



# External Quality Review Annual Technical Report

**Review Period: January 1–December 31, 2024**

**North Dakota Department of Health and Human Services  
Medical Services Division**

**April 2025**



**[ipro.org](http://ipro.org)**

**Per Title 42 CFR § 438.364(a)(7), no managed care organization was exempt from the external quality review activities conducted in 2024.**

# Table of Contents

I.	Executive Summary.....	5
	Purpose of Report.....	5
	Scope of External Quality Review Activities Conducted .....	6
	High-Level Program Findings and Recommendations.....	7
	Recommendations for BCBSND.....	9
	Recommendations for HHS .....	9
II.	North Dakota Medicaid Managed Care Program.....	11
	Managed Care in North Dakota .....	11
	North Dakota Medicaid Quality Strategy.....	12
	IPRO’s Evaluation of the 2024 North Dakota Medicaid Quality Strategy .....	14
III.	External Quality Review Activity 1: Validation of Performance Improvement Projects .....	19
	Objectives.....	19
	Technical Methods of Data Collection and Analysis .....	19
	Description of Data Obtained and Progress .....	20
	Conclusions and Comparative Findings .....	22
IV.	External Quality Review Activity 2: Validation of Performance Measures.....	29
	Objectives.....	29
	Technical Methods of Data Collection and Analysis .....	29
	Information System Capabilities Assessment (ISCA) .....	30
	Description of Data Obtained.....	32
	Conclusions .....	38
V.	External Quality Review Activity 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations .....	39
	Objectives.....	39
	Technical Methods of Data Collection and Analysis .....	39
	Description of Data Obtained.....	41
	Conclusions .....	41
VI.	External Quality Review Activity 4: Validation of Network Adequacy .....	43
	Objectives.....	43
	Technical Methods of Data Collection and Analysis .....	43
	Description of Data Obtained.....	47
	Conclusions and Recommendations .....	47
VII.	External Quality Review Activity 5: Validation of Encounter Data .....	48
	Objectives.....	48
	Technical Methods of Data Collection and Analysis .....	48
	Description of Data Obtained.....	49
	Results.....	50
	Conclusions and Recommendations .....	65
VIII.	External Quality Review Activity 6: Validation of Quality-of-Care Surveys – CAHPS Member Experience Survey .....	68
	Objectives.....	68
	Technical Methods of Data Collection and Analysis .....	68
	Description of Data Obtained.....	68
	Conclusions and Findings.....	68
IX.	URAC Accreditation .....	71
X.	BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations .....	72
	BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations.....	72
	BCBSND Responses to EQR 2024 ATR (prior year) Recommendations and IPRO Assessment of the Responses.....	73
XI.	Overall Conclusions .....	88

XII. Appendix A: Review, Update and Evaluation of the North Dakota Quality Strategy .....	89
Introduction .....	92
Quality Strategy Review and Update Process .....	92
Quality Strategy Evaluation Process.....	93
Quality Strategy Evaluation Findings .....	94
State Progress on Quality Strategy Goals and Objectives – Detailed Findings .....	97
Conclusion and Recommendations .....	100
Source Documents .....	115
Appendix A1: Assessment of North Dakota’s Quality Strategy, 1/8/2025 .....	116
Appendix A2: Progress on Meeting North Dakota Quality Strategy Goals by Medicaid Beneficiary Population.....	119

## List of Tables

Table 1: BCBSND Progress on Meeting North Dakota Quality Strategy Goals .....	17
Table 2: PIP Topics.....	19
Table 3: Overall Credibility of Results .....	20
Table 4: PIP Validation Results for PIP Elements – Quarter 4, 2024.....	22
Table 5: BCBSND COPD or Asthma in Older Adults Admission Rate PIP Interim Results .....	23
Table 6: BCBSND Diabetes Care PIP Interim Results.....	24
Table 7: BCBSND Substance Use Disorder PIP Interim Results.....	25
Table 8: Assessment of BCBSND PIP Indicator Performance .....	26
Table 9: ISCA Findings .....	31
Table 10: BCBSND Compliance with Information Systems Standards – MY 2023.....	32
Table 11: Color Key for IPRO-Validated Non-HEDIS Performance Measures.....	32
Table 12: IPRO-Validated Non-HEDIS Performance Measures – MY 2023 .....	33
Table 13: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2023 Quality Compass National Percentiles.....	35
Table 14: NCQA Certified HEDIS-Compliance Auditor-Audited HEDIS PMs for MY 2023 for BCBSND .....	35
Table 15: North Dakota Medicaid Managed Care Compliance Monitoring Standard Designations ....	41
Table 16: Compliance Review Findings.....	42
Table 17: Web Provider Directory Accuracy by Provider Specialty.....	44
Table 18: Managed Care Plan Provider Directory Access Failure Summary .....	44
Table 19: Appointment Availability and After-Hours Access Rates .....	45
Table 20: Timely Appointment Rates .....	45
Table 21: BCBSND Provider to Member Ratio, CY 2024 .....	46
Table 22: BCBSND Adherence to Provider Network Distance Standards for the Top-Six High-Volume Specialties .....	46
Table 23: Match Rates by Encounter Data Type .....	50
Table 24: Professional Data Element Discrepancies and Findings.....	50
Table 25: Institutional Inpatient Data Element Discrepancies and Findings.....	54
Table 26: Institutional Outpatient Data Element Discrepancies and Findings .....	59
Table 27: Medical Record Review Sample Information by Encounter Data Type .....	64
Table 28: Color Key for NCQA HEDIS Quality Compass National Percentiles .....	69
Table 29: BCBSND CAHPS Performance – Adult Members .....	69
Table 30: BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations .....	72
Table 31: BCBSND Responses to EQR 2024 ATR Recommendations.....	73

## List of Figures

Figure 1: North Dakota Medicaid Quality Strategy.....	13
Figure 2: North Dakota’s Quadruple Aim. ....	14
Figure 3: Sample Size.....	44
Figure 4: IPRO’s Medical Record Review (MRR) Methodology.....	64

---

Healthcare Effectiveness Data and Information Set (HEDIS®) and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). The HEDIS Compliance Audit™ is a trademark of the NCQA. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). SAS® is a registered trademark of SAS Institute, Inc. Cotiviti® is a registered trademark of Cotiviti, Inc. Quest Analytics™ is a trademark of Quest Analytics, LLC. All other trademarks herein are the property of their respective owners.

---

## I. Executive Summary

### Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care plans (MCO) 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 MCO. 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 and 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,<sup>1</sup> PAHP,<sup>2</sup> or PCCM<sup>3</sup> 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 health care services that MCO furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCO regarding health care quality, timeliness, and access, as well as making 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 2024 with a discussion between IPRO and North Dakota (ND) Department of Health and Human Services (HHS) regarding the format of the report. Between the months of October and December 2024 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 being prepared from November 2024 through mid-February 2025. IPRO Technical Writers reviewed the draft ATR before it being submitted to HHS on February 27, 2025. HHS provided comments on the draft ATR on March 7, 2025. IPRO and HHS worked together to complete a final version of the ATR by April 30, 2025, 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) who is 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 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 aged 19 and 20 years old as of January 1, 2022. Those individuals aged 19 and 20 will receive Medicaid State Plan benefits through the fee-for-service delivery system as administered and managed through the department. As of November 2024, the Medicaid Expansion program covers 22,830 members. This report presents MCO-level results of these EQR activities for BCBSND conducted during the 2024 calendar year based on MY 2023 data.

---

<sup>1</sup> prepaid inpatient health plan.

<sup>2</sup> prepaid ambulatory health plan.

<sup>3</sup> primary care case management.

## Scope of External Quality Review Activities Conducted

This EQR technical report 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.
- (ii) **CMS Required Protocol 2: Validation of Performance Measures** – This activity assesses the accuracy of performance measures (PM) reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- (iii) **CMS Required Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations** – This activity determines MCO compliance with its contract and with state and federal regulations.
- (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 its Medicaid population.
- (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 managed care organizations.
- (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 CAHPS® satisfaction survey was conducted for adult members. The member survey measured satisfaction with care received, providers, and health plan operations.

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.”

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.

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 that are 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 the **Validation of Performance Measures** section of this report.

## High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of CY 2024 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 the BCBSND **Strengths and Opportunities for Improvement, and EQR Recommendations** section.

### Quality Strategy Evaluation Summary

IPRO worked with HHS to develop the *2024 Quality Strategy*, to review and update the quality strategy currently in effect as the *2025–2027 Quality Strategy*, and to evaluate the progress of the 2024 ND quality strategy. Findings highlight measures that showed progress and present recommendations for performance indicators that did not show progress. The full quality strategy evaluation report is included in **Appendix A**.

Overall, four of the ten North Dakota measure rates (40%) met the target rate. For Aim 1 Healthier Populations, none of the 4 measures with target rates met the target rate objective. For Aim 2 Better Outcomes, 4 of the 5 measures with target rates met the target rate objective. For Aim 3 Better Experience, no target rates were set. For Aim 4 Smarter Spending there was 1 measure with a target rate set and the target rate objective was not met.

### 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 SUD PIP saw four of the five performance indicators meeting their target rates demonstrating a strong improvement from the baseline period. However, opportunities for improvement were noted for performance indicators across the COPD 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 2023 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 46 measures and sub measures that were benchmarked against NCQA Quality Compass® data, four were above the NCQA 90<sup>th</sup> percentile, seven were between the NCQA 75<sup>th</sup> and 90<sup>th</sup> percentiles, eight were between the 50<sup>th</sup> and 75<sup>th</sup> percentiles, seven were between the 25<sup>th</sup> and 50<sup>th</sup> percentiles, and 20 fell below the NCQA 25<sup>th</sup> 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% were in the following areas: Disenrollment Requirements & 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

In December 2024, 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 355 primary care providers (PCPs) 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, non-urgent sick, and after hours.

Overall, the survey found 184 of the 355 providers had telephone numbers that resulted in successful contact. Of these providers, 140 were accepting patients on the listed insurance provider and were practicing the primary specialty indicated in the provider directory. Providers had the availability to schedule well-check visit appointments within 6 weeks at a rate of 44.3% for routine visits and 16.1% for non-urgent sick visits. After-hours access for primary care and pediatric providers was found to be at 50.0%.

The BCBSND *Top 6 High Volume Specialists Geographic Access Report* produced in July of 2024 indicates that, in ND, five of the six top 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 74.6% of members able to access these providers within a 50-mile radius. The PCP-to-member ratio was 1:3.3, 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 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 areas that require further research by encounter type by BCBSND, HHS, and IPRO.

### Validation of Quality-of-Care Surveys

BCBSND is required to conduct annually the adult CAHPS surveys of a sample of members. NCQA Quality Compass was the tool used to examine quality improvement and benchmark BCBSND performance through online access to health plan Consumer Assessment of Healthcare Providers and Systems (CAHPS®) performance data. Measures performing at or above the 75th percentile were considered strengths: ease of getting necessary care (Q9), got care as soon as needed (Q4), and got check-up/ routine care appointment as soon as needed (Q6).

## URAC 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 to 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, 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.

## 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** of this report.

The following list highlights key recommendations for BCBSND:

- Medicaid Quality Strategy Evaluation: Consider new and expanded PIPs to address performance measures that did not meet target rate objectives.
- Performance Improvement Projects: For PIPs that did not show progress, conduct barrier analysis and use findings to inform modifications to interventions.
- Performance Measures: Identify drivers of and barriers to the HEDIS quality-related measures that fell below the NCQA national 25<sup>th</sup> 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 & 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 50<sup>th</sup> 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 in **Section II** of this report provide data-driven evidence to support HHS's guidance for BCBSND to implement the updated ND Medicaid quality strategy.

The following list highlights measures recommended for HHS to provide guidance to BCBSND for meeting or exceeding the new performance targets by FFY 2027:

- Breast Cancer Screening
- Colorectal Cancer Screening
- 7-day Follow-up After Emergency Department Visit for Mental Illness
- Postpartum Care
- Diabetes Short-Term Complications Admission Rate
- Member Satisfaction: 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 a fee-for-service (FFS) or FFS with primary care case management (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 federal poverty level, 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 allowing 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* (May 6, 2016) resulted in ND no longer having designated urban areas and considered rural statewide, 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 waiver 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 waiver 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 waiver 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) renewal waiver 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.

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 ND External Quality Review ATR – Review Period January–December 2024

having one MCO choice for those 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 of 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 unable to afford health insurance. The program provides much-needed access to chronic disease management, mental health services and addiction treatment programs.

### North Dakota Medicaid 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 full quality strategy evaluation report is included in **Appendix A**. IPRO and HHS reviewed the *2024 Quality Strategy* and updated it for 2025, for alignment with the following four aims:

#### Healthier Populations

Improve the overall health of North Dakotans by increasing access to preventive services, including cancer screenings and postpartum care, and by strengthening behavioral health follow-up and engagement.

#### Better Outcomes

Enhance health outcomes for Medicaid members with chronic conditions and substance use disorders through better treatment initiation, care coordination, and reduced avoidable hospitalizations.

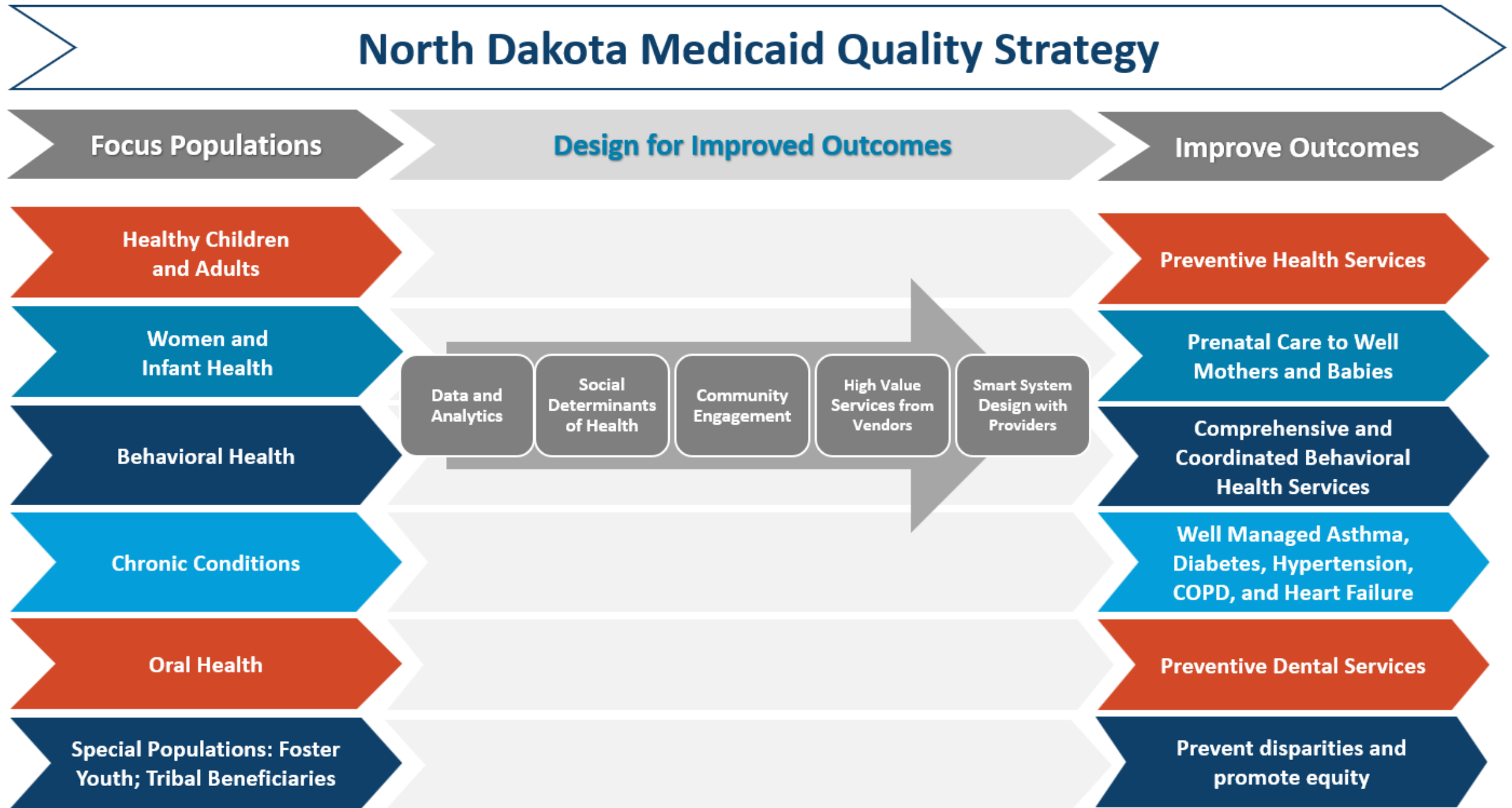
#### Better Experience

Elevate the healthcare experience by promoting timely access to care and increasing member satisfaction with both health plans and overall care received.

#### Smarter Spending

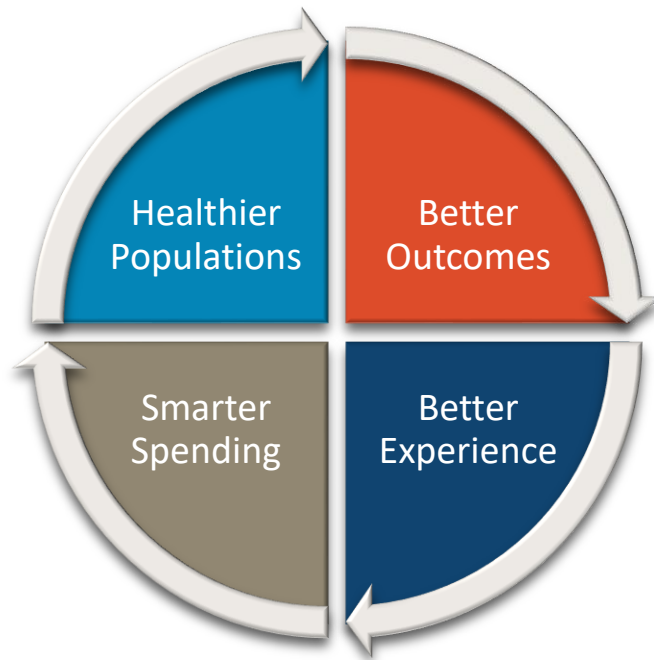
Ensure the efficient use of public resources by reducing avoidable hospital readmissions and supporting value-based care initiatives that prioritize quality over volume.

**Figure 1** depicts ND’s Medicaid quality strategy, showing the conceptual linkages between healthcare needs, quality processes, and outcomes.



**Figure 1: North Dakota Medicaid Quality Strategy** COPD: chronic obstructive pulmonary disease.

**Figure 2**, which is based on the Institute for Healthcare Improvement (IHI)'s quadruple aim, appears in the quality strategy as a guidepost to the scientific basis of quality improvement processes. Together, these aims create a framework through which ND defines and drives the overall vision for advancing the quality of care provided to the Medicaid program members. Corresponding goals, and objectives were designed to align closely with CMS's *Quality Strategy*, adapted to address ND's local priorities, challenges, and opportunities for its Medicaid program.



**Figure 2: North Dakota's Quadruple Aim.** Resource: Institute for Healthcare Improvement (IHI).

### **IPRO's Evaluation of the 2024 North Dakota 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 health care and services furnished by each MCO, PAHP, PIHP, and PCCM entity. To support HHS in meeting this requirement, IPRO, as the EQRO for ND, worked with HHS to develop the *2024 Quality Strategy*, to review and 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 of the BCBSND ATR describes the quality strategy evaluation methodology and presents findings for BCBSND; specifically, PMs that showed progress, PMs that did not show progress and, thus, represent opportunities for improvement, with corresponding recommendations.

#### **Evaluation Methodology**

- Evaluate calendar year (CY) 2023 performance indicator rate percentage point (pp) change from CY 2022 rate.
- Evaluate whether CY 2023 performance indicator rate performed better or worse than the CY 2021 Medicaid national median rate.
- For those PMs that neither met the CY 2021 Medicaid median nor made progress from CY 2022 to CY 2023, include recommendations for BCBSND for improving the quality of health care services to better support the quality strategy aims of healthier populations, better outcomes, better experience, and smarter spending.

## Findings and Recommendations

**Table 1** shows BCBSND Progress on Meeting North Dakota Quality Strategy Goals. Overall, four of the ten performance indicators with target rates set met the target objective. None of the four performance indicators for Aim 1: Healthier Populations met the target objective. For Aim 2: Better Outcomes, four of the five performance indicator rates met the target objective. There were no performance indicators with target rates set for Aim 3: Better Experience. For Aim 4: Smarter Spending, the single performance indicator did not meet the target objective.

### Performance Measures that Showed Progress

The BCBSND PMs that showed progress are summarized in the following narrative.

#### *Aim 1: Healthier Populations*

##### **Goal 1.1: Improve Preventive Health**

- **Breast Cancer Screening (BCS-AD):** BCBSND CY 2023 rate for beneficiaries ages 50-64 increased by 13.8 percentage points from CY 2022 (although the rate fell below the Medicaid median CY 2021 rate)
- **Colorectal Cancer Screening (COL-AD, ages 46-49 years):** BCBSND CY 2023 rate increased by 8.1 percentage points from CY 2022.
- **Colorectal Cancer Screening (COL-AD, ages 50-64 years):** BCBSND CY 2023 rate increased by 7.2 percentage points from CY 2022.

#### *Aim 2: Better Outcomes*

##### **Goal 2.1: Improve Outcomes for Members with Substance Use Disorder**

- **Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD):** BCBSND CY 2023 rate exceeded the Medicaid median CY 2021 rate (although the rate decreased by 6.4 percentage points from CY 2022)
- **Engagement in Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD):** BCBSND CY 2023 rate exceeded the Medicaid median CY 2021 rate (although the rate decreased by 6.9 percentage points from CY 2022)

##### **Goal 2.2: Improve Health for Members with Chronic Conditions**

- **Inpatient Hospital Admissions for Heart Failure (lower rate is better; PQI08-AD):** BCBSND CY 2023 rate decreased by 3.02 percentage points from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).
- **Inpatient Hospital Admissions for COPD (lower rate is better; PQI05-AD):** BCBSND CY 2023 rate decreased by 14.8 percentage points from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).

#### *Aim 3: Better Experience*

##### **Goal 3.1: Enhance Member Experience**

- **Getting Care Quickly (CPA-AD):** BCBSND CY 2023 rate increased by 10.0 percentage points from CY 2022.
- **Rating of Health Plan (CPA-AD):** BCBSND CY 2023 rate increased by 2.13 percentage points from CY 2022.

### Opportunities for Improvement

Findings and recommendations for performance indicators that did not show progress are summarized in the following narrative.

#### *Aim 1: Healthier Populations*

##### **Goal 1.2: Improve Postpartum Care**

- **Timely Postpartum Care (PPC-AD):** To improve this measure, BCBSND could consider conducting a performance improvement project (PIP) aimed at increasing timely postpartum

visits among Medicaid Managed Care (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.”

### **Goal 1.3: Improve Behavioral Health Care for Beneficiaries**

- **Follow-up After Emergency Department Visit for Mental Illness (FUM-AD-7 days):** To improve this measure, BCBSND could consider conducting a PIP aimed at increasing 7-day follow-up rates after an emergency department (ED) visit for mental illness for MMC recipients. Interventions for Managed Care Organization (MCO) collaboration with hospitals for discharge planning can be conducted to improve follow-up visit scheduling, transportation assistance, and attendance.

### *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):** To improve this measure, BCBSND could build on its current Diabetes Care PIP, specifically indicator four: annually decrease the number of hospital admissions with a principal diagnosis of diabetes with short term complications, such that the goal is a reduction in the rate of admissions rather than a goal to maintain the current rate. Interventions for consideration include ensuring beneficiary linkage with primary care providers (PCPs), as well as with endocrinologists for enrollees with poor diabetic control, and improving access to continuous glucose monitoring devices.

### *Experience of Care*

### **Goal 3.1: Enhance Member Experience**

- **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.

### *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):** 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 1: BCBSND Progress on Meeting North Dakota Quality Strategy Goals**

Aim/Goal	Rate Definition	BCBSND <sup>1</sup> 2022	BCBSND <sup>2</sup> 2023	BCBSND Progress <sup>4</sup> by Percentage Point Difference	Medicaid Median <sup>3</sup>	Met Target Objective
<b>Aim 1: Healthier Populations</b>						
<b>Goal 1.1: Improve Preventive Health</b>	Breast Cancer Screening, ages 50 to 64 years	30.40%	44.2%	<b>+13.8</b>	48.8%	<b>No</b>
	Colorectal Cancer Screening, ages 46 to 49 years	9.10%	17.2%	<b>+8.1</b>	N/A	<b>N/A</b>
	Colorectal Cancer Screening, ages 50 to 64 years	14.00%	21.3%	<b>+7.2</b>	N/A	<b>N/A</b>
<b>Goal 1.2: Improve Postpartum Care</b>	Prenatal and Postpartum Care, Timely Postpartum Care Rate	39.50%	38.9%	<b>-0.5</b>	75.0%	<b>No</b>
<b>Goal 1.3: Improve Behavioral Health Care for Beneficiaries</b>	FUM-AD 30-Day Follow-up, ages 18 to 64 years	51.50%	51.9%	<b>+0.5</b>	52.5%	<b>No</b>
	FUM-AD 7-Day Follow-up, Ages 18 to 64 years	35.90%	27.2%	<b>-8.8</b>	38.9%	<b>No</b>
<b>Aim 2: Better Outcomes</b>						
<b>Goal 2.1: Improve Outcomes for Members with Substance Use Disorder</b>	IET-AD, Initiation: Total AOD Abuse or Dependence, ages 18 to 64 years	51.10%	44.7%	<b>-6.4</b>	43.4%	<b>Yes</b>
	IET-AD, Engagement: Total AOD Abuse or Dependence, ages 18 to 64 years	28.00%	21.1%	<b>-6.9</b>	15.8%	<b>Yes</b>
<b>Goal 2.2: Improve Health for Members with Chronic Conditions</b>	Inpatient Hospital Admissions for Heart Failure, ages 18 to 64 years (lower is better)	25.94	22.92	<b>-3.02</b>	23.9	<b>Yes</b>
	Inpatient Hospital Admissions for	24.41	30.47	<b>6.06</b>	17.2	<b>No</b>

Aim/Goal	Rate Definition	BCBSND <sup>1</sup> 2022	BCBSND <sup>2</sup> 2023	BCBSND Progress <sup>4</sup> by Percentage Point Difference	Medicaid Median <sup>3</sup>	Met Target Objective
	Diabetes Short-Term Complications, ages 18 to 64 years (lower is better)					
	Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40 to 64 years (lower is better)	25.41	10.58	-14.83	29.8	Yes
<b>Aim 3: Better Experience</b>						
<b>Goal 3.1: Enhance Member Experience</b>	CPA-AD Getting Care Quickly (CAHPS)	79.50%	89.5%	+10.0	N/A	N/A
	CPA-AD Rating of Health Plan (CAHPS)	71.40%	73.5%	+2.1	N/A	N/A
	CPA-AD Rating of All Health Care (CAHPS)	82.10%	73.0%	-9.1	N/A	N/A
<b>Aim 4: Smarter Spending</b>						
<b>Goal 4.1: Focus on Paying for Value</b>	Plan All-Cause Readmission, Observed/Expected (O/E) Ratio (lower is better)	1.0213	1.024	0.0027	1	No

<sup>1</sup> Federal fiscal year (FFY) 2023 (calendar year [CY] 2022) data.

<sup>2</sup> FFY 2024 (CY 2023) data.

<sup>3</sup> FFY 2022 (CY 2021) data.

<sup>4</sup> Percentage points indicate absolute percentage point change from measurement year (MY) 2022 to MY 2023, where plus (+) shows an increase in percentage, and minus (-) shows a decrease in percentage. Plus (+) represents better performance, and minus (-) represents worse performance from MY 2022 to MY 2023, except for measures indicated by “lower is better,” for which minus (-) represents better performance.

BCBSND: Blue Cross Blue Shield of North Dakota; N/A: not applicable; NR: not reported; 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.

### III. External Quality Review Activity 1: Validation of Performance Improvement Projects

#### Objectives

*Title 42 CFR § 438.330(d)* establishes that state agencies that contract with MMC plans must conduct PIPs that focus on both clinical and non-clinical areas. According to CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care 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 2024. PIP topics are displayed in **Table 2**.

**Table 2: PIP Topics**

PIP Topics
PIP 1: COPD or Asthma in Older Adults Admission Rate
PIP 2: Diabetes Care
PIP 3: Substance Use Disorder

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 for relevance to 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 was 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 is 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.

I PRO performs quarterly PIP coaching reviews with BCBSND where the MCO is given the opportunity to speak on their latest updates and receive feedback from I PRO. Following the quarterly calls, I PRO sends BCBSND written evaluations to assist BCBSND 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 3** with results shown in **Table 4**.

**Table 3: Overall Credibility of Results**

Validation Level	Definition
High Confidence	The PIP was methodologically sound; produced evidence of significant improvement; and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
Moderate Confidence	The PIP was methodologically sound; produced some evidence of improvement; and 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; <u>or</u> (B) The quality improvement processes and interventions were poorly executed and could not be linked to any improvement that may have occurred.

Three of the BCBSND PIPs concluded their second interim year on December 31, 2024. Findings will be final when the PIP concludes on December 31, 2025. The findings below are preliminary.

### Description of Data Obtained and Progress

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 and undergoing at least one ambulatory or preventive visit annually.

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.
- 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.

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.
- 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 health care provider for a principal diagnosis of COPD or asthma during the CY.
- 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 and undergoing at least one ambulatory or preventive visit annually.

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.
- 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.

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.
- 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 health care provider for a principal diagnosis of diabetes during the CY.
- 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 and undergoing at least one ambulatory or preventive visit annually.

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.
- Implemented peer support services covered by BCBSND.
- 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.

## Conclusions and Comparative Findings

BCBSND submitted three second-year interim PIP reports (COPD or Asthma in Older Adults Admission Rate, Diabetes Care, and Substance Use Disorder) which are summarized in **Tables 4–8**.

