data collected and submitted are sufficient for the MCO to help inform quality improvement initiatives.

IPRO's findings are based upon the following:

- its review of the BCBSND EDV study file matches to the data warehouse, review of the values for the sampled electronic encounters, identification and research of the discrepant values, review of the discrepancy reasons received from BCBSND, and discussions with BCBSND and ND HHS; and
- MRR, which yielded an overall 95.0% match rate of electronic encounter data elements to data elements abstracted from the medical records (**Tables 29–31**). The match rate for the institutional inpatient and institutional outpatient were above the state's required 95.0% threshold. The match rate for the professional encounter type was 94.2% and within 0.8% of the 95.0% threshold. It is IPRO's opinion that it is within BCBSND's ability to improve on this rate for the next EDV study.

Recommendations

IPRO does, however, recommend that the following areas be addressed by BCBSND, ND HHS, and/or IPRO.

Recommendations for Electronic Encounter Data

All Encounter Data Types

- BILLING_PROV_ID: In five of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. In two examples the value in the IPRO data warehouse matched the values in the 837 file. The EDV study file included the Medicaid Provider ID instead of the Provider National Provider Identifier (NPI). IPRO will discuss this discrepancy with ND HHS.

Professional Encounter Data Type Only

- RENDERING_PROV_ID: In two of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. The third example reviewed did not match the 837 file or their claims system. IPRO will discuss this discrepancy with ND HHS.

- PROF_PROC_MOD_CD_1 through PROC_PROC_MOD_CD_04: Three issues were noted regarding procedure modifier codes: 1. BCBSND reported that, prior to January 1, 2026, certain modifiers were excluded from files submitted to ND HHS; 2. BCBSND advised that certain modifiers are designated for internal administrative and financial use only and are therefore not transmitted externally, including in the EDV study file; 3. During the study period, BCBSND identified system issues related to its process for extracting modifier codes submitted to ND HHS.
  -

Institutional Inpatient Encounter Data Type Only

- DRG_CD_SUBMT: In the 2024 EDV study report, IPRO requested that ND DHS provide the MCO-submitted DRG. The IPRO data warehouse is populated with the state calculated/computed DRG.
- DRG_CD_CALC: BCBSND does not have a grouper that calculates/computes a DRG. Matches were based on blank values.
- DX_EXT: BCBSND confirmed the values provided on the EDV study matched the 837 file and their claims system. IPRO will discuss this discrepancy with ND HHS.
- PROC_CD_01_DT through PROC_CD_07_DT: In the encounter example that BCBSND reviewed, the value submitted for the EDV study matched the value in the 837 file and their claims system. IPRO will discuss this discrepancy with ND HHS.

Institutional Outpatient Encounter Data Type Only

- FAC_BILL_TYPE_FREQ: In the encounter examples that BCBSND reviewed, BCBSND submitted two records for each encounter on the EDV study extract. The numeric value on one discrepant record matched the data warehouse, but the numeric value on the second record did not match.
- PROC_MOD_CD_1 through PROC_MOD_CD_4: BCBSND reported that modifiers are not included in the EDV study file because they are considered internal use modifiers for administrative and financial purposes only and are not sent externally. IPRO will discuss this discrepancy with ND HHS.

Professional and Institutional Outpatient Encounter Data Types Only

- REFERRING_PROV_ID: In three of the encounter examples that BCBSND reviewed, the values submitted for the EDV study matched the values in the 837 file and their claims system. The other example reviewed did not match. IPRO will discuss this discrepancy with ND HHS.

