North Dakota
Department of Human Services

Medicaid Expansion Program
Sanford Health Plan

Annual Technical Review Report
Measurement Year (MY) 2021

Qlarant

Submitted December 2022

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2022 Annual Technical Report

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 (NDME). The NDME 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) until December 31, 2021. This report includes 2022 Annual Technical Report results for Sanford Health Plan (SHP) for measurement year (MY) 2021, January 1, 2021 – December 31, 2021.

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 2022 and evaluated MCO compliance and performance for measurement years (MYs) 2019 through 2021, 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 2021 and terminal reporting for SHP as the MCO for NDME.

Key Findings

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

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 2021 PIP reports included remeasurement results and described

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

[2] **CMS EQR Protocols**

multifaceted interventions. For MY 2021, SHP received an overall validation score of 72% and 89.4% 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 2021, SHP received an overall rating of 100% and the performance measure results were assessed as "reportable." Fifty percent (50%) of reported measures compared favorably to the national average benchmark with nine (9) 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 NDME population during MY 2021. 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's overall weighted compliance score was 92% for the MY 2021 CR with scores of 86% or greater for all standards. This compliance score is a seven (7) percentage point decline from MY 2020 (99%). Qlarant found SHP had most systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its managed care population.

If SHP is to be considered for future contracts for this program, Qlarant would recommend a preoperational assessment of the policy associated with the Disenrollment requirements. DHS and stakeholders should have a moderate confidence in SHP's compliance with all regulatory requirements based on its overall weighted compliance score.

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. Results of the NAV task are based on SHP's last active year of participation, due to transitions for NDME's administrative MCOs.

Encounter Data Validation. SHP provided evidence of having the capability to produce accurate and complete encounter data. For encounters/claims submitted during MY 2021, 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 2021, 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 2021, 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 health care 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. Results of the CAHPS task are based on SHP's last active year of participation, due to transitions for NDME's administrative MCOs.

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 was 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 through2021). 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 2021 was a challenging year for SHP and the ND Medicaid Expansion program due to the transition from a seasoned MCO to a new MCO. Despite the difficulties, SHP's overall weighted compliance score was 92% for the MY 2021 CR with scores of 86% or greater for all standards.

Qlarant found SHP had most systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its managed care population. SHP did not have a policy to cover the Disenrollment Requirements nor updates to Enrollee Rights and Protections. If SHP is to be considered for future contracts for this program, Qlarant would recommend a preoperational assessment of the policy associated with the Disenrollment requirements. DHS and stakeholders should have a moderate confidence in SHP's compliance with all regulatory requirements based on its overall weighted compliance score.

North Dakota Medicaid Expansion Program

2022 Annual Technical Report

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 to 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

The comprehensive assessment, conducted in 2022, assessed SHP's measurement year (MY) 2021 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

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

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 2021; 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.

This comprehensive review also includes the last Network Adequacy Validation and CAHPS Survey results for Sanford Health Plan's tenure with the North Dakota Medicaid Expansion Program.

Performance Improvement Projects

Objective

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.

Step 3 Identified Population

[4] CMS EQR Protocols

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 are defined in Table 1:

Table 1. PIP Validation Ratings

Validation Score	Level of Confidence
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 of 2022, the MY 2021 MCO-PIP reports were obtained from Sanford Health Plan (SHP) after MY 2021 PMV final rates were finalized. Qlarant conducted PIP validation for each PIP topic submission. The PIP validation results, consisting of MY 2021 activities and performance measure (PM) results, are included in this report.

Table 2 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.[6]

Table 2. SHP's PIPs

2022 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 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	**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 health problems and AOD dependence
Phase	4th Remeasurement	7th 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] Only key improvement strategies are listed. Comprehensive intervention lists may not be included due to CMS's preference for a succinct report.

- 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 3 displays SHP's Comprehensive Diabetes Care PIP measure results.