**Table 4: PIP Validation Results for PIP Elements – Quarter 4, 2024**

BCBSND <sup>1</sup>	PIP 1	PIP 2	PIP 3
Validation Element <sup>2</sup>	COPD/Asthma	Diabetes Care	SUD
Topic/Rationale	Met	Met	Met
Aim	Met	Met	Met
Methodology	Met	Partial	Partial
Population analysis and stratification	Met	Met	Met
Barrier analysis	Met	Met	Met
Robust interventions	Partial	Partial	Partial
Results table	Partial	Partial	Partial
Overall Credibility of Results <sup>3</sup>	Moderate Confidence	Moderate Confidence	Moderate Confidence

<sup>1</sup> Interim Year 2 results for the COPD/Asthma, Diabetes Care and SUD PIPs.

<sup>2</sup> There are three levels of validation results: Met; Partial (Partially Met); and NM (Not Met).

PIP: performance improvement project; BCBSND: Blue Cross Blue Shield of North Dakota; COPD: chronic obstructive pulmonary disease; SUD: substance use disorder

<sup>3</sup> There are three levels of overall credibility of results: High Confidence; Moderate Confidence; and Low Confidence.

BCBSND achieved one goal out of the three indicators (Indicator 3) and continues to work towards achieving the goal rates for the additional indicators (Indicators 1 and 2). Due to declining performance in Indicators 1 and 2, IPRO recommend that the MCO conduct a drill-down analysis to understand what barriers are not being addressed with the current ITMs to assist them in reaching their target rates. Additionally, since the plan has achieved the target rate for Indicator 1, consider setting a new target rate or implementing a new indicator.

**Table 5: 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	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)	72%
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)	72%
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 health care provider for a principal diagnosis of COPD or asthma during the CY.	50.0% (15/30)	71.43% (15/21)	53.33% (8/15)	60%
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)	11.62 (21 discharges/ 170,772 MM)	6.73 (20 discharges/ 141,221 MM)	< 41.9 per 100,000 MM

BCBSND: Blue Cross Blue Shield of North Dakota; COPD: chronic obstructive pulmonary disease; PIP: performance improvement project; CY: calendar year.

BCBSND has not yet met the target rates for any of the indicators for the Diabetes Care PIP (**Table 6**). IPRO advised that BCBSND should consider setting a more ambitious goal rate for Indicator 2 (since they already achieved the goal at baseline) and investigate into why Indicators 1-3 have shown declining performance since Interim Period CY 2023.

**Table 6: BCBSND Diabetes Care PIP Interim Results**

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	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)	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)	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	3.09 (124/ 401,010 MM)	20.46 (46/ 224,843 MM)	<20 per 100,000 MM
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 health care provider for a principal diagnosis of diabetes during the CY.	81.94% (59/72)	83.12% (64/77)	80.00% (40/50)	88.00%
Indicator 4: % 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)	Not Reported	60.34%

BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; COPD: chronic obstructive pulmonary disease. Source: BCBSND Quarterly Report.

Four indicators have reached their target rates (unstratified Indicators 1 and 3, Indicator 4, and Indicator 5). for the Substance Use Disorder PIP (**Table 7**). IPRO recommended that BCBSND set higher target rates for indicators 1, 2, 3, and 5 to establish improvement goals that are both bold yet feasible. IPRO also recommended that the MCO investigate ITM 7, which has remained stagnant and determine if the intervention should be adapted or abandoned.

**Table 7: BCBSND Substance Use Disorder PIP Interim Results**

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	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)	42.63%
Indicator 1: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	American Indian and Alaska Native 37.01% (356/962) White 39.62% (735/1859)	Not Reported	American Indian and Alaska Native 41.15% (321/780) White 41.56% (527/1268)	42.00%
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)	32.53%
Indicator 2: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	American Indian and Alaska Native 29.94% (141/471) White 40.40% (265/656)	American Indian and Alaska Native 28.13% (128/455) White 35.49% (203/572)	Discontinued	32.00%
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)	22.08%
Indicator 3: Stratification for American Indian and Alaskan Native and White (non-Hispanic).	American Indian and Alaska Native 43.10% (203/471) White 54.73% (359/656)	American Indian and Alaska Native 40.00% (182/455) White 54.20% (310/572)	Discontinued	45.00%

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Interim Period CY 2024	Target Rate
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)	49.00%
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)	61.00%

BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; SUD: substance use disorder; ED: emergency department. Source: BCBSND Quarterly Report

**Table 8** displays a summary of IPRO’s improvement assessment for each project indicator by PIP topic for BCBSND. This table displays results through the second 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, 2025. 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 8: 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 not met, and performance decline demonstrated. (Red)
Indicator 1: Stratification	American Indian and Alaska Native	Target not met, and performance decline demonstrated. (Red)

Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim
Indicator 1: Stratification	White	Target not met, and performance decline demonstrated. (Red)
Indicator 2	% of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma	Target not met, and performance decline demonstrated. (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)
<b>Diabetes Care PIP</b>		
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, but performance improvement demonstrated. (Yellow)
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, and performance decline demonstrated. (Red)
Indicator 3	% of enrollees discharged for diabetes with a healthcare provider visit for diabetes	Target not met, and performance decline demonstrated. (Red)
Indicator 4	% of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (< 8.0%)	Unable to evaluate performance at this time. (Gray)
<b>Substance Use Disorder PIP</b>		
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 exceeded, and performance improvement demonstrated. (Green)
Indicator 1: Stratification	American Indian and Alaska Native	Target not met, but performance improvement demonstrated. (Yellow)
Indicator 1: Stratification	White	Target not met, but performance improvement demonstrated. (Yellow)
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 exceeded, but performance declined (Yellow)
Indicator 4	% of follow up for High-Intensity Care for Substance Use Disorder – Within 7 Days, of visits or discharges for which the member	Target exceeded, and performance improvement demonstrated. (Green)

Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim
	received follow-up for substance use disorder after the visit or discharge.	
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 exceeded, and performance improvement demonstrated. (Green)

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

### Strengths and Opportunities for Improvement

#### Strengths

The SUD PIP met their target rates for Indicators 1, 4, and 5. Stratification for Indicator 1 saw improvement in the rates for White, American Indian and Alaska Native subpopulations but did not meet their target rates. Indicator 3 met its target rate despite declining performance; however, IPRO suggested that BCBSND consider setting a more ambitious target rate. For the COPD PIP, a reduction in total admissions with a principal diagnosis of COPD/ asthma saw a reduced rate and met the target goal.

#### Opportunities for Improvement

Four of the five indicators for the COPD PIP saw a decline in performance and did not meet their target rates. For the Diabetes Care PIP, none of the target rates were met and four of the five reported rates saw a decline in performance. Two of the five indicators for the SUD PIP saw a decline in performance. For these three interim PIPs, BCBSND should consider modifications to ITMs corresponding to indicators that did not improve.

## IV. External Quality Review Activity 2: Validation of Performance Measures

### Objectives

*Title 42 CFR § 438.330(c) Performance measurement* establishes that the state must identify standard performance measures 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 its performance using the standard measures required by the state.

Medicaid MCO 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 Mandatory Protocol 2: Validation of Performance Measures* from *CMS's External Quality Review 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

#### Managed Care Plan-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. **Tables 9–11** present the HEDIS and non-HEDIS results.

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 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.

#### Managed Care Plan-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;
- IS R: Data Management and Reporting.

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

- HD 4.0: Algorithmic Compliance;
- 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 (ISCA)

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. 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 tasks outlined above. Responses to these questions assisted IPRO in assessing the extent to which BCBSND's information systems 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 9**.

**Table 9: ISCA Findings**

Category	Result	Comments
Completeness and accuracy of encounter data collected and submitted to the state	Met	<p>BCBSND’s information systems have a process in place that generates and submits encounter data to the HHS, Medical Services Division ND.</p> <p>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.</p>
Validation and/or calculation PMs	N/A	<p>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.</p> <p>BCBSND plans to use Cotiviti® for PM and HEDIS MY 2022 reporting.</p>
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 health care to the MCO’s enrollees	Met	<p>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.</p> <p>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.</p> <p>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.</p>
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 HHS, Medical Services Division ND 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.
Utility of the MCO’s information systems for linking to other information sources for quality-related reporting (e.g., immunization	Met	BCBSND’s information systems have processes in place to receive, validate, and incorporate claims data and produce internal and regulatory reports.

Category	Result	Comments
registries, health information exchanges, vital statistics, public health data)		

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 2023 FAR to determine compliance with ISCA standards. The FAR revealed BCBSND met all standards for successful reporting (**Table 10**).

**Table 10: BCBSND Compliance with Information Systems Standards – MY 2023**

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.

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. IPRO also received BCBSND’s FAR from their independent NCQA HEDIS auditor, Attest Health Care Advisors, as well as the audited HEDIS rates.

**Table 11** displays the color key for CMS 2023 Core Set Chart Pack quartile comparisons, and **Table 12** displays the IPRO-validated non-HEDIS PMs for MY 2023 for BCBSND.

**Table 11: Color Key for IPRO-Validated Non-HEDIS Performance Measures Comparisons to CMS 2023 Core Set Chart Pack Quartiles**

Color Key	How Rate Compares to the CMS 2023 Core Set Chart Pack Quartiles
Orange	Less than (<) the bottom quartile
Gray	Greater than or equal to (≥) the bottom quartile and < the median
Blue	Greater than (>) the top quartile
White	No benchmark

HEDIS: Healthcare Effectiveness Data and Information Set; CMS: Centers for Medicare and Medicaid Services. There were no rates that were ≥ the median and ≤ the top quartile.

**Table 12: IPRO-Validated Non-HEDIS Performance Measures – MY 2023**

Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to CMS 2023 Chart Pack
<b>Screening for Depression and Follow-Up plan: Age 18 and Older (CDF-AD)</b>				
Age 18-64 years	0.00%	0.00%	0.00	No Benchmark
<b>Concurrent Use of Opioids and Benzodiazepines (COB-AD)<sup>1</sup></b>				
Age 18-64 years	10.08%	9.27%	-0.01	> Top Quartile
<b>Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)<sup>1</sup></b>				
Age 18-64 years	0.00%	0.00%	0.00	0 Denominator
<b>Use of Pharmacotherapy for Opioid Use (OUD-AD)</b>				
Total	64.44%	59.22%	-0.05	≥ Bottom and <Median
Buprenorphine	46.03%	23.73%	-0.22	No Benchmark
Oral Naltrexone	2.86%	2.50%	0.00	No Benchmark
Long-Acting, Injectable Naltrexone	1.27%	0.74%	-0.01	No Benchmark
Methadone	18.41%	35.40%	0.17	No Benchmark
<b>Diabetes Short-Term Complications Admission Rate (PQI01-AD)<sup>1</sup></b>				
Age 18 to 64 years	24.41	30.47	6.06	< Bottom Quartile
<b>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)<sup>1</sup></b>				
Age 40 to 64 years	25.41	10.58	-14.83	> Top Quartile
<b>Heart Failure Admission Rate (PQI08-AD)<sup>1</sup></b>				
Age 18 to 64 years	25.94	22.92	-3.02	≥ Bottom and <Median
<b>Asthma in Younger Adults Admission Rate (PQI15-AD)<sup>1</sup></b>				
Age 18 to 39 years	1.36	0.46	-0.90	> Top Quartile
<b>Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)</b>				
Most or moderately effective contraception - 3 days	7.36%	6.56%	-0.80	< Bottom Quartile
Most or moderately effective contraception - 60 days	25.15%	31.15%	6.00	< Bottom Quartile
LARC - 3 days	0.00%	0.00%	0.00	< Bottom Quartile
LARC - 60 days	5.52%	12.30%	6.78	< Bottom Quartile

Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to CMS 2023 Chart Pack
<b>Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)</b>				
Provision of most or moderately effective contraception	15.89%	15.58%	-0.31	< Bottom Quartile
Provision of LARC	2.96%	2.98%	0.02	< Bottom Quartile
<b>Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) (HPCMI-AD)<sup>1</sup></b>				
Age 18 - 64 years	100.00%	93.14%	-6.86	≥ Bottom and <Median
<b>HIV Viral Load Suppression (HVL-AD)</b>				
Age 18 - 64 years	0.00%	0.00%	0.00	No Benchmark

<sup>1</sup> Lower rate is better.

BCBSND: Blue Cross Blue Shield of North Dakota; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year.

**Table 13** shows the color key for HEDIS PM comparisons for NCQA HEDIS MY 2023 Quality Compass national percentiles. **Table 14** shows the HEDIS PMs for MY 2023 for BCBSND along with this comparison.

**Table 13: Color Key for HEDIS Performance Measure Comparisons to NCQA HEDIS MY 2023 Quality Compass National Percentiles**

Color Key	How Rate Compares to the NCQA HEDIS MY 2023 Quality Compass 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.

**Table 14: NCQA Certified HEDIS-Compliance Auditor-Audited HEDIS PMs for MY 2023 for BCBSND**

Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to Quality Compass
<b>Effectiveness of Care</b>				
<b>Colorectal Cancer Screen (COL)</b>				
COL: Ages 46-50 Years	N/A	17.22%	N/A	<25th
COL: Ages 51-75 Years	N/A	21.26%	N/A	<25th
COL: Total	12.97%	20.23%	7.26	<25th
<b>Chlamydia Screening in Women (CHL)</b>				
CHL: Ages 21 - 24 years	N/A	37.97%	N/A	<25th
CHL: Total Rate	41.50%	37.97%	-3.53	<25th
<b>Cervical Cancer Screening (CCS)</b>				
CCS: Cervical Cancer Screening	16.90%	24.80%	7.9	<25th
<b>Effectiveness of Care: Respiratory Conditions</b>				
<b>Asthma Medication Ratio (AMR)</b>				
AMR: 19-50 years	N/A	98.51%	N/A	≥90th
AMR: 51-64 years	N/A	100%	N/A	≥90th
AMR: Total Rate	93.10%	98.97%	5.87	≥90th
<b>Effectiveness of Care: Cardiovascular Conditions</b>				
<b>Controlling High Blood Pressure (CBP)</b>				
CBP: Total Rate	N/A	53.28%	N/A	<25th
<b>Effectiveness of Care: Diabetes</b>				
<b>Effectiveness of Care: Diabetes</b>				

Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to Quality Compass
EED: Eye Exam for Patients With Diabetes	32.17%	44.42%	12.25	<25th
HBD: Hemoglobin A1c Control for Patients With Diabetes - Poor Control <sup>1</sup>	52.80%	48.91%	-3.89	<25th
HBD: Hemoglobin A1c Control for Patients With Diabetes	39.40%	40.88%	1.48	<25th
<b>Effectiveness of Care: Behavioral Health</b>				
<b>Antidepressant Medication Management (AMM)</b>				
AMM: Rate – Effect. Acute Phase Treatment	73.80%	63.36%	-10.44	≥50th and <75th
AMM: Rate – Effect. Continuation Phase Treat.	60.63%	44.78%	-15.85	≥50th and <75th
<b>Follow-Up after Hospitalization for Mental Illness (FUH)</b>				
FUH:18-64 Years 30-Day Follow-Up	N/A	41.85%	N/A	<25th
FUH: 18-64 Years 7-Day Follow-Up	N/A	24.81%	N/A	<25th
FUH: Total Rate 30-Day Follow-Up	51.17%	41.85%	-9.32	<25th
FUH: Total Rate 7-Day Follow-Up	28.83%	24.81%	-4.02	<25th
<b>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</b>				
FUM: 18-64 Years 30-Day Follow-Up	N/A	51.94%	N/A	≥50th and <75th
FUM: 18-64 Years 7-Day Follow-Up	N/A	27.16%	N/A	≥25th and <50th
FUM: Total Rate 30-Day Follow-Up	51.46%	51.94%	0.48	≥25th and <50th
FUM: Total Rate 7-Day Follow-Up	35.92%	27.16%	-8.76	<25th
<b>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)</b>				
FUA: 30-Day Follow-Up: 18+ Years	N/A	44.51%	N/A	≥75th and <90th
FUA: 7-Day Follow-Up: 18+ Years	N/A	29.97%	N/A	≥75th and <90th
FUA: 30-Day Follow-Up: Total	51.19%	44.51%	-6.68	≥75th and <90th
FUA: 7-Day Follow-Up: Total	38.06%	29.97%	-8.09	≥75th and <90th
<b>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</b>				
SSD: Rate	78.38%	79.13%	0.75	≥25th and <50th
<b>Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)</b>				
SAA: Rate	44.91%	45.32%	0.41	<25th
<b>Medication Management</b>				
<b>Avoidance of Antibiotic Treatment in Adults for Acute Bronchitis/Bronchiolitis (AAB)</b>				
AAB: 18-64 Years	N/A	59.36%	N/A	≥90th
AAB: Total Rate	56.20%	59.36%	3.16	≥25th and <50th
<b>Access/Availability of Care</b>				
<b>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</b>				
IET: Alcohol Abuse - Initiation - Total	N/A	40.58%	N/A	≥25th and <50th

Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to Quality Compass
IET: Opioid Abuse - Initiation - Total	N/A	61.36%	N/A	≥50th and <75th
IET: Other Drug Abuse - Initiation - Total	N/A	44.78%	N/A	≥50th and <75th
IET: Total - Initiation - Total	51.10%	44.73%	-6.37	≥50th and <75th
IET: Alcohol Abuse - Engagement - Total	N/A	17.23%	N/A	≥75th and <90th
IET: Opioid Abuse - Engagement - Total	N/A	41.19%	N/A	≥50th and <75th
IET: Other Drug Abuse - Engagement - Total	N/A	19.87%	N/A	≥75th and <90th
IET: Total - Engagement - Total	27.98%	21.06%	-6.92	≥75th and <90th
<b>Prenatal and Postpartum Care (PPC)</b>				
PPC: Timeliness of Prenatal Care	31.97%	48.65%	16.68	<25th
PPC: Postpartum Care	39.46%	38.92%	-0.54	<25th
<b>Utilization and Risk Adjusted Utilization</b>				
<b>Plan All-Cause Readmissions (PCR) Observed/Expected Ratio<sup>1</sup></b>				
PCR: Plan All-Cause Readmissions (18-64)	1.02	1.02	0	≥25th and <50th
PCR: Plan All-Cause Readmissions (55-64)	N/A	0.9	N/A	≥50th and <75th
PCR: Plan All-Cause Readmissions (45-54)	N/A	1.1	N/A	<25th
PCR: Plan All-Cause Readmissions (18-44)	N/A	1.05	N/A	≥25th and <50th
<b>ECDS Measures</b>				
<b>Breast Cancer Screening (BCS-E)</b>				
BCS-E Breast Cancer Screening	30.41%	44.19%	13.78	<25th

<sup>1</sup> 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; MY: measurement year; NC: no comparison, as no NCQA Quality Compass benchmark comparison is available; HbA1c: hemoglobin A1c; SUD: substance use disorder.

## Conclusions

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. MY 2023 was the first year that BCBSND submitted their rates to NCQA. IPRO also determined that the validated non-HEDIS measures were all reportable.

### Non-HEDIS Measures

Of the 13 elements that had benchmarks available, 7 were in the CMS bottom quartile (54%), 3 were in between the bottom and median quartile (23%) and 3 were in the top quartile (23%).

### HEDIS Measures

Of the 46 measures and sub measures reported by BCBSND, four were above the NCQA 90<sup>th</sup> percentile, seven were between the NCQA 75<sup>th</sup> and 90<sup>th</sup> percentiles, eight were between the 50<sup>th</sup> and 75<sup>th</sup> percentiles, seven were between the 25<sup>th</sup> and 50<sup>th</sup> percentiles, and 20 fell below the NCQA 25<sup>th</sup> percentile.

## V. External Quality Review Activity 3: 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 Children's Health Insurance Program standards is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

As required by section 2.1 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 external quality review organization must perform the review to determine managed care compliance with federal Medicaid and Children's Health Insurance Program 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 external quality review organization, states can use information obtained from a national accrediting organization review for the external quality review 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 of the report 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. The findings of the review are presented in this section.

### 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., sub standards). 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) 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 prereview 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 what specific evidence was used to assess that MCO was compliant with the standard or a rationale for why an MCO was partially compliant or non-compliant and what evidence was lacking. 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 15**.

**Table 15: North Dakota Medicaid Managed Care 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) <sup>1</sup>	Contractual element does not require a review decision; for reviewer information purposes.	-

<sup>1</sup> Elements determined to be nonapplicable were not included in the overall determination calculation. 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 QI 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.

### Conclusions

There were three categories that underperformed and had scores less than 90%: Availability of Services, Assurances of Adequate Capacity & Services, and Provider Selection (**Table 16**). 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 & Services domain contained 6 of 24 fully met and 4 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 4 were 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 16**).

**Table 16: Compliance Review Findings**

CFR Topic	Total Points	Applicable Elements	BCBSND Compliance Score
438.56 Disenrollment Requirements & Limitations	13	13	100.0%
438.100 Enrollee Rights & 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 & 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%
<b>Overall</b>	<b>625</b>	<b>657</b>	<b>95.1%</b>

CFR: Code of Federal Regulations; BCBSND: Blue Cross Blue Shield of North Dakota; QAPI: quality assurance and performance improvement.

## VI. External Quality Review Activity 4: 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 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 a review of network adequacy standards reported by BCBSND.

### Technical Methods of Data Collection and Analysis

#### Provider Access Survey Study

In December 2024, 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 355 PCPs 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, non-urgent 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 visit and non-urgent 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 get 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, pediatrician, cardiologist or behavioral health provider.

A total of 355 providers were called from the provider web directory (**Figure 3**). Of the 355 providers called, 140 providers were contacted successfully. These providers were used as the final sample size for the remainder of the survey.



**Figure 3: Sample Size** The starting sample size, exclusions for unreachable providers, and providers with practices limited to specialty care or not accepting new patients.

## Directory Accuracy Findings

Directory accuracy findings are presented in **Table 17** and **Table 18**.

**Table 17: 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 <sup>1</sup>	Provider Directory Access Rate by Specialty
Family practice/Internal medicine	163	65	39.9%
Obstetrician/Gynecologist	50	24	48.0%
Pediatrician	45	25	55.6%
Cardiologist	47	16	34.0%
BH provider	50	10	20.0%
<b>Total</b>	<b>355</b>	<b>140</b>	<b>39.4%</b>

<sup>1</sup> Providers who are participating in Medicaid and accepting new patients for the reported specialty.

**Table 18: Managed Care Plan Provider Directory Access Failure Summary**

Failure Reasons	Total Failed Providers	Failure Rate
Provider not at site	142	66.0%
Provider practice is restricted to specialty care	28	13.0%
Constant busy signal	16	7.4%
Provider not accepting new patients (closed panel)	16	7.4%
Answering machine/Voicemail system	8	3.7%
No answer	2	0.9%
Wrong number	2	0.5%
Telephone company message indicating phone out of order	1	0.5%
<b>Total</b>	<b>215</b>	<b>-</b>

<sup>1</sup> Failure reason is based on the final call attempt.

## Access and Availability-Secret Shopper Survey

The following results pertain to the 116 providers participating in the plan that were confirmed to be accepting new patients. **Table 19** shows the number of providers offering appointments to new patients for routine well-check visits and sick visits.

**Table 19: Appointment Availability and After-Hours Access Rates**

Call and Provider Type	Total Providers Surveyed	Total Appointments	Appointment Rate <sup>1</sup>
Routine – Family practice/Internal medicine	18	14	77.8%
Routine – Ob/Gyn	11	10	90.9%
Routine – Pediatrician	6	4	66.7%
Routine – Cardiologist	16	5	31.3%
Routine – Behavioral health provider	10	2	20.0%
<b>Total routine</b>	<b>61</b>	<b>35</b>	<b>57.4%</b>
Non-urgent sick – Family practice/Internal medicine	14	11	78.6%
Non-urgent sick – Ob/Gyn	13	11	84.6%
Non-urgent sick – Pediatrician	4	3	75.0%
Non-urgent sick – Cardiologist	0	-	-
Non-urgent sick – Behavioral health provider	0	0	-
<b>Total non-urgent sick</b>	<b>31</b>	<b>25</b>	<b>80.6%</b>
After-hours access <sup>2</sup> – Family practice/Internal medicine	33	15	45.5%
After-hours access <sup>2</sup> – Ob/Gyn	0	-	-
After-hours access <sup>2</sup> – Pediatrician	15	10	66.7%
After-hours access <sup>2</sup> – Cardiologist	0	-	-
After-hours access <sup>2</sup> – Behavioral health provider	0	-	-
<b>Total after-hours access</b>	<b>48</b>	<b>25</b>	<b>52.1%</b>

<sup>1</sup> Timeliness was not considered when determining appointment availability rates.

<sup>2</sup> After-hours access does not require an appointment.

## Appointment Availability Findings

**Table 20** shows the number of providers offering appointments to new patients for timely routine well-check visits and sick visits.

**Table 20: Timely Appointment Rates**

Call and Provider Type	Total Providers Surveyed	Timely Appointments	Appointment Rate <sup>1</sup>
Routine – Family practice/Internal medicine	18	13	72.2%
Routine – Ob/Gyn	11	6	54.5%
Routine – Pediatrician	6	4	66.7%
Routine – Cardiologist	16	3	18.8%
Routine – Behavioral health provider	10	1	10.0%
<b>Total routine</b>	<b>61</b>	<b>27</b>	<b>44.3%</b>
Non-urgent sick – Family practice/Internal medicine	14	3	21.4%
Non-urgent sick – Ob/Gyn	13	2	15.4%
Non-urgent sick – Pediatrician	4	0	0.0%
Non-urgent sick – Cardiologist	0	-	-

Call and Provider Type	Total Providers Surveyed	Timely Appointments	Appointment Rate <sup>1</sup>
Non-urgent sick – Behavioral health provider	0	-	-
<b>Total non-urgent sick</b>	<b>31</b>	<b>5</b>	<b>16.1%</b>
After-hours access <sup>2</sup> – Family practice/Internal medicine	33	14	42.4%
After-hours access <sup>2</sup> – Ob/Gyn	0	-	-
After-hours access <sup>2</sup> – Pediatrician	15	10	66.7%
After-hours access <sup>2</sup> – Cardiologist	0	-	-
After-hours access <sup>2</sup> – Behavioral health provider	0	-	-
<b>Total after-hours access</b>	<b>48</b>	<b>24</b>	<b>50.0%</b>

<sup>1</sup> Timely is within 72 hours for non-urgent sick, and within 6 weeks for routine type calls.

<sup>2</sup> After-hours access does not require an appointment.

Appointments were considered timely when the visit was within 6 weeks of the call for routine well-care visits and within 3 calendar days for sick visits. Providers had the availability to schedule well-care visit appointments within 6 weeks at a rate of 44.3% for routine visits and 16.1% for non-urgent sick visits. After-hours access for primary care and pediatric providers was 50.0%.

## 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 the 2nd quarter of 2024. **Table 21** displays the validated BCBSND ratio for CY 2024. BCBSND met the PCP-to-member ratio standard for CY 2024 of 1 PCP to 2,500 members.

**Table 21: BCBSND Provider to Member Ratio, CY 2024**

Specialty	Number of Providers: Members	Ratio of Providers: Members
PCPs	6,616:21,903	1:3.3

Data Source: PCP to Enrollee Ratio Report, Medicaid Expansion, July 12, 2024.

BCBSND: Blue Cross Blue Shield of North Dakota; CY: calendar year; PCP: primary care provider.

### Network Adequacy Distance Standards Findings

North Dakota requires that at least 90% of BCBSND's membership has access to providers within the established distance standards. IPRO analyzed *Top-Six High-Volume Specialists Geographic Access Report* produced in July of 2024 by BCBSND to determine if they were compliant with the HHS distance requirements (**Table 22**).

**Table 22: BCBSND Adherence to Provider Network Distance Standards for the Top-Six High-Volume Specialties**

Specialty <sup>1</sup>	Standard	% with Access
Behavioral health providers	1 in 50 miles	100.0%
Cardiology providers	1 in 50 miles	96.0%
Medical oncology providers	1 in 50 miles	74.6%
Ob/Gyn providers	1 in 50 miles	97.4%
Orthopedic surgery providers	1 in 50 miles	97.8%
Surgery providers	1 in 50 miles	99.7%

<sup>1</sup> Provider types that were top-six high-volume specialties in the 2nd quarter of 2024.

BCBSND: Blue Cross Blue Shield of North Dakota; Ob/Gyn: obstetrician/gynecologist.

## Network Information Systems Validation

The network information systems 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 2-hour virtual meeting was held on December 4, 2024, to discuss BCBSND's responses to the NAV ISCA and to conduct a review of BCBSND's information systems. 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.

BCBS was found to be compliant with the utility of the information systems for collection and maintenance of BCBSND's provider network and their information systems ability to review and calculate provider network adequacy.

## 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 Report, PCP to Enrollee Ratio Report, Top 5 High Volume Specialists Geographic Access Report, and annual Summary Access and Availability Analysis Report.

## Conclusions and Recommendations

- 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 its PCPD.
- BCBSND should include additional information needed to demonstrate compliance with the time, distance, and ratio standards detailed in MCO Contract § 2.9.1. For instance, the MCO should provide separate data on distance to PCPs for non-rural and rural enrollees.

## VII. External Quality Review Activity 5: Validation of Encounter Data

### Objectives

*Title 42 CFR § 438.242 Health Information Systems (c) Enrollee encounter data* 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 provides 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 is 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 2024, IPRO conducted this activity on HHS. IPRO aimed to verify the completeness and accuracy of encounters with service dates of July 1 to December 31, 2023, and submitted to the state between July 1, 2023, and January 31, 2024, for all encounter types and fields.

### Technical Methods of Data Collection and Analysis

The encounter data submitted to HHS was 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 for the service dates of July 1 to December 31, 2023, and submitted to the state between July 1, 2023, and January 31, 2024, for all encounter types and fields.

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 DW 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.

During calendar year 2024, IPRO initiated a review of encounters submitted with service dates from July 1 to December 31, 2023, and submitted to the state between July 1, 2023, and January 31, 2024, for all encounter types and fields. Specifically, a comparison of data housed by the managed care plan to data housed in the state's Medicaid Management Information System was performed. For each data element compared, IPRO aimed to calculate a match rate between the two data sources.

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

- professional claims,
- institutional inpatient claims,
- institutional outpatient claims,

- dental claims, and
- pharmacy claims.

The validation was conducted using an approach developed by IPRO and consistent with the CMS *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 warehouse.
4. The percentage of records with discrepant values were calculated for each data element, and those with less than a 95% 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% 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% match rate were reviewed.