Institutional Inpatient and Institutional Outpatient Encounter Data Types Only

- UNIT_COUNT_CLAIM: The issue appears to be associated with voids, where BCBSND did not submit these values as negative values as expected. For future EDV studies, IPRO will update the data request file layout instructions to indicate that negative values should be reflected for voids.
- FAC_BILL_TYPE_FREQ: In the encounter examples that BCBSND reviewed, BCBSND submitted two records for each encounter on the EDV study extract. The numeric value on one discrepant record matched the DW, but the numeric value on the second record did not match. The issue also appears to be a timing issue. For example, BCBSND reported that voided encounters that were denied by ND HHS are sent to enGen but not to ND DHS.
- DX_CD_02 through DX_CD_25: BCBSND confirmed the values provided on the EDV study matched their 837 file and claims system. In the 2024 EDV study report, IPRO requested that ND HHS populate the data warehouse monthly extracts provided to IPRO with the diagnosis codes found in Loop 2300, with the qualifier code “ABF,” in the order they appear on BCBSND’s 837 file. IPRO will discuss this discrepancy with ND HHS.

Recommendations for Future EDV Studies

- For the institutional inpatient encounter data type, IPRO will not request the DRG_CD_CALC in future EDV studies because BCBSND does not send this data element to the state.
- For the institutional inpatient and institutional outpatient encounter data types, IPRO will update the data request file layout instructions to indicate that negative values should be reflected for voids.

Recommendations for Medical Record Review

- If BCBSND is not performing their own medical record versus claim audits, they may want to consider adding this audit as an annual task.
- Continue mailing the medical record request letters using state letterhead.
- Provide BCBSND with the list of specific providers that will be part of the EDV/MRR study so they can notify that they will be included in the upcoming study.

VIII. Validation of Quality-of-care Surveys – CAHPS Member Experience Survey

Objectives

Title 42 CFR § 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *Title 42 CFR §* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual EQR.

HHS requires that BCBSND conduct a member experience survey every year for adults enrolled in an MMC plan. The goal of the survey is to get feedback from these members about how they view the healthcare services they receive. HHS uses the results from the survey to improve the quality of healthcare.

The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with healthcare. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care.

Title 42 CFR § 438.358 Activities related to external quality review(a)(1) mandates that the state or an EQRO must perform the quality-of-care survey activity. To meet this federal regulation, BCBSND contracted with a survey vendor, Press Ganey®, to administer the *2025 CAHPS 5.1 Adult Medicaid Health Plan Survey*.

This EQR ATR presents the 2025 CAHPS results for MY 2024.

Technical Methods of Data Collection and Analysis

BCBSND contracted with NCQA-certified survey vendor, Press Ganey, to conduct the member satisfaction survey for the adult (ages 18 years and over) member population in order to assess satisfaction with BCBSND and with participating providers. BCBSND's vendor followed NCQA HEDIS protocols, identified in *HEDIS MY 2024 Volume 3: Specifications for Survey Measures*. The methodology met requirements of CMS's *Protocol 6. Administration or Validation of Quality-of-Care Surveys*. The NCQA Survey Vendor Certification Program and annual HEDIS accreditation audit ensure the survey vendor follows HEDIS protocols in sample frame and selection, data collection, and survey results calculation.

The adult member satisfaction surveys were sent to a random sample of members (as of December 31, 2024) who were continuously enrolled for at least five of the last six months of 2024 and who were enrolled at the time the survey was completed.

Description of Data Obtained

IPRO received the MY 2024 CAHPS results reported by BCBSND. The CAHPS data included deidentified member-level data and the *Press Ganey Summary Report*.

Conclusions and Findings

To determine common strengths and opportunities for improvement for BCBSND, IPRO compared the CAHPS rates for adults to the national Medicaid benchmarks presented in the MY 2024 Quality Compass (**Table 32**). Measures performing at or above the 75th percentile were considered strengths; measures performing at the 50th percentile were considered average; and measures performing below the 50th percentile were identified as opportunities for improvement. Fifteen questions were below average, two questions were average, and 10 questions were above average when compared to Quality Compass (**Table 33**).

Recommendations

BCBSND should address all the measures that performed below the 50th percentile. Beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved.

Table 32: Color Key for NCQA HEDIS QC National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2024 QC National Percentiles
Orange	Below the national Medicaid 25th percentile.
Light Orange	At or above the national Medicaid 25th percentile but below the 50th percentile.
Gray	At or above the national Medicaid 50th percentile but below the 75th percentile.
Light Blue	At or above the national Medicaid 75th percentile but below the 90th percentile.
Blue	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; QC: Quality Compass.

