North Dakota
Department of Human Services

North Dakota Medicaid Expansion Program

Annual Technical Review Report Measurement Year (MY) 2020

Qlarant

Submitted by:
Qlarant
September 2021

Table of Contents

North Dakota Medicaid Expansion Program 2021 Annual Technical Report Measurement Year 2020 ... i

Executive Summary ... i

Introduction ... i

Key Findings ... i

Conclusion ... iii

North Dakota Medicaid Expansion Program 2021 Annual Technical Report Measurement Year 2020 ... 1

Introduction ... 1

Background ... 1

Purpose ... 1

Performance Improvement Project Validation ... 2

Objectives ... 2

Methodology ... 2

Results ... 4

Conclusion ... 9

Performance Measure Validation ... 10

Objectives ... 10

Methodology ... 10

Results ... 12

Conclusion ... 16

Compliance Review ... 17

Objectives ... 17

Methodology ... 17

Results ... 18

Conclusion ... 22

Network Adequacy Validation ... 22

Objectives ... 22

Methodology ... 22

Results ... 23

Conclusion ... 25

Encounter Data Validation ... 25

Objectives 25
Methodology 25
Results 26
Conclusion 34
CAHPS 34
Objectives 34
Methodology 34
Results 35
Conclusion 36
Focused Study 37
Objectives 37
Methodology 37
Results 38
Conclusion 41
MCO Quality, Access, Timeliness Assessment 41
Quality, Access, Timeliness 41
Assessment of Previous Recommendations 45
State Recommendations 47
Conclusion 48

North Dakota Medicaid Expansion Program

2021 Annual Technical Report

Measurement Year 2020

Executive Summary

Introduction

The North Dakota (ND) Department of Human Services (DHS) contracts with Qlarant, an external quality review organization (EQRO), to evaluate its managed care program, ND Medicaid Expansion. The ND Medicaid Expansion program has served its population since January 1, 2014. DHS has contracted with Sanford Health Plan (SHP) to serve as the managed care organization (MCO).

Qlarant evaluates MCO compliance with federal and state-specific requirements by conducting multiple external quality review (EQR) activities including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review (CR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey [1]
- Focused Study

Qlarant conducted EQR activities throughout 2021 and evaluated MCO compliance and performance for measurement years (MYs) 2020 and 2019, where applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.[2] This report summarizes results from all EQR activities and includes conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCO. This document serves as Qlarant's report to DHS on the assessment of MY 2020 MCO performance.

Key Findings

Key findings are summarized below for SHP. MCO-specific strengths, weaknesses, and recommendations are identified within the MCO Quality, Access, Timeliness Assessment section of the report. MCO findings correspond to performance related to the quality, accessibility, and timeliness of services provided to their members.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] CMS EQRO Protocols

Performance Improvement Project Validation

The MCO is conducting two PIPs per requirements of the North Dakota Medicaid Expansion Quality Strategy. The PIP topics focus on diabetes care and follow-up for mental health. SHP's MY 2020 PIP reports included remeasurement results and described multifaceted interventions. For MY 2020, SHP received an overall validation score of 72% and 83% for Comprehensive Diabetes Care PIP and Follow-Up for Mental Health PIP, respectively. Sustained improvement was demonstrated in the mental health PIP's Engagement of Alcohol or Other Drug (AOD) Treatment performance measure.

Performance Measure Validation

Qlarant evaluated SHP's audit elements: Data Integration and Control, Data and Processes Used to Produce Performance Measure, Measure Validation–Denominator and Numerator, Sampling Validation, and Reporting and determined SHP had appropriate system in place to calculate and produce accurate performance measure rates. For MY 2020, SHP received an overall rating of 100% and the performance measure results were assessed as "reportable." Forty-four percent (44%) of reported measures compared favorably to the national average benchmark with five (5) surpassing the 90th percentile and seven (7) exceeding the 75th percentile but below the 90th percentile.

Compliance Review

In general, SHP demonstrated compliance with federal and state regulations and requirements as it served the North Dakota Medicaid Expansion populations during MY 2020. Qlarant reviewed the managed care standards: Information Requirements, Disenrollment Requirements and Limitations, Enrollee Rights and Protections, MCO Standards, Quality Assessment and Performance Improvement Program, Grievance and Appeal System, and Program Integrity Requirements Under the Contract. SHP achieved an overall compliance score of 99% for MY 2020 compliance review. Recommendations were provided to SHP for guidance in policy and procedure revisions to help the MCO meet requirements for the next measurement year.

Network Adequacy Validation

Surveyors, assessing 24/7 access, were successful in contacting provider offices after regular business hours 97% of the time. Unsuccessful contacts were all due to provider phone not in service. For successful provider contacts, SHP demonstrated a high compliance rate of 97% with directing members to care.

Encounter Data Validation

SHP provided evidence of having the capability to produce accurate and complete encounter data. For encounters/claims submitted during MY 2020, analysts found MCO claims volume was reasonable, data was complete and included valid values, and diagnoses and procedure codes were appropriate based on member demographics. A medical record review concluded documentation supported encounter data. During MY 2020, SHP achieved a total match rate of 97%—meaning 97% of claims data submitted were supported by medical record documentation. Inpatient records registered the highest match rate (99%) in MY 2020, followed by Office Visit (98%) and Outpatient (93%).

CAHPS Survey

SHP contracted with a certified CAHPS vendor to conduct AHRQ's new *CAHPS 5.1H Medicaid Adult Survey*. The survey was designed to capture MCO enrollee experiences while obtaining and receiving healthcare services, with the objective to measure how well an MCO is meeting its enrollees' expectations. For MY 2020, the MCO received 166 completed surveys for a 12.4% response rate. Three (3) reported measures met or exceeded national average benchmarks but scored below 75th percentile benchmarks: Rating of Personal Doctor, Rating of Health Plan, and Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies.

Focused Study

Qlarant's EDV analysis revealed opioid dependency infiltrated the ND Medicaid Expansion population in 2017 and increased in an alarming and rapid rate in 2018. Based on the results, DHS contracted with Qlarant to spearhead a focused study solely on opioid dependency within ND Medicaid Expansion enrollees. The objective is to explore and attempt to identify factors that may lead to the prevention of continued upward trends in opioid dependency within the Medicaid Expansion population and fight this public health emergency effectively. MY 2019 was the first of the three year focused study (MYs 2019-2021). The study showed SHP's opioid dependence rate per 1,000 enrollees with a POV claim continues to rise to 854.1, which was more than two times the MY 2018 rate of 393.3.

Conclusion

MY 2020 was a challenging year for SHP and the ND Medicaid Expansion program due to COVID-19 public health emergency. By the end of year 2020, SHP served 25,046 Medicaid Expansion enrollees, a 24% increase from previous measurement year (20,279), which was due to CMS eligibility changes preventing member disenrollment during the pandemic. The stay-at-home mandate and temporary closure of healthcare facilities significantly reduced enrollee access to care. All these barriers have negatively impacted some of SHP's performance measure rates and PIPs results.

Despite the difficulties, SHP provided evidence of meeting most federal, state, and quality strategy requirements. SHP demonstrated their commitment to quality improvement with a high overall compliance score of 99% and 100% in CR and PMV, respectively. DHS should continue to monitor performance and collaborate with SHP to encourage the positive trend in performance and overcome public health emergency barriers.

North Dakota Medicaid Expansion Program

2021 Annual Technical Report

Measurement Year 2020

Introduction

Background

The Affordable Care Act (ACA), a comprehensive health care reform law, was enacted in March 2010 with the objective to expand the Medicaid program to cover individuals under the age of 65 with incomes below 133% of the federal poverty level (plus a five percent income disregard). The ACA was challenged and on June 28, 2012, the United States Supreme Court's ruling upheld the 2015 Medicaid Expansion, but allowed individual states to decide whether to expand their Medicaid program. Consequently, the 2013 North Dakota Legislative Assembly authorized the implementation of the Medicaid Expansion through House Bill 1362.

Subsequently, the North Dakota Department of Human Services (DHS) requested a Section 1915(b) Waiver for the Medicaid Expansion: Waiver for Managed Care Enrollment of the Medicaid Expansion of New Adult Group. With the Centers for Medicare and Medicaid Services (CMS) approval of the waiver, in December 2013, North Dakota awarded the contract to Sanford Health Plan (SHP) as the managed care organization (MCO). SHP began to serve eligible individuals between 19-64 years of age on January 1, 2014.

Purpose

The Medicaid Expansion product is a managed care model; therefore, CMS requires an External Quality Review Organization (EQRO) to perform an independent review of the managed care program. DHS contracted with Qlarant to perform such external quality review (EQR) services. Following CMS EQR Protocols, Qlarant evaluated the quality, access, and timeliness of services provided to the Medicaid Expansion program enrollees by assessing MCO performance through the following EQR activities:

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

[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The comprehensive assessment, conducted in 2021, assessed SHP's measurement year (MY) 2020 compliance with federal and state requirements, as identified in the Code of Federal Regulations (42 CFR § 438), the SHP MCO Contract, the North Dakota Medicaid Expansion Quality Strategy Plan, and the North Dakota Section 1915(b) Waiver Proposal for MCO Program: Waiver for Managed Care Enrollment of Medicaid Expansion of New Adult Group.

This annual technical report describes EQR methodologies for completing activities; provides SHP performance results for MY 2020; and includes an overview of the quality, access, and timeliness of healthcare services provided to Medicaid Expansion enrollees. Finally, recommendations for improvement are made, and if acted upon, may positively impact enrollee outcomes.

Performance Improvement Project Validation

Objectives

MCOs conduct PIPs as part of their quality assessment and performance improvement program. PIPs use a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying barriers and implementing targeted interventions to achieve and sustain improvement in clinical outcomes or administrative processes. PIP EQR activities verify the MCO used sound methodology in its design, implementation, analysis, and reporting. PIP review and validation provides the State and other stakeholders a level of confidence in results.

Methodology

The State required the MCO to report two state mandated PIP topics, which were agreed upon by the MCO, State, and EQRO. The MCO reported measurement year PIP-related activities, improvement strategies, and measure results in the MCO-PIP reports. PIP measures were audited as part of the performance measure validation (PMV) activity to provide confidence in reported measure rates. The MCO submitted its reports to Qlarant after the performance measure rates were finalized, which include a completed data and barrier analysis and identified follow-up activities for each PIP submission. The MCO used Qlarant reporting tools and worksheets to report its PIPs. Qlarant provided MCO specific technical assistance, as requested.

Qlarant reviewed each PIP to assess the MCO's PIP methodology and to perform an overall validation of PIP results. Qlarant completed these activities in a manner consistent with the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects*.[4] PIP validation steps include:

Step 1 Topic
Qlarant determines if the PIP topic targets an opportunity for improvement and is relevant to the MCO's population.

Step 2 Aim Statement
Qlarant evaluates the adequacy of the PIP aim statement, which should frame the project and define the improvement strategy, population, and time period.

[4] CMS EQRO Protocols

Step 3 Identified Population
Qlarant determines whether the MCO identifies the PIP population in relation to the aim statement.

Step 4 Sampling Method
If the MCO studied a sample of the population, rather than the entire population, Qlarant assesses the appropriateness of the MCO's sampling technique.

Step 5 Variables and Performance Measures
Qlarant assesses whether the selected PIP variables are appropriate for measuring and tracking improvement. Performance measures should be objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on member outcomes.

Step 6 Data Collection Procedures
Qlarant evaluates the validity and reliability of MCO procedures used to collect the data informing PIP measurements.

Step 7 Data Analysis and Interpretation of Results
Qlarant assesses the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used, and if the MCO analysis and interpretation was accurate.

Step 8 Improvement Strategies (Interventions)
Qlarant assesses the appropriateness of interventions for achieving improvement. The effectiveness of an improvement strategy is determined by measuring changes in performance according to the PIP's predefined measures. Data should be evaluated on a regular basis, and subsequently, interventions should be adapted based on what is learned.

Step 9 Significant and Sustained Improvement
Qlarant evaluates improvement by validating statistical significance testing results and evaluating improvement compared to baseline performance.

Qlarant PIP reviewers evaluated each element of PIP development and reporting by answering a series of applicable questions, consistent with CMS protocol worksheets and requirements. Reviewers sought additional information and/or corrections from MCO, when needed, during the evaluation. Qlarant determined a validation rating, or level of confidence, for each PIP based on the total validation score.[5] Validation ratings include:

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

[5] Validation rating refers to the overall confidence that a PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement (CMS EQR Protocol 1 – Validation of Performance Improvement Projects).

Results

In June 2021, the MY 2020 MCO-PIP reports were obtained from Sanford Health Plan (SHP) after MY 2020 PMV final rates were finalized. Qlarant conducted PIP validation for each PIP topic submission. The PIP validation results, consisting of MY 2020 activities and performance measure (PM) results, are included in this report.

Table 1 highlights key elements of the two PIPs: (1) Comprehensive Diabetes Care and (2) Follow-Up for Mental Health. The MCO improvement strategies and results for each PIP for the year under review is included in the following the tables.

Table 1. SHP's PIPs

2021 PIPs	PIP 1	PIP 2
Program	Medicaid Expansion	Medicaid Expansion
Topic	Comprehensive Diabetes Care	Follow-Up for Mental Health
Aim	Will the interventions implemented for members with diabetes increase the Comprehensive Diabetes Care rates to meet or exceed the following goals?	Will the interventions implemented for the HEDIS®[6] noncompliant population impact the PIP's measures?
Performance Measures	**PM 1:** Comprehensive Diabetes Care - HbA1c Testing **PM 2:** Comprehensive Diabetes Care - HbA1c Poor Control >9% **PM 3:** Comprehensive Diabetes Care - HbA1c Control <8% **PM 4:** Comprehensive Diabetes Care - Eye Exam (Retinal) Performed **PM 5:** Comprehensive Diabetes Care - Blood Pressure Control < 140/90 mm Hg	**PM 1:** Follow-Up After Hospitalization for Mental Health - Within 7 Days **PM 2:** Follow-Up After Hospitalization for Mental Health - Within 30 Days **PM 3:** Engagement of Alcohol or other Drug (AOD) Treatment (introduced in MY 2016)
Measure Steward	NCQA	NCQA
Population	Members with type 1 and 2 diabetes	Members with mental illness and AOD dependence
Phase	3nd Remeasurement	6th Remeasurement

PIP 1: Comprehensive Diabetes Care

Interventions

SHP's reported targeted interventions, which include:

Member-focused intervention(s):

- Letter to members who were not compliant with HbA1c testing, microalbuminuria testing or eye exam.
- Letter/Postcard to members about eye exam benefit.

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

- Vouchers for glucometers mailed to members.

Provider-focused intervention(s):

- Letter to participating eye care practitioners regarding waive of copay for diabetic eye exam.
- Create and distribute diabetes related care gap lists to attributed providers.
- Data sharing with providers to monitor, track, and close care gaps for diabetic members.