Following the teleconference with BCBS, 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 that BCBSND provide all electronic encounters residing in their claims transaction system, with dates of service from July 1 to December 31, 2023, and submitted to the state between July 1, 2023, and January 31, 2024, for professional, institutional inpatient and institutional outpatient. 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 \$0.00) 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 was 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. This is described further in this section of the ATR.

## Results

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.

### Match Rates by Encounter Data Type

**Table 23: Match Rates by Encounter Data Type**

Encounter Data Type	Total Encounters (n)	Matched Encounters (n)	Match Rate (%)	Non-matched Encounters (n)	Non-match Rate (%)
Professional	390,214	370,151	94.86	20,063	5.14
Institutional inpatient	29,136	18,844	64.68	10,292	35.32
Institutional outpatient	238,804	216,206	90.54	22,598	9.46
Total	658,154	605,201	91.95	52,953	8.05

Data elements with less than a 95% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type. Findings are summarized in **Tables 24–26**.

**Table 24: Professional Data Element Discrepancies and Findings**

BCBSND Professional Data Element Discrepancies and Findings (Total Encounters=370,151)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Unique Medicaid number assigned to the recipient (MMIS_ID)	370,140	100	11	0.00	
The unique identifier of the claim. Also known as TCN, or Transaction Control Number (CLAIM_ID)	370,151	100	0	0.00	
The Adjustment Original Claim ID is the Transaction Control Number of the first original claim adjusted in the adjustment chain (ADJ_ORIG_CLM_ID)	NV	NV	NV	NV	ND HHS advised that any time a claim is adjusted, the TCN is not going to be the same; an external claim ID has been added to its system, but no historical data were available.  IPRO to remove this data element from future EDV studies.
Date on which the statement period on the claim began, start date of service on the header (START_DT)	370,151	100	0	0.00	

**BCBSND Professional Data Element Discrepancies and Findings (Total Encounters=370,151)**

<b>Data Element Description (Data Element Name)</b>	<b>Match (n)</b>	<b>Match Rate (%)</b>	<b>Non-match (n)</b>	<b>Non-match Rate (%)</b>	<b>Notable Findings</b>
Date on which the statement period on the claim ended, end date of service on the header (END_DT)	370,151	100	0	0.00	
Date on which the statement period on the claim for the detailed line item (DTL_SVC_DT)	370,151	100	0	0.00	<p>This data element was missing for all matched professional claim IDs in the DW. Instead, IPRO had a 100% match for the SVC_DT data element, as reflected in this table.</p> <p>ND HHS indicated that this data element is applicable only to facility claims.</p> <p>For future EDV studies, IPRO will request the SVC_DT for professional encounter data types instead of this data element.</p>
A code to indicate where the service was provided - Place of service (PLACE_CD)	369,442	99.81	709	0.19	
The first or principal diagnosis code (DX_CD)	370,130	99.99	21	0.01	
Second diagnosis (DX_CD_02)	370,130	99.99	21	0.01	
Third diagnosis (DX_CD_03)	370,138	100	13	0.00	
Fourth diagnosis (DX_CD_04)	370,145	100	6	0.00	
Fifth diagnosis (DX_CD_05)	370,147	100	4	0.00	
Sixth diagnosis (DX_CD_06)	370,147	100	4	0.00	
Seventh diagnosis (DX_CD_07)	370,151	100	0	0.00	
Eighth diagnosis (DX_CD_08)	370,151	100	0	0.00	
Ninth diagnosis (DX_CD_09)	370,151	100	0	0.00	
Tenth diagnosis (DX_CD_10)	370,151	100	0	0.00	
Eleventh diagnosis (DX_CD_11)	370,151	100	0	0.00	
Twelfth diagnosis (DX_CD_12)	370,151	100	0	0.00	
The financial amount of the encounter the MCO paid on the claim header (NET_PAY_ENCOUNTER)	NV	NV	NV	NV	<p>ND HHS advised that this data element pertains to the header level only.</p> <p>IPRO to remove this data element from future EDV studies.</p>
The financial amount of the encounter the MCO paid on the claim for the detailed line item (NET_PAYMENT_W_DTL)	NV	NV	NV	NV	<p>ND HHS advised that this data element pertains to the header level only.</p>

BCBSND Professional Data Element Discrepancies and Findings (Total Encounters=370,151)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
					IPRO to remove this data element from future EDV studies.
Paid date from the claim header (PAID_DT)	NV	NV	NV	NV	BCBSND submitted the paid date on its 837 file, but ND HHS's DW was reflecting the MMIS paid/accepted date.  IPRO to remove this data element from future EDV studies.
Paid date from the claim detail (PAID_DT_DTL)	NV	NV	NV	NV	BCBSND submitted the paid date on its 837 file, but ND HHS's DW was reflecting the MMIS paid/accepted date.  IPRO to remove this data element from future EDV studies.
The Third Party Liability submitted amount from the header for header paid claims (AMT_TPL_SUBM_HDR)	NV	NV	NV	NV	ND HHS advised that this data element was not available and was not populated in the DW.  IPRO to remove this data element from future EDV studies.
This is the Third Party Liability submitted amount from the detail (AMT_TPL_SUBM_DTL)	NV	NV	NV	NV	ND HHS advised that this data element was not available and is not populated in the DW.  IPRO to remove this data element from future EDV studies.
Procedure/supplies/service code, i.e., CPT-4, CPT-CAT-II, and/or HCPCS (PROC_CD)	370,151	100	0	0.00	
Logical Observation Identifiers Names and Codes (LOINC)	NV	NV	NV	NV	The data element was not validated because LOINC codes are not submitted to ND HHS. BCBSND does not store LOINC codes and did not provide any values.  IPRO to remove this data element from future EDV studies.
Systematized Nomenclature of Medicine (SNOMED)	NV	NV	NV	NV	The data element was not validated because SNOMED CT® codes are not submitted to ND HHS. BCBSND does not store SNOMED codes and did not provide any values.  IPRO to remove this data element from future EDV studies.
The units of service billed at the detail level. (UNIT_COUNT_CLAIM)	364,049	98.35	6,102	1.65	
The first of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_1)	300,720	81.24	69,431	18.76	BCBSND confirmed the values it provided on its 837 file matched the EDV study file. BCBSND noted that its EDV study file includes adjudicated codes but that the IPRO DW houses

BCBSND Professional Data Element Discrepancies and Findings (Total Encounters=370,151)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
The second of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_2)	357,452	96.57	12,699	3.43	only the submitted codes. ND HHS advised that it sent the data elements in the exact order found in the state system.  IPRO to request that BCBSND send the submitted codes instead of the adjudicated codes for future EDV studies.
The third of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_3)	369,033	99.70	1,118	0.30	
The fourth of up to four procedure/service/supplies modifier if applicable (PROF_PROC_MOD_CD_4)	370,092	99.98	59	0.02	
The national drug code for the drug dispensed on the claim if present (NDC_NBR_J_CD)	370,151	100	0	0.00	
Billing Provider Medicaid ID (BILLING_PROV_ID)	356,792	96.39	13,359	3.61	BCBSND submitted provider NPI. ND HHS advised that IPRO needs to use the provider ID crosswalk to get the provider NPI which is reflected in this table.
Rendering Provider Medicaid ID (RENDERING_PROV_ID)	356,052	96.19	14,099	3.81	BCBSND submitted provider NPI. ND HHS advised that IPRO needs to use the provider ID crosswalk to get the provider NPI which is reflected in this table.
Referring Provider Medicaid ID (REFERRING_PROV_ID)	358,128	96.75	12,023	3.25	BCBSND submitted provider NPI. ND HHS advised that IPRO needs to use the provider ID crosswalk to get the provider NPI which is reflected in this table.

BCBSND: Blue Cross Blue Shield of North Dakota; EDV: encounter data validation; ND: North Dakota; HHS: Department of Health and Human Services; NV: not validated for the study because the determination was made during the review process that the data element was not needed or not available from ND HHS; TCN: transaction control number; ID: identification; DW: data warehouse; MMIS: Medicaid Management Information System; MCO: managed care organization; CPT®: Current Procedural Terminology; HCPCS: Healthcare Common Procedure Coding System; LOINC: Logical Observation Identifiers Names and Codes; SNOMED CT®: Systematized Nomenclature of Medicine Clinical Terms; NPI: National Provider Identifier.

**Table 25: Institutional Inpatient Data Element Discrepancies and Findings**

BCBSND Institutional Inpatient Data Element Discrepancies and Findings (Total Encounters = 18,844)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Unique Medicaid number assigned to the recipient (MMIS_ID)	18,844	100	0	0.00	
The unique identifier of the claim. Also known as TCN, or Transaction Control Number (CLAIM_ID)	18,844	100	0	0.00	
The Adjustment Original Claim ID is the Transaction Control Number of the first original claim adjusted in the adjustment chain (ADJ_ORIG_CLM_ID)	NV	NV	NV	NV	ND HHS advised that any time a claim is adjusted, the TCN is not going to be the same; an external claim ID has been added to its system, but no historical data are available.  IPRO to remove this data element from future EDV studies.
Date that the recipient was admitted to a facility (FAC_ADM_DT)	0	0.00	18,844	100	The data element had no values populated in the DW.  IPRO has requested that ND HHS add this data element to the DW monthly extracts provided to IPRO.
Date on which the statement period on the claim began, start date of service on the header (START_DT)	18,844	100	0	0.00	
Date on which the statement period on the claim ended, end date of service on the header (END_DT)	18,844	100	0	0.00	
Date on which the statement period on the claim for the detailed line item (DTL_SVC_DT)	18,844	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)	18,844	100	0	0.00	
Discharge status (FAC_DSCHRG_STAT_CD)	18,844	100	0	0.00	
Type of bill (FAC_BILL_TYPE_CD)	18,844	100	0	0.00	
DRG code; please submit value in this data element only if it is an inpatient claim paid on a DRG rate as reported on the encounter	15,962	84.71	2,882	15.29	BCBSND confirmed the values it provided in the EDV study match its 837 file.

**BCBSND Institutional Inpatient Data Element Discrepancies and Findings (Total Encounters = 18,844)**

<b>Data Element Description (Data Element Name)</b>	<b>Match (n)</b>	<b>Match Rate (%)</b>	<b>Non-match (n)</b>	<b>Non-match Rate (%)</b>	<b>Notable Findings</b>
(DRG_PAYMENT_CD)					<p>IPRO is receiving the <i>calculated/computed State DRG</i>. (ND HHS advised that it does not use the same grouping for Medicaid expansion as it does for the existing Medicaid fee-for-service program. The DRG is set by the MMIS when claims are received.)</p> <p>IPRO has requested that ND HHS populate the DW extract provided to IPRO with the <i>MCO-submitted DRG</i> instead of the <i>calculated/computed State DRG</i>.</p>
The first or principal diagnosis code (DX_CD)	18,844	100	0	0.00	
Second diagnosis (DX_CD_02)	819	4.35	18,025	95.65	<p>BCBSND confirmed the values it provided on the EDV study matches its 837 file.</p> <p>ND HHS advised that all the secondary diagnosis codes, other than the principal diagnosis code, are being carried into the secondary diagnosis code data elements in the DW. For example, if there is a Patient Reason for a Visit (E-Code), that is also carried in a secondary diagnosis code data element.</p> <p>IPRO has 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.</p>
Third diagnosis (DX_CD_03)	40	0.21	18,804	99.79	
Fourth diagnosis (DX_CD_04)	94	0.50	18,750	99.50	
Fifth diagnosis (DX_CD_05)	398	2.11	18,446	97.89	
Sixth diagnosis (DX_CD_06)	779	4.13	18,065	95.87	
Seventh diagnosis (DX_CD_07)	1,310	6.95	17,534	93.05	
Eighth diagnosis (DX_CD_08)	1,990	10.56	16,854	89.44	
Ninth diagnosis (DX_CD_09)	2,643	14.03	16,201	85.97	
Tenth diagnosis (DX_CD_10)	3,491	18.53	15,353	81.47	
Eleventh diagnosis (DX_CD_11)	4,570	24.25	14,274	75.75	
Twelfth diagnosis (DX_CD_12)	5,542	29.41	13,302	70.59	
Thirteenth diagnosis (DX_CD_13)	6,483	34.40	12,361	65.60	
Fourteenth diagnosis (DX_CD_14)	13,314	70.65	5,530	29.35	
Fifteenth diagnosis (DX_CD_15)	14,016	74.38	4,828	25.62	
Sixteenth diagnosis (DX_CD_16)	14,394	76.39	4,450	23.61	
Seventeenth diagnosis (DX_CD_17)	14,866	78.89	3,978	21.11	
Eighteenth diagnosis (DX_CD_18)	15,234	80.84	3,610	19.16	
Nineteenth diagnosis (DX_CD_19)	15,600	82.78	3,244	17.22	
Twentieth diagnosis (DX_CD_20)	15,921	84.49	2,923	15.51	
Twenty-first diagnosis (DX_CD_21)	16,150	85.70	2,694	14.30	
Twenty-second diagnosis (DX_CD_22)	16,466	87.38	2,378	12.62	
Twenty-third diagnosis (DX_CD_23)	16,733	88.80	2,111	11.20	
Twenty-fourth diagnosis (DX_CD_24)	16,915	89.76	1,929	10.24	

BCBSND Institutional Inpatient Data Element Discrepancies and Findings (Total Encounters = 18,844)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Twenty-fifth diagnosis (DX_CD_25)	17,225	91.41	1,619	8.59	
The principal ICD surgical procedure code on the facility claim (PROC_CD_01)	17,802	94.47	1,042	5.53	For some matched encounters, the DW had a blank value where the BCBSND EDV data extract has a non-blank value. This does not appear to be a BCBSND data extraction issue.  IPRO has reported the issue to ND HHS.
Surgical code 2 (PROC_CD_02)	18,158	96.36	686	3.64	
Surgical code 3 (PROC_CD_03)	18,430	97.80	414	2.20	
Surgical code 4 (PROC_CD_04)	18,575	98.57	269	1.43	
Surgical code 5 (PROC_CD_05)	18,625	98.84	219	1.16	
Surgical code 6 (PROC_CD_06)	18,721	99.35	123	0.65	
Surgical code 7 (PROC_CD_07)	18,733	99.41	111	0.59	
The financial amount of the encounter the MCO paid on the claim header (NET_PAY_ENCOUNTER)	NV	NV	NV	NV	ND HHS advised that this data element pertains to the header level only.  IPRO to remove this data element from future EDV studies.
The financial amount of the encounter the MCO paid on the claim for the detailed line item (NET_PAYMENT_W_DTL)	NV	NV	NV	NV	ND HHS advised that this data element pertains to the header level only.  IPRO to remove this data element from future EDV studies.
Paid date from the claim header (PAID_DT)	NV	NV	NV	NV	BCBSND is submitting its paid date on its 837 file, but the DW is reflecting the MMIS paid/accepted date.  IPRO to remove this data element from future EDV studies.
Paid date from the claim detailed line item (PAID_DT_DTL)	NV	NV	NV	NV	BCBSND is submitting its paid date on its 837 file, but the DW is reflecting the MMIS paid/accepted date.  IPRO to remove this data element from future EDV studies.
The Third Party Liability submitted amount from the header for header paid claims (AMT_TPL_SUBM_HDR)	NV	NV	NV	NV	ND HHS advised that this data element is not available and is not populated in the DW.  IPRO to remove this data element from future EDV studies.

BCBSND Institutional Inpatient Data Element Discrepancies and Findings (Total Encounters = 18,844)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
This is the Third Party Liability submitted amount from the detail (AMT_TPL_SUBM_DTL)	NV	NV	NV	NV	ND HHS advised that this data element is not available and is not populated in the DW.  IPRO to remove this data element from future EDV studies.
The claim status code indicates if a claim was paid or denied at a header level. (CLAIM_STAT_CD)	NV	NV	NV	NV	BCBSND does not submit this data element on its 837 file.  IPRO to remove this data element from future EDV studies.
The claim status detail code indicates if the individual claim line was paid or denied (CLAIM_STAT_DTL_CD)	NV	NV	NV	NV	BCBSND does not submit this data element on its 837 file.  IPRO to remove this data element from future EDV studies.
Procedure code if applicable (PROC_CD)	7,057	37.45	11,787	62.55	This is an EDV study data extraction issue. BCBSND incorrectly provided the ICD-10 procedure code (if available) in the procedure code data element.  IPRO to request that BCBSND send the CPT®-4, CPT®-category-II, or HCPCS code for future studies.
Logical Observation Identifiers Names and Codes (LOINC)	NV	NV	NV	NV	The data element was not validated because LOINC codes are not submitted to ND HHS. BCBSND does not store LOINC codes and did not provide any values.  IPRO to remove this data element from future EDV studies.
Systematized Nomenclature of Medicine (SNOMED)	NV	NV	NV	NV	The data element was not validated because SNOMED CT® codes are not submitted to ND HHS. BCBSND does not store SNOMED codes and did not provide any values.  IPRO to remove this data element from future EDV studies.
The units of service billed at the detail (UNIT_COUNT_CLAIM)	17,932	95.16	912	4.84	
The first of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_1)	18,841	99.98	3	0.02	BCBSND confirmed the values it provided on its 837 file matched the EDV study file. BCBSND noted that its EDV study file includes adjudicated codes but that the IPRO DW houses only the submitted codes. ND HHS advised that it sent the data elements in the exact order found in the state system.
The second of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_2)	18,844	100	0	0.00	

BCBSND Institutional Inpatient Data Element Discrepancies and Findings (Total Encounters = 18,844)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
The third of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_3)	18,844	100	0	0.00	IPRO to request that BCBSND send the submitted codes instead of the adjudicated codes for future EDV studies.
The fourth of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_4)	18,844	100	0	0.00	
The CMS standard revenue code from the UB facility claim (FAC_REVENUE_CD)	18,844	100	0	0.00	
The national drug code for the drug dispensed on the institutional claim if present (NDC_NBR_J_CD)	18,844	100	0	0.00	
Billing Provider Medicaid ID (BILLING_PROV_ID)	18,155	96.34	689	3.66	BCBSND submits provider NPI. ND HHS advised that IPRO needs to use the provider ID crosswalk to get the provider NPI which is reflected in this table.
Attending Provider Medicaid ID (ATTENDING_PROV_ID)	18,385	97.56	459	2.44	BCBSND submits provider NPI. ND HHS advised that IPRO needs to use the provider ID crosswalk to get the provider NPI which is reflected in this table.
Referring Provider Medicaid ID (REFERRING_PROV_ID)	NV	NV	NV	NV	BCBSND does not submit this data element on its 837 file.  IPRO to remove this data element from future EDV studies.
Operating Provider Medicaid ID (OPERATING_PROV_ID)	7,064	37.49	11,780	62.51	All values for matched encounters were blank in the DW but not in the BCBSND EDV study file.  IPRO has requested that ND HHS add this data element to the DW monthly extracts provided to IPRO.

BCBSND: Blue Cross Blue Shield of North Dakota; EDV: encounter data validation; ND: North Dakota; HHS: Department of Health and Human Services; NV: not validated for the study because a determination was made during the review process that the data element was not needed or not available from ND HHS; TCN: transaction control number; ID: identification; DW: data warehouse; MMIS: Medicaid Management Information System; MCO: managed care organization; ICD-10: International Classification of Diseases, Tenth Revision; CPT®: Current Procedural Terminology; HCPCS: Healthcare Common Procedure Coding System; LOINC: Logical Observation Identifiers Names and Codes; SNOMED CT®: Systematized Nomenclature of Medicine Clinical Terms; NPI: National Provider Identifier; DRG: diagnosis-related group; UB: uniform bill.

**Table 26: Institutional Outpatient Data Element Discrepancies and Findings**

BCBSND Institutional Outpatient Data Element Discrepancies and Findings (Total Encounters = 216,206)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
Unique Medicaid number assigned to the recipient (MMIS_ID)	216,206	100	0	0.00	
The unique identifier of the claim. Also known as TCN, or Transaction Control Number (CLAIM_ID)	216,206	100	0	0.00	
The Adjustment Original Claim ID is the Transaction Control Number of the first original claim adjusted in the adjustment chain (ADJ_ORIG_CLM_ID)	NV	NV	NV	NV	ND HHS advised that any time a claim is adjusted, the TCN is not going to be the same; an external claim ID has been added to the system, but no historical data are available.  IPRO to remove this data element from future EDV studies.
Date that the recipient was admitted to a facility (FAC_ADM_DT)	216,206	100	0	0.00	
Date on which the statement period on the claim began, start date of service on the header (START_DT)	216,206	100	0	0.00	
Date on which the statement period on the claim ended, end date of service on the header (END_DT)	216,206	100	0	0.00	
Date on which the statement period on the claim for the detailed line item (DTL_SVC_DT)	216,206	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)	216,206	100	0	0.00	
Discharge status (FAC_DSCHRG_STAT_CD)	216,206	100	0	0.00	
Type of bill (FAC_BILL_TYPE_CD)	216,206	100	0	0.00	
DRG code; please submit value in this data element only if it is an inpatient claim paid on a DRG rate as reported on the encounter (DRG_PAYMENT_CD)	216,206	100	0	0.00	

BCBSND Institutional Outpatient Data Element Discrepancies and Findings (Total Encounters = 216,206)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
The first or principal diagnosis code (DX_CD)	216,206	100	0	0.00	
Second diagnosis (DX_CD_02)	32,092	14.84	184,114	85.16	BCBSND confirmed the values it provided on the EDV study matches its 837 file.
Third diagnosis (DX_CD_03)	47,129	21.80	169,077	78.20	
Fourth diagnosis (DX_CD_04)	71,648	33.14	144,558	66.86	ND HHS advised that all the secondary diagnosis codes, other than the principal diagnosis code, are being carried into the secondary diagnosis code data elements in the DW. For example, if there is a Patient Reason for a Visit (E-Code), that is also carried in a secondary diagnosis code data element.
Fifth diagnosis (DX_CD_05)	94,787	43.84	121,419	56.16	
Sixth diagnosis (DX_CD_06)	114,622	53.02	101,584	46.98	
Seventh diagnosis (DX_CD_07)	131,131	60.65	85,075	39.35	
Eighth diagnosis (DX_CD_08)	145,663	67.37	70,543	32.63	
Ninth diagnosis (DX_CD_09)	157,146	72.68	59,060	27.32	
Tenth diagnosis (DX_CD_10)	167,632	77.53	48,574	22.47	
Eleventh diagnosis (DX_CD_11)	174,573	80.74	41,633	19.26	
Twelfth diagnosis (DX_CD_12)	181,660	84.02	34,546	15.98	
Thirteenth diagnosis (DX_CD_13)	187,654	86.79	28,552	13.21	
Fourteenth diagnosis (DX_CD_14)	206,924	95.71	9,282	4.29	IPRO has 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.
Fifteenth diagnosis (DX_CD_15)	208,307	96.35	7,899	3.65	
Sixteenth diagnosis (DX_CD_16)	209,029	96.68	7,177	3.32	
Seventeenth diagnosis (DX_CD_17)	210,395	97.31	5,811	2.69	
Eighteenth diagnosis (DX_CD_18)	211,519	97.83	4,687	2.17	
Nineteenth diagnosis (DX_CD_19)	212,081	98.09	4,125	1.91	
Twentieth diagnosis (DX_CD_20)	212,897	98.47	3,309	1.53	
Twenty-first diagnosis (DX_CD_21)	213,763	98.87	2,443	1.13	
Twenty-second diagnosis (DX_CD_22)	214,041	99.00	2,165	1.00	
Twenty-third diagnosis (DX_CD_23)	214,664	99.29	1,542	0.71	
Twenty-fourth diagnosis (DX_CD_24)	215,152	99.51	1,054	0.49	
Twenty-fifth Diagnosis (DX_CD_25)	215,325	99.59	881	0.41	
The principal ICD surgical procedure code on the facility claim (PROC_CD_01)	216,206	100	0	0.00	
Surgical code 2 (PROC_CD_02)	216,206	100	0	0.00	
Surgical code 3 (PROC_CD_03)	216,206	100	0	0.00	
Surgical code 4 (PROC_CD_04)	216,206	100	0	0.00	
Surgical code 5 (PROC_CD_05)	216,206	100	0	0.00	
Surgical code 6	216,206	100	0	0.00	

BCBSND Institutional Outpatient Data Element Discrepancies and Findings (Total Encounters = 216,206)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
(PROC_CD_06)					
Surgical code 7 (PROC_CD_07)	216,206	100	0	0.00	
The financial amount of the encounter plan paid on the claim header (NET_PAY_ENCOUNTER)	NV	NV	NV	NV	ND HHS advised that this data element pertains to the header level only.  IPRO to remove this data element from future EDV studies.
The financial amount of the encounter plan paid on the claim for the detailed line item (NET_PAYMENT_W_DTL)	NV	NV	NV	NV	ND HHS advised that this data element pertains to the header level only.  IPRO to remove this data element from future EDV studies.
Paid date from the claim header (PAID_DT)	NV	NV	NV	NV	BCBSND is submitting the paid date on its 837 file, but the DW is reflecting the MMIS paid/accepted date.  IPRO to remove this data element from future EDV studies.
Paid date from the claim detailed line item (PAID_DT_DTL)	NV	NV	NV	NV	BCBSND is submitting the paid date on its 837 file, but the DW is reflecting the MMIS paid/accepted date.  IPRO to remove this data element from future EDV studies.
The Third Party Liability submitted amount from the header for header paid claims (AMT_TPL_SUBM_HDR)	NV	NV	NV	NV	ND HHS advised that this data element is not available and is not populated in the DW.  IPRO to remove this data element from future EDV studies.
This is the Third Party Liability submitted amount from the detail (AMT_TPL_SUBM_DTL)	NV	NV	NV	NV	ND HHS advised that this data element is not available and is not populated in the DW.  IPRO to remove this data element from future EDV studies.
The claim status code indicates if a claim was paid or denied at a header level. (CLAIM_STAT_CD)	NV	NV	NV	NV	BCBSND does not submit this data element on its 837 file.  IPRO to remove this data element from future EDV studies.
The claim status detail code indicates if the individual claim line was paid or denied (CLAIM_STAT_DTL_CD)	NV	NV	NV	NV	BCBSND does not submit this data element on its 837 file.  IPRO to remove this data element from future EDV studies.
Procedure code if applicable (PROC_CD)	24,697	11.42	191,509	88.58	BCBSND incorrectly provided the ICD-10 procedure code (if available) in the procedure code data element.

BCBSND Institutional Outpatient Data Element Discrepancies and Findings (Total Encounters = 216,206)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
					IPRO to request that BCBSND send the CPT®-4, CPT®-category-II or HCPCS code for future studies.
Logical Observation Identifiers Names and Codes (LOINC)	NV	NV	NV	NV	The data element was not validated because LOINC codes are not submitted to ND HHS. BCBSND does not store LOINC codes and did not provide any values.  IPRO to remove this data element from future EDV studies.
Systematized Nomenclature of Medicine (SNOMED)	NV	NV	NV	NV	The data element was not validated because SNOMED CT® codes are not submitted to ND HHS. BCBSND does not store SNOMED codes and did not provide any values.  IPRO to remove this data element from future EDV studies.
The units of service billed at the detail (UNIT_COUNT_CLAIM)	201,243	93.08	14,963	6.92	All discrepant values appeared to be voids and had negative values in the DW but positive values in the BCBSND EDV study file.  IPRO to ask BCBSND to submit negative values for voids in future EDV studies.
The first of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_1)	190,199	87.97	26,007	12.03	BCBSND confirmed the values it provided on its 837 file matched the EDV study file. BCBSND noted that its EDV study file includes adjudicated codes but that the IPRO DW houses only the submitted codes. ND HHS advised that it sent the data elements in the exact order found in the state system.  IPRO to request that BCBSND send the submitted codes instead of the adjudicated codes for future EDV studies.
The second of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_2)	214,445	99.19	1,761	0.81	
The third of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_3)	216,103	99.95	103	0.05	
The fourth of up to four procedures/services/supplies modifiers if applicable (PROF_PROC_MOD_CD_4)	216,206	100	0	0.00	
The CMS standard revenue code from the UB facility claim (FAC_REVENUE_CD)	216,205	100	1	0.00	

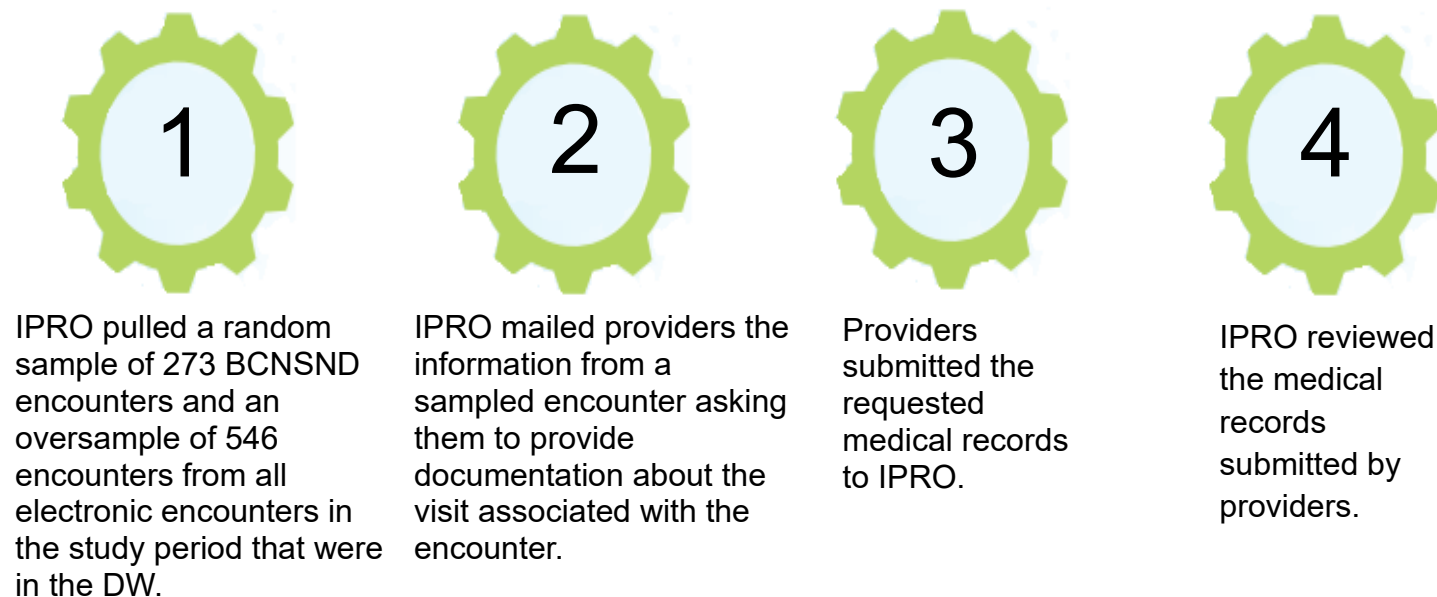
BCBSND Institutional Outpatient Data Element Discrepancies and Findings (Total Encounters = 216,206)					
Data Element Description (Data Element Name)	Match (n)	Match Rate (%)	Non-match (n)	Non-match Rate (%)	Notable Findings
The national drug code for the drug dispensed on the institutional claim if present (NDC_NBR_J_CD)	216,023	99.92	183	0.08	
Billing Provider Medicaid ID (BILLING_PROV_ID)	204,714	94.68	11,492	5.32	
Attending Provider Medicaid ID (ATTENDING_PROV_ID)	213,150	98.59	3,056	1.41	BCBSND submits provider NPI. ND HHS advised that IPRO needs to use the provider ID crosswalk to get the provider NPI which is reflected in this table.
Referring Provider Medicaid ID (REFERRING_PROV_ID)	199,502	92.27	16,704	7.73	For some encounters, the DW has a blank value where the BCBSND EDV data extract has a non-blank value. This does not appear to be a BCBSND data extraction issue.  IPRO has reported the issue to ND HHS.
OPERATING_PROV_ID	116,825	54.03	99,381	45.97	All values for matched encounters were blank in the DW but not in the BCBSND EDV study file.  IPRO has requested that ND HHS add this data element to the DW monthly extracts provided to IPRO.