Table 33: BCBSND CAHPS Performance – Adult Members

CAHPS Measure	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate[1]	Change from MY 2023–2024
Getting Needed Care (Usually + Always)	81.2%	83.5%	81.3% (≥ 25th and < 50th)	-2.2
Q9. Ease of getting necessary care, tests, or treatment needed	84.8%	89.2%	84.9% (≥ 25th and < 50th)	-4.3
Q20. Getting appointments with specialists as soon as needed	77.6%	77.8%	77.8% (≥ 25th and < 50th)	0
Getting Care Quickly (Usually + Always)	79.5%	89.5%	89.3% (≥ 90th)	-.2
Q4. Got care as soon as needed when care was needed right away	82.9%	95.3%	93.9% (≥ 90th)	-1.4
Q6. Got check-up/routine care appointment as soon as needed	76.1%	83.6%	84.7% (≥ 75th and < 90th)	1.1
How Well Doctors Communicate (Usually + Always)	90.1%	92.6%	99.6% (≥ 90th)	7.0
Q12. Personal doctor explained things in an understandable way	95.6%	89.6%	100.0% (≥ 90th)	10.4
Q13. Personal doctor listened carefully to you	88.2%	92.6%	98.5% (≥ 90th)	5.9
Q14. Personal doctor showed respect for what you had to say	91.2%	95.6%	100.0% (≥ 90th)	4.4
Q15. Personal doctor spent enough time with you	85.3%	92.6%	100.0% (≥ 90th)	7.4
Customer Service (Usually + Always)	89.0%	89.9%	86.8% (< 25th)	-3.1
Q24. Customer service provided information or help	81.3%	85.7%	79.4% (< 25th)	-6.3
Q25. Customer service treated member with courtesy and respect	96.8%	94.1%	94.1% (≥ 25th and < 50th)	0
Coordination of Care (Q17) (Usually + Always)	88.4%	82.5%	98.0% (≥ 90th)	15.5

CAHPS Measure	MY 2022 Rate	MY 2023 Rate	MY 2024 Rate[1]	Change from MY 2023–2024
Ease of Filling Out Forms (Q27) (Summary Rate = 8 + 9 + 10)	97.3%	93.9%	98.4% (≥ 90th)	4.5
Rating of Health Care (Q8)	82.1%	73.0%	69.4% (< 25th)	-3.6
Rating of Personal Doctor (Q18)	86.2%	80.5%	83.2% (≥ 25th and < 50th)	-3.5
Rating of Specialist (Q22)	87.0%	72.5%	82.4% (≥ 25th and < 50th)	9.9
Rating of Health Plan (Q28)	71.4%	73.5%	70.0% (< 25th)	2.1
Rating of Health Care (9 + 10)	53.8%	56.8%	47.1% (< 25th)	-9.7
Rating of Personal Doctor (9 + 10)	64.4%	67.1%	70.5% (≥ 25th and < 50th)	3.4
Rating of Specialist (9 + 10)	76.1%	56.9%	64.7% (< 25th)	-3.6
Rating of Health Plan (9 + 10)	52.7%	58.8%	55.4% (< 25th)	-3.4
Advising Smokers and Tobacco Users to Quit	64.9%	66.2%	73.4% (≥ 25th and < 50th)	7.2
Discussing Cessation Medications	50.0%	52.6%	53.8% (≥ 50th and < 75th)	1.2
Discussing Cessation Strategies	43.2%	46.7%	47.4% (≥ 50th and < 75th)	3.5

[1] Colors indicate BCBSND percentile ranking in measurement year (MY) 2024 Quality Compass.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; BCBSND: Blue Cross Blue Shield of North Dakota.

IX. MCO Quality Ratings

Objectives

IPRO collaborates with HHS to produce an annual MCO report card that presents the performance for Medicaid Expansion on selected measures related to **quality** and **access**. The guide is intended to help members compare MCO performance and to assist members in choosing an MCO. IPRO updates the MCO report card annually.