MCO-focused intervention(s):

- Implementation of Krames On-Demand Education Resources.
- Clinical interventions will be assessed and documented by RN case managers.

PIP Measure Results

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

Table 2. SHP Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Remeasurement Year 3 MY 2020	Improvement	Statistically Significant Improvement
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing	92.62%	89.05%	No	No
Comprehensive Diabetes Care - HbA1c Poor Control (>9%) *Lower rate is better*	30.58%	39.66%	No	No
Comprehensive Diabetes Care - HbA1c Control (<8%)	55.01%	49.39%	No	No
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	50.09%	48.42%	No	No
Comprehensive Diabetes Care - Blood Pressure Control (< 140/90 mm Hg)	77.86%	72.75%	No	No

Comprehensive Diabetes Care PIP Performance Measure Rates

Table 3 includes SHP's Comprehensive Diabetes Care PIP performance measure rates.

Table 3. Comprehensive Diabetes Care Performance Measure Rates

Performance Measure	Measurement Year	Eligible Population or Denominator	Numerator	Rate
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing	2017	527	569	92.62%
	2018	536	579	92.57%
	2019	371	411	90.27%
	2020	366	411	89.05%
Comprehensive Diabetes Care - HbA1c Poor Control (>9%) *Lower rate is better*	2017	174	569	30.58%
	2018	186	579	32.12%
	2019	118	411	28.71%
	2020	163	411	39.66%

Performance Measure	Measurement Year	Eligible Population or Denominator	Numerator	Rate
Comprehensive Diabetes Care - HbA1c Control (<8%)	2017	313	569	55.01%
	2018	324	579	55.96%
	2019	250	411	60.83%
	2020	203	411	49.39%
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	2017	285	569	50.09%
	2018	296	579	51.12%
	2019	204	411	49.64%
	2020	199	411	48.42%
Comprehensive Diabetes Care - Blood Pressure Control (< 140/90 mm Hg)	2017	443	569	77.86%
	2018	445	579	76.86%
	2019	304	411	73.97%
	2020	299	411	72.75%

PIP Validation Results

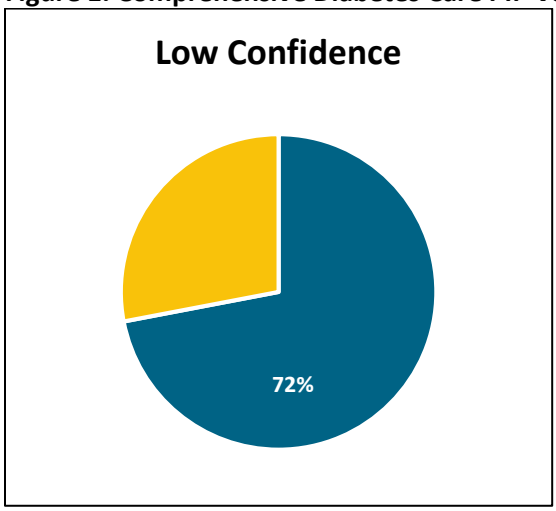
Table 4 displays SHP's Comprehensive Diabetes Care PIP validation results for each step reviewed and an overall score.

Table 4. Comprehensive Diabetes Care PIP Validation Results

PIP Step	Assessment	SHP
1. PIP Topic	Met	100%
2. PIP Aim Statement	Met	100%
3. PIP Population	Met	100%
4. Sampling Method	Met	100%
5. PIP Variables and Performance Measures	Met	100%
6. Data Collection Procedures	Partially Met	90%
7. Data Analysis and Interpretation of Results	Partially Met	95%
8. Improvement Strategies (Interventions)	Partially Met	60%
9. Significant and sustained Improvement	Partially Met	10%
Validation Score		**72%**
Level of Confidence		**Low Confidence** ❖

Figure 1 displays SHP's Comprehensive Diabetes Care PIP validation rating.

Figure 1. Comprehensive Diabetes Care PIP Validation Rating



PIP 2: Follow-Up for Mental Health

Interventions

SHP's reported targeted interventions, which include:

Member-focused intervention(s):

- Provider member education on the importance of 7 day follow-up with a qualified behavioral health specialist.
- Informed the member they have a behavioral health case manager.
- Sent educational resources to members electronically via email, their PCP, etc.

Provider-focused intervention(s):

- Met with inpatient mental health facilities to network, discuss workflows, and accessibility to appointments.
- Educated social worker on the importance of scheduling the 7 day follow-up appointment with a qualified behavioral health specialist (not a PCP).

MCO-focused intervention(s):

- Established a workflow between utilization management and behavioral health team regarding reviewing requests submitted for AOD and appropriateness of setting.

PIP Measure Results

Table 5 displays SHP's Follow-Up for Mental Health PIP measure results.

Table 5. SHP Follow-Up for Mental Health PIP Measure Results

Performance Measure	Baseline Year MY 2014	Remeasurement Year 6 MY 2020	Improvement	Statistically Significant Improvement
Follow-Up After Hospitalizations for Mental Health - Within 7 Days	21.88%	25.12%	Yes	No
Follow-Up After Hospitalizations for Mental Health - Within 30 Days	38.84%	43.55%	Yes	No
Engagement of Alcohol or Other Drug (AOD) Treatment (introduced in MY 2016)	17.32%	19.81%	Yes	No

Follow-Up for Mental Health PIP Performance Measure Rates

Table 6 includes SHP's Follow-Up for Mental Health PIP performance measure rates.

Table 6. Follow-Up for Mental Health Performance Measure Rates

Performance Measure	Measurement Year	Eligible Population or Denominator	Numerator	Rate
Follow-Up After Hospitalizations for Mental Health - Within 7 Days	2014	49	224	21.88%
	2015	73	266	27.44%
	2016	77	314	24.52%
	2017	114	351	32.48%
	2018	116	413	28.09%
	2019	82	418	19.62%
	2020	109	434	25.12%
Follow-Up After Hospitalizations for Mental Health - Within 30 Days	2014	87	224	38.84%
	2015	132	266	49.62%
	2016	147	314	46.82%
	2017	182	351	51.85%
	2018	210	413	50.85%
	2019	144	418	34.45%
	2020	189	434	43.55%
Engagement of Alcohol or Other Drug (AOD) Treatment	2016	268	1547	17.32%
	2017	299	1658	18.03%
	2018	362	1739	20.82%
	2019	324	1749	18.52%
	2020	428	2160	19.81%

PIP Validation Results

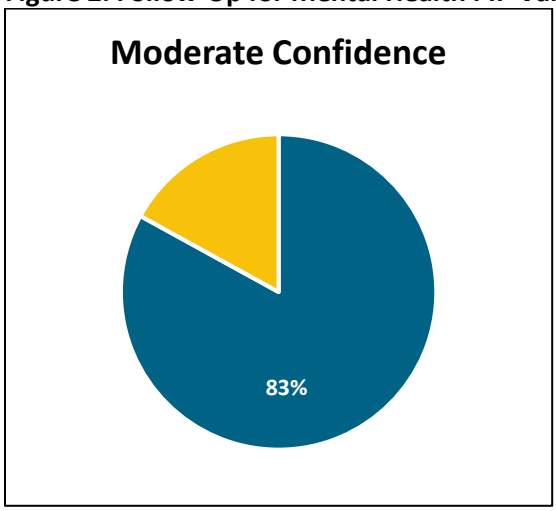
Table 7 displays SHP's Follow-Up for Mental Health PIP validation results for each step reviewed and an overall score.

Table 7. Follow-Up for Mental Health PIP Validation Results

PIP Step	Assessment	SHP
1. PIP Topic	Met	100%
2. PIP Aim Statement	Partially Met	80%
3. PIP Population	Met	100%
4. Sampling Method	NA	NA
5. PIP Variables and Performance Measures	Met	100%
6. Data Collection Procedures	Partially Met	90%
7. Data Analysis and Interpretation of Results	Partially Met	95%
8. Improvement Strategies (Interventions)	Partially Met	60%
9. Significant and sustained Improvement	Partially Met	75%
Validation Score		**83%**
Level of Confidence		**Moderate Confidence**

Figure 2 displays SHP's Follow-Up for Mental Health PIP validation rating.

Figure 2. Follow-Up for Mental Health PIP Validation Rating



Conclusion

Summary conclusions for each of the State mandated PIPs are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

Comprehensive Diabetes Care PIP

- SHP reported remeasurement three results for its Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9%), HbA1c Control (<8%), Eye Exam (Retinal) Performed, and Blood Pressure Control (< 140/90 mm Hg) measures.
- SHP's validation score was 72% (low confidence).
- SHP reported the stay at home mandate during COVID-19 public health emergency has negatively impacted the overall Comprehensive Diabetes Care PIP performance.

Follow-Up for Mental Health PIP

- SHP reported remeasurement six results for its Follow-Up After Hospitalizations for Mental Health - Within 7 Days, Follow-Up After Hospitalizations for Mental Health - Within 30 Days, Engagement of Alcohol or Other Drug (AOD) Treatment measures.
- SHP's validation score was 83% (moderate confidence).
- SHP reported the stay at home mandate during COVID-19 public health emergency has delayed the intervention execution; hence, did not yield the expected results.

Performance Measure Validation

Objectives

DHS uses performance measures (PM) to monitor performance of SHP at a point in time, track performance over time, and compare performance to national benchmarks. The PMV activity evaluates the accuracy and reliability of measures produced and reported by the MCO and determines the extent to which the MCO followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates is essential to ascertaining whether the MCO's quality improvement efforts resulted in improved health outcomes. Further, the validation process allows DHS to have confidence in MCO measure results.

Methodology

Qlarant validated DHS-selected PMs during the 2021 PMV activity. Selected HEDIS, CAHPS, and CMS Adult Core Set measures were used to calculate MY 2020 performance. Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 2 – Validation of Measures*.[7]

The validation process was interactive and concurrent to the MCO calculating the measures. Validation activities occurred before, during, and after an onsite visit to the MCO and included two principle components:

- An overall assessment of the MCO's information systems (IS) capability to capture and process data required for reporting
- An evaluation of the processes (e.g. source code programs) the MCO used to prepare each measure

Essential PMV activities included:

- Review of the MCO's data systems and processes used to construct the measures
- Assessment of the calculated rates for algorithmic compliance to required specifications
- Verification the reported rates were reliable and based on accurate sources of information

Information from several sources was used to satisfy validation requirements. These sources included, but were not limited to, the following documents provided by the MCO:

[7] CMS EQRO Protocols

- Information Systems Capabilities Assessment (ISCA)
- HEDIS Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report, if available
- Other documentation (e.g. specifications, data dictionaries, program source code, data queries, policies and procedures)
- Observations made during the onsite visit
- Interviews with key MCO staff
- Information submitted as part of the follow-up items requested after the onsite visit

Qlarant conducted onsite MCO PMV review activities via virtual desk audit in May 2021 due to the COVID-19 public health emergency and concluded all post-onsite review activities in June 2021 when the MCO reported final measure rates. After Qlarant approved final rates, Qlarant reported findings for the following audit elements including: Data Integration and Control, Data and Processes Used to Produce Performance Measure, Measure Validation–Denominator and Numerator, Sampling Validation, and Reporting. Audit element descriptions are provided below.

Data Integration and Control
Assessment of data integration and control procedures determine whether the MCO had appropriate processes and documentation in place to extract, manipulate, and link data for accurate and reliable measure rate construction.

Data and Processes Used to Produce Performance Measure
Assessment of measurement procedures and programming specifications, which include examining data sources, programming logic, and computer source codes, ensure data were accurate and complete and the MCO had sufficient processes to produce reliable and reportable performance measure rates.

Measure Validation – Denominator
Validation of measure denominator calculations assesses the extent to which the MCO used appropriate and complete data to identify the entire population and the degree to which the MCO followed measures specifications for calculating the denominator.

Measure Validation – Numerator
Validation of the numerator determines if the MCO correctly identified and evaluated all qualifying medical events for appropriate inclusion or exclusion in the numerator for each measure and if the MCO followed measure specifications for calculation of the numerator.

Sampling
Evaluation of sample size and replacement methodology specifications confirms the sample was not biased, if applicable.

Reporting
Validation of measure reporting confirms if the MCO followed DHS specifications.

Qlarant calculated a validation rating for the MCO based on audit element findings. The rating provides a level of confidence in the MCO's reported PM results. Validation ratings include:

- 95% - 100%: high confidence in MCO results
- 80% - 94%: moderate confidence in MCO results
- 75% - 79%: low confidence in MCO results
- ≤74%: no confidence in MCO results

Lastly, the table includes a Reporting Designation. This component may be assessed with any one of the following designations:

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

Results

Medical Record Over-Read Results

Two measures were selected for medical record over-read review to ensure SHP has an accurate and reliable medical record abstraction process. In May 2021, Qlarant obtained a sample size of 30 medical records for each measure from SHP. Results are displayed in Table 8 below.

Table 8. Performance Measure Medical Record Over-Read Results

Medical Record Over-Read Agreement			
Measure	Record Sample Size	Compliant Records	SHP Agreement
Comprehensive Diabetes Care: HbA1c Testing	30	30	100%
Comprehensive Diabetes Care: HbA1c Control (<8%)	30	30	100%

Agreement rates for the selected measures exceeded the 90% minimum requirement, registering at 100%.

Performance Measure Validation Results

SHP had appropriate systems in place to produce measure rates. Table 9 includes 2021 MCO PMV results based on MCO calculation of MY 2020 measure rates.

Table 9. MCO PMV Results

PMV Element	SHP
Data Integration and Control	100%
Data and Process Used to Produce Measure	100%
Measure Validation - Denominator	100%
Measure Validation - Numerator	100%
Sampling Validation	100%
Reporting	100%
Overall Rating	100%
Reporting Designation	R
Level of Confidence	High Confidence ❖

SHP was compliant with each PMV element and all performance measures are "Reportable."

Figure 3 displays level of confidence in MCO compliance.

Figure 3. SHP's Level of Confidence in PM Results

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

In June 2021, Qlarant obtained SHP's 2021 (MY 2020) performance measure final rates, which include a combination of 48 HEDIS, CAHPS, and CMS Adult Core Set measures, per 2021 North Dakota Medicaid Expansion Program Quality Strategy. Performance measure results are compared to benchmarks based on the NCQA Quality Compass 2020 National Medicaid for HMOs and 2020 CMS Adult Core Set Chart. Comparisons are made using a diamond rating system:

♦♦♦♦ MCO rate is equal to or exceeds the 90th Percentile.
♦♦♦ MCO rate is equal to or exceeds the 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCO rate is equal to or exceeds the National Average, but does not meet the 75th Percentile.
♦ MCO rate is below the National Average

Table 10 trends the MCO performance measures for MYs 2018-2020 and compares performance to national benchmarks. In addition to the 48 measures, the table also includes three retired HEDIS measures by NCQA in 2021. Green and red represents positive and negative trends for three consecutive measurement years, respectively.