BCBSND: Blue Cross Blue Shield of North Dakota; EDV: encounter data validation; ND: North Dakota; HHS: Department of Health and Human Services; NV: not validated for the study because a determination was made during the review process that the data element was not needed or not available from ND HHS; TCN: transaction control number; ID: identification; DW: data warehouse; MMIS: Medicaid Management Information System; ICD-10: International Classification of Diseases, Tenth Revision; CPT®: Current Procedural Terminology; HCPCS: Healthcare Common Procedure Coding System; LOINC: Logical Observation Identifiers Names and Codes; SNOMED CT®: Systematized Nomenclature of Medicine Clinical Terms; NPI: National Provider Identifier; DRG: diagnosis-related group; UB: uniform bill.

## 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 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.

## Analysis of Medical Records



**Figure 4: IPRO’s Medical Record Review (MRR) Methodology**

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.

**Table 27: Medical Record Review Sample Information by Encounter Data Type**

Encounter Data Type	Electronic Encounters Matched (n)	Sample Size (n)	Oversample Size (n) <sup>1</sup>	Reviews Completed (n)	Reviews Completed for Verified Records <sup>2</sup>
Professional	370,151	162	324	120	106
Institutional inpatient	18,844	12	24	5	5
Institutional outpatient	216,206	99	198	56	53
Total	605,201	273	546	181	164

<sup>1</sup> An oversample of 200% was selected to provide the number of adequate reviews for each encounter data type to meet the required sample size.

<sup>2</sup> 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.

## Conclusions and Recommendations

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:

1. Its review of the BCBSND EDV study file matches to the DW, 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.
2. The medical record review yielded an overall 92.49% match rate of electronic encounter data elements to data elements abstracted from the medical records that IPRO obtained from providers, below the state's required 95% threshold. The match rates for the professional and institutional inpatient encounter types were within less than 2% of the 95% threshold, and it is IPRO's opinion that it is within BCBSND's ability to improve on this rate within the next year

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

### Electronic Encounter Data

#### All Encounter Data Types

- ADJ\_ORIG\_CLM\_ID: ND HHS advised that any time a claim is adjusted, the TCN is not going to be the same; an external claim ID has been added to its system, but no historical data are available. IPRO to remove this data element from future EDV studies.
- NET\_PAY\_ENCOUNTER: ND HHS advised that this data element pertains to the header level only. IPRO to remove this data element from future EDV studies.
- NET\_PAYMENT\_W\_DTL: ND HHS advised that this data element pertains to the header level only. IPRO to remove this data element from future EDV studies.
- PAID\_DT: BCBSND submitted the paid date on its 837 file, but ND HHS's DW was reflecting the MMIS paid/accepted date. IPRO to remove this data element from future EDV studies.
- PAID\_DT\_DTL: BCBSND submitted the paid date on its 837 file, but ND HHS's DW was reflecting the MMIS paid/accepted date. IPRO to remove this data element from future EDV studies.
- AMT\_TPL\_SUBM\_HDR and AMT\_TPL\_SUBM\_DTL: ND HHS advised that this data element was not available and is not populated in the DW. IPRO to remove these data elements from future EDV studies.
- LOINC and SNOMED: BCBSND does not store LOINC or SNOMED CT® codes and did not provide any values. IPRO to remove these data elements from future EDV studies.
- PROF\_PROC\_MOD\_CD\_1 through PROF\_PROC\_MOD\_CD\_4: BCBSND confirmed the values it provided on its 837 file matched the EDV study file. It noted that its EDV study file includes adjudicated codes but that the IPRO DW houses only the submitted codes. IPRO to request that BCBSND send the submitted codes instead of the adjudicated codes for future EDV studies.

#### Professional Encounter Data Type Only

- DTL\_SVC\_DT: This data element was missing for all professional claim IDs in the DW. IPRO had a 100.00% match for the SVC\_DT data element. ND HHS indicated that this data element is applicable only to facility claims. For future EDV studies, IPRO will request the SVC\_DT for professional encounter data types instead of this data element.

### Institutional Inpatient and Institutional Outpatient Encounter Data Types Only

- DX\_CD\_02 through DX\_CD\_25: BCBSND confirmed the values it provided on the EDV study matches its 837 file. ND HHS advised that all the secondary diagnosis codes, other than the principal diagnosis code, are being carried into the secondary diagnosis code data elements in the DW. For example, if there is a Patient Reason for a Visit (E-Code), that is also carried in a secondary diagnosis code data element. IPRO has 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 the BCBSND’s 837 file.
- CLAIM\_STAT\_CD and CLAIM\_STAT\_DTL\_CD: BCBSND does not submit this data element on its 837 file. IPRO to remove these data elements from future EDV studies.
- PROC\_CD: This is an EDV study data extraction issue. BCBSND incorrectly provided the International Classification of Diseases, Tenth Revision (ICD-10) procedure code (if available) in the procedure code data element. IPRO to request that BCBSND send the CP®-4, CPT®-category-II, or HCPCS code for future studies.
- OPERATING\_PROV\_ID: The data element is in the DW but has no values populated. IPRO has requested that ND HHS add this data element to the DW monthly extracts provided to IPRO.

### Institutional Inpatient Encounter Data Type Only

- FAC\_ADM\_DT: The data element is in the DW but has no values populated. IPRO has requested that ND HHS add this data element to the DW monthly extracts provided to IPRO.
- DRG\_PAYMENT\_CD: BCBSND confirmed the value it provided in the EDV study matches its 837 file. IPRO is receiving the *calculated/computed State DRG*. IPRO has requested that ND HHS populate its DW monthly extracts provided to IPRO with the *MCO-submitted DRG* instead.
- REFERRING\_PROV\_ID: BCBSND does not submit this data element on its 837 file. IPRO to remove this data element from future EDV studies.

### Future EDV Studies

- Remove data elements from future EDV studies:
  - All encounter data types:
    - ADJ\_ORIG\_CLM\_ID
    - NET\_PAY\_ENCOUNTER
    - NET\_PAYMENT\_W\_DTL
    - PAID\_DT
    - PAID\_DT\_DTL
    - AMT\_TPL\_SUBM\_HDR
    - AMT\_TPL\_SUBM\_DTL
    - LOINC
    - SNOMED
  - Professional encounter data type only:
    - DTL\_SVC\_DT
  - Institutional inpatient and institutional outpatient encounter data types only:
    - CLAIM\_STAT\_CD
    - CLAIM\_STAT\_DTL\_CD
  - Institutional inpatient encounter data type only:
    - REFERRING\_PROV\_ID
- For these data elements, ND HHS or BCBSND to either add the data element to its data or change the way they are populating the data element:
  - All encounter data types:
    - PROF\_PROC\_MOD\_CD\_1 through PROF\_PROC\_MOD\_CD\_4
  - Professional encounter data type only:
    - IPRO to only request SVC\_DT for the professional encounter data type, not DTL\_SVC\_DT

- Institutional inpatient and institutional outpatient encounter data types only:
  - DX\_CD\_02 through DX\_CD\_25
  - PROC\_CD
  - OPERATING\_PROV\_ID
- Institutional inpatient file encounter data type only:
  - FAC\_ADM\_DT
  - DRG\_PAYMENT\_CD

### Medical Record Review

For future EDV studies, IPRO recommends using the state letterhead for the letters that would be sent to providers requesting medical records. This would stress the importance of the medical record review effort.

## VIII. External Quality Review Activity 6: 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, *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 health care services they receive. HHS uses the results from the survey to improve the quality of health care.

The overall objective of the CAHPS study is to capture accurate and complete information about consumer-reported experiences with health care. 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 *2024 CAHPS 5.1 Adult Medicaid Health Plan Survey*.

This EQR report presents the 2022 CAHPS results for MY 2022.

### 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 (aged 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 2023 Volume 3: Specifications for Survey Measures*. The methodology met requirements of *CMS EQR 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, 2023) who were continuously enrolled for at least 5 of the last 6 months of 2023 and who were enrolled at the time the survey was completed.

### Description of Data Obtained

IPRO received the MY 2023 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 (**Table 29**) to the national Medicaid benchmarks presented in the *Quality Compass 2024/MY 2023* (**Table 28**). Measures performing at or above the 75th percentile were considered strengths; measures performing at the 50th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement.

Eighteen questions were below average, two questions were average, and eight questions were above average when compared to Quality Compass.

**Table 28: Color Key for NCQA HEDIS Quality Compass National Percentiles**

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass 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).

**Table 29: BCBSND CAHPS Performance – Adult Members**

CAHPS Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to Quality Compass
Getting Needed Care (usually + always)	81.20%	83.50%	2.30	≥50th and <75th
Q9. Ease of getting necessary care, tests, or treatment needed	84.80%	89.20%	4.40	≥75th and <90th
Q20. Getting appointments with specialists as soon as needed	77.60%	77.80%	0.20	≥25th and <50th
Getting Care Quickly (usually + always)	79.50%	89.50%	10.00	≥90th
Q4. Got care as soon as needed when care was needed right away	82.90%	95.30%	12.40	≥90th
Q6. Got check-up/routine care appointment as soon as needed	76.10%	83.60%	7.50	≥75th and <90th
How Well Doctors Communicate (usually + always)	90.10%	92.60%	2.50	≥25th and <50th
Q12. Personal doctor explained things in an understandable way	95.60%	89.60%	-6.00	<25th
Q13. Personal doctor listened carefully to you	88.20%	92.60%	4.40	≥25th and <50th
Q14. Personal doctor showed respect for what you had to say	91.20%	95.60%	4.40	≥50th and <75th
Q15. Personal doctor spent enough time with you	85.30%	92.60%	7.30	≥50th and <75th

CAHPS Measure	MY 2022 Rate	MY 2023 Rate	Change From MY 2022 to 2023	MY 2023 Compared to Quality Compass
Customer Service (usually + always)	89.00%	89.90%	0.90	≥50th and <75th
Q24. Customer service provided information or help	81.30%	85.70%	4.40	≥50th and <75th
Q25. Customer service treated member with courtesy and respect	96.80%	94.10%	-2.70	≥25th and <50th
Coordination of Care (Q17) (usually + always)	88.40%	82.50%	-5.90	<25th
Ease of Filling out Forms (Q27) (Summary Rate = 8 + 9 + 10)	97.30%	93.90%	-3.40	≥25th and <50th
Rating Items (Summary Rate = 8 + 9 + 10)				
Rating of Health Care (Q8)	82.10%	73.00%	-9.10	≥25th and <50th
Rating of Personal Doctor (Q18)	86.20%	80.50%	-5.70	<25th
Rating of Specialist (Q22)	87.00%	72.50%	-14.50	<25th
Rating of Health Plan (Q28)	71.40%	73.50%	2.10	<25th
Rating Items (Summary Rate = 9 + 10)				
Rating of Health Care (Q8)	53.80%	73.00%	19.20	≥25th and <50th
Rating of Personal Doctor (Q18)	64.40%	80.50%	16.10	<25th
Rating of Specialist (Q22)	76.10%	72.50%	-3.60	<25th
Rating of Health Plan (Q28)	52.70%	73.50%	20.80	<25th
Effectiveness of Care Measures (Current Year)				
Advising Smokers and Tobacco Users to Quit	64.90%	66.20%	1.30	<25th
Discussing Cessation Medications	50.00%	52.60%	2.60	≥25th and <50th
Discussing Cessation Strategies	43.20%	46.70%	3.50	≥50th and <75th

<sup>1</sup> BCBSND percentile ranking in measurement year 2023 Quality Compass.

CAHPS: Consumer Assessment of Healthcare Providers and Systems; BCBSND: Blue Cross Blue Shield of North Dakota.

## IX. URAC Accreditation

Section 2.13.3 of the ND state contract requires that BCBSND be accredited by NCQA or URAC for its Medicaid product. BCBSND holds full URAC accreditation for “Health Plan” and “Health Plan with Health Insurance Marketplace.” URAC is an independent, non-profit health care accrediting organization that is dedicated to promoting health care 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 delivering quality products and exceptional customer service to its 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.

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. The information provided here is the latest update on BCBSND’ URAC accreditation. BCBSND has initiated the process of obtaining NCQA accreditation.

## X. BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations

**Table 30** highlights BCBSND’s performance strengths, opportunities for improvement and recommendations based on the aggregated results of January to December 2024 activities as they relate to **quality**, **timeliness**, and **access**.

### BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations

**Table 30: BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations**

EQR Activity	Strengths	Opportunity for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
Medicaid Quality Strategy Evaluation	For Aim 2 Better Outcomes, 4 out of the 5 performance measures with target rates set met the target rate objective.	Overall, 6 out of the 10 performance measures with target rates set did not meet the target rate objective.	Recommendations were made in the <i>Quality Strategy Evaluation</i> which included considerations for new PIPs, expanding on existing PIPs, and conducting beneficiary focus groups.	X	X	X
PIP	The substance use PIP saw four of the five performance indicators meeting their target rates.	Opportunities for improvement were noted for performance indicators across the COPD and Diabetes PIPs where target rates were not met for the majority of performance indicators.	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 46 measures/sub-measures that were benchmarked against NCQA Quality Compass data, four were above the 90th percentile, seven were above the 75th percentile but below the 90th percentile, and eight were above the 50th percentile but below the 75th percentile.	There were 20 measures that fell below the 25th percentile.	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 & 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 & Services, and Provider Selection.	X	X	X

EQR Activity	Strengths	Opportunity 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 North Dakota's requirement that at least 90% of an BCBSND's membership has access to providers within the established distance standards. IPRO found that PCP to member ratio for PCPs is 1:3.3 which met contractual standards.	<ul style="list-style-type: none"> <li>Providers had the availability to schedule timely well-check visit appointments at a rate of 44.3% for routine visits and 16.1% for non-urgent sick visits. After-hours access for family practice and pediatricians was evaluated at 50.0%</li> <li>Overall only 116 out of 305 providers surveyed had telephone numbers that resulted in successful contact and were accepting patients for the specialty listed.</li> </ul>	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 needed care, getting care quickly, and customer service.	BCBSND had nine CAHPS measures performing below the national 25th percentile.	BCBSND should address all the measures that performed below the 50th percentile.	X	X	X

BCBSND: Blue Cross Blue Shield of North Dakota; EQR: external quality review; PIP: performance improvement project; COPD: chronic obstructive pulmonary disease; ISCA: information systems capabilities assessment; HEDIS: Healthcare Effectiveness Data and Information Set; CHIP: Children's Health Insurance Program; PCP: primary care provider; CAHPS: Consumer Assessment of Healthcare Providers and Systems; NCQA: National Committee for Quality Assurance.

### BCBSND Responses to EQR 2024 ATR (prior year) Recommendations and IPRO Assessment of the Responses

Table 31 presents BCBSND's responses to EQR 2024 ATR recommendations and IPRO's assessment of the responses.

Table 31: BCBSND Responses to EQR 2024 ATR Recommendations

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
To ensure the accuracy and reliability of the data reported by BCBSND, BCBSND should consider conducting a thorough review of their work.	<b>BCBSND Response:</b> The ATR was not clear to the specific data discrepancies that were identified so we reached out to IPRO who provided a copy of comments from the IPRO team when the 2024 ATR was being created. It would be helpful for future recommendations for our Plan to indicate the version of the PIP forms being used to help us address the recommendations so we can better identify the issue and what corrections were made if applicable. These PIPs are updated continuously throughout the calendar year following	Addressed pending IPRO review of ongoing PIP reporting.

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response																				
<p>Addressing the data discrepancies will not only enhance the credibility of the PIP reports, but also contribute to the overall efficiency and effectiveness of their interventions.</p>	<p>guidance and recommendations from quarterly IPRO PIP reviews. Our Plan has made significant progress and improvement on completing the PIPs since working with IPRO on the PIP reviews began in 2023.</p> <p>In addition, there were various issues and challenges with the first two years of PIP reporting that included:</p> <ul style="list-style-type: none"> <li>• Being new to this PIP process and the form required.</li> <li>• ME was a new population; therefore, the intake of new data into our platform, etc. created some challenges and issues.</li> <li>• The Quality Management team was new and was learning about quality measures, the PIP process, and understanding the data for this population.</li> <li>• Issues were identified in the analytic platform used to monitor some of the PIP metrics which required solutioning which took time to correct by our vendor and validated by our internal analytic team.</li> </ul> <p>Responses to the comments:</p> <p><b>Table 4: COPD or Asthma in Older Adults PIP Interim Results</b></p> <p><b>Table 4: BCBSND COPD or Asthma in Older Adults Admission Rate PIP Interim Results</b></p> <table border="1" data-bbox="548 821 1620 1256"> <thead> <tr> <th>Indicator</th> <th>Baseline Period CY 2022</th> <th>Interim Period CY 2023</th> <th>Target Rate</th> </tr> </thead> <tbody> <tr> <td>Indicator 1: % of enrollees with at least one annual visit for COPD/asthma</td> <td>67.18% (350/521)</td> <td>62.20% (204/328)</td> <td>72%</td> </tr> <tr> <td>Indicator 2: % of enrollee discharges for COPD/asthma</td> <td>3.27% (26/795)</td> <td>1.24% (3/242)</td> <td>&lt; 3.27%</td> </tr> <tr> <td>Indicator 3: % of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma</td> <td>53.85% (14/26)</td> <td>66.67% (2/3)</td> <td>60%</td> </tr> <tr> <td>Indicator 4: % of admissions with a principal diagnosis of COPD/asthma per 100,000 population</td> <td>13.96 (24 discharges/ 171,937 MM)</td> <td>2.81 (6 discharges/ 705 MM)</td> <td>&lt; 41.9</td> </tr> </tbody> </table> <p>BCBSND: Blue Cross Blue Shield of North Dakota; COPD: chronic obstructive pulmonary disease; PIP: performance improvement project; CY: calendar year.</p>	Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate	Indicator 1: % of enrollees with at least one annual visit for COPD/asthma	67.18% (350/521)	62.20% (204/328)	72%	Indicator 2: % of enrollee discharges for COPD/asthma	3.27% (26/795)	1.24% (3/242)	< 3.27%	Indicator 3: % of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma	53.85% (14/26)	66.67% (2/3)	60%	Indicator 4: % of admissions with a principal diagnosis of COPD/asthma per 100,000 population	13.96 (24 discharges/ 171,937 MM)	2.81 (6 discharges/ 705 MM)	< 41.9	
Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate																			
Indicator 1: % of enrollees with at least one annual visit for COPD/asthma	67.18% (350/521)	62.20% (204/328)	72%																			
Indicator 2: % of enrollee discharges for COPD/asthma	3.27% (26/795)	1.24% (3/242)	< 3.27%																			
Indicator 3: % of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma	53.85% (14/26)	66.67% (2/3)	60%																			
Indicator 4: % of admissions with a principal diagnosis of COPD/asthma per 100,000 population	13.96 (24 discharges/ 171,937 MM)	2.81 (6 discharges/ 705 MM)	< 41.9																			

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response																								
	<p><b>Indicator 4: Indicator 4: % of admissions with a principal diagnosis of COPD/asthma per 100,000 population.</b></p> <p>Comments:</p> <ul style="list-style-type: none"> <li>• What is % per 100,000? BCBSND Response: Indicator 4 is for the PQI 05 measure. At the time our team set these indicators, we were new to the PQI measures and were learning how they are reported. We learned that they are not reported as a percentage. This is now Indicator 3 in the 2024 PIP forms and has been corrected to be reported as discharges/100,00 member months.</li> <li>• Indicator says per 100,000 population, but reported as per member months (MM) See above comment. In reviewing our methodology for 2024, we list population but our goal lists member months. We have made this correction to the Q4 2024 PIP report.</li> <li>• Target rate &lt;41.9 what? Per 100,000? This should be number of discharges per 100,000 member months. We have made this correction to the Q4 2024 PIP report. When we had more detail in the Target Rate field of the results table (e.g., calling out discharges per 100,000 member months), we were advised by the IPRO PIP reviewer during a quarterly review to only add the target rate in this field. If this should be different, can clarification be provided as to how to document the Target Rate, so we all have the same understanding?</li> </ul> <p><b>Table 5: Diabetes Care Interim Results</b></p> <p>Table 5: BCBSND Diabetes Care PIP Interim Results</p> <table border="1" data-bbox="532 950 1650 1497"> <thead> <tr> <th>Indicator</th> <th>Baseline Period CY 2022</th> <th>Interim Period CY 2023</th> <th>Target Rate</th> </tr> </thead> <tbody> <tr> <td>Indicator 1: % of enrollees with at least one annual visit for diabetes</td> <td>83.11% (1,550/1,865)</td> <td>70.73% (1,160/1,640)</td> <td>88%</td> </tr> <tr> <td>Indicator 2: % of enrollee discharges for diabetes</td> <td>5.52% (69/1,249)</td> <td>9.34% (34/364)</td> <td>5%</td> </tr> <tr> <td>Indicator 3: % of enrollees discharged for diabetes with a healthcare provider visit for COPD/asthma</td> <td>82.26% (51/62)</td> <td>70.59% (24/34)</td> <td>88%</td> </tr> <tr> <td>Indicator 4: % of diabetes admissions with short-term complications per 100,000 member months (MM)<sup>1</sup></td> <td>1.92% (54/2,817)</td> <td>7.01% (30/1,427)</td> <td>1.9%</td> </tr> <tr> <td>Indicator 5: % of diabetes admissions per 100,000 MM ages 21–64 years<sup>1</sup></td> <td>24.41 (96 discharges/ 393,239MM)</td> <td>4.68 (10 discharges/ 1,427 MM)</td> <td>The adult core set for the national median is the</td> </tr> </tbody> </table>	Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate	Indicator 1: % of enrollees with at least one annual visit for diabetes	83.11% (1,550/1,865)	70.73% (1,160/1,640)	88%	Indicator 2: % of enrollee discharges for diabetes	5.52% (69/1,249)	9.34% (34/364)	5%	Indicator 3: % of enrollees discharged for diabetes with a healthcare provider visit for COPD/asthma	82.26% (51/62)	70.59% (24/34)	88%	Indicator 4: % of diabetes admissions with short-term complications per 100,000 member months (MM) <sup>1</sup>	1.92% (54/2,817)	7.01% (30/1,427)	1.9%	Indicator 5: % of diabetes admissions per 100,000 MM ages 21–64 years <sup>1</sup>	24.41 (96 discharges/ 393,239MM)	4.68 (10 discharges/ 1,427 MM)	The adult core set for the national median is the	
Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate																							
Indicator 1: % of enrollees with at least one annual visit for diabetes	83.11% (1,550/1,865)	70.73% (1,160/1,640)	88%																							
Indicator 2: % of enrollee discharges for diabetes	5.52% (69/1,249)	9.34% (34/364)	5%																							
Indicator 3: % of enrollees discharged for diabetes with a healthcare provider visit for COPD/asthma	82.26% (51/62)	70.59% (24/34)	88%																							
Indicator 4: % of diabetes admissions with short-term complications per 100,000 member months (MM) <sup>1</sup>	1.92% (54/2,817)	7.01% (30/1,427)	1.9%																							
Indicator 5: % of diabetes admissions per 100,000 MM ages 21–64 years <sup>1</sup>	24.41 (96 discharges/ 393,239MM)	4.68 (10 discharges/ 1,427 MM)	The adult core set for the national median is the																							

IPRO Recommendation	MCO Response				IPRO Assessment of MCO Response																				
	<table border="1"> <thead> <tr> <th data-bbox="532 177 1094 277">Indicator</th> <th data-bbox="1094 177 1303 277">Baseline Period CY 2022</th> <th data-bbox="1303 177 1486 277">Interim Period CY 2023</th> <th data-bbox="1486 177 1663 277">Target Rate</th> </tr> </thead> <tbody> <tr> <td data-bbox="532 277 1094 378"></td> <td data-bbox="1094 277 1303 378"></td> <td data-bbox="1303 277 1486 378"></td> <td data-bbox="1486 277 1663 378">targeted rate for this indicator</td> </tr> <tr> <td data-bbox="532 378 1094 440">Indicator 6: % of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (&lt; 8.0%)</td> <td data-bbox="1094 378 1303 440">29.44% (121/411)</td> <td data-bbox="1303 378 1486 440">Not Reported</td> <td data-bbox="1486 378 1663 440">60.34%</td> </tr> <tr> <td data-bbox="532 440 1094 503">Indicator 7: % of enrollees with diabetes whose HbA1c was in poor control (&gt; 9.0%)</td> <td data-bbox="1094 440 1303 503">65.21% (268/411)</td> <td data-bbox="1303 440 1486 503">Not Reported</td> <td data-bbox="1486 440 1663 503">29.44%</td> </tr> <tr> <td data-bbox="532 503 1094 573">Indicator 8: % of enrollees with diabetes who had a retinal eye exam</td> <td data-bbox="1094 503 1303 573">30.21% (268/411)</td> <td data-bbox="1303 503 1486 573">20.17% (305/1,512)</td> <td data-bbox="1486 503 1663 573">63.33%</td> </tr> </tbody> </table>	Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate				targeted rate for this indicator	Indicator 6: % of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (< 8.0%)	29.44% (121/411)	Not Reported	60.34%	Indicator 7: % of enrollees with diabetes whose HbA1c was in poor control (> 9.0%)	65.21% (268/411)	Not Reported	29.44%	Indicator 8: % of enrollees with diabetes who had a retinal eye exam	30.21% (268/411)	20.17% (305/1,512)	63.33%				
Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate																						
			targeted rate for this indicator																						
Indicator 6: % of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (< 8.0%)	29.44% (121/411)	Not Reported	60.34%																						
Indicator 7: % of enrollees with diabetes whose HbA1c was in poor control (> 9.0%)	65.21% (268/411)	Not Reported	29.44%																						
Indicator 8: % of enrollees with diabetes who had a retinal eye exam	30.21% (268/411)	20.17% (305/1,512)	63.33%																						
<p><sup>1</sup> Indicators 4 and 5 are reported in discharged per 100,000 MM.  BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; COPD: chronic obstructive pulmonary disease. Source: BCBSND Quarterly Report.</p>																									
<p><b>Indicator 4: % of diabetes admissions with short-term complications per 100,000 member months (MM)<sup>1</sup></b></p>																									
<p>Comments:</p>																									
<ul style="list-style-type: none"> <li>Interim Period CY 2023: Rate should be 2.1%. It states 7.01% (30/1427): BCBSND Response: This rate came from what was displaying in our analytic tool. We discovered that our vendor for this analytic tool was not calculating the rate correctly. It took some time to get this corrected; however, once it was corrected the rates entered into the PIP should be correct.</li> </ul>																									
<p><b>Indicator 4: % of diabetes admissions with short-term complications per 100,000 member months (MM)<sup>1</sup></b></p>																									
<p>Comments:</p>																									
<ul style="list-style-type: none"> <li>% per 100,00 member months? But it is reported just as a percentage BCBSND Response: Indicator 4 is for the PQI 01 measure. At the time our team set these indicators, we were new to the PQI measures and were learning how they are reported. We learned that they are not reported as a percentage. This is now indicator 2 and results table reflects discharges/100,000 member months.</li> <li>For Interim Period CY 2023: I don't know where they got 4.68 or how their population went from 393,239 to 1,427. if they are presenting it as a rate per 100,000 then <math>10/1427 * 100,000 = 700.8</math> per 100,000. CY 2022 was presented as per 100,000 so reporting should remain consistent despite a significantly reduced population. BCBSND Response: This rate came from what was displaying in our analytic tool. We discovered that our vendor for this analytic tool was not</li> </ul>																									

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<p>calculating the rate correctly. It took some time to get this corrected; however, once it was corrected the rates entered into the PIP should be correct.</p> <p><b>Indicator 8: % of enrollees with diabetes who had a retinal eye exam</b></p> <p>Comments:</p> <ul style="list-style-type: none"> <li>For Baseline Period CY 2022, rate is listed as 30.21% (268/411). It should be 65.21% BCBSND Response: For 2024, this indicator was removed. For Interim MY 2022, the rate of 30.21% was the pre-hybrid medical record review rate. For MY 2022, we followed the hybrid methodology (medical record review) for the EED measure which then increased the rate to 65.21%.</li> </ul> <p>Other Comments:</p> <ul style="list-style-type: none"> <li>For the Diabetes Care PIP (Table 5), IPRO determined that there was no evidence of estimated or true frequency, margin of error, or confidence intervals for the sampling used. BCBSND Response: We could not find this information under Table 5. It appears it might be under the Data Collection and Analysis Procedures - Sampling Procedures? If under that section, we addressed the sample methodology as following the HEDIS specifications and hybrid methodology for the HEDIS for HBD measure. Adding the above has not been brought up during any of the IPRO PIP quarterly reviews. We do not perform our own sampling rules but follow NCQA HEDIS specifications. If the above is required, we would need guidance and training as our team is clinical.</li> <li>Additionally, BCBSND should list their performance indicators and target rates as numerical values. Indicators #6 and #7 were missing rates BCBSND Response: These two indicator rates come from the hybrid methodology. The interim results were likely not populated as we did not have final rates from hybrid review yet. It is hard to research not knowing which Interim Results version of reporting were used to identify this issue. The final MY 2023 PIP report has the rates populated for Indicators 6 and 7. For 2024, we are only reviewing HbA1c &lt;8%.</li> </ul>	

**IPRO Recommendation**

**MCO Response**

**IPRO Assessment of MCO Response**

**Table 6: Hypertension PIP Interim Results**

**Table 6: BCBSND Hypertension PIP Interim Results**

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate
Indicator 1: % of enrollees with at least one annual visit for hypertension	65.39% (1,644/2,514)	66.88% (1,028/1,537)	70%
Indicator 2: % of hospital discharges for a principal diagnosis of hypertension	0% (0/1,141)	0.27% (1/364)	0.25%
Indicator 3: % of enrollee hospital discharges for a principal diagnosis of hypertension who also had a PCP visit for hypertension	Not Reported	100% (1/1)	0%
Indicator 4: % of admissions with a principal diagnosis of hypertension per 100,000 population ages 21–64 years	Not Reported	4.20 (6/1,427)	< 3%
Indicator 5: % of enrollees ages 21–64 years with a diagnosis of hypertension whose BP was adequately controlled (< 140/90 mm Hg)	32.85% (135/411)	3.71% (5/1,347)	> 65.1%

BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; PCP: primary care provider; BP: blood pressure. Source: BCBSND Quarterly Report.