Technical Methods of Data Collection and Analysis

To distinguish quality among the accredited MCOs, NCQA calculates an "overall rating" for each MCO as part of the Health Plan Ratings Program. The overall rating is the weighted average of an MCO's HEDIS and CAHPS measure ratings, plus accreditation bonus points (if the plan is accredited by NCQA), rounded to the nearest half point and displayed as stars.

Overall ratings are calculated annually and presented in the health plan ratings that are released every September. The NCQA 2025 Health Plan Ratings methodology used to calculate an overall rating is based on MCO performance for measures related to care and is calculated on a scale in half points of 0–5 stars, with 5 stars being the highest. Performance includes these three subcategories (also scored on a scale in half points of 0–5 stars):

- Patient Experience: Patient-reported experience of care, including experience with doctors, services, and customer service (measures in the Patient Experience category).
- Rates for Clinical Measures: The proportion of eligible members who received preventive services (Prevention and Equity measures) and the proportion of eligible members who received recommended care for certain conditions (Treatment measures).
- NCQA Health Plan Accreditation: For a plan with an accredited or provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displaying the score as stars. A plan with an interim status receives 0.15 bonus points added to the overall rating before rounding to the nearest half point and displaying the score as stars.

The NCQA rating scale and definitions for each are displayed in **Table 34**.

Table 34: NCQA Health Plan Star Rating Scale

Star Ratings	Rating Definition
★★★★★	The top 10% of health plans, which are also statistically different from the mean. (Highest performance)
★★★★☆	Health plans in the top one-third of health plans that are not in the top 10% and are statistically different from the mean. (High performance)
★★★☆☆	The middle one-third of health plans and health plans that are not statistically different from the mean. (Average performance)
★★☆☆☆	Health plans in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean. (Low performance)
★☆☆☆☆	The bottom 10% of health plans, which are statistically different from the mean. (Lowest performance)

NCQA: National Committee for Quality Assurance.

Description of Data Obtained

IPRO received the MY 2024 HEDIS and CAHPS results reported by BCBSND. The HEDIS data included the Interactive Data Submission System (IDSS) workbook and comma-separated value (CSV) files. The CAHPS data included deidentified member-level data and NCQA summary reports. In addition, IPRO accessed the NCQA *Health Plan Report Cards* website to review the *Health Plan Report Cards 2025*[4] for BCBSND. Star ratings, accreditation status, plan type, and distinctions were displayed for each MCO. On the MCO-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall rating. The data presented here were last updated as of October 15, 2025.

Conclusions and Findings

Quality ratings were determined using MY 2024 performance data. The MCO Quality Report Card in **Table 35** displays the MCO's overall health plan star ratings.

Table 35: MCO NCQA Ratings by Category, 2025

Health Care Categories[1]	BCBSND
Overall Rating	★☆☆☆☆
Getting care	Small denominator
Satisfaction with plan physicians	Small denominator
Satisfaction with plan and plan services	★★☆☆☆
Women's reproductive health	★★½☆☆
Cancer screening	★★½☆☆
Other preventive services	★★☆☆☆
Respiratory treatment	★★½☆☆
Diabetes treatment	★½☆☆☆
Heart disease treatment	★½☆☆☆
Behavioral health − care coordination	★★☆☆☆
Behavioral health − medication adherence	★★½☆☆
Behavioral health − access, monitoring, and safety	★★½☆☆
Plan all-cause readmissions	★★★☆☆

[1] This information comes from NCQA's health plan ratings as of 10/15/2025.

BCBSND received an overall ratings of 1 star (**Table 35**). The majority of categories fell below 2 stars, which places BCBSND in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean (low performance).

[4] Retrieved from: Health Plans - NCQA.