Table 10. SHP Performance Measure Rates for MYs 2018-2020

Performance Measure	SHP MY 2018 Rate	SHP MY 2019 Rate	SHP MY 2020 Rate	Comparison to Benchmarks
Adherence to Antipsychotics for Individuals with Schizophrenia Ages 19-64**	61.36%	52.29%	40.91%	♦
Adult Body Mass Index Assessment Ages 19-64+	93.33%	94.17%	NR	NC
Antidepressant Medication Management Ages 19-64: Effective Acute Phase Treatment**	64.33%	61.85%	63.13%	♦♦♦
Antidepressant Medication Management Ages 19-64: Effective Continuation Phase Treatment**	48.17%	46.72%	49.66%	♦♦♦♦
Asthma Medication Ratio Ages 19-50**	NR	55.00%	73.28%	♦♦♦♦
Asthma Medication Ratio Ages 51-64**	NR	51.72%	73.58%	♦♦♦♦
Asthma Medication Ratio Ages 19-64 (Total) **	NR	53.93%	73.37%	♦♦♦
Breast Cancer Screening Ages 50-64	54.97%	54.69%	52.27%	♦
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia Ages 19-64	NA	NA	50.00%	♦
Cervical Cancer Screening Ages 21-64	43.60%	44.79%	42.37%	♦
Chlamydia Screening in Women Ages 21-24	40.52%	46.03%	46.69%	♦
Comprehensive Diabetes Care Ages 19-64: Blood Pressure Controlled < 140/90 mm Hg	76.86%	73.97%	72.75%	♦♦♦
Comprehensive Diabetes Care Ages 19-64: Eye (Retinal) Exam	51.12%	49.64%	48.42%	♦
Comprehensive Diabetes Care: HbA1c Control (<7%) for a Selected Population Ages 19-64+	41.61	NR	NR	NC
Comprehensive Diabetes Care Ages 19-64: HbA1c Control (<8%)	55.96%	60.83%	49.39%	♦
Comprehensive Diabetes Care Ages 19-64: HbA1c Pool Control (>9%) *Lower rate is better*	32.12%	28.71%	39.66%	♦♦
Comprehensive Diabetes Care Ages 19-64: HbA1c Testing	92.57%	90.27%	89.05%	♦♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy Ages 19-64+	93.61%	89.05%	NR	NC
Controlling High Blood Pressure Ages 19-64	68.37%	70.00%	67.40%	♦♦
Diabetes Monitoring for People With Diabetes and Schizophrenia Ages 19-64	NA	NA	NA	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication Ages 19-64**	85.30%	85.15%	79.70%	♦
Flu Shots for Adults Ages 19-64	38.93%	38.60%	34.38%	♦
Follow-Up After Emergency Room Department Visit for Alcohol and Other Drug Abuse or Dependence Ages 19-64: 7 Days Follow-Up	NR	24.75%	20.19%	♦

Performance Measure	SHP MY 2018 Rate	SHP MY 2019 Rate	SHP MY 2020 Rate	Comparison to Benchmarks
Follow-Up After Emergency Room Department Visit for Alcohol and Other Drug Abuse or Dependence Ages 19-64: 30 Days Follow-Up	NR	31.33%	28.10%	♦
Follow-Up After Emergency Room Visit for Mental Illness Ages 19-64: 7 Days follow-Up	NR	32.20%	25.27%	♦
Follow-Up After Emergency Room Visit for Mental Illness Ages 19-64: 30 Days follow-Up	NR	44.49%	44.32%	♦
Follow-Up After Hospitalization for Mental Illness Ages 19-64: 7 Days Follow-Up	28.11%	19.62%	25.12%	♦
Follow-Up After Hospitalization for Mental Illness Ages 19-64: 30 Days Follow-Up	51.62%	34.45%	43.55%	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Initiation of AOD Treatment - Alcohol Abuse**	42.80%	41.70%	42.44%	♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Engagement of AOD Treatment - Alcohol Abuse**	17.98%	14.57%	15.58%	♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Initiation of AOD Treatment - Opioid Abuse**	61.35%	62.50%	57.97%	♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Engagement of AOD Treatment - Opioid Abuse**	41.43%	43.55%	40.68%	♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Initiation of AOD Treatment - Other Drug Abuse**	43.08%	41.97%	41.05%	♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Engagement of AOD Treatment - Other Drug Abuse**	24.33%	17.27%	18.82%	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Initiation of AOD Treatment - Total**	43.99%	44.31%	44.31%	♦♦
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Engagement of AOD Treatment - Total**	20.82%	18.52%	19.81%	♦♦♦
Medical Assistance With Smoking and Tobacco Use Cessation Ages 19-64: Advised to Quit Smoking (2 year rolling average)	78.22%	76.90%	75.18%	♦
Medical Assistance With Smoking and Tobacco Use Cessation Ages 19-64: Discussing Cessation Medication (2 year rolling average)	54.19%	52.10%	51.75%	♦
Medical Assistance With Smoking and Tobacco Use Cessation Ages 19-64: Discussing Cessation Strategies (2 year rolling average)	52.33%	48.10%	50.00%	♦♦
Plan All-Cause Readmissions Rate: Ages 19-44 *Lower rate is better*	NR	1.5441	1.1574	NC

Performance Measure	SHP MY 2018 Rate	SHP MY 2019 Rate	SHP MY 2020 Rate	Comparison to Benchmarks
Plan All-Cause Readmissions Rate: Ages 45-54 *Lower rate is better*	NR	1.5655	0.7341	NC
Plan All-Cause Readmissions Rate: Ages 55-64 *Lower rate is better*	NR	1.1399	1.0522	NC
Plan All-Cause Readmissions Rate: Ages 19-64 (Total) *Lower rate is better**	NR	1.4182	1.0214	♦
PQI 01: Diabetes Short-Term Complications Admission Rate (denominator is total member months x100,00 for Ages 19-64, Rate is numerator events/100,000 member months) *Lower rate is better**	40.85	46.53	42.41	♦
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (denominator is total member months x100,00 for ages 40-64, Rate is numerator events/100,000 member months) *Lower rate is better**	28.97	48.58	29.83	♦♦♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate (denominator is total member months x100,00 for ages 19-64, Rate is numerator events/100,000 member months) *Lower rate is better**	29.07	27.11	32.91	♦
PQI 15: Asthma Admission Rate in Younger Adults (denominator is total member months x100,00 for ages 19-39, Rate is numerator events/100,000 member months) *Lower rate is better**	3.47	2.90	3.93	♦♦
Use of Opioids at High Dosage in Persons Ages 19-64** (rate is calculated per 1000 members) *Lower rate is better*	2.79	2.75	0.47	♦♦♦♦
Use of Opioids From Multiple Providers Ages 19-64: Multiple Prescribers** (rate is calculated per 1000 members) *Lower rate is better*	4.75	5.02	4.64	♦♦
Use of Opioids From Multiple Providers Ages 19-64: Multiple Pharmacies** (rate is calculated per 1000 members) *Lower rate is better*	24.95	27.28	21.27	♦
Use of Opioids From Multiple Providers Ages 19-64: Multiple Prescribers and Pharmacies** (rate is calculated per 1000 members) *Lower rate is better*	4.10	4.45	3.43	♦

Interpret and trend results with caution due to measure specification changes for COVID-19 public health emergency.
* Benchmark data source: Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set Chart, October 2020
**Measure performance may have been impacted by January 2020 pharmacy benefit carve-out of the MCP contract.
+ Measure retired by NCQA.
NA Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate
NR Not Reported in previous year(s) due to new measure was added
NC No comparison made due to NA, no rate or/and benchmark available

Conclusion

Summary conclusions for the PMV activity are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

- The MCO received overall PMV rating of 100%, providing high confidence in MCO measure calculations and reporting.
- The MCO reported the decrease in MY 2020 performance measure rates was largely due to the stay at home mandate and temporary closure of healthcare facilities during COVID-19 public health emergency.
- Of the 48 measures (retired measures not included), an analysis of MY 2020 MCO demonstrates:
    - 48% of measures (23 of 48) scored below national average benchmarks.
    - 44% of measures (21 of 48) compared favorably to the national average benchmark.
        - 19% of measures (9 of 48) met or exceeded national average benchmarks but below 75th percentile benchmarks.
        - 15% of measures (7 of 48) met or exceeded 75th percentile benchmarks but below 90th percentile benchmarks.
        - 10% of measures (5 of 48) met or exceeded the 90th percentile benchmarks:
            - Antidepressant Medication Management Ages 19-64: Effective Continuation Phase Treatment
            - Asthma Medication Ages 19-50
            - Asthma Medication Ages 51-64
            - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Ages 19-64: Engagement of AOD Treatment - Other Drug Abuse
            - Use of Opioids at High Dosage in Persons Ages 19-64
    - No comparison could be made for four (4) measures due to small denominator or no benchmarks.
- Forty-six percent (46%) or 22 of 48 measure rates decreased from previous measurement year.
- Twelve (12) of 48 measures had rates available for MYs 2018-2020 and allowed for a trending analysis. Eighty-three percent (83%) or 10 of 12 measures demonstrated a negative trend. Only 17% or two (2) measures demonstrated a positive trend. Remaining measures did not produce a trend.

Compliance Review

Objectives

CRs assess MCO compliance with structural and operational standards, which may impact the quality, timeliness, or accessibility of health care services provided to managed care beneficiaries. The comprehensive review determines compliance with federal and state managed care program requirements. The CR provides DHS an independent assessment of MCO capabilities, which can be used to promote accountability and improve quality related processes and monitoring.

Methodology

Qlarant conducted a comprehensive review of applicable CFR standards for the 2021 compliance review. Qlarant reviews the following 42 CFR §438 standards:

- Subpart A §438.10: Information Requirements

- Subpart B §438.56: Disenrollment Requirements and Limitations
- Subpart C §438.100 - §438.114: Enrollee Rights and Protections
- Subpart D §438.206 - §438.242: MCO Standards
- Subpart E §438.330: Quality Assessment and Performance Improvement Program
- Subpart F §438.402 - §438.424: Grievance and Appeal System
- Subpart H §438.608: Program Integrity Requirements Under the Contract

Below are the new standards for 2020, which are included in this review cycle but not scored due to baseline assessment:

- Subpart B: §438.56 Disenrollment Requirements and Limitations
- Subpart C: Enrollee Rights and Protections
    - §438.102 Provider-Enrollee Communications
    - §438.114 Emergency and Poststabilization Services

Standards are comprised of elements and components, all of which are individually reviewed and scored. Qlarant uses the following scale when evaluating MCO compliance for each element and/or component:

- **Met.** Demonstrates full compliance. 1 point.
- **Partially Met.** Demonstrates at least some, but not full, compliance. 0.5 point.
- **Not Met.** Does not demonstrate compliance on any level. 0 points.
- **Not Applicable.** Requirement does not apply and is not scored.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally, an overall CR compliance score is calculated. Based on this overall score, a level of confidence in the MCO's CR results is determined. Compliance ratings include:

- 95% - 100%: high confidence in MCO compliance
- 85% - 94%: moderate confidence in MCO compliance
- 75% - 84%: low confidence in MCO compliance
- ≤74%: no confidence in MCO compliance

The 2021 CR evaluated MY 2020 compliance. Qlarant completed review activities in a manner consistent with *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations.* Review activities were interactive and occurred before, during, and after the onsite visit to the MCO. Pre-onsite visit activities included evaluating policies, reports, meeting minutes, and other supporting documents shared by the MCO. Onsite visit activities focused on MCO staff interviews, process demonstrations, and record reviews. Post-onsite visit activities included an opportunity for the MCO to respond to preliminary findings and provide additional evidence of compliance, if available. For the 2021 CR, onsite visit activities occurred in May 2021. Qlarant conducted a virtual onsite audit due to the COVID-19 public health emergency.

Results

Table 11 displays MY 2020 MCO CR results by substandard, standard, and total. A level of confidence in the MCO's compliance is assigned based on the overall weighted compliance score.

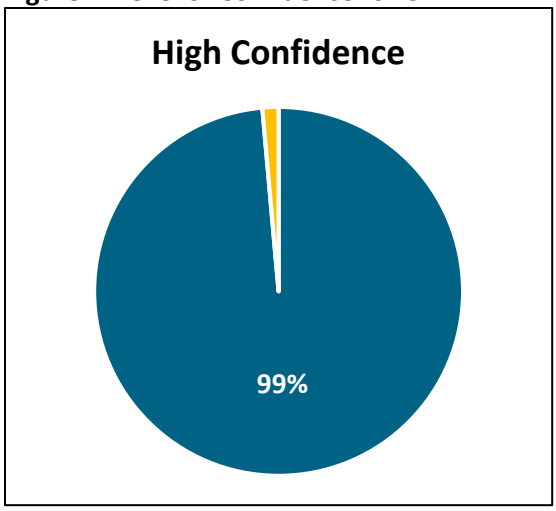
Table 11. MY 2020 MCO CR Results

Standard	Assessment	SHP
Subpart A: Information Requirements	**Partially Met**	**98%**
§438.10 Information Requirements	Partially Met	98%
Subpart B: Disenrollment Requirements and Limitations *Baseline*	**NA**	**NA**
§438.56 Disenrollment Requirements and Limitations *Baseline*	NA	NA
Subpart C: Enrollee Rights and Protections	**Met**	**100%**
§438.100 Enrollee Rights	Met	100%
§438.102 Provider – Enrollee Communications *Baseline*	NA	NA
§438.114 Emergency and Poststabilization Services *Baseline*	NA	NA
Subpart D: MCO Standards	**Partially Met**	**97%**
§438.206 Availability of Services	Partially Met	93%
§438.207 Assurance of Adequate Capacity and Services	Partially Met	83%
§438.208 Coordination and Continuity of Care	Partially Met	95%
§438.210 Coverage and Authorization of Services	Met	100%
§438.214 Provider Selection	Met	100%
§438.224 Confidentiality	Met	100%
§438.228 Grievance and Appeal Systems	Met	100%
§438.230 Subcontractual Relationships and Delegation	Met	100%
§438.236 Practice Guidelines	Met	100%
§438.242 Health Information Systems	Met	100%
Subpart E: Quality Measurement and Improvement	**Met**	**100%**
§438.330 Quality Assessment and Performance Improvement Program	Met	100%
Subpart F: Grievance and Appeal System	**Met**	**100%**
§438.402 General Requirements	Met	100%
§438.404 Timely and Adequate Notice of Adverse Benefit Determination	Met	100%
§438.406 Handling of Grievances and Appeals	Met	100%
§438.408 Resolution and Notification: Grievances and Appeals	Met	100%
§438.410 Expedited Resolution of Appeals	Met	100%
§438.414 Information About the Grievance and Appeal System to Providers and Subcontractors	Met	100%
§438.416 Recordkeeping Requirements	Met	100%
§438.420 Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending	Met	100%
§438.424 Effectuation of Reversed Appeal Resolutions	Met	100%
Subpart H: Program Integrity Requirements Under Contract	**Met**	**100%**
§438.608 Program Integrity Requirement – Fraud, Waste, and Abuse (FWA)	Met	100%
Overall Weighted Compliance Score		**99%**
Level of Confidence		**High Confidence** ❖

SHP's overall weighted compliance score was 99% for the MY 2020 Compliance review. Qlarant found SHP had systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its managed care population.