**Indicator 4: % of admissions with a principal diagnosis of hypertension per 100,000 population ages 21–64 years**

Comments:

- Interim Period CY 2023: Rates listed as 4.20 (6/1427) – What is % per 100,000? BCBSND Response: Indicator 4 is for the PQI 07 measure. At the time our team set these indicators, we were new to the PQI measures and were learning how they are reported. We learned that they are not reported as a percentage. This PIP has since been retired.
- Have they reported the rate per 1000 but the indicator says per 100,000 (Interim CY 2023)? BCBSND Response: This rate came from what was displaying in our analytic tool. We discovered that our vendor for this analytic tool was not calculating the rate correctly and rates were displaying as per 1000 instead of per 100,000. It took some time to get this corrected; however, once it was corrected the rates entered into the PIP should be correct.
- Target Rate: Indicator is per 100,000 but target rate is set to a percent, shouldn't it remain consistent when reporting data? There should be number of discharges per 100,000 member months. This was corrected in 2023 PIP reports.

**Indicator 5: % of enrollees ages 21–64 years with a diagnosis of hypertension whose BP was adequately controlled (< 140/90 mm Hg)**

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response																								
	<p>Comments:</p> <ul style="list-style-type: none"> <li>Interim CY 2023: Should be 0.37% (listed as 3.71%). BCBSND Response: Interim results would have come from our monitoring analytic tool. We have multiple versions of the PIP reports during the year that represent each quarter and then there are updated versions if recommendations for corrections are made by the IPRO PIP reviewer. We could not find which version the comment is referencing. It would be helpful to understand which version was used for the comments if a more detailed responses is required. In general, it is possible that we simply had a keying error in either the rate or numerator/denominator. It is also possible that there were issues in our vendor analytic tool. For MY 2022 and MY 2023, the tool we use to report interim rates had various issues that were being addressed and corrected.</li> </ul> <p>Other Comments:</p> <ul style="list-style-type: none"> <li>For the Hypertension PIP (Table 6), IPRO determined that the sampling technique did not specify estimated or true frequency, margin of error, or confidence intervals. BCBSND Response: We could not find this information under Table 5. It appears it might be under the Data Collection and Analysis Procedures - Sampling Procedures? If under that section, we addressed the sample methodology as following the HEDIS specifications and hybrid methodology for the HEDIS for CBP measure. Adding the above has not been brought up during any of the IPRO PIP quarterly reviews. We do not perform our own sampling rules but follow NCQA HEDIS specifications. If the above is required, we would need guidance and training as our team is clinical.</li> </ul> <p><b>Table 7: Substance Use Disorder PIP</b></p> <table border="1" data-bbox="540 967 1634 1442"> <thead> <tr> <th>Indicator</th> <th>Baseline Period CY 2022</th> <th>Interim Period CY 2023</th> <th>Target Rate</th> </tr> </thead> <tbody> <tr> <td>Indicator 1: % of Medicaid Expansion enrollees who have had at least one preventive care visit for a principal diagnosis of SUD or drug overdose</td> <td>37.63% (1,098/2,918)</td> <td>34.29% (874/2,549)</td> <td>42.63%</td> </tr> <tr> <td>Indicator 2: % of ED visits for which the enrollee received follow-up within 7 days.</td> <td>33.31% (393/1,180)</td> <td>25.98% (172/662)</td> <td>32.53%</td> </tr> <tr> <td>Indicator 3: % of ED visits for which enrollee received follow-up within 30 days.</td> <td>45.59% (538/1,180)</td> <td>41.09% (272/662)</td> <td>32.53%</td> </tr> <tr> <td>Indicator 4: % of new SUD episodes resulting in treatment initiation within 14 days.</td> <td>48.57% (442/910)</td> <td>40.46% (666/1,646)</td> <td>52.93%</td> </tr> <tr> <td>Indicator 5: % of new SUD episodes that have evidence of treatment engagement within 34 days.</td> <td>20.11% (183/910)</td> <td>19.32% (318/1,646)</td> <td>22.47%</td> </tr> </tbody> </table> <p>BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; SUD: substance use disorder; ED: emergency department. Source: BCBSND Quarterly Report</p>	Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate	Indicator 1: % of Medicaid Expansion enrollees who have had at least one preventive care visit for a principal diagnosis of SUD or drug overdose	37.63% (1,098/2,918)	34.29% (874/2,549)	42.63%	Indicator 2: % of ED visits for which the enrollee received follow-up within 7 days.	33.31% (393/1,180)	25.98% (172/662)	32.53%	Indicator 3: % of ED visits for which enrollee received follow-up within 30 days.	45.59% (538/1,180)	41.09% (272/662)	32.53%	Indicator 4: % of new SUD episodes resulting in treatment initiation within 14 days.	48.57% (442/910)	40.46% (666/1,646)	52.93%	Indicator 5: % of new SUD episodes that have evidence of treatment engagement within 34 days.	20.11% (183/910)	19.32% (318/1,646)	22.47%	
Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate																							
Indicator 1: % of Medicaid Expansion enrollees who have had at least one preventive care visit for a principal diagnosis of SUD or drug overdose	37.63% (1,098/2,918)	34.29% (874/2,549)	42.63%																							
Indicator 2: % of ED visits for which the enrollee received follow-up within 7 days.	33.31% (393/1,180)	25.98% (172/662)	32.53%																							
Indicator 3: % of ED visits for which enrollee received follow-up within 30 days.	45.59% (538/1,180)	41.09% (272/662)	32.53%																							
Indicator 4: % of new SUD episodes resulting in treatment initiation within 14 days.	48.57% (442/910)	40.46% (666/1,646)	52.93%																							
Indicator 5: % of new SUD episodes that have evidence of treatment engagement within 34 days.	20.11% (183/910)	19.32% (318/1,646)	22.47%																							

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<p>Comments:</p> <ul style="list-style-type: none"> <li>For the Substance Use Disorder PIP (Table 7), IPRO indicated that BCBSND should consider linking all interventions and tracking measures to the actual barrier for that indicator and consider how the intervention is addressing the barrier to that indicator. BCBSND Response: Early on, our team was learning how to complete the barrier analysis of the PIPs to link to the indicators. The IPRO PIP reviewer worked with us in 2023 to help us improve this process and documentation. We continue to improve in this area as IPRO provides recommendations.</li> <li>IPRO also noted that BCBSND should review denominators for all measures to ensure accuracy. BCBSND Response: In 2022, our team identified that our vendor analytic tool for monitoring was not counting ER visits accurately (some were being counted more than once). Our analytic team worked extensively with our vendor to research and get this corrected which did take some time. It has been corrected since and our analytic team validated the measures to ensure they are calculating correctly. In addition, the baseline period denominators for 2022 are different than for 2023 but this is likely due to the issue we identified with our vendor. Also, some of these indicators are no longer in place.</li> </ul> <p>Final Comments: We have had one person primarily responsible for completion of the PIP forms including pulling the data from our monitoring vendor analytic tool. This person has done a great job of putting together the PIP reports and accepting and implementing feedback from the IPRO PIP reviews. The Medicaid Expansion population was new to BCBSND in 2022, and use of this analytic tool was also new. There were some issues identified early on in 2022 and 2023 in working in a new analytic tool to monitor the HEDIS measures and PQI indicators; however, we are confident that these issues have been corrected due to enhancements and corrections implemented by our vendor and extensive review and validation occurring by our internal analytics team.</p>	
<p>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, particularly for measures in the Prevention and Screening domain and the Overuse/ Appropriateness domain.</p>	<p>Pg. 36 of ATR  QM Response: The Quality Management team learned from the IPRO email received on 12/30/24 that the 2024 Annual Technical Report had been released. The ATR identifies the following measures for MY 2022 as being below the NCQA National 25th percentile:</p> <p><b>General Comments:</b></p> <ul style="list-style-type: none"> <li>Some rates for MY 2022 may have reflected lower as we did not have historical data for this new population. Measures such as BCS and CCS have lookback periods up to 5 years. As we have added more data for this population since their first year (MY 2022), rates are reflecting this.</li> <li>The care management team did not get fully onboarded to begin seeing members until the fourth quarter of 2022. The Care Management team can help close gaps by making outreach to members to encourage them to engage with their health care and see a primary care provider.</li> </ul>	<p>Partially Addressed, MY 2023 HEDIS rates continue to fall below the national 25th percentile however IPRO notes the addition of a clinical quality analyst to perform deep-dives into measures which present opportunities for improvement.</p>

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<ul style="list-style-type: none"> <li>• In January 2024, several HEDIS Tip Sheets were developed that included education on specific HEDIS measures and provided best practices for providers.</li> <li>• In 2022 and 2023, education was provided at all provider quality calls around submission of CPT Category II codes for the HBD and CBP measures.</li> <li>• Between May and August 2024, the Quality Management team conducted quality collaboration visits with the BlueAlliance Care+ providers (value-based program for Medicaid Expansion). All BlueAlliance Care+ providers received a quality collaboration visit (onsite or virtual) with over 84% being in-person visits.</li> <li>• Starting in the fourth quarter of 2024, BCBSND began ingesting supplemental data with three provider locations submitting supplemental data by the end of 2024. We expect this to capture data we couldn't capture via claims data (e.g., global billing for PPC measure or compliance for cancer screening prior to 2022).</li> <li>• In May 2024, the ME CHAMPION mailer was sent to all ME members. This mailer provided education around the importance of connecting with primary care, provided some behavioral health resources, encouraged cancer screenings, etc.</li> <li>• In late 2024, work began on a Behavioral Health specific CHAMPION mailer/flyer with a goal to distribute in the first half of 2025.</li> </ul> <p>BCS: For MY 2024, the BCS measure was added to the Medicaid Expansion value-based program (BlueAlliance Care+). Between MY 2022 and MY 2023, rates for this measure improved over 13%.</p> <p>CBP: For MY 2024, the CBP measure was added to the Medicaid Expansion value-based program (BlueAlliance Care+). Between MY 2022 and MY 2023, rates for this measure improved by over 5%. This measure was ran using the hybrid medical record methodology. In 2023, our team provided education to BlueAlliance Care+ providers on CPT Category II codes which can help measure compliance. Recently in the fourth quarter of 2024, we started taking in supplemental data from 3 providers which should also help improve rates as we capture the data.</p> <p>CCS: For MY 2024, the CCS measure was added to the Medicaid Expansion value-based program (BlueAlliance Care+). Between MY 2022 and MY 2023, rates for this measure improved by almost 8%. In January 2025, Medicaid Expansion members will receive a postcard around the importance of cervical cancer screening.</p> <p>CHL: The rates for this measure have remained steady; however, it has not been a primary focus. Indirectly, we have been working with our providers and care management team to engage members with primary care visits which should help improve screening rates.</p>	

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<p>EED: Between MY 2022 and MY 2023, rates for this measure improved over 12. In addition, the care management team began seeing members in the fourth quarter of 2022 to help close gaps and engage these members.</p> <p>FUH (7-day): The FUH measure was added to our value-based Program for 2024 as a shadow measure, so providers are able to review their own data in our analytic tool. The 7-day rate has been more challenging to meet some initiatives that were implemented include: Discharge reports were sent daily to the care management team so they can help connect members with discharge appointments. Providers are also working to improve access for behavioral health appointments. A Behavioral Health CHAMPION mailer is in the planning; and development stages with a goal for distribution in 2025.</p> <p>Hba1c &lt;8% and HbA1c &gt;9: For MY 2024, the HBD measure was added to the Medicaid Expansion value-based program (BlueAlliance Care+). This measure was ran using the hybrid medical record methodology. In 2023, our team provided education to BlueAlliance Care+ providers on CPT Category II codes which can help measure compliance. Recently in the fourth quarter of 2024, we started taking in supplemental data from 3 providers which should also help improve rates as we capture the data. Also, the Care Management team has been able to collect HbA1cs as well and continues to encourage and assist these members to connect with a primary care provider.</p> <p>Timeliness of Prenatal Care: The rates for this measure improved over 16% from MY 2022 – MY 2023; however, it has not been a primary focus. The reason this measure has not been a primary focus is that if a Medicaid Expansion member becomes pregnant, they are encouraged to transition to traditional Medicaid. This does not always occur though and the number of members that are pregnant are much lower compared to other HEDIS measure denominators. In addition, a number of our providers submit global billing for pregnancy care, delivery and post-partum care; therefore, we are not able to capture the HEDIS specific dates for the measure.</p> <p>Postpartum Care: The rates for this measure improved from MY 2022 – MY 2023; however, it has not been a primary focus. The reason this measure has not been a primary focus is that if a Medicaid Expansion member becomes pregnant, they are encouraged to transition to traditional Medicaid. This does not always occur though and the number of members that are pregnant are much lower compared to other HEDIS measure denominators. In addition, a number of our providers submit global billing for pregnancy care, delivery and post-partum care; therefore, we are not able to capture the HEDIS specific dates for the measure.</p>	

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<p>Adherence to Antipsychotic Medications for Individuals with Schizophrenia: Rates for this measure remained stable between MY 2022 and MY 2023. As the denominator for this measure is low, this measure has not been a primary focus. Indirectly, we work on behavioral health outcomes for these members through monitoring of the FUH and FUM measures. In addition, providers have been working to get members in for follow-up appointments following and ER visit or hospital admission for mental illness.</p> <p><b>Monitoring:</b> Our analytic tool continues to be enhanced with more accurate and improved reporting. The Enterprise Data Analytics Solution team provides support in helping develop dashboards to monitor quality measures. In addition, the Quality Management team review the rates at a minimum monthly in the analytic tool to monitor measure performance and provide insights to our providers during the quarterly calls on performance. With the launch of taking in supplemental data, our analytics team is testing the data from each facility as it is submitted to ensure formats, etc. are correct. Following successful validation of testing the supplemental data source, the analytic tool is updated. With our first provider submitting supplemental data at the end of September, we have observed a positive impact across many measures. We continue to onboard more supplemental data in 2025.</p> <p>In 2025, the Quality Management team will be adding a Clinical Quality Analyst to provide analytic support to clinical quality and utilization measures. They will be asked to help perform deep-dives into the measure to identify trends and opportunities for improvement.</p>	
<p>BCBSND should focus on the three domains that performed poorly: Availability of Services, Assurances of Adequate Capacity &amp; Services, and Provider Selection.</p>	<p>438.206 Availability of Services: 2.8.1(A), 2.8.6, 2.9.6(A)(1), 2.9.6(A)(2), 2.9.6(A)(3), 2.9.6(A)(4), 2.9.3(A), 2.9.6(A) - BCBSND has ensured that accessibility reports are run each quarter, to include all applicable providers where such exceptions to coverage might be granted: Top 6 High Volume Specialists, IHS Provider, Accessibility to Indian ME Members, Network Analysis of ME network by zip code and PCP to Enrollee Ratio Report. In June 2024, reports were produced for Q1, July for Q2, and quarterly going forward. The expected outcome was to be aware on a quarterly basis of network accessibility and identify concerns in a timely manner. These reports are reviewed and utilized as a part of our ongoing process of ensuring 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.</p> <p>438.206 Availability of Services: 2.9.6(B), 2.9.6(B)(6) - This process has been updated on all this ME report.</p> <p>438.206 Availability of Services: 2.9.6(B)(7) - Report and summary of results is shared with BCBSND teams to review needs for contingent interventions to address gaps-in-care due to network gaps.</p> <p>438.206 Availability of Services: 2.9.3(B) - Summary will include this information.</p> <p>438.206 Availability of Services: 2.9.3(E), 2.9.2(A) - Questions were asked in secret shopper work.</p>	<p>Addressed pending results of next 2026 compliance review.</p>

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<p>438.206 Availability of Services: 2.9.7(A) - Report will be shared at the February QMC and language of strategy will be included in the summary of this report.</p> <p>438.207 Assurances of Adequate Capacity &amp; Services: 2.8.2(A), 2.8.2(A)(1), 2.9.4(A), 2.9.4(C), 2.9.1(D), 2.9.5(A), 2.8.8(A) - BCBSND has ensured that accessibility reports are run each quarter, to include all applicable providers where such exceptions to coverage might be granted: Top 6 High Volume Specialists, IHS Provider, Accessibility to Indian ME Members, Network Analysis of ME network by zip code and PCP to Enrollee Ratio Report. In June 2024, reports were produced for Q1, July for Q2, and quarterly going forward. The expected outcome was to be aware on a quarterly basis of network accessibility and identify concerns in a timely manner. These reports are reviewed and utilized as a part of our ongoing process of ensuring 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.</p> <p>438.207 Assurances of Adequate Capacity &amp; Services: 2.9.1(B), 2.9.1(C) - In 2024, BCBSND implemented a process to utilize the State ND Medicaid enrollment report to compare to our commercial network. When it is found that there are providers who are enrolled in our commercial network AND enrolled in ND Medicaid, but not in the BCBSND ME network, provider contracting reaches out to provider organization to contract. A retroactive comparative review of our commercial network to the ND Medicaid enrollment file began in Q1 of 2024 and continues on a monthly basis going forward. Since Q1, 2024, the expected outcome is to ensure all providers who are in our commercial network and NE Medicaid have an opportunity to enroll in the ME network. Using quarterly reporting as well as semi-annual reporting, we are able to determine growth in the ME network.</p> <p>438.207 Assurances of Adequate Capacity &amp; Services: 2.9.5(D), 2.8.8(G) - Provider and Member handbook were updated to clarify that when an Enrollee chooses to travel further than established standards in order to access a preferred Provider, the Enrollee shall be responsible for travel arrangements and costs unless there is not a qualified Provider meeting the accessibility standards within BCBSND's Provider Network. Provider and Member handbook were updated in Q1, 2024. The expected outcome was to provide clarify for Enrollees traveling further than established access standards in order to access a preferred Provider. N/A - manual update</p> <p>438.214 Provider Selection: 2.8.3(E)(1), 2.8.3(E)(2), 2.8.3(E)(3), 2.8.3(E)(4) - Minutes are maintained for every Credentialing Committee meeting but were not submitted as evidence. See the attachment (evidence 438.214 10 19 2022 Credentialing Committee Minutes_REDACTED follow up 2025) for a copy of redacted minutes from Oct 2022 as an example. More minutes can be shared, if requested. Chair and Credentialing representative monitor the quarterly Cred Committee agenda to assure minutes are retained, reviewed by the Cred Committee, and signed by the medical director.</p> <p>438.214 Provider Selection: 2.8.3(J)(3), 2.8.3(J)(3)(b), 2.8.3(J)(3)(c), 2.8.3(J)(3)(d) - Moderate and high-risk Providers have been defined by BCBSND as those providers who have had quality of care complaints that warranted an office site visit. This was discussed with representatives at a previous audit and deemed to be acceptable. IPRO was unable to locate the Site Assessment Process DLP (see</p>	

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	attachment, evidence 438.214 Jan 2025 response Site Assessment Process Version 2 (1)) with the other 2025 updates. Please note on that DLP that the state representative approved this Dec 2021, as meeting requirements. Not applicable as future actions not required as site visit DLP is current. Not applicable as no additional action was required other than to share the documents that were not found during the initial audit. Not applicable, though quality of care complaints are on the quarterly Credentialing Committee agenda if any are found.	
Survey results indicate a need for BCBSND to increase timely appointment rates for PCPs to ensure members are able to access primary care 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.	Providers not meeting standards were referred to Provider Education for education on their Medicaid Expansion Contractual obligation. Education conducted outreach to inform provider they didn't meet accessibility standards. Follow-up is planned for 6-month re-evaluation of standards to ensure compliance. If not complaint, provider will be informed they don't meet accessibility standards and will be re-educated to meet the appropriate standards. If termination is necessary, the standard termination process would occur. The initial education was provided at the time of secret shopper survey or within a few weeks. Upon re-survey, if they are not compliant for any of the standards or measures then BCBSND will re- evaluate and again provide education. Those results will be shared with contracting for term review. To address wait times for PCP and other specialties, BCBSND we will be conducting a wait time survey Q1, 2025, for all participating providers via an online survey to address any wait time needs in the state and collaboration with the provider community to understand their limitations to meet the wait time requirements. The expected outcome is to continue to broaden outreach and education to ensure providers are aware of expectations. Provider contracting continues to work to ensure all eligible providers, who are enrolled in ND Medicaid, are also enrolled in the BCBSND Medicaid Expansion network. BCBSND will continue the process of ongoing wait time surveys, provider education and network building activities.	Not Addressed, timely appointment rates remain low.
BCBSND should address all the measures that performed below the 50th percentile.	<p>Pg. 36 of ATR  QM Response: The Quality Management team learned from the IPRO email received on 12/30/24 that the 2024 Annual Technical Report had been released. The ATR identifies the following CAHPS measures for MY 2022 as being below the NCQA National 50th percentile:</p> <p>General: Compared to the CAHPS survey administered for MY 2022, all questions that performed below the NCQA national 50th percentile demonstrated improvement with 7 of the 12 measures performing at the 50th percentile or greater.</p> <ul style="list-style-type: none"> <li>• MY 2022 was the first year of managing these members. We did not have historical experience with this population so there was a lot to learn and processes and initiatives to be implemented.</li> <li>• The Medicaid Expansion Advisory Committee launch in 2023. In both 2023 and 2024, we brought some survey questions where opportunities existed to this committee for their feedback and input; however, member representation is very small.</li> </ul>	Addressed, BCBSND should continue to focus on improving measures that still fall below the NCQA national 50th percentile despite improvement from last year.

IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<ul style="list-style-type: none"> <li>• Supplemental questions were added to the survey sent in 2024 to further gather information around responses from the survey sent in 2023. Questions added in 2024 were around: 1. How do the prefer to learn about information from the Health Plan? 2. What prevents you from using the Member portal? 3. In your opinion, how important is it to you to have a personal doctor on a scale of 1-10? 4. If you did not think it was easy to get the care, test or treatment you needed, what was the main problem? 5. Thinking of your most recent visit to the ER, what was the reason for going? 6. In the last six months, if you needed mental health or substance abuse services for yourself, did you access them?</li> <li>• For the survey being administered in 2025, we analyzed the opportunities identified in the 2024 survey to add supplemental questions to drive improvement and understand member’s responses.</li> <li>• The Care Management team and our providers have been helpful at working to improve engagement with members.</li> <li>• Our Medicaid Expansion customer contact center team in 2022 was still working on staffing and training staff. As this moved to a steadier state, it has likely contributed to improvement of some responses.</li> <li>• Regular touchpoints occur with internal and external stakeholders to ensure the needs of ME members are being met.</li> </ul> <p>Q20. Getting appointments with specialists as soon as needed: Rates remained steady from MY 2022 to MY 2023.</p> <p>Q4. Get care as soon as needed when care was needed right away. More than a 12% improvement noted from MY 2022 – MY 2023. The MY 2023 CAHPS report lists the MY 2023 rate for this measure as being in the 100th percentile.</p> <p>Q6. Got check-up/routine care appointment as soon as needed. More than a 7% improvement was noted from MY 2022-MY 2023 putting this measure over the 50th percentile and nearly at the 75th percentile.</p> <p>Q13. Personal Doctor listened carefully to you. A 4.4% improvement from MY 2022 – MY 2023 was made moving this measure from below the 10th percentile to the 45th percentile.</p> <p>Q14. Personal doctor showed respect for what you had to say. A 4.4% improvement from MY 2022 – MY 2023 was made moving this measure from below the 10th percentile to the 74th percentile.</p> <p>Q15. Personal doctor spent enough time with you. A 7.3% improvement from MY 2022 – MY 2023 was made moving this measure from below the 10th percentile to the 78th percentile.</p>	

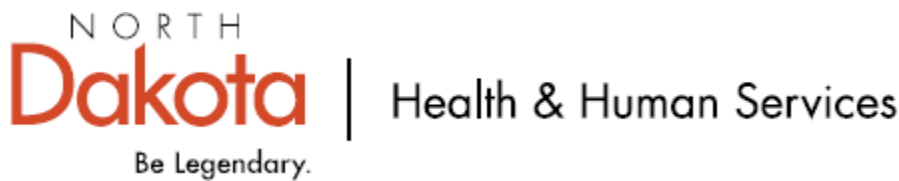
IPRO Recommendation	MCO Response	IPRO Assessment of MCO Response
	<p>Q8. Rating of Health Care. A 3% improvement from MY 2022 – MY 2023 was made moving this measure from below the 50th percentile to the 58th percentile.</p> <p>Q18. Rating of Personal Doctor: A 2.7% improvement from MY 2022 – MY 2023 was made.</p> <p>Q28. Rating of Health Plan: A 6.1% improvement from MY 2022 – MY 2023 was made moving this measure from below the 10th percentile to the 29th percentile.</p> <p>Advising Smokers and Tobacco Users to Quit., A 1.3% improvement from MY 2022 – MY 2023 was made moving this measure from below the 10th percentile to the 15th percentile.</p> <p>Discussing Cessation Strategies. A 2.6% improvement from MY 2022 – MY 2023 was made moving this measure from below the 50th percentile to the 58th percentile.</p> <p>Discussion Cessation Medications. A 3.5% improvement from MY 2022 – MY 2023 was made moving this measure from below the 10th percentile to the 54th percentile.</p> <p>Monitoring: Each year we monitor the survey; however, the information provided in our vendor’s tool during administration of the survey was not as detailed and we had to wait for the final report when it was released in August each year. Our vendor announced they have made improvements to their platform for 2025 which we understand will provide our team the ability to have more insightful monitoring during the survey process allowing us to work on any opportunities for improvement before the final survey results are available.</p>	

BCBSND: Blue Cross Blue Shield of North Dakota; EQR: external quality review; MCO: managed care organization; ATR: annual technical report; PIP: performance improvement project; 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.

## **XI. Overall Conclusions**

Overall, findings from calendar year 2024 EQR activities highlight BCBSNDs' 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 report due April 2026 EQR technical report.

## XII. Appendix A: Review, Update and Evaluation of the North Dakota Quality Strategy



### Department of Health and Human Services Medical Services Division North Dakota

### Review, Update and Evaluation of the North Dakota Quality Strategy

DRAFT

April 2025



Better healthcare,  
realized.

Corporate Headquarters  
1979 Marcus Avenue  
Lake Success, NY 11042-1072  
(516) 326-7767  
ipro.org

ISO  
9001:2015  
CERTIFIED

## Table of Appendix A Contents

Introduction .....	92
Quality Strategy Goals .....	92
Quality Strategy Review and Update Process .....	92
Year 1 2024: Review and Update of the 2024 North Dakota Medicaid Quality Strategy Plan .....	92
Year 2 2025: Review, Update and Evaluation of the <i>North Dakota Medicaid Quality Strategy</i> .....	93
Quality Strategy Evaluation Process .....	93
IPRO Evaluation Objectives.....	93
Evaluation Methodology .....	94
Quality Strategy Evaluation Findings .....	94
Methodologic Adherence to <i>Title 42 CFR § 438.340</i> Managed Care State Quality Strategy .....	94
State Progress on Quality Strategy Goals and Objectives- Summary of Findings Regarding Target Rates .....	94
State Progress on Quality Strategy Goals and Objectives – Detailed Findings .....	97
Aim 1: Healthier Populations.....	97
Aim 2: Better Outcomes.....	98
Aim 3: Better Experience .....	99
Aim 4: Smarter Spending.....	99
Conclusion and Recommendations .....	100
Aim 1: Healthier Populations – BCBSND.....	105
Aim 2: Better Outcomes – BCBSND .....	107
Aim 3: Better Experience – BCBSND .....	108
Aim 4: Smarter Spending – BCBSND.....	109
Aim 1: Healthier Populations – FFS.....	110
Aim 2: Better Outcomes – FFS .....	111
Aim 3: Better Experience –FFS .....	113
Aim 4: Smarter Spending – FFS.....	114
Source Documents .....	115
Appendix A1: Assessment of North Dakota’s Quality Strategy, 1/8/2025 .....	116
Appendix A2: Progress on Meeting North Dakota Quality Strategy Goals by Medicaid Beneficiary Population.....	119

### List of Appendix A Tables

Table A1: State Progress on Meeting North Dakota Quality Strategy Goals .....	95
Table A2: Summary of IPRO Recommendations Based on the State Progress on Quality Strategy Goals and Objectives.....	101
Table A1.1: IPRO Assessment of North Dakota’s Quality Strategy .....	116
Table A2.1: BCBSND Progress on Meeting North Dakota Quality Strategy Goals .....	119
Table A2.2: FFS Progress on Meeting North Dakota Quality Strategy Goals .....	120

### List of Appendix A Figures

Figure A1: BCBSND Follow-up After an Emergency Department Visit for Mental Illness (FUM-AD) 7-Days Performance .....	105
Figure A2: BCBSND Prenatal and Postpartum Care: Postpartum (PPC-AD) Performance.....	106
Figure A3: BCBSND Diabetes Short-Term Complications Admission Rate (PQI01-AD) Performance .....	107
Figure A4: BCBSND Rating of All Health Care Performance.....	108
Figure A5: BCBSND: Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) Performance .....	109

Figure A6: FFS Follow-up After Emergency Department Visit for Mental Illness (FUM-AD) – 7-Day and 30-Day Follow-up Performance ..... 110

Figure A7: FFS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Performance ..... 111

Figure A8: FFS Hospital Admission for COPD, Heart Failure, and Diabetes (PQI08-AD, PQI01-AD, PQI05-AD) Performance ..... 112

Figure A9: FFS Rating of Health Plan Performance ..... 113

Figure A10: FFS Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) Performance ..... 114

---

HEDIS® and Quality Compass® are registered trademarks of the National Committee for Quality Assurance (NCQA). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). All other trademarks herein are the property of their respective owners.