X. URAC Accreditation

Section 2.13.3 of the ND state contract requires that BCBSND be accredited by NCQA or URAC for their Medicaid product. BCBSND holds full URAC accreditation for “Health Plan” and “Health Plan with Health Insurance Marketplace.” URAC is an independent, nonprofit healthcare accrediting organization that is dedicated to promoting healthcare quality through accreditation, education, and measurement.

The URAC accreditation process demonstrates a commitment to quality service and serves as a framework for improving business processes through benchmarking organizations against nationally recognized standards. URAC accreditation demonstrates BCBSND’s focus on efficiency, continuous improvement, and delivery of quality products and exceptional customer service to members.

BCBSND underwent a URAC validation review in October 2023; full accreditation was granted for Medicaid Health Plan with a Six-Month Follow-Up for two standards. This follow-up for these two standards applied to all three of the accreditation applications:

- RM 2-1a: The finding had to do with the annual review of medical criteria not being as clearly documented in the minutes as it could have been.
- UM 13-1a: A couple of cases were identified where the appeal peer reviewer did not possess a license or certification in a health profession that is of the type and scope that permits them to apply their clinical judgement.

CAPs for each finding were implemented and provided to URAC. A return visit was held on 3/21/24. The URAC reviewer was satisfied with the implemented corrective actions, passed both standards, and found no new issues. The information provided here is the latest update on BCBSND’s URAC accreditation. BCBSND’s URAC Health Plan accreditation expires on 11/1/2026.

In addition to URAC Health Plan accreditation, BCBSND is one of the first two plans to obtain URAC’s Mental Health and Substance Use Disorder Parity accreditation for Medicaid, Commercial-Individual, and Commercial-Large plans. BCBSND’s URAC accreditation is valid until 5/1/2028.

BCBSND has initiated the process of obtaining NCQA accreditation. All documents were submitted to NCQA by 12/1/2025. A virtual visit will occur in early February 2026 that includes file reviews.

XI. BCBSND Strengths, Opportunities for Improvement, and EQR Recommendations

Table 36 summarizes BCBSND's strengths, opportunities for improvement, and EQR recommendations for this year's EQR. The EQRO recommendations are provided to ND HHS to support improvement in the quality, timeliness, and access to healthcare services, and thus to drive progress toward achieving the goals on ND HHS' Quality Strategy.

Table 36: BCBSND Strengths, Opportunities for Improvement, and EQR Recommendations

EQR Activity	Strengths	Opportunities for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
Medicaid quality strategy evaluation	Four measure rates improved from CY2023 to CY2024 and three measures achieved their target objectives.	Overall, 11 out of the 14 performance measures with target rates set did not meet the target rate objective.	Recommendations were made in the *Quality Strategy Evaluation*, which included considerations for new PIPs, expanding on existing PIPs, and conducting beneficiary focus groups.	X	X	X
PIP	The COPD PIP saw two of the three performance indicators meeting their target rates, as well as both stratification populations for Indicator 1 meeting the target rate.	Opportunities for improvement were noted for performance indicators across the SUD and Diabetes Care PIPs, where target rates were not met.	BCBSND should examine the factors behind the lack of improvement in certain performance indicators and explore potential modifications to ITMs to drive progress.	X	X	X
Performance measures	Of the 62 HEDIS measures and submeasures reported by BCBSND, two were above the NCQA 90th percentile, 12 were between the NCQA 75th and 90th percentiles, and 13 were between the 50th and 75th percentiles.	There were 16 HEDIS measures that fell below the 25th percentile. Of the 18 non HEDIS measures, with benchmarks, six performed better than the median.	Focusing on the HEDIS quality-related measures that fell below the NCQA national 25th percentile, BCBSND should continue to identify barriers and consider interventions to improve performance.	X	X	X
Compliance with Medicaid standards	Six of the 15 domains were 100% fully compliant. The overall score across all domains was 95.1%.	Availability of Services, Assurances of Adequate Capacity and Services, and Provider Selection domains scored below 85%.	BCBSND should focus on the three domains that performed poorly: Availability of Services, Assurances of Adequate Capacity and Services, and Provider Selection.	X	X	X