Figure 4 displays MCO level of confidence for CR.

Figure 4. Level of Confidence for CR



DHS and stakeholders should have high confidence in SHP's compliance with all regulatory requirements based on its overall weighted compliance score.

Table 12 illustrates MCO CR Results for MYs 2018-2020

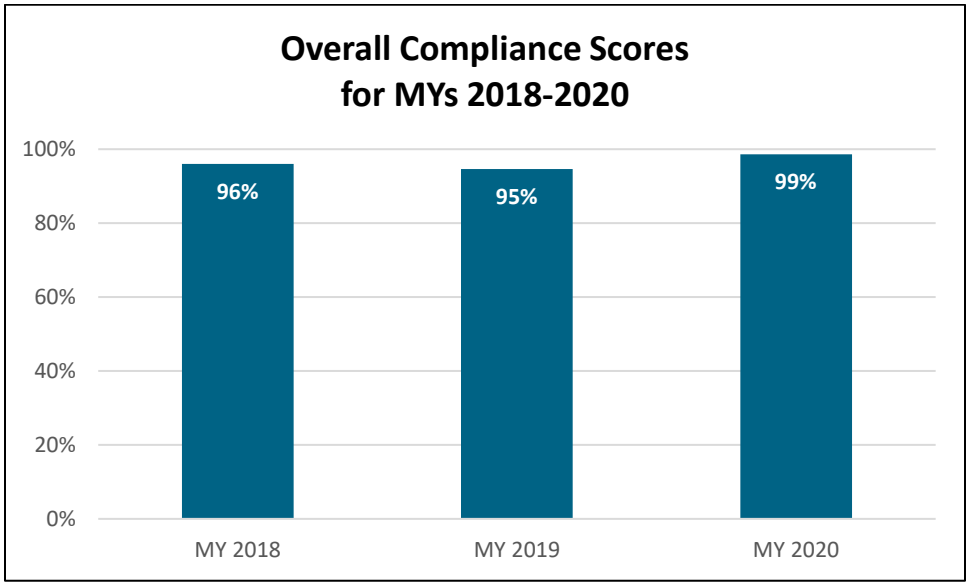
Table 12. MCO CR Results for MYs 2018-2020

Standard	MY 2018	MY 2019	MY 2020
Subpart A: Information Requirements	**98%**	**96%**	**98%**
§438.10 Information Requirements	98%	96%	98%
Subpart B: Disenrollment Requirements and Limitations *Baseline*	**NA**	**NA**	**NA**
§438.56 Disenrollment Requirements and Limitations *Baseline*	NA	NA	NA
Subpart C: Enrollee Rights and Protections	**100%**	**100%**	**100%**
§438.100 Enrollee Rights	100%	100%	100%
§438.102 Provider – Enrollee Communications *Baseline*	NA	NA	NA
§438.114 Emergency and Poststabilization Services *Baseline*	NA	NA	NA
Subpart D: MCO Standards	**98%**	**98%**	**97%**
§438.206 Availability of Services	97%	97%	93%
§438.207 Assurance of Adequate Capacity and Services	83%	83%	83%
§438.208 Coordination and Continuity of Care	100%	100%	95%
§438.210 Coverage and Authorization of Services	97%	97%	100%
§438.214 Provider Selection	100%	100%	100%
§438.224 Confidentiality	100%	100%	100%
§438.228 Grievance and Appeal Systems	100%	100%	100%
§438.230 Subcontractual Relationships and Delegation	100%	100%	100%
§438.236 Practice Guidelines	100%	100%	100%
§438.242 Health Information Systems	100%	100%	100%
Subpart E: Quality Measurement and Improvement	**100%**	**100%**	**100%**
§438.330 Quality Assessment and Performance Improvement Program	100%	100%	100%
Subpart F: Grievance and Appeal System	**91%**	**88%**	**100%**

Standard	MY 2018	MY 2019	MY 2020
§438.402 General Requirements	94%	94%	100%
§438.404 Timely and Adequate Notice of Adverse Benefit Determination	100%	92%	100%
§438.406 Handling of Grievances and Appeals	78%	72%	100%
§438.408 Resolution and Notification: Grievances and Appeals	86%	86%	100%
§438.410 Expedited Resolution of Appeals	100%	100%	100%
§438.414 Information About the Grievance and Appeal System to Providers and Subcontractors	50%	100%	100%
§438.416 Recordkeeping Requirements	100%	83%	100%
§438.420 Continuation of Benefits while the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending	100%	100%	100%
§438.424 Effectuation of Reversed Appeal Resolutions	100%	75%	100%
Subpart H: Program Integrity Requirements Under Contract	**100%**	**100%**	**100%**
§438.608 Program Integrity Requirement – Fraud, Waste, and Abuse (FWA)	100%	100%	100%
Overall Weighted Compliance Score	**96%**	**95%**	**99%**
Level of Confidence	**High Confidence** ❖	**High Confidence** ❖	**High Confidence** ❖

Figure 5 displays MCO CR overall compliance scores for MYs 2018-2020

Figure 5. MCO CR Overall Compliance Scores for MYs 2018-2020



Conclusion

Summary conclusions for the CR activity are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

- The MCO achieved a commendable overall weighted compliance score of 99% with a four percentage point improvement from MY 2019.
- The MCO maintained 100% compliance in Enrollee Rights and Protections, Quality Assessment and Performance Improvement Program, and Program Integrity.
- The MCO achieved full compliance in Grievance and Appeals Systems, with 12 percentage points higher than MY 2019 rate (88%).
- The MCO was cooperative and open to feedback from Qlarant reviewers during the audit.
- Opportunities exist in the following CR standards, which include the new standards: Information Requirements, Disenrollment Requirements and Limitations (new standards), Enrollee Rights and Protections (new standards), and MCO Standards. Most of the identified opportunities include minor revisions to the policies.

Network Adequacy Validation

Objectives

NAV evaluates whether an MCO is maintaining adequate provider networks and meeting availability service requirements. The Code of Federal Regulations, 42 CFR §438.206 - Availability of Services, requires the MCO to make services included in its contract available 24 hours a day, 7 days a week (24/7), when medically necessary. If providers are not readily available after regular business hours, they should have a process in place to direct enrollees to care. NAV results provide DHS and other stakeholders with a level of confidence in provider compliance with the 24/7 requirement including directing enrollees to care during nonbusiness hours.

Methodology

Qlarant completed an annual validation activity by selecting and surveying a random sample of primary care providers (PCP) from the MCO's online provider directory. Qlarant surveyed a mix of PCPs who provided services to the ND Medicaid Expansion Population. Qlarant surveyors called each provider office after business hours and/or on weekends to determine provider compliance with the access standard. Information collected during telephone surveys evaluated the accessibility of each MCO's network of PCPs and instructions given to enrollees after the provider offices closed for the day.

Compliance is assessed as meeting one of the following criteria. Calls are answered by a(n):

- Live person employed by the practice who provided guidance to the caller seeking care
- Answering service (live person provided guidance to the caller seeking care)
- On-call provider who provided guidance to the caller seeking care

- Recorded or automated message which provided instruction to go to the nearest emergency room or call 911 for an emergency situation, call a nurse line, or similar instruction on how to obtain care

Results

In June of 2020, Qlarant selected and surveyed a sample size of primary care providers. Table 13 includes the percentage of MY 2020 provider surveys resulting in successful contact for the MCO. Surveys were deemed successful if contact was made with a live person, answering service, on-call provider, or recorded/automated message.

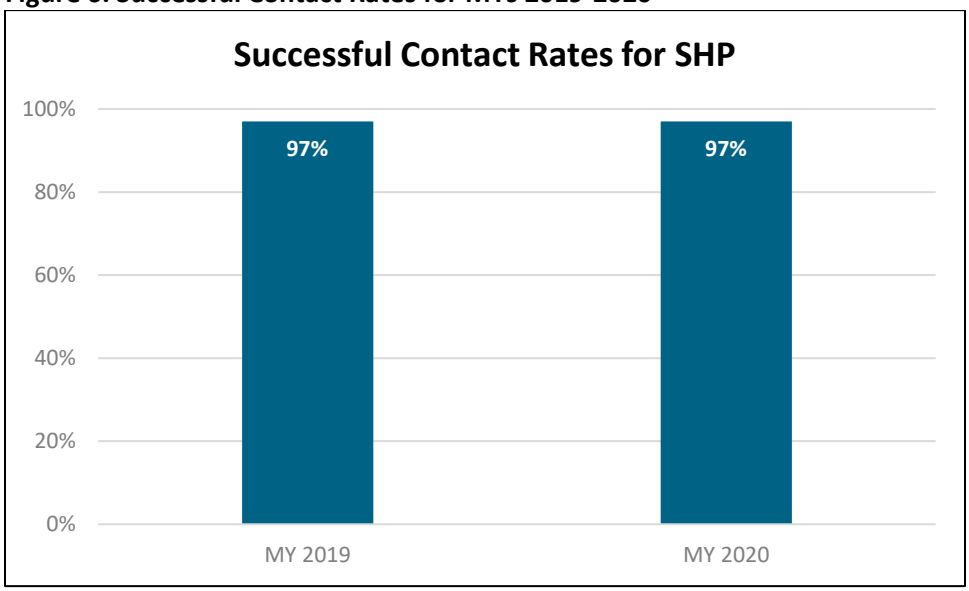
Table 13. Successful Contact for SHP

2020 NAV	SHP
Successful Contact	97%

The MCO had a contact success rate of 97%.

Figure 6 illustrates the percentage of provider surveys that resulted in successful contact for MYs 2020 and 2019.

Figure 6. Successful Contact Rates for MYs 2019-2020

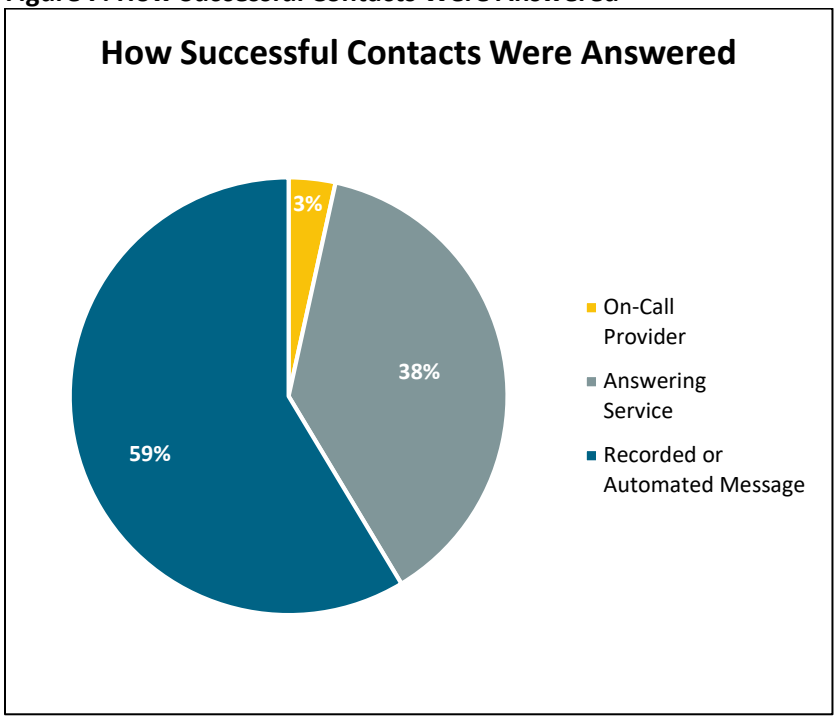


MY 2020 successful contact results include:

- SHP maintained MY 2019 successful contact rate of 97%.
- The one reason for all SHP unsuccessful contacts was provider phone not in service.

Figure 7 displays how successful contacts were answered.

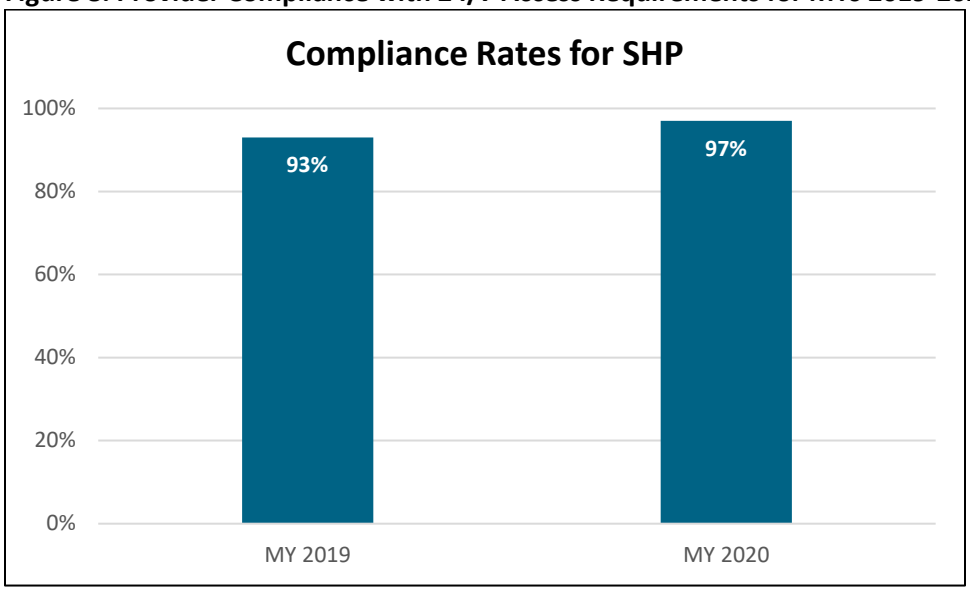
Figure 7. How Successful Contacts Were Answered



Most successful contacts (59%) were answered by a recorded or automated message, followed by answering service (38%) with the remaining by an on-call provider (3%).

Figure 8 displays the MYs 2019-2020 SHP level of provider compliance with the 24/7 access requirements.

Figure 8. Provider Compliance with 24/7 Access Requirements for MYs 2019-2020



MY 2020 provider compliance with the 24/7 access requirements results include:

- SHP demonstrated a four percentage point improvement from MY 2019 (93%) registering at 97%.
- All SHP provider noncompliance was due to a recorded/automated message not directing the enrollee to care.