---

## Introduction

States are required by *Title 42 Code of Federal Regulations (CFR) Section (§) 438.340* to draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each managed care organization (MCO), prepaid ambulatory health plan (PAHP), prepaid inpatient health plan (PIHP), and primary care case management (PCCM) entity. To support North Dakota (ND) Health and Human Services (HHS) in meeting this requirement, IPRO, as the external quality review organization (EQRO) for ND, worked with HHS to develop, review and evaluate the progress and effectiveness of the *2024 North Dakota Medicaid Quality Strategy Plan* (also referred to as the *2024 Quality Strategy Plan*). IPRO/HHS also updated and developed the quality strategy currently in effect as the *North Dakota Medicaid Quality Strategy 2025–2027*. This report presents the quality strategy review, update and evaluation process, as well as findings and recommendations.

## Quality Strategy Goals

North Dakota's Quality Strategy is grounded in aims, goals, and objectives designed to improve healthcare delivery, outcomes, and member experience, supported by measurable performance metrics. Aligned with the CMS Quality Strategy and the Institute for Healthcare Improvement (IHI)'s Triple Aim framework, North Dakota's 2024 Quality Strategy identifies the following four aims:

### Healthier Populations

Improve the overall health of North Dakotans by increasing access to preventive services, including cancer screenings and postpartum care, and by strengthening behavioral health follow-up and engagement.

### Better Outcomes

Enhance health outcomes for Medicaid members with chronic conditions and substance use disorders through better treatment initiation, care coordination, and reduced avoidable hospitalizations.

### Better Experience

Elevate the healthcare experience by promoting timely access to care and increasing member satisfaction with both health plans and overall care received.

### Smarter Spending

Ensure the efficient use of public resources by reducing avoidable hospital readmissions and supporting value-based care initiatives that prioritize quality over volume.

## Quality Strategy Review and Update Process

The quality strategy review, update, and evaluation process entailed a 2-year process that integrated the review, update, and evaluation processes, as described in this section.

### Year 1 2024: Review and Update of the 2024 North Dakota Medicaid Quality Strategy Plan

In 2024, IPRO, on behalf of and in consultation with HHS, reviewed and updated the *2024 North Dakota Medicaid Quality Strategy Plan* that was effective January 1, 2024. The MCO baseline rates were updated to represent federal fiscal year (FFY) 2023 (calendar year [CY] 2022) rates for Blue Cross Blue Shield of North Dakota (BCBSND), as prior year MCO data represented another Medicaid MCO no longer active in ND. New performance targets were set based on FFY 2023 (CY 2022) MCO baseline rates provided by HHS for BCBSND. Fee-for-service (FFS) rates were not yet available for the required posting for public comment during December 2024.

FFY 2027 (CY 2026) target rates for Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures were set as the rate of the 50th CY 2023 Medicaid Quality Compass® (QC) percentile or higher, as indicated by baseline rates that performed better than the 50th QC percentile. Target rates for the prevention quality indicator (PQI) measures were set at FFY 2022 (CY 2021) national Medicaid median rates or, if median rates had been attained, target rates were set for the highest quartile. The resulting revised quality strategy was renamed *North Dakota Medicaid Quality Strategy 2025–2027* and posted to the HHS website for public comment.

Centers of Medicare and Medicaid Services (CMS) feedback on the *2024 North Dakota Medicaid Quality Strategy Plan* was addressed by the *North Dakota Medicaid Quality Strategy 2025–2027* regarding:

- The Medical Care Advisory Committee was engaged in the quality strategy review process.
- Clarification and links were added regarding quality metrics published annually in the annual technical report (ATR).
- Details were added regarding the conduct of disparity assessments and the state’s definition of disability.
- Network adequacy standards were added.
- Clinical practice guideline examples were provided.

HHS provided additional updates to the *North Dakota Medicaid Quality Strategy 2025–2027* for consistency with existing and updated regulations.

### [Year 2 2025: Review, Update and Evaluation of the North Dakota Medicaid Quality Strategy](#)

In 2025, the review, update and evaluation process were three-fold. First, IPRO addressed public comments on the draft of the *North Dakota Medicaid Quality Strategy 2025–2027*, specifically feedback from BCBSND, by ensuring that the MCO’s performance improvement project (PIP) interventions were up to date. Second, ND HHS provided IPRO with a spreadsheet that included performance measure (PM) data for measurement year (MY) 2023 rates for the MCO, FFS, and ND and requested IPRO review of these updated rates relative to the CY 2021 national Medicaid median set as the target in the *2024 North Dakota Medicaid Quality Strategy Plan*. IPRO integrated into this spreadsheet the MCO, FFS, and ND state CY 2022 performance indicator rates, as well as CAHPS MY 2022 and MY 2023 data from ND state CAHPS reports. Third, IPRO’s evaluation addressed CMS feedback on the *North Dakota Medicaid Quality Strategy 2025–2027*.

### **Quality Strategy Evaluation Process**

IPRO, the EQRO for ND, conducted the evaluation of the North Dakota Medicaid Quality Strategy.

#### **IPRO Evaluation Objectives**

- Consistent with CMS guidance in the *Medicaid Managed Care Quality Strategy Toolkit* (CMS, 2021), identify PMs that neither met the CY 2021 Medicaid median nor made progress from CY 2022 to CY 2023.
- For those PMs that neither met the CY 2021 Medicaid median nor made progress from CY 2022 to CY 2023, include recommendations for the MCO, FFS, and ND for improving the quality of health care services to better support the four aims laid out in the North Dakota Medicaid Quality Strategy: healthier populations, better outcomes, better experience, and smarter spending.
- Include recommendations for improving methodologic adherence to *Title 42 CFR § 438.340* requirements and/or updating the scope and format of the quality strategy based on the state’s latest reports.

## Evaluation Methodology

IPRO assessed the state's progress on its quality strategy goals and objectives by evaluating MCO, FFS, and ND performance indicator progress from baseline MY (CY) 2022 to MY (CY) 2023, as well as the extent to which the quality strategy measure baseline rates reached the Medicaid median CY 2021 rates originally benchmarked for the 2024 *North Dakota Medicaid Quality Strategy Plan*. Data sources are indicated in the **Source Documents** section. In addition, IPRO evaluated methodological adherence to *Title 42 CFR § 438.340* requirements for a state quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity.

## Quality Strategy Evaluation Findings

### Methodologic Adherence to *Title 42 CFR § 438.340* Managed Care State Quality Strategy

IPRO utilized the *Assessment of North Dakota's Quality Strategy* tool (**Appendix A1**) to comprehensively evaluate methodologic adherence to *Title 42 CFR § 438.340* requirements. All requirements were met.

Recommendations to ND for methodologic adherence to *Title 42 CFR § 438.340 Managed Care State Quality Strategy* for the next quality strategy review, update and evaluation will address CMS's most recent feedback, as of 3/6/2025, on the *North Dakota Medicaid Quality Strategy 2025–2027*, as follows:

- Modify the quality strategy by adding to the end of Section I a list of managed care metrics included in the BCBSND ATR but not in the quality strategy's Table 1. Add a link to the ATR that includes data on these measures. The subheader for this section should read, "Additional Managed Care Quality Metrics in the Annual Technical Report."
- Modify the quality strategy by adding to the end of subsection Disparities Plan (*Title 42 CFR § 438.340[b][6]*) a description of the methods the state will use to evaluate and reduce disparities based on disability status. For example, the state can provide a working definition of disability status that BCBSND can use to stratify PM reporting for PIPs.
- Pending state final approval of the quality strategy evaluation report, post the report to the state website with links included in the revised quality strategy and for BCBSND ATR, also pending final approval by the state.

### State Progress on Quality Strategy Goals and Objectives- Summary of Findings Regarding Target Rates

The state's progress on meeting its quality strategy goals and objectives is summarized in the below narrative for PMs with target rates set as the CY 2021 Medicaid median in the 2024 *North Dakota Medicaid Quality Strategy Plan*. **Table A1** presents the North Dakota State data and progress towards meeting target objectives for each measure based on the Medicaid median benchmarks. Findings are presented by the four quality strategy aims of healthier populations, better outcomes, better experience, and smarter spending. Overall, five of the ten North Dakota measure rates (50%) met the target rate. Detailed findings regarding measure rate change from CY 2022 to CY 2023 are provided in the narrative below **Table A1**. In **Appendix A2**, **Table A2.1** presents the data for the BCBSND population and **Table A2.2** presents the data for the FFS population.

#### Aim 1: Healthier Populations

North Dakota Overview: Goal 1.1 is to improve preventive health. One of the three measures did not meet the target objective, and two of the three measures did not have Medicaid median benchmarks to compare to. Goal 1.2 is to improve postpartum care. The timely postpartum care measure did not meet the target objective. Goal 1.3 is to improve behavioral health care for beneficiaries. One of the two measures met the target rate.

Target rates were met for FFS CY 2023 rates for 30-Day and 7-Day Follow-up After Emergency Department Visit for Mental Illness (FUM-AD). North Dakota met the 30-Day, but not the 7-Day FUM-AD target rate. BCBSND did not meet either the 30-Day or the 7-Day FUM-AD rate. Breast Cancer Screening (BCS-AD) CY 2023 rates for FFS, BCBSND and ND did not meet the target rates. For Prenatal and Postpartum Care, Postpartum Care CY 2023 rates for FFS, BCBSND and ND did not meet the target rates.

**Aim 2: Better Outcomes**

North Dakota Overview: Goal 2.1 is to improve outcomes for members with substance use disorders. One of the two measures for this goal met the target objective. Goal 2.2 is to improve health for members with chronic conditions. Two of the three measures met the target objective.

Target rates were met by BCBSND for CY 2023 for both Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD). North Dakota met the target rate for Engagement but not Initiation of Alcohol and Other Drug Abuse or Dependence Treatment. FFS CY 2023 rates met neither the IET-AD Initiation nor Engagement target rates. Target rates were met for FFS CY 2023 rates for the Diabetes Short-Term Complications Admission Rate (PQI01-AD), COPD or Asthma in Older Adults Admission Rate (PQI05-AD), and the Heart Failure Admission rate. BCBSND and ND met the target rates for the COPD or Asthma in Older Adults Admission Rate (PQI05-AD) and Heart Failure Admission Rate (PAI08-AD), but not the Diabetes Short-Term Complications Admission Rate (PQI01-AD).

**Aim 3: Better Experience**

North Dakota Overview: Goal 3.1 is to enhance member experience. None of the three measures for this aim had Medicaid median benchmarks.

**Aim 4: Smarter Spending**

North Dakota Overview: Goal 4.1 is to focus on paying for value. The all-cause readmission observed/ expected ratio did meet the target objective.

FFS and ND CY 2023 rates for Plan All-Cause Readmission (PCR-AD) met the target rate; however, the BCBSND CY 2023 rate did not.

**Table A1: State Progress on Meeting North Dakota Quality Strategy Goals**

Rate Definition	State 2022 <sup>1</sup>	State 2023 <sup>2</sup>	State Progress <sup>3</sup>	Medicaid Median <sup>4</sup>	Met Target Objective
<b>Aim 1: Healthier Populations</b>					
<b>Goal 1.1: Improve Preventive Health</b>					
+Breast Cancer Screening, ages 50 to 64 years	28.10%	36.5%	+8.4	48.8%	No
Colorectal Cancer Screening, ages 46 to 49 years	12.30%	20.0%	+7.7	N/A	N/A
Colorectal Cancer Screening, ages 50 to 64 years	24.60%	31.2%	+6.6	N/A	N/A
<b>Goal 1.2: Improve Postpartum Care</b>					
Prenatal and Postpartum Care, Timely Postpartum Care Rate	41.10%	54.7%	+13.5	75.0%	No
<b>Goal 1.3: Improve Behavioral Health Care for Beneficiaries</b>					
FUM-AD 30-Day Follow-up, ages 18 to 64 years	57.30%	59.7%	+2.4	52.5%	Yes

Rate Definition	State 2022 <sup>1</sup>	State 2023 <sup>2</sup>	State Progress <sup>3</sup>	Medicaid Median <sup>4</sup>	Met Target Objective
FUM-AD 7-Day Follow-up, Ages 18 to 64 years	40.00%	37.1%	-2.9	38.9%	No
<b>Aim 2: Better Outcomes</b>					
<b>Goal 2.1: Improve Outcomes for Members with Substance Use Disorder</b>					
IET-AD, Initiation: Total AOD Abuse or Dependence, ages 18 to 64 years	46.80%	42.6%	-4.2	43.4%	No
IET-AD, Engagement: Total AOD Abuse or Dependence, ages 18 to 64 years	22.10%	19.0%	-3.1	15.8%	Yes
<b>Goal 2.2: Improve Health for Members with Chronic Conditions</b>					
Inpatient Hospital Admissions for Heart Failure, ages 18 to 64 years (lower is better)	31.77	16.36	-15.41	23.9	Yes
Inpatient Hospital Admissions for Diabetes Short-Term Complications, ages 18 to 64 years (lower is better)	20.28	22.99	2.71	17.2	No
Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40 to 64 years (lower is better)	38.11	17.6	-20.51	29.8	Yes
<b>Aim 3: Better Experience</b>					
<b>Goal 3.1: Enhance Member Experience</b>					
CPA-AD Getting Care Quickly	82.20%	90.2%	+8.0	N/A	N/A
CPA-AD Rating of Health Plan	71.20%	72.0%	+0.8	N/A	N/A
CPA-AD Rating of All Health Care	75.10%	81.6%	+6.5	N/A	N/A
<b>Aim 4: Smarter Spending</b>					
<b>Goal 4.1: Focus on Paying for Value</b>					
Plan All-Cause Readmission, Observed/Expected (O/E) Ratio (lower is better)	1.0213	0.7742	-0.2471	1.0000	Yes
Total number of measures that met target objectives					5

<sup>1</sup> Federal fiscal year (FFY) 2023 (calendar year [CY] 2022) data.

<sup>2</sup> FFY 2024 (CY 2023) data.

<sup>3</sup> Percentage points indicate absolute percentage point change from measurement year (MY) 2022 to MY 2023, where plus (+) shows an increase in percentage, and minus (-) shows a decrease in percentage. Plus (+) represents better performance, and minus (-) represents worse performance

from MY 2022 to MY 2023, except for measures indicated by “lower is better,” for which minus (–) represents better performance.

<sup>4</sup> FFY 2022 (CY 2021) data.

Color legend: In the “Progress” column, green font indicates performance measure improvement from MY 2022 to MY 2023 (of one percentage point or more for proportions), red font indicates worse performance from MY 2022 to MY 2023 (of one percentage point or more for proportions), bold black font indicates no change in performance of one percentage point or more from MY 2022 to MY 2023. N/A: not applicable; NR: not reported; 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.

## State Progress on Quality Strategy Goals and Objectives – Detailed Findings

The state’s progress on its quality strategy goals and objectives are discussed in the below narrative based upon the MCO CY 2023 baseline data in the *North Dakota Medicaid Quality Strategy 2025–2027* published on the ND Medicaid website as of 1/8/2025, as well as the updated data for FFS and state measures. Progress was evaluated as change in percentage points (pps), rates, or ratios from CY 2022 to CY 2023, for PMs with both CY 2022 and CY 2023 data for the MCO, FFS, and the state. Findings are presented by the four quality strategy aims of healthier populations, better outcomes, better experience, and smarter spending.

### Aim 1: Healthier Populations

#### Goal 1.1: Improve Preventive Health

##### *Breast Cancer Screening (BCS-AD)*

- State: ND state CY 2023 rate for beneficiaries ages 50–64 years increased by 8.4 pps from CY 2022 but fell below the Medicaid median CY 2021 rate.
- FFS: FFS CY 2023 rate for beneficiaries ages 50–64 years increased by 2.2 pps from CY 2022 but fell below the Medicaid median CY 2021 rate.
- MCO: BCBSND CY 2023 rate for beneficiaries ages 50–64 years increased by 13.8 pps from CY 2022 but fell below the Medicaid median CY 2021 rate.

##### *Colorectal Cancer Screening (COL-AD, Ages 46–49 Years)*

- State: ND state CY 2023 rate increased by 7.7 pps from CY 2022. The Medicaid median CY 2021 rate was not available for incorporation into the 2024 *Quality Strategy Plan*.
- FFS: FFS CY 2023 rate increased by 7.1 pps from CY 2022. The Medicaid median CY 2021 rate was not available for incorporation into the 2024 *Quality Strategy Plan*.
- MCO: BCBSND CY 2023 rate increased by 8.1 pps from CY 2022. The Medicaid median CY 2021 rate was not available for incorporation into the 2024 *Quality Strategy Plan*.

##### *Colorectal Cancer Screening (COL-AD, Ages 50–64 Years)*

- State: ND state CY 2023 rate increased by 6.6 pps from CY 2022. The Medicaid median CY 2021 rate was not available for incorporation into the 2024 *Quality Strategy Plan*.
- FFS: FFS CY 2023 rate increased by 5.5 pps from CY 2022. The Medicaid median CY 2021 rate was not available for incorporation into the 2024 *Quality Strategy Plan*.
- MCO: BCBSND CY 2023 rate increased by 7.2 pps from CY 2022. The Medicaid median CY 2021 rate was not available for incorporation into the 2024 *Quality Strategy Plan*.

#### Goal 1.2: Improve Postpartum Care

##### *Timely Postpartum Care (PPC-AD)*

- State: ND state CY 2023 rate increased by 13.5 pps and fell below the Medicaid median CY 2021 rate.

- FFS: FFS CY 2023 rate increased by 15.0 pps and fell below the Medicaid median CY 2021 rate.
- MCO: BCBSND CY 2023 rate decreased by 0.5 pps from CY 2022 and fell below the Medicaid median CY 2021 rate.

### Goal 1.3: Improve Behavioral Health Care for Beneficiaries

#### *Follow-up After Emergency Department Visit for Mental Illness (FUM-AD-30 Days)*

- State: ND state CY 2023 state rate increased by 2.4 pps from CY 2022 and exceeded the CY 2021 Medicaid median rate.
- FFS: FFS CY 2023 rate increased by 4.3 pps from CY 2022 and exceeded the CY 2021 Medicaid median rate.
- MCO: BCBSND CY 2023 rate increased by 0.5 pps from CY 2022 but fell below the Medicaid median CY 2021 rate.

#### *Follow-up After Emergency Department Visit for Mental Illness (FUM-AD-7 Days)*

- State: ND state CY 2023 state rate decreased by 2.9 pps from CY 2022 and fell below the CY 2021 Medicaid median rate.
- FFS: FFS CY 2023 rate increased by 2.9 pps from CY 2022 and exceeded the CY 2021 Medicaid median rate.
- MCO: BCBSND CY 2023 rate decreased by 8.8 pps from CY 2022 and fell below the Medicaid median CY 2021 rate.

### Aim 2: Better Outcomes

#### Goal 2.1: Improve Outcomes for Members with Substance Use Disorders

##### *Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD)*

- State: ND state CY 2023 rate decreased by 4.2 pps from CY 2022 and fell below the Medicaid median CY 2021 rate.
- FFS: FFS CY 2023 rate decreased by 6.9 pps from CY 2022 and fell below the Medicaid median CY 2021 rate.
- MCO: BCBSND CY 2023 rate decreased by 6.4 pps from CY 2022 and exceeded the Medicaid median CY 2021 rate.

##### *Engagement in Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD)*

- State: ND state CY 2023 rate decreased by 3.1 pps from CY 2022 and exceeded the Medicaid median CY 2021 rate.
- FFS: FFS CY 2023 rate decreased by 5.1 pps from CY 2022 and fell below the Medicaid median CY 2021 rate.
- MCO: BCBSND CY 2023 rate decreased by 6.9 pps from CY 2022 and exceeded the Medicaid median CY 2021 rate.

#### Goal 2.2: Improve Health for Members with Chronic Conditions

##### *Inpatient Hospital Admissions for Heart Failure (PQI08-AD)*

- State: ND state CY 2023 rate decreased by 15.41 hospitalizations/100,000 beneficiary months from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).
- FFS: FFS CY 2023 rate decreased by 31.10 hospitalizations/100,000 beneficiary months from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).
- MCO: BCBSND CY 2023 rate decreased by 3.02 hospitalizations/100,000 beneficiary months from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).

#### *Inpatient Hospital Admissions for Diabetes Short-Term Complications (PQI01-AD)*

- State: ND state CY 2023 rate increased by 2.71 hospitalizations/100,000 beneficiary months from CY 2022 and was higher than the Medicaid median CY 2021 rate (lower is better).
- FFS: FFS CY 2023 rate decreased by 1.61 hospitalizations/100,000 beneficiary months from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).
- MCO: BCBSND CY 2023 rate increased by 6.06 hospitalizations/100,000 beneficiary months from CY 2022 and was higher than the Medicaid median CY 2021 rate (lower is better).

#### *Inpatient Hospital Admissions for COPD or Asthma in Older Adults (PQI05-AD)*

- State: ND state CY 2023 rate decreased by 20.51 hospitalizations/100,000 beneficiary months and fell below the Medicaid median CY 2021 rate (lower is better).
- FFS: FFS CY 2023 rate decreased by 28.23 hospitalizations/100,000 beneficiary months and fell below the Medicaid median CY 2021 rate (lower is better).
- MCO: BCBSND CY 2023 rate decreased by 14.83 hospitalizations/100,000 beneficiary months from CY 2022 and fell below the Medicaid median CY 2021 rate (lower is better).

### Aim 3: Better Experience

#### Goal 3.1: Enhance Member Experience

##### *Getting Care Quickly (CPA-AD)*

- State: ND state CY 2023 rate increased by 8.0 pps from CY 2022.
- FFS: FFS CY 2023 rate increased by 6.0 pps from CY 2022.
- MCO: BCBSND CY 2023 rate increased by 10.0 pps from CY 2022.

##### *Rating of Health Plan (CPA-AD)*

- State: ND state CY 2023 rate increased by 0.8 pps from CY 2022.
- FFS: FFS CY 2023 rate decreased by 0.5 pps from CY 2022.
- MCO: BCBSND CY 2023 rate increased by 2.1 pps from CY 2022.

##### *Rating of All Health Care (CPA-AD)*

- State: ND state CY 2023 rate increased by 6.5 pps from Cy 2022.
- FFS: FFS CY 2023 rate increased by 22.1 pps from CY 2022.
- MCO: BCBSND CY 2023 rate decreased by 9.1 pps from CY 2022.

### Aim 4: Smarter Spending

#### Goal 4.1: Focus on Paying for Value

##### *Ratio of Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio)*

- State: ND state CY 2023 ratio decreased by 0.2471 from CY 2022 and fell below the Medicaid median CY 2021 (lower is better).
- FFS: CY 2022 data were not reported. The FFS CY 2023 ratio fell below the Medicaid median CY 2021 rate (lower is better).
- MCO: BCBSND CY 2023 ratio increased by 0.0027 from CY 2022 and was higher than the Medicaid median CY 2021 rate (lower is better).

## Conclusion and Recommendations

Findings for the ND Medicaid MCO and FFS populations showed opportunities for improvement across the four quality strategy aims: healthier populations, better outcomes, better experience, and smarter spending. IPRO recommendations aim to foster improvements in these domains for BCBSND and FFS populations, as well as recommendations to the state to provide guidance for implementation of recommended interventions. In addition, to improve health outcomes across the lifespan of members, recommendations are included for ND to improve rates for the indicated pediatric measures; these recommendations pertain to the FFS ATR rather than the *North Dakota Medicaid Quality Strategy 2025–2027*. **Table A2** presents a summary of IPRO recommendations based on the Quality Strategy Evaluation findings. Corresponding figures follow the table and display CY Medicaid median CY 2021 rates, CY 2022 rates, and CY 2023 rates.

To support ND's population health approach to improve health outcomes across the lifespan for children and adults, the quality strategy evaluation findings apply to both the ND MCO and FFS populations, as only the latter provides pediatric and maternity care. Consistent with regulations in *Title 42 CFR § 438.340(a)* and *Title 42 CFR § 457.1240(e)*, CMS requires state Medicaid agencies that contract with MCOs to develop and maintain a Medicaid quality strategy to assess and improve the quality of health care and services provided by MCOs. Therefore, the scope of the *North Dakota Medicaid Quality Strategy 2025–2027* and any forthcoming revisions are specific to Medicaid managed care (MMC).

**Table A2: Summary of IPRO Recommendations Based on the State Progress on Quality Strategy Goals and Objectives**

Measure Aim	Measure Description	Measure Code	Core Set	Rate Definition	Recommendation
Healthier Populations	Breast Cancer Screening	BCS-AD	Adult	Ages 50 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 52.68%. BCBSND might consider a PIP to improve access to breast cancer screening. FFS providers can collaborate with the ND PPS hospital systems to drive performance improvement for the Breast Cancer Screening measure.
Healthier Populations	Colorectal Cancer Screening	COL-AD	Adult	Ages 46 to 49 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 41.72%. BCBSND might consider a PIP to improve access to colorectal cancer screening. FFS providers can collaborate with the ND PPS hospital systems to drive performance improvement for the Colorectal Cancer Screening measure.
Healthier Populations	Colorectal Cancer Screening	COL-AD	Adult	Ages 50 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 41.72%. BCBSND might consider a PIP to improve access to colorectal cancer screening. FFS providers can collaborate with the ND PPS hospital systems to drive performance improvement for the Colorectal Cancer Screening measure.
Healthier Populations	Follow-up After Emergency Department Visit for Mental Illness	FUM-AD	Adult	30-Day Follow-up: Ages 18 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 53.82%. To build on the progress of these adult PMs for both 30-day and 7-day follow-up, FFS providers could identify the drivers of success and apply to improve the effectiveness of BH care among Medicaid enrolled youth, including foster care youth and other vulnerable populations ( <b>Figure A6</b> ).
Healthier Populations	Follow-up After Emergency Department Visit for Mental Illness	FUM-AD	Adult	7-Day Follow-up: Ages 18 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 38.62%. To improve this measure, BCBSND could consider conducting a PIP aimed at increasing 7-day follow-up rates after an ED visit for mental illness for MMC recipients. Interventions for MCO collaboration with hospitals for discharge planning can be conducted to improve follow-up visit scheduling, transportation assistance, and attendance ( <b>Figure A1</b> ).
Healthier Populations	<i>Suggested new measure for FFS ATR: Topical Fluoride</i>	<i>TFL-CH</i>	<i>Child</i>	<i>Ages 1 through 20 years</i>	Opportunities for the state to build on existing provider collaborative efforts to improve this measure are supported by this measure’s inclusion as a quality measure in the ND PPS Hospital VBP Program.
Healthier Populations	<i>Suggested new measure for FFS ATR: Follow-up Within 7 and 30 Days of</i>	<i>FUH7-CH, FUH30-CH</i>	<i>Child</i>	<i>Ages 6 to 17 years</i>	The state can stratify this measure by demographic characteristics to identify opportunities for improving this measure among susceptible subgroups.

Measure Aim	Measure Description	Measure Code	Core Set	Rate Definition	Recommendation
	<i>Hospitalization for Mental Illness</i>				
Healthier Populations	<i>Suggested new measure for FFS ATR: First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i>	<i>APP-CH</i>	<i>Child</i>	<i>Ages 1 to 17 years</i>	The state can stratify this measure by demographic characteristics to identify opportunities for improving this measure among susceptible subgroups.
Healthier Populations	Prenatal and Postpartum Care: Postpartum Care	PPC-AD	Adult	Postpartum Visit Rate	The state can aim to meet or exceed by FFY 2027 the new performance target of 80.23%. To improve this measure, BCBSND could consider conducting a PIP aimed at increasing timely postpartum visits among MMC recipients ( <b>Figure A2</b> ). An intervention for consideration would be using provider performance incentives for postpartum visits conducted according to the schedule recommended in the ACOG clinical practice guidelines, <i>Optimizing Postpartum Care</i> .
Better Outcomes	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET-AD	Adult	Initiation: Total AOD Abuse or Dependence: Ages 18 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target for IET – Initiation of 54.68%. To prepare for implementation in 2026 of the IET-AD measure as part of the ND PPS Hospital VBP Program, FFS providers can collaborate with eligible health systems to identify patient-provider relationships for the program ( <b>Figure A7</b> ).
Better Outcomes	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET-AD	Adult	Engagement: Total AOD Abuse or Dependence: Ages 18 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target for IET – Engagement of 29.94%. To prepare for implementation in 2026 of the IET-AD measure as part of the ND PPS Hospital VBP Program, FFS providers can collaborate with eligible health systems to identify patient-provider relationships for the program ( <b>Figure A7</b> ).
Better Outcomes	<i>Suggested new measure for FFS ATR:</i>	<i>W30-CH,</i>	<i>Child</i>	<i>W30-CH: Six or more well-child visits in the First 15</i>	Opportunities for the state to build on existing provider collaborative efforts to improve these measures are supported by their inclusion as quality measures in the ND PPS Hospital VBP Program.