EQR Activity	Strengths	Opportunities for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
Network adequacy	IPRO found that five out of the top six high-volume specialties were compliant with ND's requirement that at least 90% of BCBSND's membership has access to providers within the established distance standards. IPRO found that the PCP-to-member ratio is 1:3.4, which met contractual standards.	• Providers had the availability to schedule timely routine visit appointments at a rate of 35.8% for routine visits and 25.8% for nonurgent sick visits. After-hours access for family practice/internal medicine was evaluated at 90.9% • Overall, only 159 out of 425 providers surveyed had telephone numbers that resulted in successful contact and were accepting patients for the specialty listed. • Medical oncology providers failed to meet the standard of at least 90% of BCBSND's membership has access to providers within the established distance standards.	Survey results indicate a need for BCBSND to increase timely appointment rates to ensure members are able to access providers and obtain appointments in a timely manner. Based on the survey findings, there is a clear need for BCBSND to undertake measures to enhance the accuracy and accessibility of its provider directory.	-	X	X
Quality-of-care surveys – member	BCBSND showed above-average performance for measures related to getting care quickly, how well doctors communicate, and coordination of care.	BCBSND had seven CAHPS measures performing below the national 25th percentile.	BCBSND should address all the measures that performed below the 50th percentile.	X	X	X
Encounter Data	BCBS showed a strong overall match rates and data integrity. The encounter data validation demonstrated a 98.8% overall match rate for electronic encounter data, reflecting substantial improvement over prior years. Match rates improved across all encounter types compared to the	Lower match rates and discrepancies were noted for provider identifiers (billing, rendering, and referring), procedure modifiers, and select diagnosis codes. These issues were often tied to inconsistent use of Medicaid Provider IDs versus NPIs or omission of modifiers in some files.	Standardize and clarify data element requirements BCBSND, ND HHS, and IPRO should jointly align on required provider identifiers, modifier reporting, and diagnosis coding rules, with updated submission guidance to eliminate ambiguity. Strengthen voided encounter guidance and controls	X		

EQR Activity	Strengths	Opportunities for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
	previous study, suggesting that corrective actions and process changes implemented by BCBSND were effective and sustained. Medical Record Review (MRR) largely meets standards. Institutional inpatient and outpatient encounters exceeded the state's 95% threshold, and professional encounters were only marginally below at 94.2%, indicating generally strong alignment between medical records and submitted encounter data.	The handling of voided encounters remains an area of concern, particularly around inconsistent reporting of negative units and timing misalignment between systems. Although close, professional encounters did not meet the 95% MRR threshold, signaling a need for more targeted remediation in this encounter category.	Update file layout instructions to explicitly require negative values for voided encounters and ensure consistent processing logic across all systems involved in encounter creation and submission. Implement focused audits or reviews on professional encounters to close the remaining gap to the 95% threshold. This may include targeted training, validation checks, or vendor-specific remediation.			
Quality Ratings and Accreditation	BCBS holds full URAC accreditation for "Health Plan" and "Health Plan with Health Insurance Marketplace" Is actively pursuing NCQA accreditation	BCBSND received an overall 1-star rating, placing it in the bottom third of plans and signaling widespread performance challenges. Many categories scored below 2 stars, notably satisfaction with plan physicians, cancer screening, and behavioral health care coordination. Low ratings in women's reproductive health, cancer screening, diabetes, and heart disease treatment suggest persistent preventive and chronic care shortcomings Weak performance in behavioral health coordination, medication adherence, and all-cause	BCBS should focus improvement initiatives on the areas that scored less than 2 stars.	X	X	X

EQR Activity	Strengths	Opportunities for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
		readmissions points to care integration and transition issues.				

BCBSND: Blue Cross Blue Shield of North Dakota; EQR: external quality review; PIP: performance improvement project; COPD: chronic obstructive pulmonary disease; SUD: substance use disorder; ITM: intervention tracking measure; HEDIS: Healthcare Effectiveness Data and Information Set; PCP: primary care provider; CAHPS: Consumer Assessment of Healthcare Providers and Systems; NCQA: National Committee for Quality Assurance; ND: North Dakota.