Conclusion

Qlarant conducted an annual survey evaluating provider compliance with 24/7 access requirements. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

- The MCO had a contact success rate of 97%.
- The MCO had a provider compliance rate of 97% with the 24/7 access requirements.
- Overall, the compliance rate shows SHP has an adequate provider network available to enrollees 24 hours a day, 7 days a week, when medically necessary.

Encounter Data Validation

Objectives

States rely on valid and reliable encounter/claims data submitted by MCOs to make key decisions.[8] For example, states may use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. Valid and reliable encounter data is critical to states with Medicaid managed care programs as states aim to reach goals of transparency and payment reform to support efforts in quality measurement and improvement. Various provisions of the Affordable Care Act demonstrate transparency of payment and delivery of care as an important part of health reform. Results of the EDV study provide DHS with a level of confidence in the completeness and accuracy of encounter data submitted by the MCO.

Methodology

Qlarant completed validation activities in a manner consistent with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*.[9] To assess the completeness and accuracy of MCO encounter data, Qlarant completed the following activities:

- Reviewed state requirements for collecting and submitting encounter data
- Reviewed each MCO's capability to produce accurate and complete encounter data, which included an evaluation of the MCO's Information Systems Capabilities Assessment and interviews with key MCO staff
- Analyzed MCO electronic encounter data for accuracy and completeness including an examination for consistency, accuracy, and completeness

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

- Reviewed medical records gathered for inpatient, outpatient, and office visit settings to confirm electronic encounter data accuracy
- Submitted findings to the State, which includes results, strengths, and recommendations.

Results

This section includes EDV results for SHP, and is based on an assessment of encounters/claims from services occurred during MY 2020 (January 1, 2020 – December 31, 2020).

MCO's Capability to Produce Accurate and Complete Encounter Data

In April 2021, Qlarant obtained and reviewed the completed 2021 ISCA, HEDIS Roadmap, and supportive documents from SHP as part of the pre-onsite documentation review. In May 2021, Qlarant further reviewed the MCO's information system and key processes by interviewing key SHP personnel as part of the PMV onsite phase. From both activities, Qlarant determined SHP had the capability to produce accurate and complete encounter data.

Analysis of MCO Electronic Encounter Data for Accuracy and Completeness

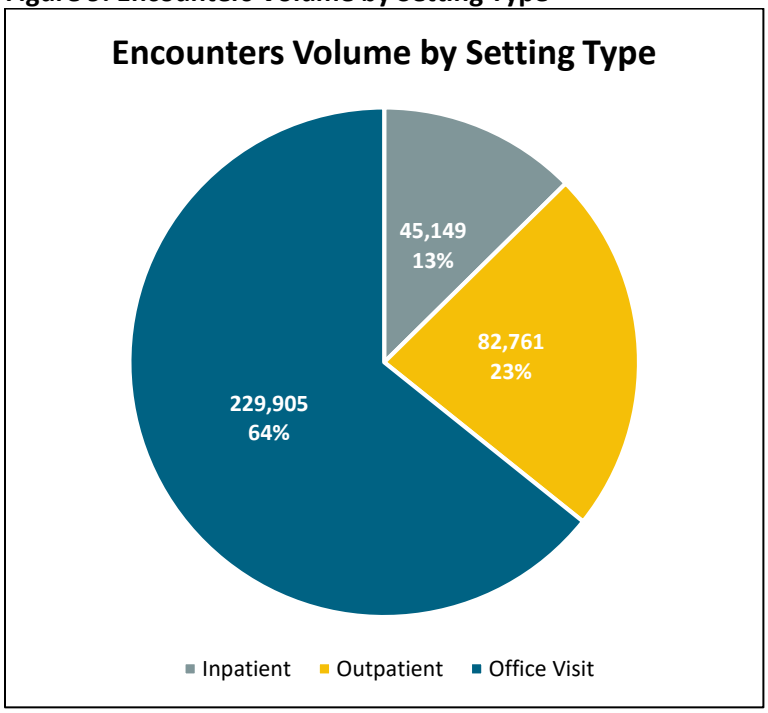
In April 2021, SHP submitted two MY 2020 data files, encounter/claim data and member data files, to Qlarant. Qlarant conducted an assessment evaluating data completeness and accuracy, below are the results:

- Encounter volume was reasonable.
- Diagnosis and procedure codes were appropriate according to members' age and/or gender.
- Revenue codes for inpatient and outpatient settings are appropriate.

The MCO's member data file contains 31,881 unduplicated unique members. Of those members, 22,109 (69%) received at least one service for inpatient, outpatient, and office visit settings during MY 2020.

Figure 9 displays the MCO encounters volume by setting type.

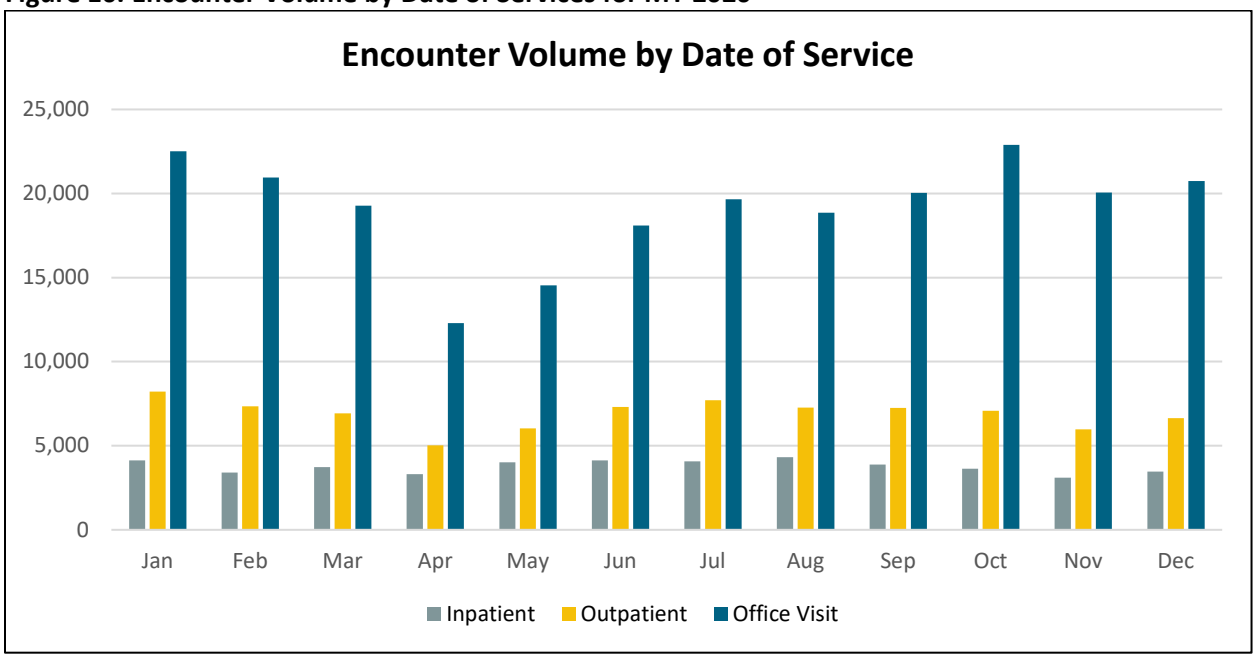
Figure 9. Encounters Volume by Setting Type



Analysis showed most encounters occurred in office visit setting (64%), followed by outpatient (23%) with the remaining attributed to inpatient setting (13%).

Qlarant also examined monthly variation for each setting to identify potential gaps in data submission. Figure 10 displays encounter volume by date of service (month) for MY 2020.

Figure 10. Encounter Volume by Date of Services for MY 2020



- The claims volume by date of service for all three settings appeared reasonable.
- The volume for three settings combined, peaked in January 2020 with 34,864 claims.
- The volume declined substantially in April 2020 with 20,632 claims, consistent with the COVID-19 public health emergency stay at home orders.

Within the ISCA documentation, SHP stipulated the providers were required to submit all claims within 365 days from the date of service. However, Qlarant could not determine SHP's claim submission timeliness due to SHP's encounter data file did not contain a date of claim received field.

Analysis of Medical Records to Confirm Encounter Data Accuracy

In April 2021, Qlarant identified all members with an inpatient, outpatient, or office visit claim in the encounter/claims data file submitted by the MCO. A sample size was selected to ensure a 90% confidence interval with a 5% +/- error rate for sampling. An oversample was added to ensure an adequate number of records were received.

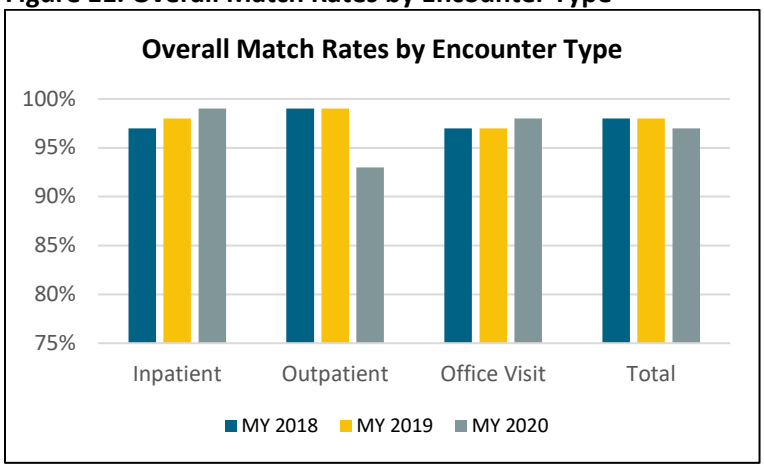
In May of 2021, medical records were requested directly from the sampled providers via letter. Between June and July of 2021, Qlarant received medical records from the requested providers and conducted medical record reviews. Qlarant's medical record review evaluated the accuracy of diagnosis, procedure, and where applicable, revenue codes in the electronic encounter data.

Overall results of this validation process for all three settings are displayed in Table 14 and Figure 11. MY 2018 and MY 2019 results are included for comparative purposes.

Table 14. Overall Match Rates by Encounter Type

Encounter Types	Percentage of Matched Elements		
	MY 2018	MY 2019	MY 2020
Inpatient	97%	98%	99%
Outpatient	99%	99%	93%
Office Visit	97%	97%	98%
Total	**98%**	**98%**	**97%**

Figure 11. Overall Match Rates by Encounter Type



SHP performed well in all key elements of importance to encounter data quality:

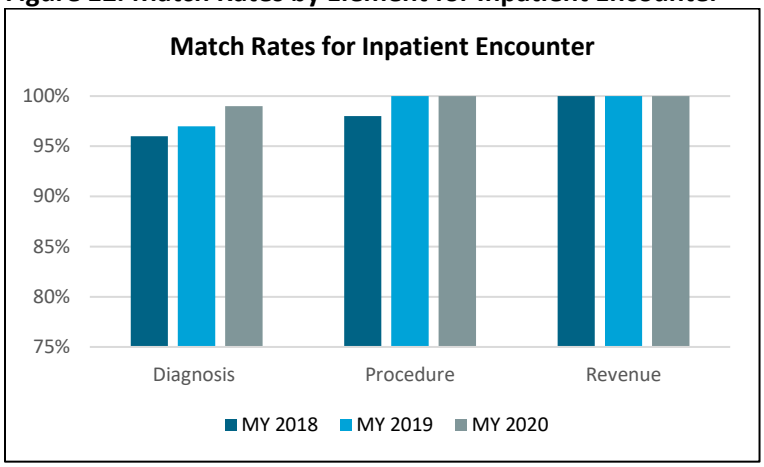
- MY 2020 overall match rate (97%) declined by one (1) percentage point from MYs 2018 and 2019 (98%).
- Inpatient match rate demonstrated a year over year improvement.
- Outpatient match rate declined by six (6) percentage points from MYs 2018 and 2019.
- Office visit match rate increased by one (1) percentage point from MYs 2018 and 2019.

Tables 15-17 and Figures 12-14 illustrate MY 2020 EDV results by encounter type and review element. The elements reviewed for each encounter type were diagnosis codes, procedure codes, and revenue codes (not applicable for Office Visit encounters). MY 2018 and MY 2019 results are included for purposes of comparison.

Table 15. Match Rates by Element for Inpatient Encounter

Elements	Inpatient Encounters Match Rates		
	MY 2018	MY 2019	MY 2020
Diagnosis Code	96%	97%	99%
Procedure Code	98%	100%	100%
Revenue Code	100%	100%	100%

Figure 12. Match Rates by Element for Inpatient Encounter



For MY 2020 inpatient records:

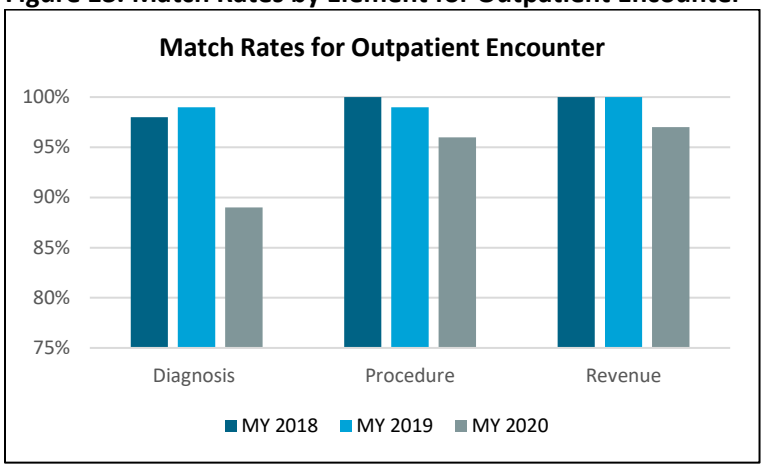
- Diagnosis codes match rate demonstrated a year over year improvement.
- All procedure codes matched, maintaining a 100% match rate from MY 2019.
- Revenue codes maintained a 100% match rate for three consecutive years.