Table 3. SHP Comprehensive Diabetes Care PIP Measure Results

Performance Measure	Baseline Year MY 2017	Remeasurement Year 4 MY 2021	Improvement	Statistically Significant Improvement
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) Testing	92.62%	50.36%	No	No
Comprehensive Diabetes Care - HbA1c Poor Control (>9%) *Lower rate is better*	30.58%	35.77%	No	No
Comprehensive Diabetes Care - HbA1c Control (<8%)	55.01%	85.40%	No	No
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	50.09%	45.50%	No	No
Comprehensive Diabetes Care - Blood Pressure Control (< 140/90 mm Hg)	77.86%	70.56%	No	No

Comprehensive Diabetes Care PIP Performance Measure Rates

Table 4 includes SHP's Comprehensive Diabetes Care PIP performance measure rates.

Table 4. 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%
	2021	351	411	85.40%
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
	2021	147	411	35.77%
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%
	2021	207	411	50.36%
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%
	2021	187	411	45.50%
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%
	2021	290	411	70.56%

PIP Validation Results

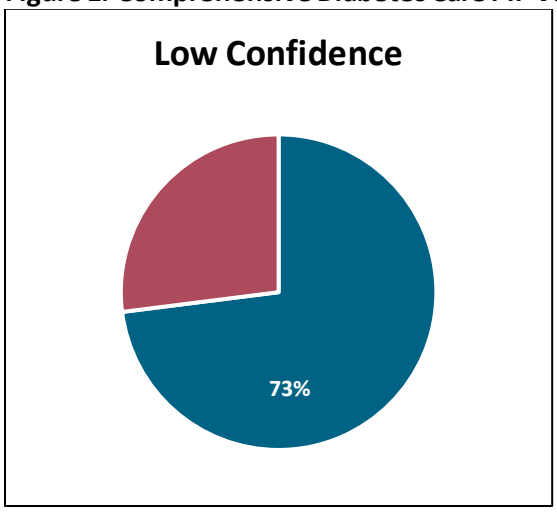
Table 5 displays SHP's Comprehensive Diabetes Care PIP validation results for each step reviewed and an overall score.

Table 5. 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	Met	100%
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		**73%**
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 (i.e. via email, the PCP)

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

Table 6. SHP Follow-Up for Mental Health PIP Measure Results

Performance Measure	Baseline Year MY 2014	Remeasurement Year 7 MY 2021	Improvement	Statistically Significant Improvement
Follow-Up After Hospitalizations for Mental Health - Within 7 Days	21.88%	31.24%	Yes	No

Performance Measure	Baseline Year MY 2014	Remeasurement Year 7 MY 2021	Improvement	Statistically Significant Improvement
Follow-Up After Hospitalizations for Mental Health - Within 30 Days	38.84%	51.99%	Yes	No
Engagement of Alcohol or Other Drug (AOD) Treatment (introduced in MY 2016)	17.32%	22.80%	Yes	No

Follow-Up for Mental Health PIP Performance Measure Rates

Table 7 includes SHP's Follow-Up for Mental Health PIP performance measure rates.

Table 7. 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%
	2021	149	477	31.24%
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%
	2021	248	477	51.99%
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%
	2021	680	2983	22.80%

PIP Validation Results

Table 8 displays SHP's Follow-Up for Mental Health PIP validation results for each step reviewed and an overall score.

Table 8. 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	Met	100%
7. Data Analysis and Interpretation of Results	Partially Met	95%
8. Improvement Strategies (Interventions)	Partially Met	60%
9. Significant and sustained Improvement	Met	100%
Validation Score		**89.47%**
Level of Confidence		**Moderate Confidence**

Conclusion

Summary conclusions for each of the State mandated PIPs are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 36 within the **MCO Quality, Access, and Timeliness Assessment** section, later in the report.

Comprehensive Diabetes Care PIP

- When comparing the latest Diabetes Care PIP remeasurement results to baseline performance, no improvement was identified in any of the diabetes measures.
- SHP did not demonstrate sustained performance.
- SHP reported all five diabetes measures fell short of its goal by 6.5 to 9.77 percentage points.
- SHP reported many targeted interventions; however it did not observe the desired impact from the interventions.
- Qlarant recommended SHP to provide additional details to describe its quality improvement process and strategy to address root causes or barriers in MY 2020. This recommendation was not followed in MY 2021, and causes for performance and lessons learned were not identified to apply to the study during data analysis.
- Qlarant encouraged SHP to use the Plan-Do-Study-Act (PDSA), or similar approach, to test improvement strategies in MY 2020. This recommendation was not followed in MY 2021; and the use of PDSA, or a similar approach, was not used to test improvement strategies.