BCBSND Responses to Previous Recommendations and IPRO Assessment of the Responses

Table 37 presents BCBSND's responses to the EQR 2024 ATR recommendations and IPRO's assessment of the responses.

Table 37: BCBSND Responses to EQR 2024 ATR Recommendations

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
Recommendations were made in the Quality Strategy Evaluation which included considerations for new PIPs, expanding on existing PIPs, and conducting beneficiary focus groups.	BCBSND collaborates with the North Dakota Department of Health and Human Services (ND DHHS) to identify and prioritize areas for quality improvement initiatives. Performance quality metrics and population health data are reviewed to determine focus areas and guide the development of targeted quality improvement initiatives. Member engagement is achieved through the Member Advisory Committee, where topics, including those related to Performance Improvement Projects (PIPs), are presented for member input and feedback. In addition, feedback from the External Quality Review Organization is actively sought to ensure that strategies align with best practices and evaluation standards.	Addressed, pending IPRO review of ongoing PIP reporting.
BCBSND should examine the factors behind the lack of improvement in certain performance indicators and explore potential modifications to ITMs to drive progress.	BCBSND is dedicated to ongoing quality improvement and regularly reviews performance indicators to identify opportunities for progress. To strengthen our approach to Intervention Tracking Measures (ITMs), we hold quarterly collaborative meetings with the External Quality Review Organization to discuss updates, evaluate barriers, and refine ITMs as needed. For each performance indicator, we conduct barrier analyses and develop targeted interventions to support measurable improvement. When data collection challenges arise, we work proactively with internal and external stakeholders to enhance data quality and measurement processes. These efforts are complemented by increased coordination across teams and expanded engagement activities, all aimed at strengthening the effectiveness of quality improvement initiatives and achieving meaningful outcomes for our members. We are also working together to find new ways to add or update initiatives that engage members and drive quality improvement and positive outcomes.	Partially addressed, pending ongoing PIP reporting and updated. Interventions to drive PIP progress.
Focusing on the HEDIS quality-related measures that fell below the NCQA national 25th percentile, BCBSND should continue	BCBSND has taken proactive steps to improve HEDIS quality measures that were below the NCQA national 25th percentile for Medicaid. Through targeted initiatives such as preventive care campaigns, enhanced provider data collection, and integration of quality metrics into value-based programs, measurable progress has been achieved in several areas. For example, colorectal cancer screening	Partially addressed, MY 2024 HEDIS rates continue to fall below the national 25th percentile.

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
to identify barriers and consider interventions to improve performance.	rates improved by 14% from MY 2023 to MY 2024, and breast cancer screening rates also increased following outreach efforts. Chronic condition management saw gains through supplemental data intake and focused interventions for blood pressure and diabetes care. Behavioral health follow-up rates improved with dedicated outreach and collaboration with providers. Organization-wide strategies—including annual provider collaboration visits, expanded analytical capacity, and the development of provider education tools—have further supported these improvements.	
BCBSND should focus on the three domains that performed poorly: Availability of Services, Assurances of Adequate Capacity & Services, and Provider Selection.	BCBSND has 100% of hospitals and 99% of doctors in ND in the BCBSND Medicaid Expansion network and BCBSND continues to evaluate telehealth opportunities with vendors who serve the Medicaid population. BCBSND ensures accessibility reports are run each quarter to include all applicable providers. This allows BCBSND to be aware on a quarterly basis of network accessibility and identify concerns in a timely manner. These reports are reviewed and utilized as part of our ongoing process of ensuring that all providers who are enrolled with ND Medicaid are also enrolled in the BCBSND ME network. We utilize this process as a proactive approach to contracting.	Addressed, pending results of next 2026 compliance review.
Survey results indicate a need for BCBSND to increase timely appointment rates to ensure members are able to access providers and obtain appointments in a timely manner. Based on the survey findings, there is a clear need for BCBSND to undertake measures to enhance the accuracy and accessibility of its provider directory.	BCBSND employs a multi-pronged approach to ensure providers keep their directory information up to date. BCBSND sends out a quarterly outreach via mailed letters, providers are also expected to validate their directory information every 90 days. These regular check-ins help maintain accurate listings for members and ensure compliance with federal regulations. To streamline the process, BCBSND utilizes the Availity Essentials portal, where providers can log in and use the Directory Validation tool found under the BCBSND Payer Spaces. This tool allows providers to add or remove details, update Tax ID/NPI combinations, and submit changes directly to BCBSND. Beyond digital tools and quarterly outreach, BCBSND also engages in direct outreach. This may include emails or contact from provider relations representatives if discrepancies are identified	Not addressed, timely appointment rates remain low.
BCBSND should address all the measures that performed below the 50th percentile.	The CAHPS survey provides valuable insights into members' experiences with their health plan and healthcare providers. BCBSND made notable progress in several areas of member experience as measured by the CAHPS survey in 2025. The most significant improvements include: • Provider Communication: Scores for provider communication improved substantially, now ranking above the 95th percentile, reflecting clearer explanations and attentive listening from personal doctors.	Partially addressed, the following CAHPS survey measures remain below the 25th percentile: Customer Service (Usually + Always)