Table 16. Match Rates by Element for Outpatient Encounter

Elements	Outpatient Encounters Match Rates		
	MY 2018	MY 2019	MY 2020
Diagnosis Code	98%	99%	89%
Procedure Code	100%	99%	96%

Elements	Outpatient Encounters Match Rates		
	MY 2018	MY 2019	MY 2020
Revenue Code	100%	100%	97%

Figure 13. Match Rates by Element for Outpatient Encounter



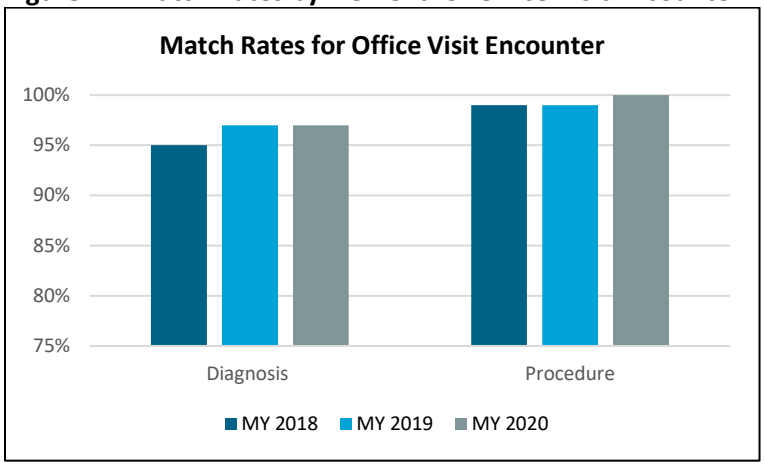
For MY 2020 outpatient records:

- Diagnosis code match rate declined substantially from MY 2019 by ten (10) percentage points.
- Procedures code match rate decreased for three consecutive years.
- Revenue codes registered 97% match rate, declining by three (3) percentage points from previous measurement years (100%).

Table 17. Match Rates by Element for Office Visit Encounter

Elements	Office Visit Encounters Match Rates		
	MY 2018	MY 2019	MY 2020
Diagnosis Code	95%	97%	97%
Procedure Code	99%	99%	100%

Figure 14. Match Rates by Element for Office Visit Encounter



For MY 2020 office visit records:

- Diagnosis codes maintained a match rate of 97% from MY 2019.
- Procedure codes registered a match rate of 100% and improved from MYs 2018 and 2019 by one (1) percentage point.

"No Match" Results

Overall "No Match" results of this validation process for all three settings are displayed in Table 18 and Figure 15. MY 2018 and MY 2019 results are included for comparative purposes.

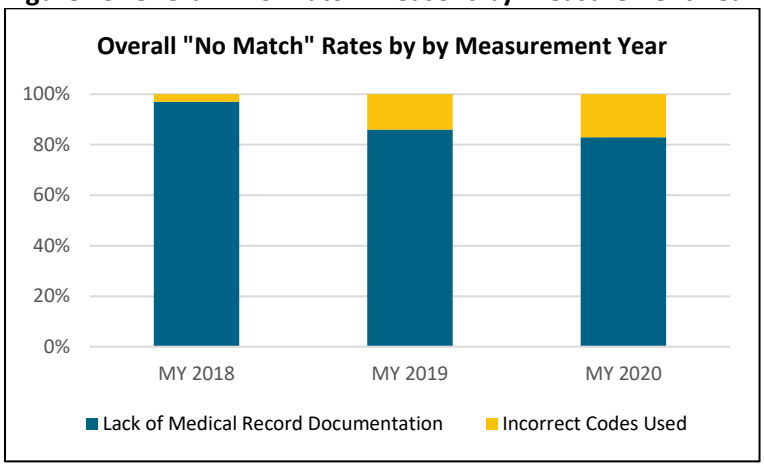
Reasons for determining a "no match" include:

- Lack of medical record documentation
- Incorrect codes used

Table 18. "No Match" Reasons by Encounter Type for MYs 2018-2020

Encounter Type	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used
	MY 2018	MY 2018	MY 2019	MY 2019	MY 2020	MY 2020
Inpatient	5	0	2	1	3	0
Outpatient	3	0	1	3	18	4
Office Visit	23	1	21	0	8	2
Total	**31**	**1**	**24**	**4**	**29**	**6**
Total Percentage	**97%**	**3%**	**86%**	**14%**	**83%**	**17%**

Figure 15. Overall "No Match" Reasons by Measurement Year



- MY 2020 has more total "No Match" counts (35) compared to MYs 2018 (32) and 2019 (28).
- Majority of MY 2020 "No Match" Reasons is due to lack of medical record documentation registering at 83%.
- Incorrect codes used registered at 17%

Tables 19-21 and Figures 16-18 illustrate the principle reasons for "no match" errors for each setting.

Reasons for determining a "no match" include:

- Lack of medical record documentation
- Incorrect codes used

Table 19. "No Match" Reasons by Element for Inpatient Encounter

Inpatient Encounter Element Counts	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used
	MY 2018	MY 2018	MY 2019	MY 2019	MY 2020	MY 2020
Diagnosis	4	0	2	1	3	0
Procedure	1	0	0	0	0	0
Revenue	0	0	0	0	0	0
Total	**5**	**0**	**2**	**1**	**3**	**0**
Total Percentage	**100%**	**0%**	**66%**	**34%**	**100%**	**0%**

- All inpatient "no match" diagnosis codes were resulted in lack of medical record documentation (3 or 100%).
- There were no mismatches in procedure and revenue codes for inpatient records.

Figure 16. "No Match" Rates for Inpatient Encounter

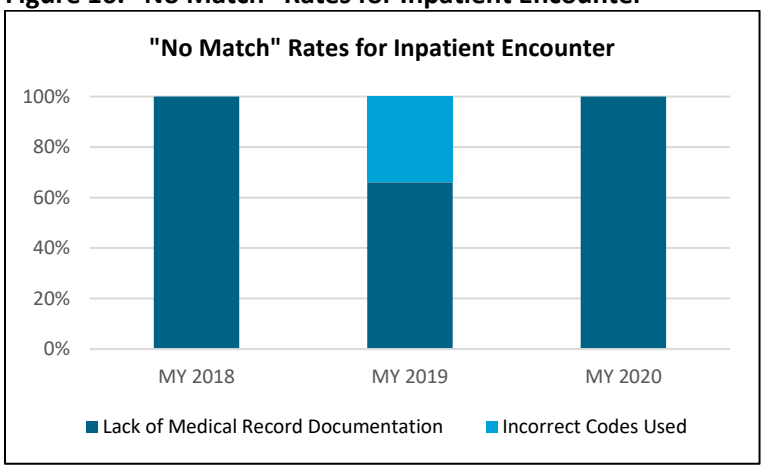


Table 20. "No Match" Reasons by Element for Outpatient Encounter

Outpatient Encounter Element Counts	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used
	MY 2018	MY 2018	MY 2019	MY 2019	MY 2020	MY 2020
Diagnosis	3	0	1	1	15	1
Procedure	0	0	0	2	1	3
Revenue	0	0	0	0	2	0
Total	**3**	**0**	**1**	**3**	**18**	**4**
Total Percentage	**100%**	**0%**	**25%**	**75%**	**82%**	**18%**

- The outpatient mismatch diagnosis reasons were due to lack of medical record documentation (15 or 94%) and incorrect diagnosis code (1 or 6%).
- The "no match" procedure codes found in outpatient encounters were contributed by lack of medical record documentation (1 or 25%) and incorrect procedure codes (3 or 75%).
- All outpatient "no match" revenue codes were due to lack of medical record documentation (2 or 100%).

Figure 17. "No Match" Rates for Outpatient Encounter

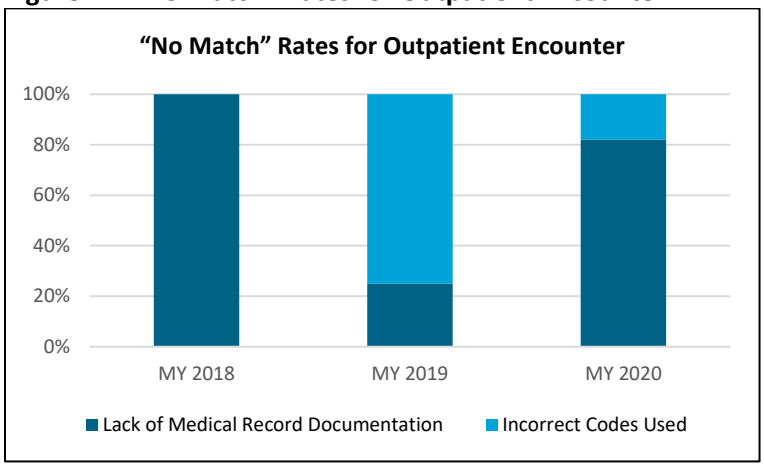
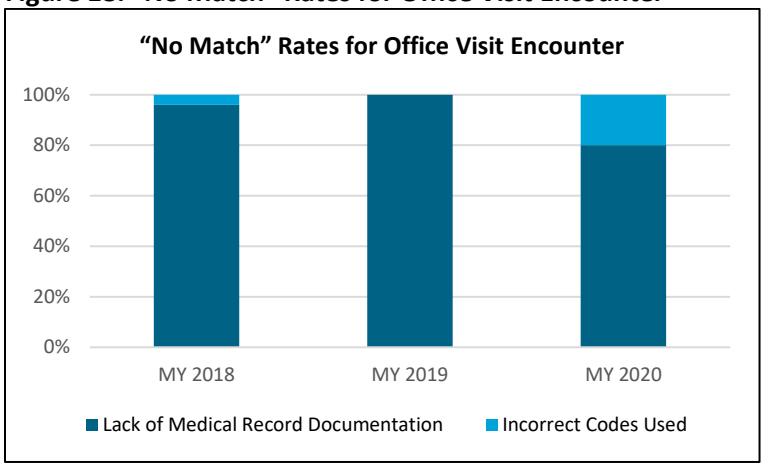


Table 21. "No Match" Reasons by Element for Office Visit Encounter

Office Visit Encounter Element Counts	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used	Lack of Medical Record Documentation	Incorrect Codes Used
	MY 2018	MY 2018	MY 2019	MY 2019	MY 2020	MY 2020
Diagnosis	22	1	16	0	8	2
Procedure	1	0	5	0	0	0
Total	**23**	**1**	**21**	**0**	**8**	**2**
Total Percentage	**96%**	**4%**	**100%**	**0%**	**80%**	**20%**

- The office visit "no match" diagnosis codes were resulted by lack of medical record documentation (8 or 80%) and incorrect diagnosis codes (2 or 20%).
- There were no mismatches in procedure codes for office visit setting.

Figure 18. "No Match" Rates for Office Visit Encounter



Conclusion

Summary conclusions for the EDV activity are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

- An evaluation of SHP's Information Systems Capabilities Assessment determined the MCO had the capability to produce accurate and complete encounter data for MY 2020.
- Analysis of claims occurred in MY 2020 confirmed reasonable encounter volume, and/or valid values, and appropriate usage of codes.
- Qlarant could not determine SHP's claim submission timeliness due to SHP's encounter data file did not contain a date of claim received field.
- A medical record review determined a high level of encounter data accuracy. The MCO match rate was 97%.

CAHPS

Objectives

CAHPS survey is a study that captures MCO enrollee experiences while obtaining and receiving healthcare services, with the objective to measure how well a MCO is meeting its enrollees' expectations by comparing the results to National benchmarks. Strengths and opportunities for improvement are identified to further help the MCO in improving enrollee quality of care.

Methodology

SHP contracted with a NCQA-Certified survey vendor to administer the Adult CAHPS survey using the NCQA HEDIS protocols, *HEDIS MY 2020 Volume 3: Specifications for Survey Measures,* a methodology that meets the requirement of *CMS EQR Protocol 6 – Administration or Validation of Quality of Care Surveys*.[10] The NCQA Survey Vendor Certification Program and annual HEDIS accreditation audit ensure the survey vendor follows the HEDIS protocols in sample frame and selection, data collection, and survey results calculation.

For MY 2020, SHP's survey vendor administered AHRQ's new *CAHPS 5.1H Medicaid Adult Survey*, with minor changes to capture both in person care and telehealth (by phone or video) from a clinic, emergency room, or doctor's office. Dental care and overnight hospital stay experience was excluded from the survey. To be eligible for the survey, an enrollee must be 18 years and older as of December 31 of the measurement year and continuously enrolled in the MCO for at least five of the last six months of the measurement year. The surveys were sent out to the sampled eligible enrollees by mail and collected back through a mail, phone, and internet methodology.

Overall enrollee satisfaction is measured with four rating questions: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Rating of Health Plan. The enrollees or respondents were asked to assess their overall experience on a scale of 0-10, where 0 is the worst

[10] CMS EQRO Protocols

possible assessment and 10 is the best possible assessment. The result for each rating is the sum of the top three most favorable responses – 8, 9, and 10.

Composite scores provide enrollee insight in four areas: Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, and Customer Service. Each composite comprises of two or more underlying questions. The response choices for all questions in each composite are: Never, Sometimes, Usually, or Always. The result for each composite is the sum of proportional averages for questions that received Usually or Always.

The experience of care is measured with one single question focusing in Coordination of Care. The response choices are: Never, Sometimes, Usually, or Always. The result for Coordination of Care is the sum of Usually and Always responses.

In addition, four effectiveness of care survey measures were collected by SHP's survey vendor using NCQA HEDIS protocols, *HEDIS MY 2020 & MY 2021 Volume 2: Technical Specifications for Health Plans.* The survey measures include Flu Vaccinations for Adults Ages 18–64 and Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit, Discussing Cessation Medications, and Discussing Cessation Strategies (rolling 2 year average).

Results

On February 24, 2021, SHP's survey vendor distributed 1,350 surveys with May 19, 2021 set as the last day to accept completed surveys. For MY 2020, the survey vendor deemed 11 surveys as ineligible or invalid and removed them from the study. Out of 1,339 surveys, SHP received 166 completed surveys yielding a response rate of 12.4%.

In July 2021, Qlarant obtained SHP's final CAHPS survey results, which was prepared by its survey vendor. CAHPS survey results are compared to the 2020 NCQA Quality Compass Medicaid HMO benchmarks. Comparisons are made using a diamond rating system:

♦♦♦♦ MCO rate is equal to or exceeds the 90th Percentile.
♦♦♦ MCO rate is equal to or exceeds the 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCO rate is equal to or exceeds the National Average, but does not meet the 75th Percentile.
♦ MCO rate is below the National Average.

Table 22 trends the MCO CAHPS results for MYs 2018-2020 and compares performance to national benchmarks. Green and red represents positive and negative trends for three consecutive measurement years, respectively.

Table 22. SHP CAHPS Results

Measure	MY 2018 Rate	MY 2019 Rate	MY 2020 Rate	Compared to Benchmarks
Getting Care Quickly Composite	78.94%	NA	NA	NC
Getting Needed Care Composite	80.46%	89.60%	NA	NC
How Well Doctors Communicate Composite	92.28%	96.50%	NA	NC
Customer Service Composite	NA	NA	NA	NC
Coordination of Care Composite	NA	NA	NA	NC
Rating of All Health Care (8+9+10)	75.61%	81.00%	74.07%	♦
Rating of Personal Doctor (8+9+10)	85.71%	90.30%	85.94%	♦♦
Rating of Specialist Seen Most often (8+9+10)	NA	NA	NA	NC
Rating of Health Plan (8+9+10)	74.38%	80.30%	81.48%	♦♦
Flu vaccination: Had flu shot or spray in the nose since July 1, 2020	38.93%	38.60%	34.38%	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (rolling 2 year average)	78.22%	76.90%	75.18%	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (rolling 2 year average)	54.19%	52.10%	51.75%	♦
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (rolling 2 year average)	52.23%	48.10%	50.00%	♦♦

Interpret and trend results with caution due to survey methodology changes for COVID-19 public health emergency.
NA Response rate of less than 100 observations; too small to calculate a reliable rate.
NC No comparison made due to no rate or/and benchmark available.