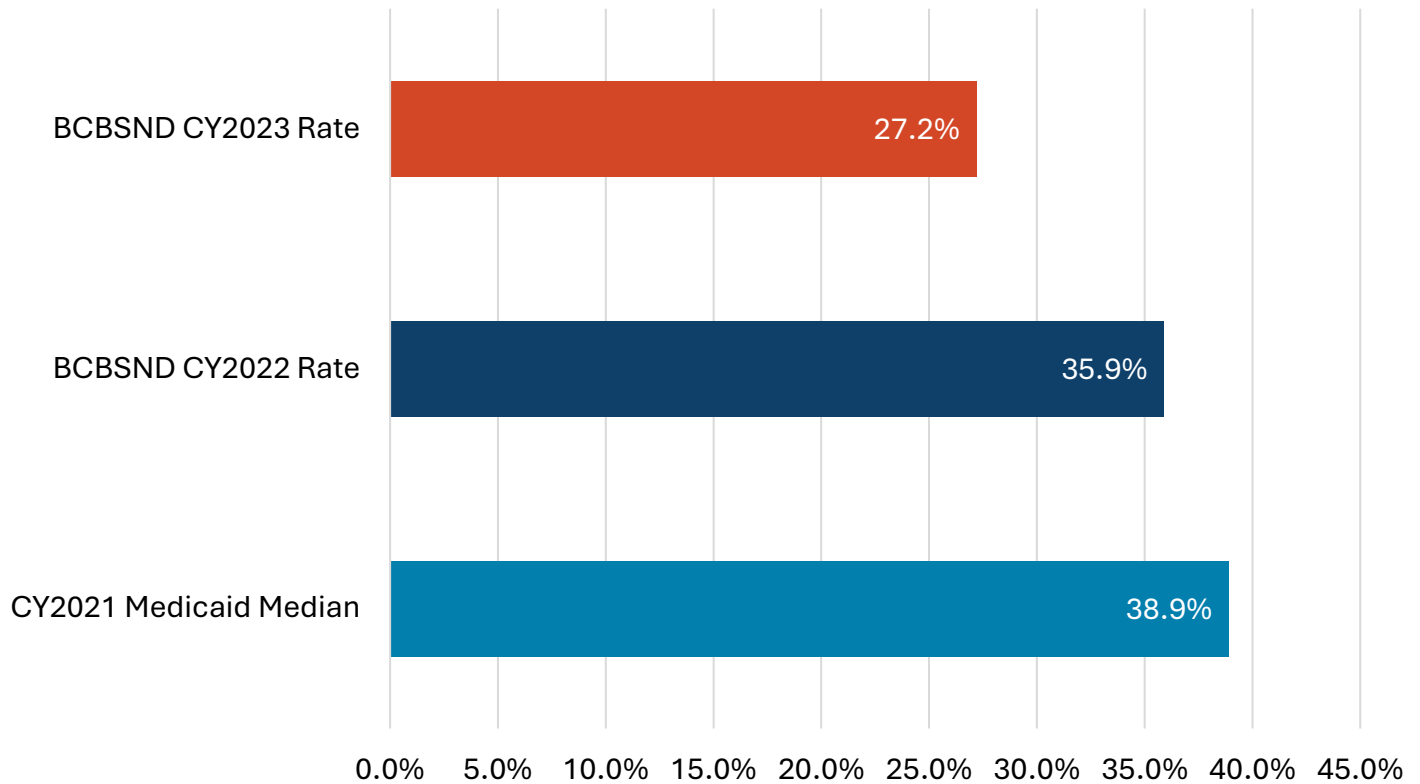
Measure Aim	Measure Description	Measure Code	Core Set	Rate Definition	Recommendation
	<i>Well-Child Visits</i>	<i>WCV-CH</i>		<i>months; Two or more well-child visits for children who turned age 30 months</i>	
Better Outcomes	Heart Failure Admission Rate	PQI08-AD	Adult	Ages 18 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 23.9. Consider spreading the success of the Heart Failure Admission Rate measure among the FFS population by expanding the ND PPS Hospital VBP Program to additional hospital systems ( <b>Figure A8</b> ).
Better Outcomes	Diabetes Short-Term Complications Admission Rate	PQI01-AD	Adult	Ages 18 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 17.2. To improve the Diabetes Short-Term Complications Rate among the MCO population, where lower rates are better, BCBSND could build on its current Diabetes Care PIP, specifically on indicator four: annually decrease the number of hospital admissions with a principal diagnosis of diabetes with short-term complications, such that the goal is a reduction in the rate of admissions rather than a goal to maintain the current rate ( <b>Figure A3</b> ). Interventions for consideration include ensuring beneficiary linkage with PCPs, as well as with endocrinologists for enrollees with poor diabetes control, and improving access to continuous glucose monitoring devices.  Consider spreading the success of the Diabetes Short-Term Complications Admission Rate measure among the FFS population by expanding the ND PPS Hospital VBP Program to additional hospital systems ( <b>Figure A8</b> ).
Better Outcomes	COPD or Asthma in Older Adults Admission Rate	PQI05-AD	Adult	Ages 40 to 64 years	The state can aim to meet or exceed by FFY 2027 the new performance target of 23.2. Consider spreading the success of the COPD or Asthma in Older Adults Admission Rate measure among the FFS population by expanding the ND PPS Hospital VBP Program to additional hospital systems ( <b>Figure A8</b> ).
Better Experience	Timely Access to Care: Beneficiary getting care quickly	CPA-AD	Survey (Adult)	Survey responses: always and usually	The state can aim to meet or exceed by FFY 2027 the new performance target of 81.12.
Better Experience	Member Satisfaction: Beneficiary	CPA-AD	Survey (Adult)	Survey responses: 8, 9 and 10	The state can aim to meet or exceed by FFY 2027 the new performance target of 77.71. FFS beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved ( <b>Figure A9</b> ).

Measure Aim	Measure Description	Measure Code	Core Set	Rate Definition	Recommendation
	rating of health plan				
Better Experience	Member Satisfaction: Rating of all health care	CPA-AD	Survey (Adult)	Survey responses: 8, 9 and 10	The state can aim to meet or exceed by FFY 2027 the new performance target of 82.61. BCBSND beneficiary focus groups might be conducted to identify the reasons for beneficiary dissatisfaction and ask beneficiaries how satisfaction might be improved ( <b>Figure A4</b> ).
Better Experience	Parent-rated doctor, health care, and health plan	CPC-CH	Survey (Child)	CAHPS Health Plan Survey, Child Version	These measures provide a means for direct beneficiary feedback on satisfaction with the children's health care, and thus, highlight opportunities to improve health care for the pediatric population.
Smarter Spending	Plan All-Cause Readmission	PCR-AD	Adult	Observed/Expected (O/E) Ratio	<p>The state can aim to meet or exceed by FFY 2027 the new performance target of 0.9853. To improve this measure, where lower rates are better, BCBSND could consider conducting a PIP aimed at decreasing hospital readmissions among ND MMC recipients (<b>Figure A5</b>). 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.</p> <p>For FFS providers, consider spreading the success of the O/E Ratio PM by expanding the ND PPS Hospital VBP Program to additional hospital systems (<b>Figure A10</b>).</p>

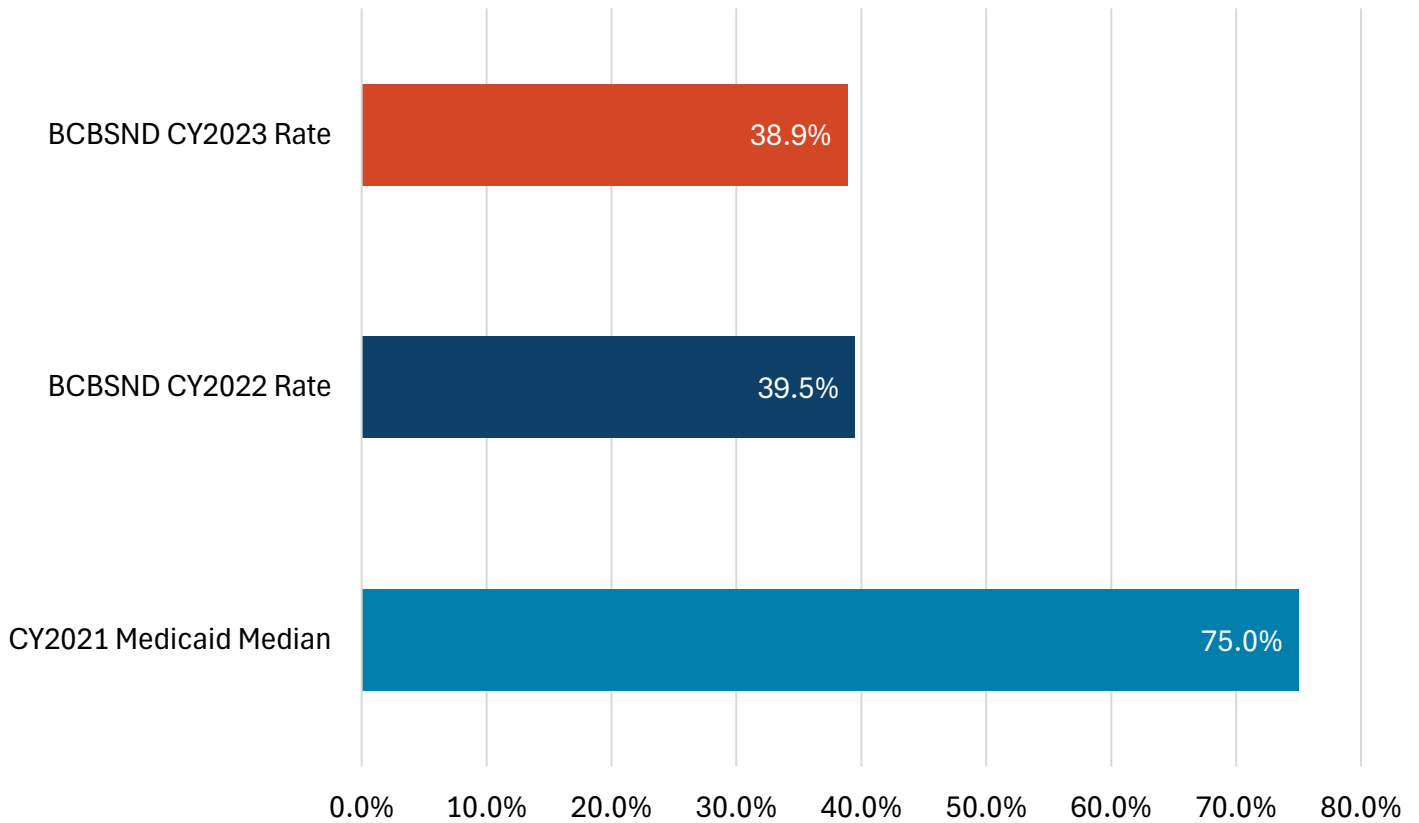
FFY: federal fiscal year; BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; FFS: fee-for-service; ND: North Dakota; PPS: prospective payment system; PM: performance measure; BH: behavioral health; ED: emergency department; ATR: annual technical report; MMC: Medicaid managed care; MCO: managed care organization; VBP: value-based purchasing; ACOG: American College of Obstetricians and Gynecologists; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; PCP: primary care provider; COPD: chronic obstructive pulmonary disease; Consumer Assessment of Healthcare Providers and Systems.

## Aim 1: Healthier Populations – BCBSND

**Figure A1** and **Figure A2** present BCBSND's performance on two key healthcare quality measures aligned with the quality strategy aim of achieving healthier populations. **Figure A1** displays the CY 2022 and CY 2023 rates for 7-Day Follow-up After an Emergency Department Visit for Mental Illness (FUM-AD), while **Figure A2** shows the CY 2022 and CY 2023 rates for the postpartum care component of the Prenatal and Postpartum Care (PPC-AD) measure; both are compared to the CY 2021 Medicaid median rate.



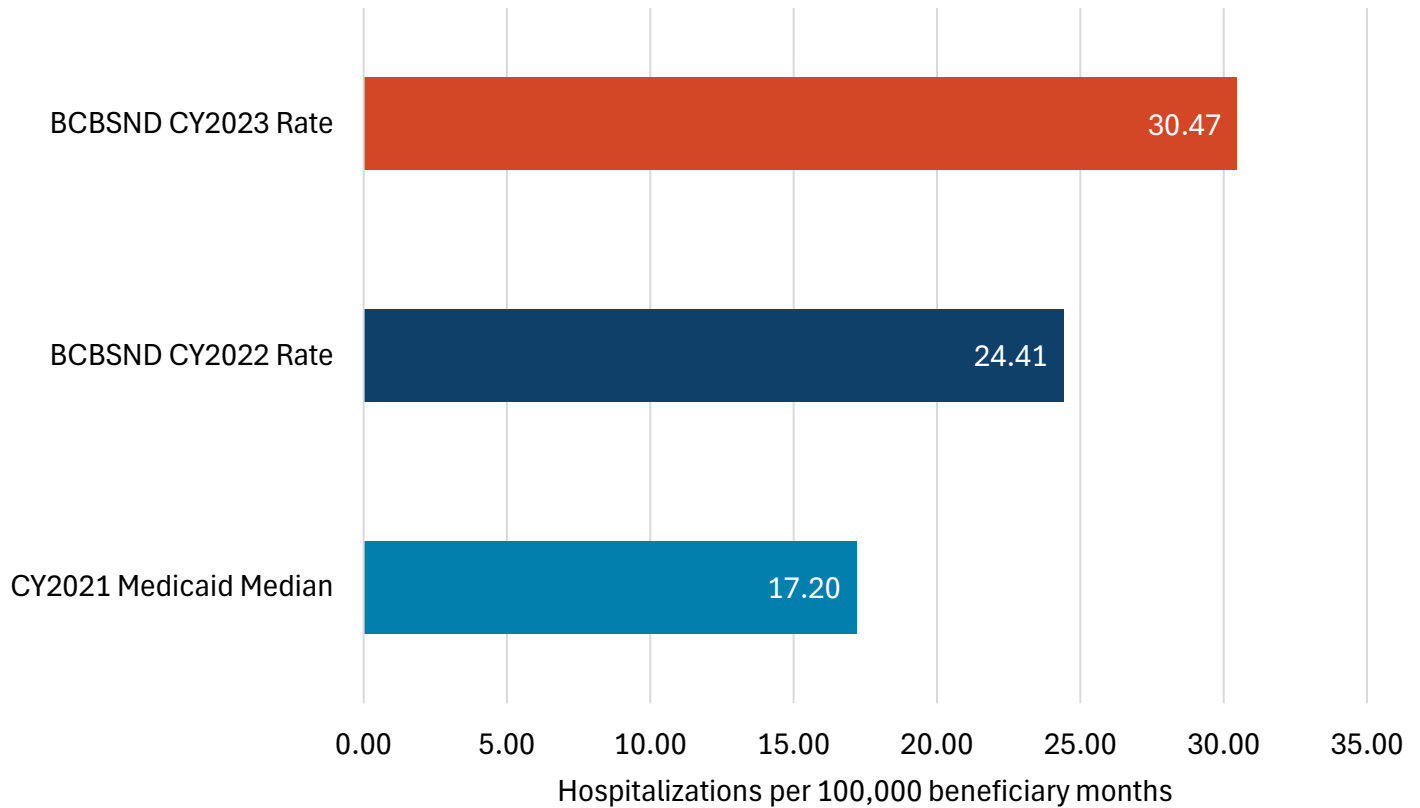
**Figure A1: BCBSND Follow-up After an Emergency Department Visit for Mental Illness (FUM-AD) 7-Days Performance** Calendar year (CY) 2021 Medicaid median rate (blue bar), CY 2022 rate for Blue Cross Blue Shield of North Dakota (BCBSND; dark blue bar), and CY 2023 rate for BCBSND (red bar) for the FUM-AD 7-Days measure.



**Figure A2: BCBSND Prenatal and Postpartum Care: Postpartum (PPC-AD) Performance**  
 Calendar year (CY) 2021 Medicaid median rate (blue bar), CY 2022 rate for Blue Cross Blue Shield of North Dakota (BCBSND; dark blue bar), and CY 2023 rate for BCBSND (red bar) for the PPC-AD measure.

## Aim 2: Better Outcomes – BCBSND

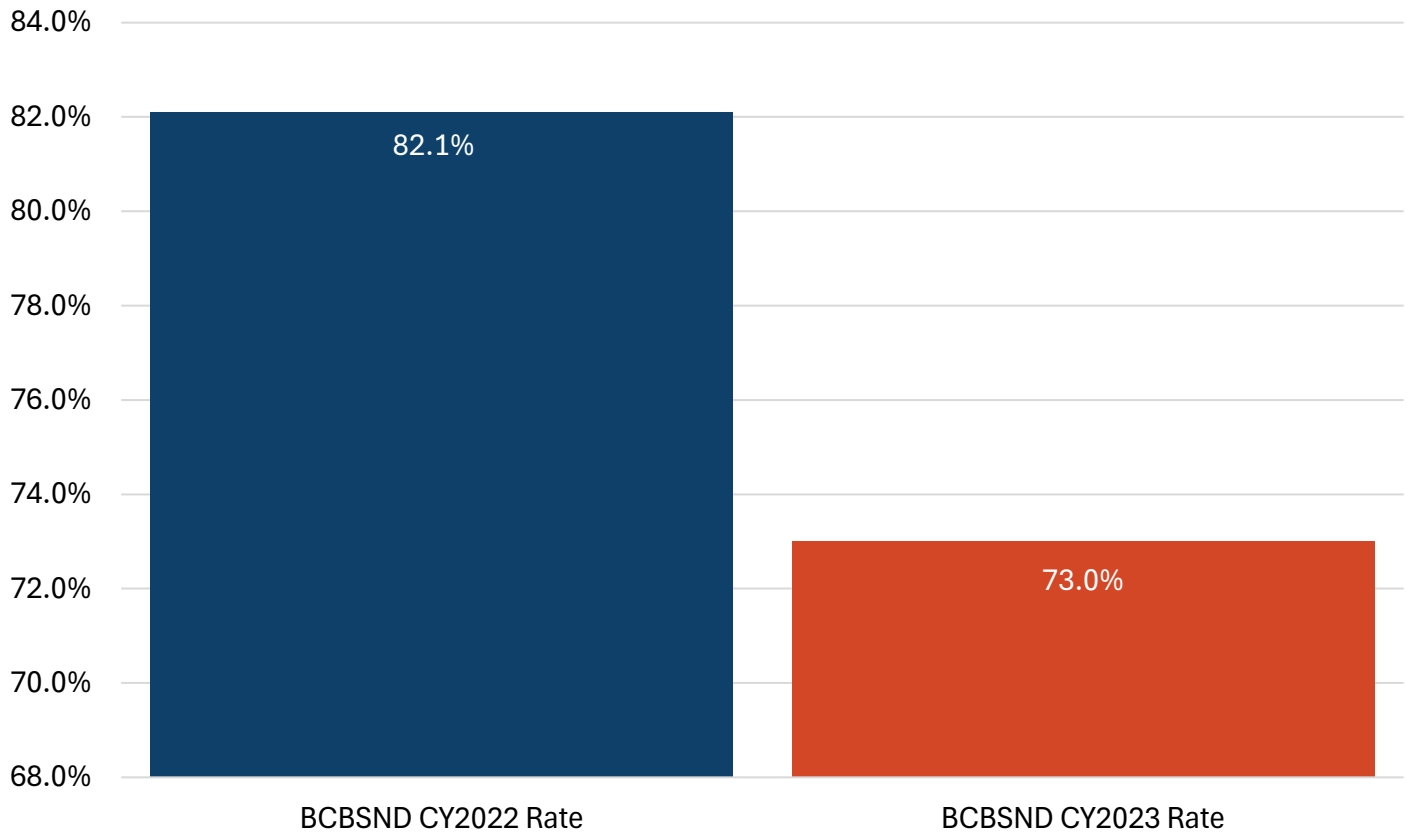
**Figure A3** highlights BCBSND's performance on a key healthcare quality measure aligned with the quality strategy aim of achieving better outcomes. The CY 2022 and CY 2023 rates for diabetes short-term complications admission (PQI01-AD), reported as hospitalizations per 100,000 beneficiary months, are compared to the CY 2021 Medicaid median rate (**Figure A3**).



**Figure A3: BCBSND Diabetes Short-Term Complications Admission Rate (PQI01-AD) Performance** Calendar year (CY) 2021 Medicaid median rate (blue bar), CY 2022 rate for Blue Cross Blue Shield of North Dakota (BCBSND; dark blue bar), and CY 2023 rate for BCBSND (red bar) for the PQI01-AD measure.

### Aim 3: Better Experience – BCBSND

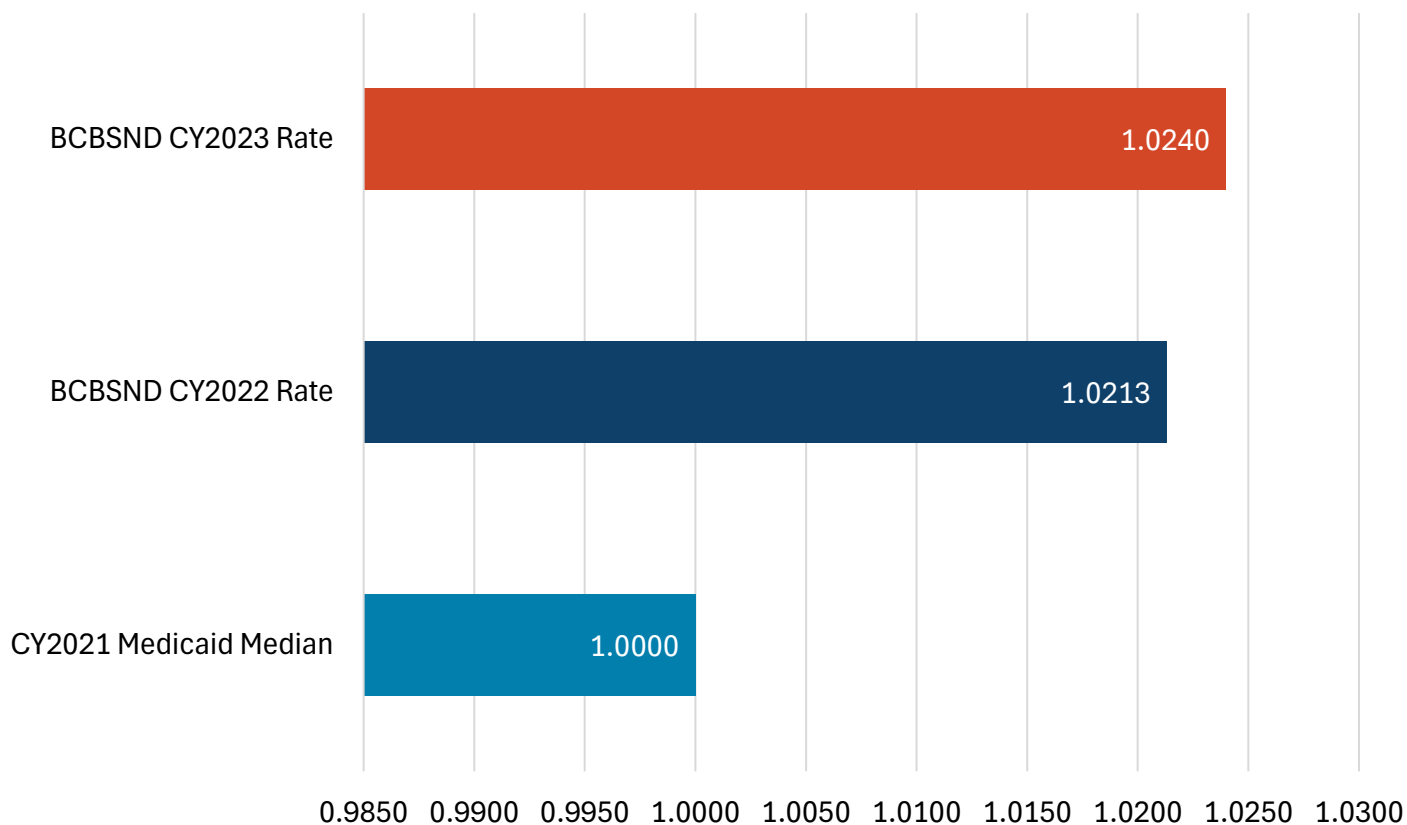
**Figure A4** reflects BCBSND's performance on a healthcare quality measure aligned with the quality strategy aim of providing a better experience. The CY 2022 and CY 2023 rates are shown for the overall rating of all health care, which capture members' satisfaction with the care they received (**Figure A4**).



**Figure A4: BCBSND Rating of All Health Care Performance** Calendar year (CY) 2022 rate for Blue Cross Blue Shield of North Dakota (BCBSND; dark blue bar), and CY 2023 rate for BCBSND (red bar) for the Rating of All Health Care measure.

#### Aim 4: Smarter Spending – BCBSND

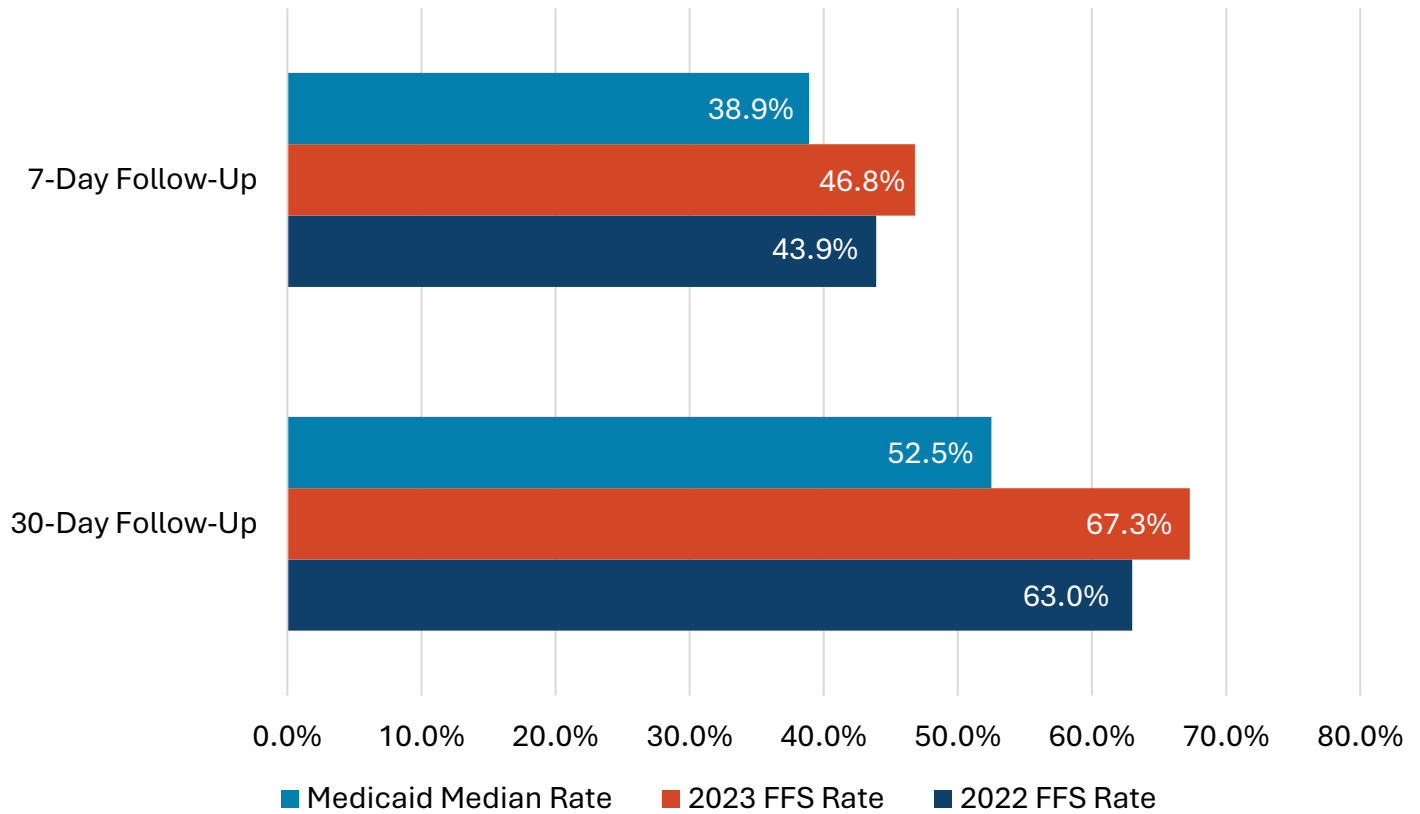
**Figure A5** presents BCBSND's performance on a healthcare quality measure aligned with the quality strategy aim of smarter spending. Specifically, **Figure A5** shows the CY 2022 and CY 2023 observed-to-expected (O/E) readmission ratios for all-cause hospital readmissions, compared to the CY 2021 Medicaid median, indicating how actual readmissions compare to what was expected.



**Figure A5: BCBSND: Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) Performance** Calendar year (CY) 2021 Medicaid median rate (blue bar), CY 2022 rate for Blue Cross Blue Shield of North Dakota (BCBSND; dark blue bar), and CY 2023 rate for BCBSND (red bar) for the Observed All-Cause Readmissions to Expected Readmissions measure.