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	• Care Coordination: Coordination of care also saw marked improvement, with scores rising above the 95th percentile, indicating better collaboration among healthcare providers. • Specialist Ratings: Member satisfaction with specialists increased, demonstrating enhanced access and quality in specialist care. While BCBSND has made meaningful progress in provider communication, care coordination, and specialist ratings, the CAHPS survey results show there are still opportunities to further enhance member experience. In 2025, the following areas remained below the 50th percentile: • Rating of Personal Doctor: Although member ratings improved, this measure is still below the national 50th percentile benchmark. • Access to Specialist Appointments: Member ratings for timely access to specialists improved; however, remains below the 50th percentile indicating an ongoing opportunity to further enhance this aspect of care. • Customer Service: Member ratings for courteous and respectful service did not keep pace with national benchmarks, highlighting an opportunity for further improvement. • Overall Health Plan Experience: Member satisfaction with the health plan was lower in the most recent survey, highlighting an opportunity for continued enhancement. BCBSND is actively addressing related areas—such as access, customer service, and provider relationships—which are expected to positively influence overall health plan ratings in the future. To build on areas of success and address opportunities for improvement, BCBSND has launched several initiatives, including enhanced provider communication and coordination, targeted behavioral health campaigns, annual provider collaboration visits, provider education tools, and regular review of survey results. A cross-functional work group plays a central role in these efforts by bringing together expertise from across the organization to identify priority survey domains and develop focused action plans. Additionally, BCBSND is actively working to address perceptions and misconceptions sometimes associated with Medicaid coverage through targeted internal and external education and awareness campaigns. This collaborative approach ensures strategies are comprehensive, aligned with best practices, and reflect BCBSND's commitment to improving access, service, and satisfaction for all members.	Q24. Customer service provided information or help Rating of Health Care (Q8) Rating of Health Plan (Q28) Rating of Health Care (9 + 10) Rating of Specialist (9 + 10) Rating of Health Plan (9 + 10)

BCBSND: Blue Cross Blue Shield of North Dakota; EQR: external quality review; MCO: managed care organization; ATR: annual technical report; PIP: performance improvement project; ITM: intervention tracking measure; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; NCQA: National Committee for Quality Assurance; MY: measurement year; ME: Medicaid Expansion; NPI: National Provider Identifier.

XII. Overall Conclusions

Overall, findings from CY 2025 EQR activities highlight BCBSND's continued commitment to achieving the goals of the ND Medicaid quality strategy. Strengths related to **quality**, **timeliness**, and **access** were observed across all covered populations. However, numerous quality measures showed room for improvement. BCBSND will be required to take action to address the opportunities identified in this report, and those actions will be summarized in the next EQR ATR, due April 2027.