Conclusion

Summary conclusions for the CAHPS activity are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

- MY 2020 survey response rate of 12.4% has decreased 1.7 percentage points from MY 2019 rate of 14.1%.
- An analysis of MY 2020 MCO demonstrates 23% of measures (3 of 13) met or exceeded national average benchmarks but scored below 75th percentile benchmarks:
  - Rating of Personal Doctor
  - Rating of Health Plan
  - Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies
- Four (4) of 13 measures had rates available for MYs 2018-2020 and allowed for a trending analysis. Seventy-five percent (75%) or 3 of 4 measures demonstrated a negative trend. Only 25% or one measure demonstrated a positive trend. Remaining measures did not produce a trend.

Focused Study

Objectives

On October 26, 2017, the U.S. Department of Health and Human Services declared the "opioid crisis" a public health emergency and strategized to combat the crisis.[11] Consistent with nationwide opioid misuse and dependency, ND experienced a 10.6 percent increase in the number of opioid prescriptions dispensed from 2010 to 2017, resulting in 9.2 drug overdose deaths per 100,000 ND residents in 2017.[12]

Qlarant's EDV analysis revealed opioid dependency infiltrated the ND Medicaid Expansion population in 2017, but increased in an alarming and rapid rate in 2018, as shown below in Table 23.

Table 23. Opioid Dependence Rate per 1,000 Enrollees with POV Claim for MYs 2017-2018

Measurement Year	Total Number of Enrollees with At Least One POV Claim	Enrollees with Opioid Dependence in POV Claim		Claims with Opioid Dependence, Uncomplicated (F11.20)	
		Number	Rate	Number*	Rate per 1,000 enrollees with POV Claim
2017	21,640	255	1.2%	2,628	121.4
2018	21,330	403	1.9%	8,390	393.3

Upon receiving the findings, DHS contracted Qlarant to spearhead a focused study solely on opioid dependency within ND Medicaid Expansion enrollees. The objective of this focused study is to explore and attempt to identify factors that may lead to the prevention of continued upward trends in opioid dependency within the Medicaid Expansion population and to fight this public health emergency effectively. Qlarant will complete a three-year focused study (MYs 2019-2021), to conduct analysis of opioid dependence encounters, with the following study questions:

- *Is opioid dependence increasing within the North Dakota Medicaid Expansion population?*
- *Do study results identify a specific subpopulation that should be targeted for interventions?*

Methodology

Qlarant conducted the focused study using the CMS EQR Protocol 9, *Conducting Focus Studies of Health Care Quality.*[13]

Qlarant utilized the two data files submitted by SHP, MY 2019 encounter/claims data and member data files, to analyze encounter data that contains uncomplicated opioid dependence diagnosis code, F11.20, in a physician office visit (POV) setting. The Qlarant analytic team analyzed the data to determine:

- the number of unique enrollees who received F11.20 diagnoses
- the opioid dependence rate by age and gender
- the opioid dependence rate by geographic distribution
- the number of times the enrollees were given F11.20 diagnoses

[11] U.S. Department of Health and Human Services. (2017). HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. Accessed September 24, 2019 from hhs.gov
[12] North Dakota State Government. (2019). Substance Use in North Dakota. Accessed on September 25, 2019 from prevention.nd.gov.
[13] CMS EQRO Protocols

- the number of providers who diagnosed enrollees with F11.20

Results

The obtained SHP encounter/claim data and member data files of MY 2019 were analyzed. Table 24 demonstrates how Qlarant calculated opioid dependence rate per 1,000 enrollees with POV claim for MY 2019.

Table 24. Opioid Dependence Rate per 1,000 Enrollees with POV Claim for MY 2019

Measurement Year	Total Number of Enrollees with At Least One POV Claim	Enrollees with Opioid Dependence in POV Claim		Claims with Opioid Dependence, Uncomplicated (F11.20)	
		Number	Rate	Number*	Rate per 1,000 Enrollees with POV Claim
2019	20,964	531	2.5%	17,906	854.1

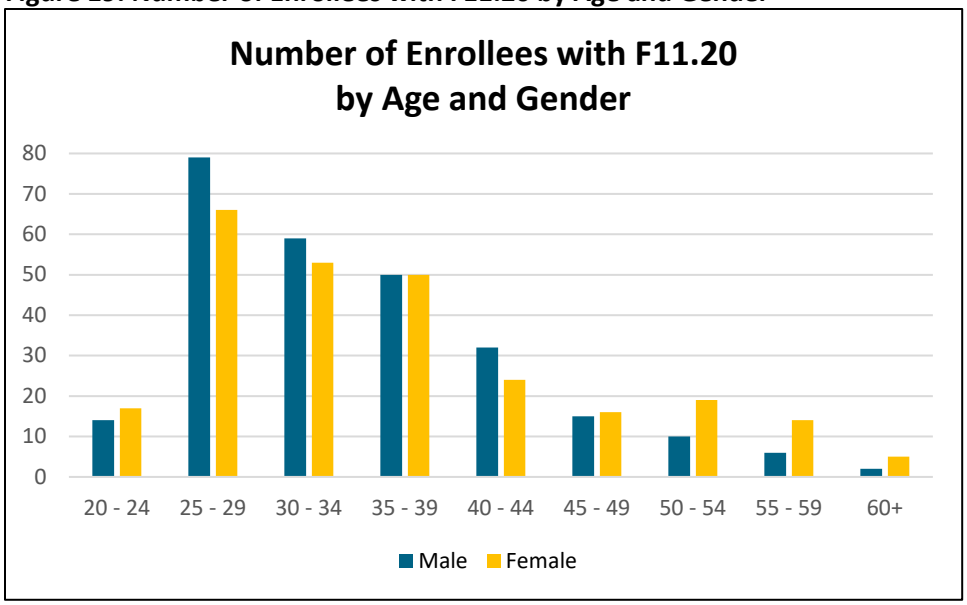
*The number of encounter diagnoses does not represent unique enrollees. For example, one enrollee may have multiple claims with the F11.20 diagnosis on the same date of service. The number represents the frequency in which the diagnosis appeared in the claims data.

The analyses revealed:

- Of the 20,964 enrollees served in POV setting, 531 enrollees with opioid dependency were identified.
- The identified enrollees generated 17,906 claims with opioid dependence diagnosis code, F11.20.
- MY 2019 has the highest opioid dependence rate per 1,000 enrollees with POV claim to date, registering at 854.1.

Figure 19 illustrates the number of enrollees with F11.20 by Age and Gender. Of the 531 enrollees, 50.3% (267) is male and 49.7% (264) is female.

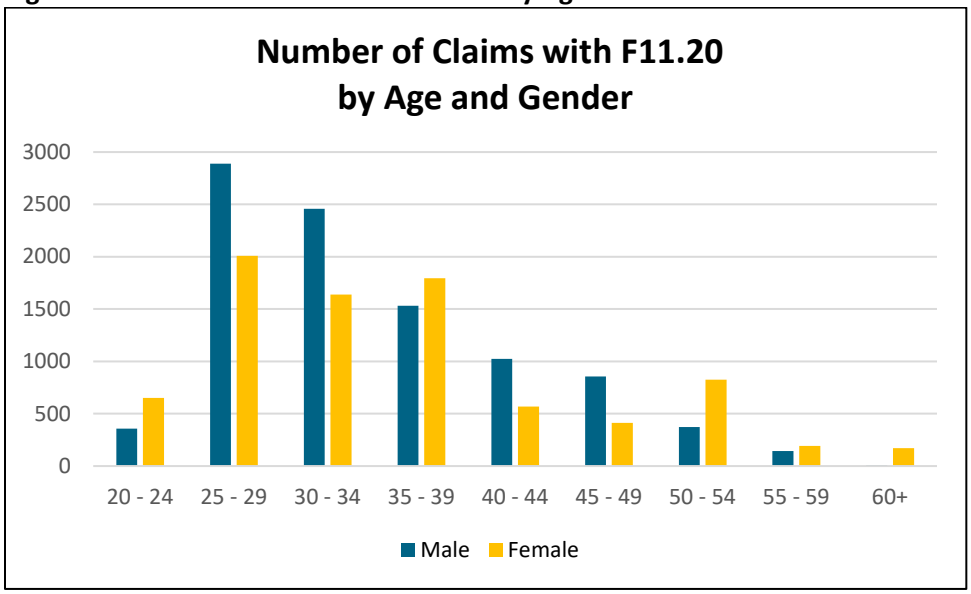
Figure 19. Number of Enrollees with F11.20 by Age and Gender



For both genders, the 25-29 year old age group was the largest, accounting for 25 percent of the females and 30 percent of the males, and followed by 30-34 and 35-39 year old age groups.

Figure 20 shows the number of claims with F11.20 by age and gender.

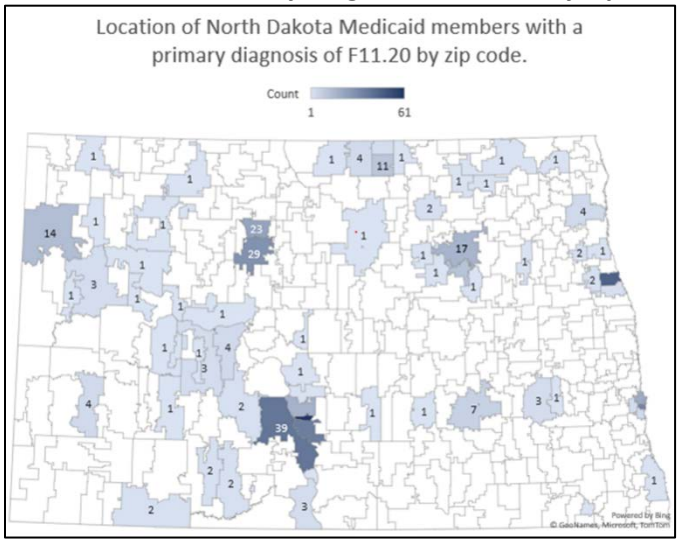
Figure 20. Number of Claims with F11.20 by Age and Gender



Consistent with the previous graph, the 25-29 year old age group was the largest for both genders. 79 males and 66 females had obtained 2,899 and 2,008 opioid dependence related services in a POV setting, respectively.

Figure 21 shows the geographic distribution of the 531 enrollees who received a primary diagnosis of F11.20 is shown by zip code. The enrollees were located in 91 of North Dakota's 382 zip codes.

Figure 21. Location of North Dakota Medicaid Expansion Enrollees with a Primary Diagnosis of F11.20 by Zip Codes

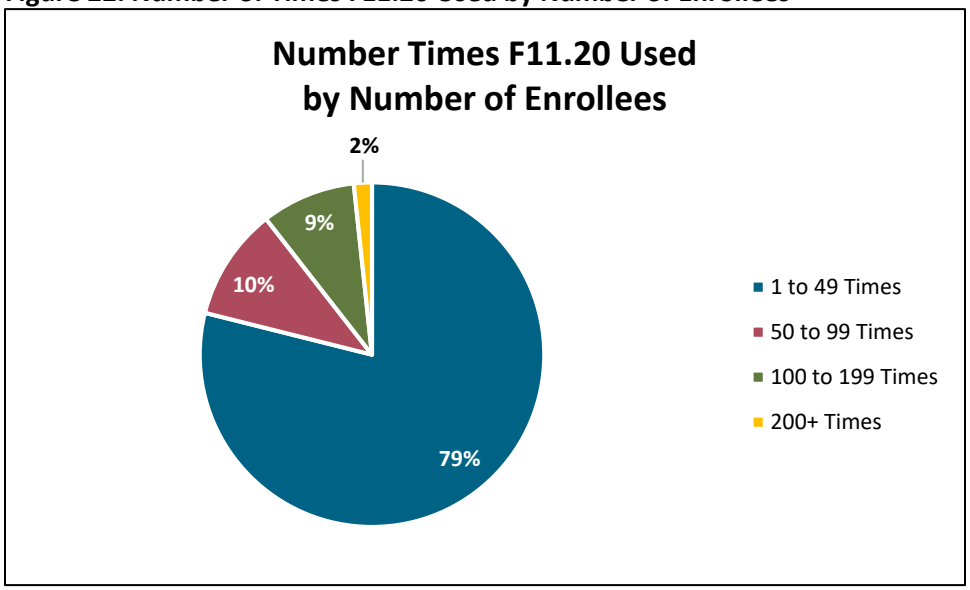


The top five areas with the largest number of enrollees were associated with densely populated regions:

- Bismarck (zip codes 58501, 58554, 58504, and 58503)
- Fargo (zip codes 58103, 58102, 58104, and 58078)
- Minot (zip codes 58701 and 58703)
- Grand Forks (zip code 58201)
- Fort Totten/Devil's Lake/St. Michael area (zip codes 58335, 58301, and 58370)

Figure 22 shows the number of times F11.20 used by number of enrollees.

Figure 22. Number of Times F11.20 Used by Number of Enrollees



Of the 531 identified enrollees, F11.20 diagnosis code was used:

- 1 to 49 times by 419 enrollees (79%)
- 50 to 99 times by 56 enrollees (10%)
- 100 to 199 times by 47 enrollees (9%)
- Over 200 times by 9 enrollees (2%).

Out of 4,674 providers in the physician office setting, 157 providers gave at least one F11.20 primary diagnosis. Six providers were identified as high prescribing providers, issuing 13,101 (73%) of 17,906 total claims with F11.20. The analysis also indicated F11.20 was the number one diagnosis code used for all six providers in MY 2019.

Of the 531 identified enrollees, 232 (44%) were seen by at least one of the six high prescribing providers. Of the 232 enrollees, 149 (64%) were seen by more than one of the six providers and one enrollee had a claim with the diagnosis from five of the six providers.

Conclusion

Summary conclusions for the focused study activity are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 25 within the MCO Quality, Access, Timeliness Assessment section, later in the report.

- For patients with current opioid dependency diagnoses, network providers should be encouraged to explore prescribing medications for addiction treatment (MAT) and MAT retention strategies.[14]
- SHP should educate enrollees about available preventive care that may reduce opioid dependence rate, such as behavioral health or peer support services.
- DHS and SHP should share the focused study results with SHP's network providers and use the available data to create outreach programs targeting the identified enrollees.
- SHP should work with its internal Special Investigations Unit (SIU) to prevent any potential fraud, waste, and abuse (FWA) cases.
- DHS and SHP should monitor the performance measures related to drug dependence and use of opioids. Interventions to address and improve performance maybe warranted.
- The focused study topic should continue in order to trend and identify any areas of concern.