Aim 1: Healthier Populations – FFS

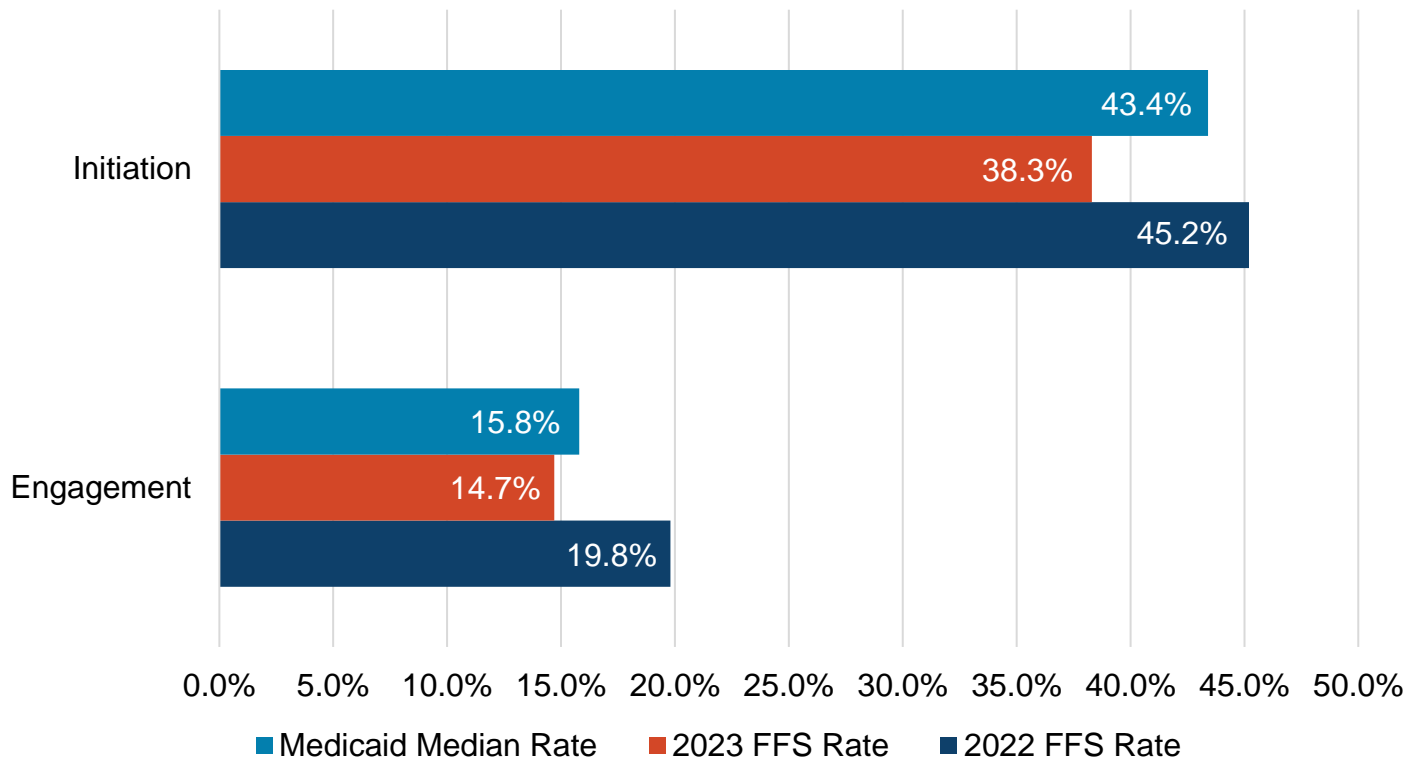
**Figure A6** displays performance data for the FFS population on a healthcare quality measure aligned with the quality strategy aim of healthier populations. Specifically, **Figure A6** presents the 7-Day And 30-Day Follow-up After an Emergency Department Visit For Mental Illness (FUM-AD) rates for CY 2022 and CY 2023, compared to the CY 2021 Medicaid median rates.



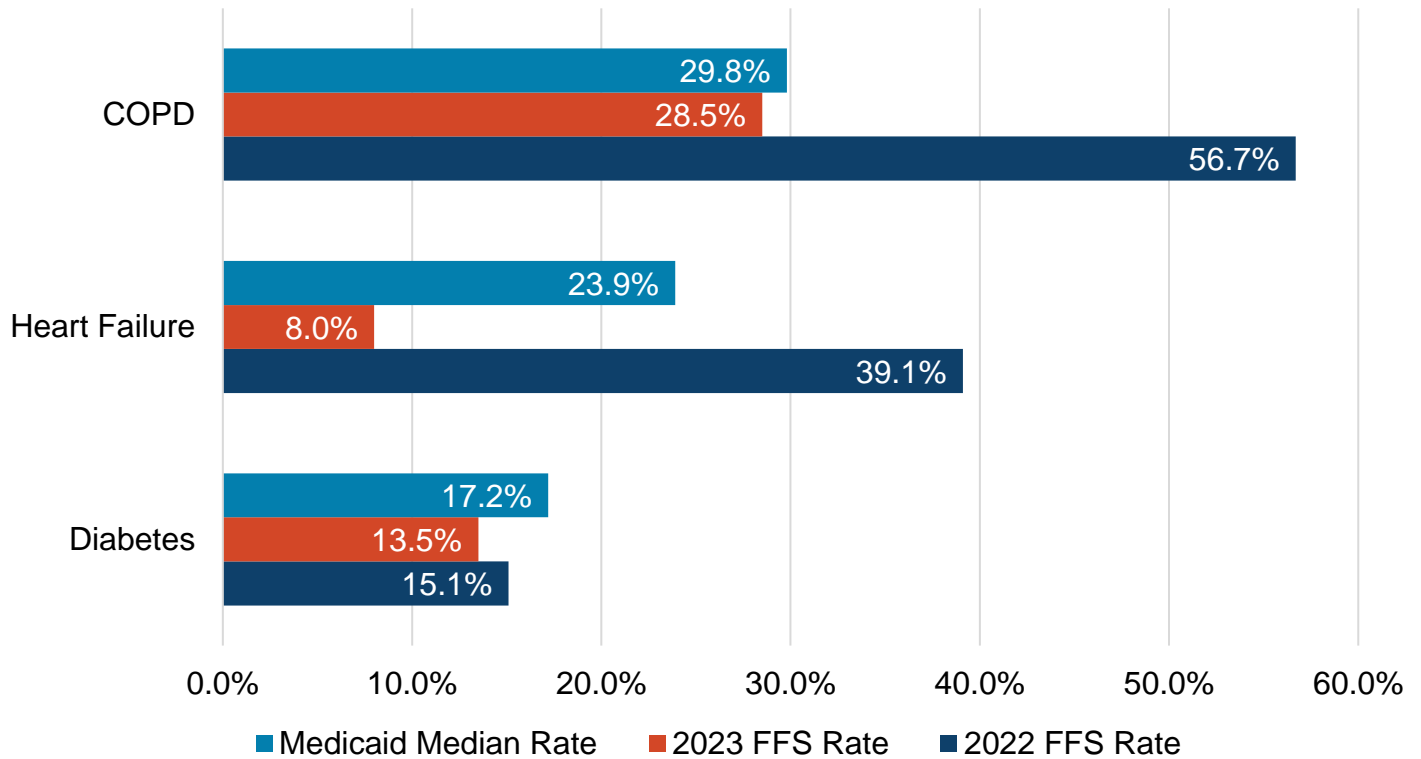
**Figure A6: FFS Follow-up After Emergency Department Visit for Mental Illness (FUM-AD) – 7-Day and 30-Day Follow-up Performance** Calendar year (CY) 2021 Medicaid median rate (blue bar), CY 2022 rate for Fee-for-Service (FFS; dark blue bar), and CY 2023 rate for FFS (red bar) for the FUM-AD-30 and -7 Days measures.

## Aim 2: Better Outcomes – FFS

**Figure A7** and **Figure A8** show FFS performance on key healthcare quality measures aligned with the quality strategy aim of achieving better outcomes. **Figure A7** presents CY 2022 and CY 2023 rates for the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD), compared to the CY 2021 Medicaid median. **Figure A8** displays CY 2022 and CY 2023 hospital admission rates for chronic obstructive pulmonary disease (COPD), heart failure, and diabetes (PQI08-AD, PQI01-AD, PQI05-AD), also compared to the CY 2021 Medicaid median rates.



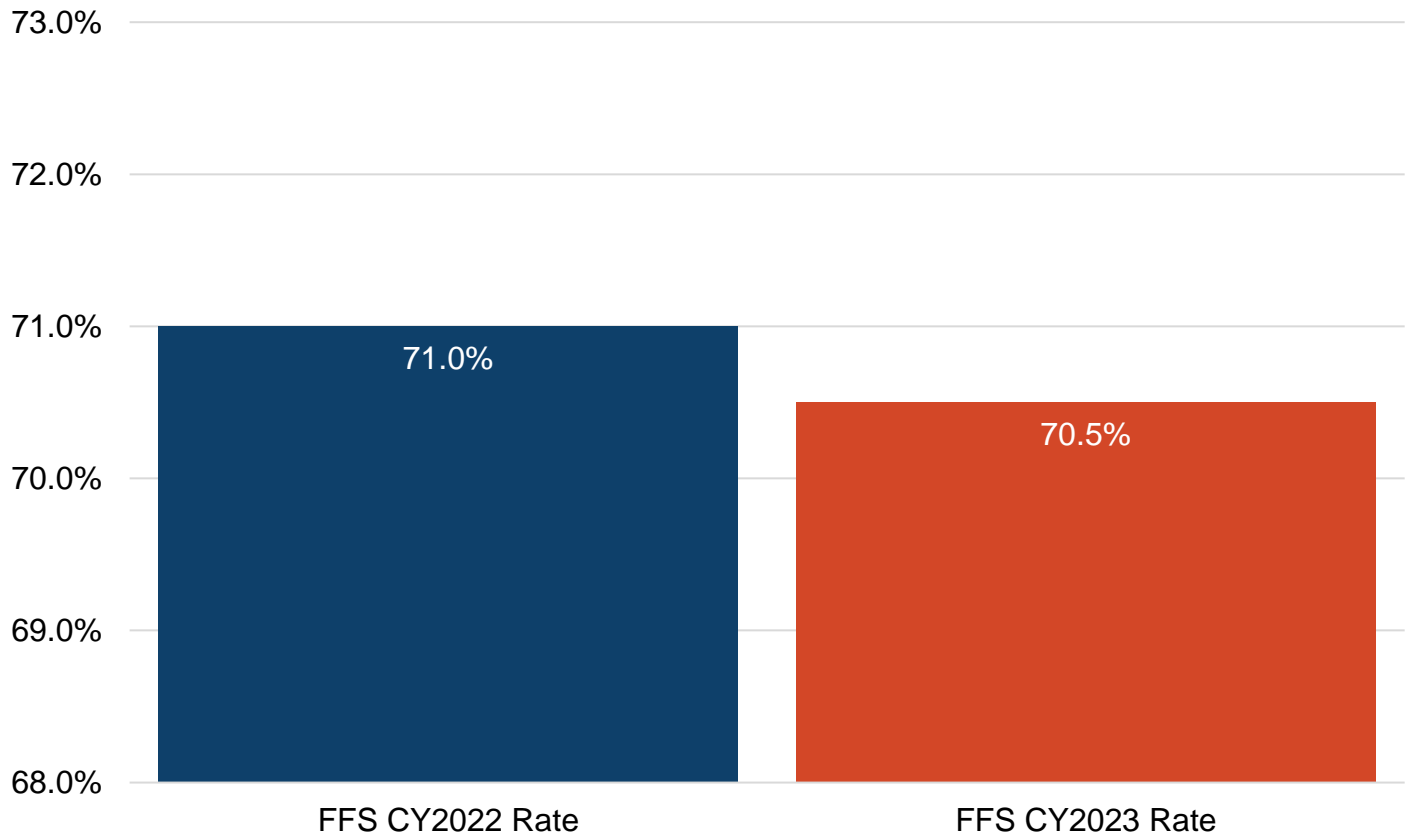
**Figure A7: FFS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Performance** Calendar year (CY) 2021 Medicaid median rates (blue bars), CY 2022 rates for Fee-for-Service (FFS; dark blue bars), and CY 2023 rates for FFS (red bars) for the Initiation and Engagement in Alcohol, Opioid, or Other Drug Abuse Treatment (IET-AD) measure.



**Figure A8: FFS Hospital Admission for COPD, Heart Failure, and Diabetes (PQI08-AD, PQI01-AD, PQI05-AD) Performance** Calendar year (CY) 2021 Medicaid median rate (blue bar), CY 2022 rate for Fee-for-Service (FFS; dark blue bar), and CY 2023 rate for FFS (red bar) for the PQI08-AD, PQI01-AD and PQI05-AD measures. COPD: chronic obstructive pulmonary disease.

Aim 3: Better Experience –FFS

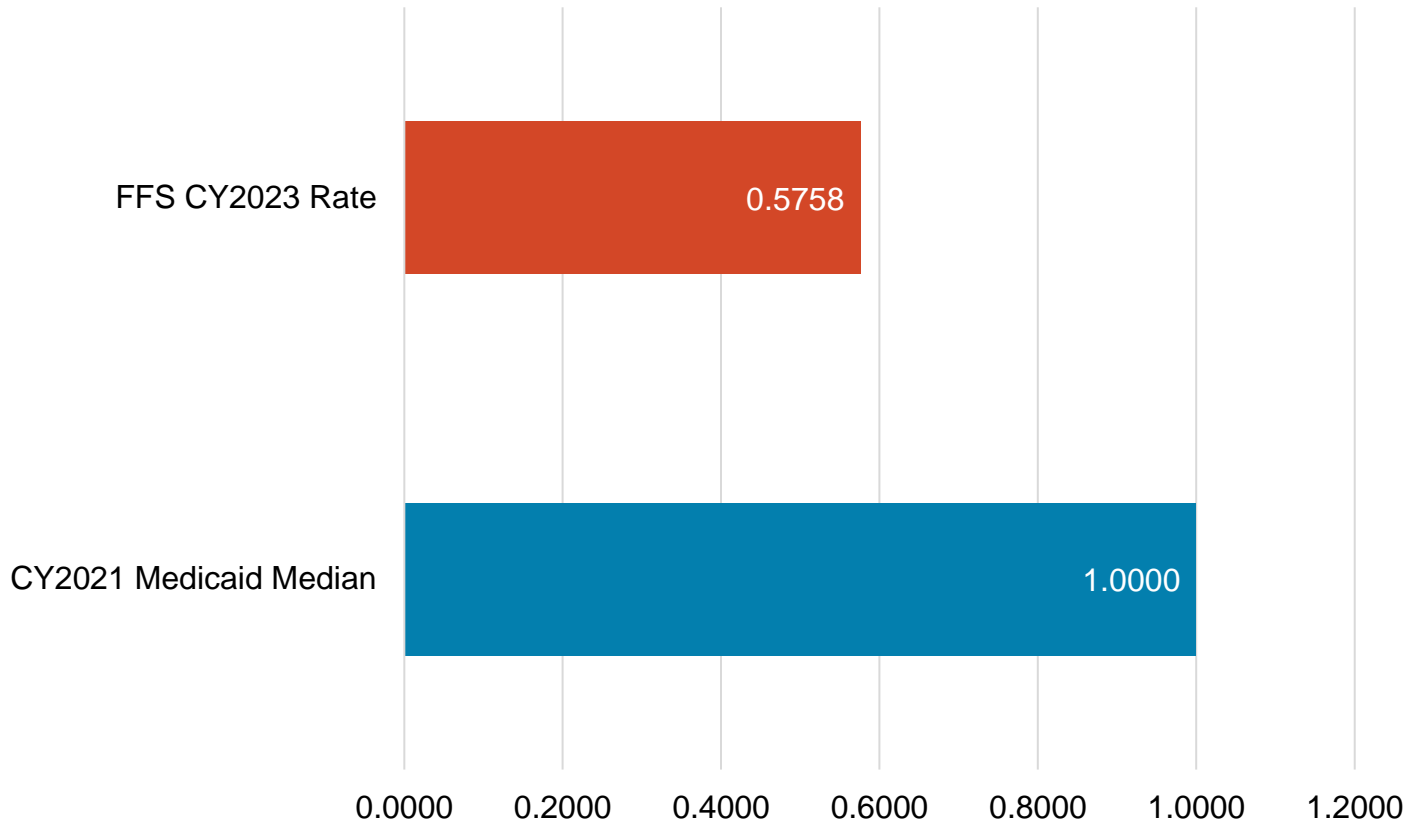
**Figure A9** highlights FFS performance on a healthcare quality measure aligned with the quality strategy aim of providing a better experience. Specifically, **Figure A9** displays the CY 2022 and CY 2023 rates for members' overall rating of their health plan.



**Figure A9: FFS Rating of Health Plan Performance** Calendar year (CY) 2022 rate for Fee-for-Service (FFS; dark blue bar), and CY 2023 rate for FFS (red bar) for the Rating of Health Plan measure.

Aim 4: Smarter Spending – FFS

**Figure A10** shows FFS performance on a healthcare quality measure aligned with the quality strategy aim of smarter spending. The CY 2023 observed-to-expected (O/E) readmission ratio for all-cause hospital readmissions compared to the CY 2021 Medicaid median is shown in **Figure A10**.



**Figure A10: FFS Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) Performance** Calendar year (CY) 2021 Medicaid median rate (light blue bar) and CY 2023 rate for FFS (dark blue bar) for the Observed All-Cause Readmissions to Expected Readmissions (O/E Ratio) measure.

## Source Documents

Centers for Medicare & Medicaid Services (CMS). Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit. June 2021.

North Dakota Health & Human Services. North Dakota PPS Hospital Value-base Purchasing (VBP) Program. Version 3.1, July 11, 2024. Retrieved February 7, 2025, from: <https://www.hhs.nd.gov/healthcare/medicaid/provider/vbp> .

North Dakota Medicaid Quality Strategy (draft posted to state website on 12/2024) 2025–2027 (MCO CY 2022 performance indicator rates for adult core set measures).

North Dakota Medicaid Quality Strategy Plan 2024 (FFY 2022/ CY 2021 Medicaid median).

ND Medicaid FFY 2024 Cores Set Reporting Rates (Report provided by ND HHS on 1/14/2025 with adult and child core set performance measure data for MY 2023).

North Dakota Medicaid Quality Measure Annual Report, Adult Core Set FFY 2023 (MCO, FFS and ND state performance indicator CY 2022 rates for adult and child core set measures, by age group).

CAHPS MY 2023 Adult Color coded\_1-08Jan2025 (MY 2022 and MY 2023 for FFS and MCO CAHPS rates).

**Appendix A1: Assessment of North Dakota’s Quality Strategy, 1/8/2025**

**Table A1.1: IPRO Assessment of North Dakota’s Quality Strategy**

<b>Title 42 CFR § 438.340 Managed Care State Quality Strategy</b>	<b>Topic</b>	<b>State Quality Strategy Reference</b>	<b>IPRO Findings</b>
(a) <b>General rule.</b> Each State contracting with an MCO, PIHP, or PAHP as defined in § 438.2 or with a PCCM entity as described in § 438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity.	Existence of Quality Strategy	North Dakota Medicaid Quality Strategy 2025–2025 Retrieved 1/8/25 from <a href="https://www.hhs.nd.gov/healthcare/medicaid/publications">https://www.hhs.nd.gov/healthcare/medicaid/publications</a>	Met
(b) <b>Elements of the State quality strategy.</b> At a minimum, the State's quality strategy must include the following:	Elements of the State Quality Strategy		Met
(1) The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §§ 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with § 438.236.	Network Adequacy and Availability of Services Standards  Clinical Practice Guidelines	Network Adequacy Validation on page 18 Network Adequacy Standards on pages 22–25  Clinical Practice Guidelines on pages 40–41	Met
(2) The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2).	Goals and Objectives	Goals and Objectives on Page 9	Met
(3) A description of— (i) The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with § 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website required under § 438.10(c)(3); and,	Quality Metrics and Performance Targets	Quality Metrics and Performance Targets on pages 9–12	Met
(3)(ii) The performance improvement projects to be implemented in accordance with § 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.	Performance Improvement Projects	Performance Improvement Projects on page 44	Met

Title 42 CFR § 438.340 Managed Care State Quality Strategy	Topic	State Quality Strategy Reference	IPRO Findings
(4) Arrangements for annual, external independent reviews, in accordance with § 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, and PAHP contract.	External Independent Review	External Independent Review on Page 16	Met
(5) A description of the State's transition of care policy required under § 438.62(b)(3).	Transition of Care Policy	Transition of Care Policy on page 28	Met
(6) The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. For purposes of this paragraph (b)(6), “disability status” means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status.	Health Disparities	Health Disparities on page 13	Met
(7) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	Intermediate Sanctions	Sanctions on page 48	Met
(8) The mechanisms implemented by the State to comply with § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	Identification of Persons Needing LTSS and Persons with SHCN	Special Health Care Needs on page 13 LTSS on page 44	Met
(9) The information required under § 438.360(c) (relating to nonduplication of EQR activities).	Non-duplication of EQR Activities	Non-duplication of EQR Activities on page 21	Met
(10) The State's definition of a “significant change” for the purposes of paragraph (c)(3)(ii) of this section. (c) <b>Development, evaluation, and revision.</b> In drafting or revising its quality strategy, the State must:	Content of Quality Strategy	Significant change on pages 50 and 51	Met
(10)(c)(1) Make the strategy available for public comment before submitting the strategy to CMS for review in accordance with paragraph (c)(3) of this section, including: (i) Obtaining input from the Medical Care Advisory Committee (established by § 431.12 of this chapter), beneficiaries, and other stakeholders.	Content of Quality Strategy	Public Comment <a href="https://www.hhs.nd.gov/healthcare/medicaid/publications">https://www.hhs.nd.gov/healthcare/medicaid/publications</a>	Met

Title 42 CFR § 438.340 Managed Care State Quality Strategy	Topic	State Quality Strategy Reference	IPRO Findings
(ii) If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.310(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy.			
(10)(c)(2) Review and update the quality strategy as needed, but no less than once every 3 years. (i) This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years. (ii) The State must make the results of the review, including the evaluation conducted pursuant to paragraph (c)(2)(i) of this section, available on the website required under § 438.10(c)(3). (iii) Updates to the quality strategy must take into consideration the recommendations provided pursuant to § 438.364(a)(4).	Content of Quality Strategy	Medical Care Advisory Committee and Tribal Consultation on page 51	Met
(10)(c)(3) Prior to adopting as final, submit to CMS the following: (i) A copy of the initial strategy for CMS comment and feedback. (ii) A copy of the strategy— (A) Every 3 years following the review in paragraph (c)(2) of this section; (B) Whenever significant changes, as defined in the State's quality strategy per paragraph (b)(10) of this section, are made to the document; (C) Whenever significant changes occur within the State's Medicaid program. (d) <b>Availability.</b> The State must make the final quality strategy available on the Web site required under § 438.10(c)(3).	Content of Quality Strategy	Review, update and evaluation in progress January-March 2025	Evaluation in progress.

CFR: Code of Federal Regulations; §: section; MCO: managed care organization; PIHP: prepaid inpatient health plan; PAHP: prepaid ambulatory health plan; PCCM: primary care case management; HHS: Health and Human Services; LTSS: long-term services and supports; SHCN: special health care needs; EQR: external quality review; CMS: Centers of Medicare and Medicaid Services.

## Appendix A2: Progress on Meeting North Dakota Quality Strategy Goals by Medicaid Beneficiary Population

Table A2.1: BCBSND Progress on Meeting North Dakota Quality Strategy Goals

Rate Definition	BCBSND 2022 <sup>1</sup>	BCBSND 2023 <sup>2</sup>	BCBSND Progress <sup>3</sup>	Medicaid Median <sup>4</sup>	Met Target Objective
<b>Aim 1: Healthier Populations</b>					
<b>Goal 1.1: Improve Preventive Health</b>					
Breast Cancer Screening, ages 50 to 64 years	30.40%	44.2%	+13.8	48.8%	No
Colorectal Cancer Screening, ages 46 to 49 years	9.10%	17.2%	+8.1	N/A	N/A
Colorectal Cancer Screening, ages 50 to 64 years	14.00%	21.3%	+7.2	N/A	N/A
<b>Goal 1.2: Improve Postpartum Care</b>					
Prenatal and Postpartum Care, Timely Postpartum Care Rate	39.50%	38.9%	-0.5	75.0%	No
<b>Goal 1.3: Improve Behavioral Health Care for Beneficiaries</b>					
FUM-AD 30-Day Follow-up, ages 18 to 64 years	51.50%	51.9%	+0.5	52.5%	No
FUM-AD 7-Day Follow-up, Ages 18 to 64 years	35.90%	27.2%	-8.8	38.9%	No
<b>Aim 2: Better Outcomes</b>					
<b>Goal 2.1: Improve Outcomes for Members with Substance Use Disorder</b>					
IET-AD, Initiation: Total AOD Abuse or Dependence, ages 18 to 64 years	51.10%	44.7%	-6.4	43.4%	Yes
IET-AD, Engagement: Total AOD Abuse or Dependence, ages 18 to 64 years	28.00%	21.1%	-6.9	15.8%	Yes
<b>Goal 2.2: Improve Health for Members with Chronic Conditions</b>					
Inpatient Hospital Admissions for Heart Failure, ages 18 to 64 years (lower is better)	25.94	22.92	-3.02	23.9	Yes
Inpatient Hospital Admissions for Diabetes Short-Term Complications, ages 18 to 64 years (lower is better)	24.41	30.47	6.06	17.2	No
Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40 to 64 years (lower is better)	25.41	10.58	-14.83	29.8	Yes
<b>Aim 3: Better Experience</b>					
<b>Goal 3.1: Enhance Member Experience</b>					
CPA-AD Getting Care Quickly	79.50%	89.5%	+10.0	N/A	N/A
CPA-AD Rating of Health Plan	71.40%	73.5%	+2.1	N/A	N/A
CPA-AD Rating of All Health Care	82.10%	73.0%	-9.1	N/A	N/A

Rate Definition	BCBSND 2022 <sup>1</sup>	BCBSND 2023 <sup>2</sup>	BCBSND Progress <sup>3</sup>	Medicaid Median <sup>4</sup>	Met Target Objective
<b>Aim 4: Smarter Spending</b>					
<b>Goal 4.1: Focus on Paying for Value</b>					
Plan All-Cause Readmission, Observed/Expected (O/E) Ratio (lower is better)	1.0213	1.024	<b>0.0027</b>	1.0000	<b>No</b>
Total number of measures that met target objectives					<b>4</b>

<sup>1</sup> Federal fiscal year (FFY) 2023 (calendar year [CY] 2022) data.

<sup>2</sup> FFY 2024 (CY 2023) data.

<sup>3</sup> Percentage points indicate absolute percentage point change from measurement year (MY) 2022 to MY 2023, where plus (+) shows an increase in percentage, and minus (–) shows a decrease in percentage. Plus (+) represents better performance, and minus (–) represents worse performance from MY 2022 to MY 2023, except for measures indicated by “lower is better,” for which minus (–) represents better performance.

<sup>4</sup> FFY 2022 (CY 2021) data.

Color legend: In the “Progress” column, green font indicates performance measure improvement from MY 2022 to MY 2023 (of one percentage point or more for proportions), red font indicates worse performance from MY 2022 to MY 2023 (of one percentage point or more for proportions), bold black font indicates no change in performance of one percentage point or more from MY 2022 to MY 2023.

BCBSND: Blue Cross Blue Shield of North Dakota; N/A: not applicable; NR: not reported; 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.

**Table A2.2: FFS Progress on Meeting North Dakota Quality Strategy Goals**

Rate Definition	FFS 2022 <sup>1</sup>	FFS 2023 <sup>2</sup>	FFS Progress <sup>3</sup>	Medicaid Median <sup>4</sup>	Met Target Objective
<b>Aim 1: Healthier Populations</b>					
<b>Goal 1.1: Improve Preventive Health</b>					
Breast Cancer Screening, ages 50 to 64 years	25.50%	27.70%	<b>+2.2</b>	48.8%	<b>No</b>
Colorectal Cancer Screening, ages 46 to 49 years	16.70%	23.80%	<b>+7.1</b>	N/A	<b>N/A</b>
Colorectal Cancer Screening, ages 50 to 64 years	37.90%	43.40%	<b>+5.5</b>	N/A	<b>N/A</b>
<b>Goal 1.2: Improve Postpartum Care</b>					
Prenatal and Postpartum Care, Timely Postpartum Care Rate	41.30%	56.30%	<b>+15.0</b>	75.0%	<b>No</b>
<b>Goal 1.3: Improve Behavioral Health Care for Beneficiaries</b>					
FUM-AD 30-Day Follow-up, ages 18 to 64 years	63.00%	67.30%	<b>+4.3</b>	52.5%	<b>Yes</b>
FUM-AD 7-Day Follow-up, Ages 18 to 64 years	43.90%	46.80%	<b>+2.9</b>	38.9%	<b>Yes</b>
<b>Aim 2: Better Outcomes</b>					
<b>Goal 2.1: Improve Outcomes for Members with Substance Use Disorder</b>					
IET-AD, Initiation: Total AOD Abuse or Dependence, ages 18 to 64 years	45.20%	38.30%	<b>-6.9</b>	43.4%	<b>No</b>

Rate Definition	FFS 2022 <sup>1</sup>	FFS 2023 <sup>2</sup>	FFS Progress <sup>3</sup>	Medicaid Median <sup>4</sup>	Met Target Objective
IET-AD, Engagement: Total AOD Abuse or Dependence, ages 18 to 64 years	19.80%	14.70%	<b>-5.1</b>	15.8%	<b>No</b>
<b>Goal 2.2: Improve Health for Members with Chronic Conditions</b>					
Inpatient Hospital Admissions for Heart Failure, ages 18 to 64 years (lower is better)	39.11	8.01	<b>-31.1</b>	23.9	<b>Yes</b>
Inpatient Hospital Admissions for Diabetes Short-Term Complications, ages 18 to 64 years (lower is better)	15.07	13.46	<b>-1.61</b>	17.2	<b>Yes</b>
Inpatient Hospital Admissions for COPD or Asthma in Older Adults, ages 40 to 64 years (lower is better)	56.71	28.48	<b>-28.23</b>	29.8	<b>Yes</b>
<b>Aim 3: Better Experience</b>					
<b>Goal 3.1: Enhance Member Experience</b>					
CPA-AD Getting Care Quickly	84.90%	90.90%	<b>+6.0</b>	N/A	<b>N/A</b>
CPA-AD Rating of Health Plan	71.00%	70.50%	<b>-0.5</b>	N/A	<b>N/A</b>
CPA-AD Rating of All Health Care	68.10%	90.20%	<b>+22.1</b>	N/A	<b>N/A</b>
<b>Aim 4: Smarter Spending</b>					
<b>Goal 4.1: Focus on Paying for Value</b>					
Plan All-Cause Readmission, Observed/Expected (O/E) Ratio (lower is better)	NR	0.5758	N/A	1.0000	<b>Yes</b>
Total number of measures that met target objectives					<b>6</b>

<sup>1</sup> Federal fiscal year (FFY) 2023 (calendar year [CY] 2022) data.

<sup>2</sup> FFY 2024 (CY 2023) data.

<sup>3</sup> Percentage points indicate absolute percentage point change from measurement year (MY) 2022 to MY 2023, where plus (+) shows an increase in percentage, and minus (–) shows a decrease in percentage. Plus (+) represents better performance, and minus (–) represents worse performance from MY 2022 to MY 2023, except for measures indicated by “lower is better,” for which minus (–) represents better performance.

<sup>4</sup> FFY 2022 (CY 2021) data.

Color legend: In the “Progress” column, green font indicates performance measure improvement from MY 2022 to MY 2023 (of one percentage point or more for proportions), red font indicates worse performance from MY 2022 to MY 2023 (of one percentage point or more for proportions), bold black font indicates no change in performance of one percentage point or more from MY 2022 to MY 2023.

FFS: fee-for-service; N/A: not applicable; NR: not reported; 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.