MCO Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths and weaknesses for the MCO based on results of the EQR activities. These strengths and weaknesses correspond to the quality, access, and timeliness of services provided to members. Qlarant adopted the following definitions for these domains:

Quality, as stated in the federal regulations as it pertains to EQR, is the degree to which a MCO "…increases the likelihood of desired outcomes of its enrollees through (1) its structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidenced-based-knowledge, and (3) interventions for performance improvement." (CFR §438.320).

Access (or accessibility), as defined by NCQA, is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services" *(NCQA Health Plan Standards and Guidelines*).

Timeliness, as stated by the Institute of Medicine is "reducing waits and sometimes harmful delays" and is interrelated with safety, efficiency, and patient-centeredness of care. Long waits in provider offices or EDs and long waits for test results may result in physical harm. For example, a delay in test results can cause delayed diagnosis or treatment—resulting in preventable complications.

[14] Retention Strategies for Medications for Addiction Treatment in Adults With Opioid Use Disorder: A Rapid Evidence Review. (2020). Scientific Resource Center. Accessed on December 9, 2020 from effectivehealthcare.ahrq.gov.

Tables 25 highlight strengths and weaknesses for the MCO. Qlarant correlated each strength and weakness to the quality, access, and/or timeliness of services delivered to MCO members. Only applicable domains impacted by performance are checked. Domain strengths are identified with a green check (✓). Domain weaknesses are identified with a red check (✓). In the absence of a check, the domain was not impacted by performance. Where appropriate, weaknesses include recommendations.

Table 25. MCO Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Performance Improvement Projects			
Comprehensive Diabetes Care PIP			
✓			**Weakness.** SHP received a score of 72% (low confidence). All SHP's MY 2020 Comprehensive Diabetes Care PIP measure results scored below the baseline rates. The MCO attributed the poor performance largely due to the COVID-19 pandemic. **Recommendation.** SHP should identify COVID-19 pandemic barriers and explore new ways or utilize its existing outreach initiatives to communicate to its members the importance of completing routine diabetes care, the availability of telehealth services, and how provider practices are following safety protocols.
Follow-Up for Mental Health PIP			
✓	✓	✓	**Strength.** SHP sustained improvement in one Follow-Up for Mental Health PIP measure, Engagement of Alcohol or Other Drug (AOD) Treatment. All remeasurements exceeded baseline performance.
✓			**Weakness.** SHP received a score of 83% (moderate confidence). SHP attributes not exceeding their goal to the delay in interventions due to COVID-19; therefore, the desired impact was not realized through interventions. However, SHP did not identify lessons learned that can be applied to the study. **Recommendation.** SHP should identify COVID-19 pandemic barriers and explore why certain interventions did not work by using 5-Whys or similar methods. In addition, SHP should communicate to its members the importance of continuous mental health care, the availability of telehealth services, and how provider practices are following safety protocols.
Performance Measure Validation			
✓	✓	✓	**Strength.** SHP received an overall score of 100% (high confidence). Information systems were adequate and all measure rates were assessed as "reportable."

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
✓			**Weakness.** Forty-six percent (46%) or 22 of 48 measure rates decreased from previous measurement year. SHP attributed the poor performance was largely due to the COVID-19 public health emergency. **Recommendation.** SHP should identify the COVID-19 public health emergency barriers and improve the performance measure rates by exploring ways to communicate to its members the importance of personal health care, the availability of telehealth service, and how provider practices are following safety protocols.
✓			**Weakness.** Eighty-three percent (83%) or 10 of 12 trending performance measures demonstrated a negative trend. **Recommendation.** Beyond COVID-19 barriers, SHP should explore why these 10 performance measures performed poorly for three consecutive years. SHP should complete a root-cause analysis for each measure and develop effective member, provider, and MCO related interventions to improve the measure rates.
Compliance Review			
✓	✓	✓	**Strength.** SHP received a high overall compliance score of 99% (high confidence).
Information Requirements			
✓	✓	✓	**Strength.** SHP received a score of 98% in the Information Requirements standard.
✓	✓		**Weakness.** SHP did not include linguistic capabilities of provider offices and the definition for icons used in the hardcopy Provider Directory. **Recommendation.** SHP should include linguistic capabilities of provider offices and the definition for icons used in the hardcopy Provider Directory to improve access to care for ND Medicaid Expansion enrollees.
Disenrollment Requirements and Limitations			
Not applicable. These are new standards for 2020 and not scored due to baseline assessment.			
Enrollee Rights and Protections			
✓			**Strength.** SHP received a score of 100% in the Enrollee Rights Standard.
Provider – Enrollee Communications and Emergency and Poststabiization Services are new standards for 2020 and not scored due to baseline assessment.			
MCO Standards			
✓	✓	✓	**Strength.** SHP received a score of 97% in the MCO Standards.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
	✓	✓	**Weakness.** SHP's 2020 timeliness of care results for behavioral health (non-prescribers and prescribers), maternity care, primary care, and specialists (high impact and high volume) range from 22.22% to 63.64%, well below the compliance rate of 90%. **Recommendation.** SHP should monitor all the poor performing providers for compliance with the State standard for timely access to care and services. SHP should require corrective action when providers fail to meet access standards. Qlarant recommends SHP develop a process for monthly monitoring of corrective action plans and resurveying providers to ensure compliance with SHP-established requirements.
✓	✓		**Weakness.** SHP did not provide evidence of corrective action for providers who failed to meet access and availability standards. **Recommendation.** SHP should document corrective action taken for situations as outlined in SHP's Provider Access and Availability Standards Policy.
	✓		**Weakness.** SHP did not meet provider access within 50 miles requirements for hematology/oncology providers, registering at 69.2%, which is well below DHS's threshold of 85%. **Recommendation.** SHP should attempt to close the provider geographic access gap for access to hematology/oncology providers and continue to focus on providing transportation and telehealth services, as needed, to meet the needs of the population.
✓	✓	✓	**Weakness.** SHP developed a workflow for the New Member Survey mailing process, but did not document the process of initial screening of each enrollee's needs within 90 days of the effective day or enrollment day for all new enrollees in a policy and procedure. **Recommendation.** SHP should document the full initial screening process, including best efforts to obtain a returned form, within a policy and procedure.
Quality Measurement and Improvement			
✓			**Strength.** SHP received a score of 100% in the Quality Assessment and Performance Improvement Program standard.
Grievance and Appeal System			
✓	✓	✓	**Strength.** SHP received a score of 100% in Grievance and Appeal System standard.
Program Integrity Requirements Under Contract			
✓			**Strength.** SHP received a score of 100% in Program Integrity Requirements Under Contract standard.
Network Adequacy Validation			
	✓	✓	Strength. SHP received a score of 97% with the 24/7 access requirement. Overall, survey results determined enrollees were directed to care during non-business hours.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Encounter Data Validation			
✓			**Strength.** SHP achieved an encounter data accuracy, or match rate of 97%.
		✓	**Weakness.** Qlarant could not determine SHP's claim submission timeliness due to SHP's encounter data file did not contain a date of claim-received field. **Recommendation.** To ensure timely receipt of provider claims analysis, SHP should add a field to its encounter data to document the date a claim is received. This will make it easier to assess if providers are submitting claims within 365 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.
CAHPS Survey			
✓			**Weakness.** The survey results indicate SHP enrollees are not satisfied with their healthcare services, when compared to previous measurement years and national benchmarks. **Recommendation.** SHP should share the negative responses with the involved providers, and require them to follow-up and resolve the issues with enrollees. SHP should monitor the progress and assess the resolution to ensure the enrollee quality of care is improved.
Focused Study			
	✓		**Weakness.** SHP's opioid dependence rate per 1,000 enrollees with a POV claim continues to rise to 854.1, which was more than two times the MY 2018 rate of 393.3. **Recommendation.** SHP should strategize to provide immediate care to the identified enrollees who have opioid dependence by sharing the focused study results and collaborating with its network providers.

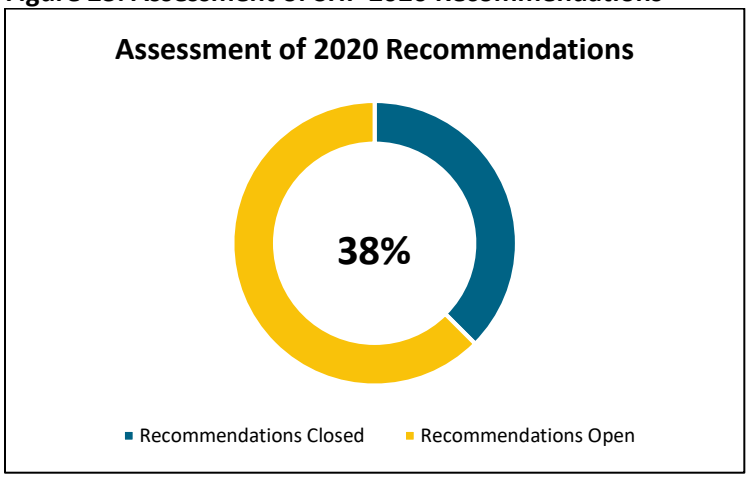
Assessment of Previous Recommendations

During the course of conducting 2021 EQR activities, Qlarant evaluated the MCO's compliance in addressing 2020 recommendations.[15] Assessment outcomes are illustrated in Figure 23. MCO-specific recommendations and follow-up assessments are summarized in Table 26. Assessments identify whether the MCO adequately addressed 2020 recommendations. Green and red arrow symbols specify results:

- The MCO adequately addressed the recommendation.
- The MCO did not adequately address the recommendation.

[15] In some instances, one recommendation may summarize or capture multiple, but similar, issues. The number of recommendations should not be used to gauge MCO performance alone.

Figure 23. Assessment of SHP 2020 Recommendations



SHP complied with three of eight recommendations, demonstrating a 38% compliance rating.

Table. 26 Assessment of SHP's Previous Annual Recommendations

2020 Recommendations	2021 Assessment
Performance Improvement Projects	
Comprehensive Diabetes Care PIP	
Adjust goals to ensure SHP is consistently facilitating quality improvement.	**Continues to be an improvement opportunity.** SHP adjusted two goals, but none of the Comprehensive Diabetes Care PIP measures met nor exceeded their respective goals.
Follow-Up for Mental Health PIP	
Explore opportunities to help close the gap in mental health care services and improve Follow-Up for Mental Health PIP for any performance measure.	**Compliant** SHP made improvement in all three Follow-Up for Mental Health PIP measures. The Follow-Up for Mental Health – Within 7 and 30 Days measures exceeded the MCO's goal.
Performance Measure Validation	
Review the performance measure survey results and focus on identifying and implementing strategies to improve performance particularly for measures that did not meet the national average benchmarks.	**Continues to be an improvement opportunity.** SHP should continue to review performance measure results and develop strategies to improve rates that did not meet the national average benchmarks. For MY 2020, twenty-three (23) measures performed below the national average benchmarks, compared to 18 in MY 2019.
Compliance Review	
Review and act on specific recommendations found in the detailed CR Report in order to improve processes and obtain full compliance.	**Compliant** SHP made a 12 percentage point improvement for Grievance and Appeal System standards and yielded an overall compliance rate of 99%, an improvement from MY 2019 (95%).

2020 Recommendations	2021 Assessment
Attempt to close the provider geographic-access gap in the following provider types: Behavioral Health/Chemical Dependency Facilities and Hematology and Oncology.	**Continues to be an improvement opportunity.** SHP did not meet provider access within 50 miles requirements for hematology/oncology providers, registering at 69.2%, which is well below DHS's threshold of 85%. Ensuring timely access to provider appointments continues to be a challenge for SHP.
SHP has opportunity for improvement related to timely access to next available appointments for the following provider types: behavioral health, maternity, primary care, and specialists.	**Continues to be an improvement opportunity.** SHP did not meet the State standards for timely access to care and services, taking into account the urgency of the need for services. SHP needs to meet 90% compliance rate in order to receive a finding of met.
Ensure that all grievances are acknowledged in a timely manner	**Compliant** For MY 2020, SHP resolved all sampled grievance and appeal files in a timely manner.
Encounter Data Validation	
Add a field to encounter data to document date claim is received. This will make it easier to assess if providers are submitting claims within 365 days of the date of service and will also aid in monitoring SHP's timeliness in paying claims.	**Continues to be an improvement opportunity.** SHP did not add a field to the encounter data to document date claim is received.

State Recommendations

- Continue to support, provide guidance, and work collaboratively with SHP as the organization works to meet all requirements.
- Continue to work with SHP to overcome the challenges the MCO, providers, and enrollees face during COVID-19 public health emergency.
- Continue to review reports from SHP and provide recommendations as needed.
- Require SHP to follow-up on recommendations made by the EQRO in the Compliance Review.
- Continue to work with the EQRO and SHP to identify measures meaningful to the Medicaid Expansion population.
- Encourage SHP to identify barriers and interventions to help close the gap in Comprehensive Diabetes Care PIP measures.
- Encourage SHP to implement interventions targeting performance measures and CAHPS measures that did not meet the national average benchmarks.
- Clearly define the State's objectives and articulate measurable goals for encounter data completeness and accuracy. The industry standard is 95%.
- Include encounter data completeness and accuracy goals and monitoring processes as a component of North Dakota's overall Quality Strategy for the Medicaid Expansion Program.

Conclusion

The nationwide COVID-19 public health emergency was declared in March of 2020 and has presented many challenges to the ND Medicaid Expansion program. CMS made eligibility changes to prevent member disenrollment during the pandemic, as the result, SHP served a larger population (25,046) by 24% from MY 2019 (20,279). The stay-at-home mandate and temporary closure of healthcare facilities restricted Medicaid Expansion populations in obtaining care. With the widened denominator (enrollment) and decreased numerator hits (lack of access), 46% of SHP's performance measure rates declined when compared to previous measurement year; the Comprehensive Diabetes Care PIP measure rates also demonstrated a decline. In spite of the challenges, SHP provided evidence of meeting most of federal, state, and quality strategy requirements. SHP received a high overall compliance score of 99% (high confidence) in CR and achieved full compliance (high confidence) in PMV.

SHP is actively working to address deficiencies identified during the course of the review; for example, the barriers presented by the public health emergency. SHP has developed a quality program that measures and monitors performance. With a maturing program, the MCO is able to trend performance to gauge where it meets and exceeds requirements and to identify opportunities for improvement. By implementing interventions and addressing these opportunities, the MCO will facilitate improvement in the areas of quality, access, and timeliness of care for the Medicaid Expansion population. During the public health emergency, North Dakota DHS supported, managed oversight, and collaboratively worked with SHP and the EQRO to ensure successful program operations and monitoring of performance.