Follow-Up for Mental Health PIP

- All remeasurements exceeded baseline performance.
- Sustained improvement was reported by SHP for all three measures: Follow-Up after Emergency Department Visit for Mental Health – 7 Day and 30 Day Follow-Up, and Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment.
- Qlarant recommended SHP to provide additional details to describe its quality improvement process and strategy to address root causes or barriers in MY 2020. This recommendation was not followed in MY 2021, and causes for performance and lessons learned were not identified to apply to the study during data analysis.

- Qlarant encouraged SHP to use the Plan-Do-Study-Act (PDSA), or similar approach, to test improvement strategies in MY 2020. This recommendation was not followed in MY 2021; and the use of PDSA, or a similar approach, was not used to test improvement strategies.

Performance Measure Validation

Objectives

Performance measure validation (PMV) is a required external quality review (EQR) activity regulated by the Code of Federal Regulations (CFR) and the Centers for Medicare and Medicaid Services (CMS) EQR Protocol[7]. Qlarant determines the extent to which SHP followed specifications established by NDDHS for calculating and reporting performance measures. The PMV activity evaluates accuracy and reliability of measures produced and reported by SHP. Accuracy and reliability of the reported rates are essential to determining whether SHP's quality improvement efforts have resulted in improved health outcomes.

This report includes PMV-related findings for SHP from measurement year (MY) 2021, a reporting period from January 1, 2021 through December 31, 2021.

Methodology

Qlarant's process for assessing data collection and reporting of MCO performance measures is consistent with *CMS EQR Protocol 2 - Validation of Performance Measures*. Qlarant's validation process includes interactive assessments that are concurrent with SHP calculation of performance measures. Evaluations of SHP occur in three phases, consisting of a pre-site, site, and post-site visit. Qlarant and NDDHS collaborate to define the scope of the annual validation, based on the specific set of standard performance measures included in SHP's quality assessment and performance improvement program. SHP performance is monitored, tracked over time, and compared to national benchmarks.

Essential PMV activities include:

- Conduct an SHP Information Systems Capabilities Assessment (ISCA).
- Assess data integration and evaluate processes SHP uses to construct each measure.
- Validate SHP medical record data collection and review.
- Evaluate calculated rates for accuracy and reliability, determined by algorithmic compliance to required specifications.
- Complete a detailed review of measures.
- Assess and document the accuracy of final performance measure reports.

Qlarant's audit team and SHP quality staff communicate throughout the review process to ensure review activities are secure and timely. Qlarant conducts a pre-site conference with SHP to prepare for the site visit, completes medical record review, and obtains appropriate pre-site documentation to prepare for the site visit. Information from several sources is used to satisfy validation requirements.

These sources may include, but are not limited to, the following documents provided by SHP:

[7] CMS EQR Protocols

- Information Systems Capabilities Assessment (ISCA)
- HEDIS®[8] Record of Administration, Data Management and Processes (Roadmap)
- HEDIS Final Audit Report
- Source code
- Policies and procedures
- Other documentation (e.g. specifications, data dictionaries, data queries)

Qlarant's audit team conducted PMV site review activities in May 2022. Due to the ongoing COVID-19 public health emergency, SHP's audit occurred via virtual desktop. Post-site activities concluded in June 2022 with SHP's submission, and Qlarant's approval, of final performance measure rates. Information from several sources is used to satisfy validation requirements.

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.

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

At the end of the validation process, Qlarant scores MCO findings using a 100-point scale. The assessment provides a level of confidence in SHP-reported results. Qlarant's scoring system is identified in Table 9.

Table 9. PMV Scoring

Audit Score	Level of Confidence
95% - 100%	**High Confidence** in SHP compliance
80% - 94%	**Moderate Confidence** in SHP compliance
75% - 79%	**Low Confidence** in SHP compliance
<74%	**No Confidence** in SHP compliance

Qlarant also assigns a reporting designation for all measures SHP calculates, as shown in Table 10.

Table 10. Reporting Designation

Designation	Definition
R - Reportable	Measure was compliant with state specifications.
NR - Not Reportable	Measure was not reported; MCO did not offer the required benefit.
NA - Not Applicable	Measure did not require reporting.
DNR - Do Not Report	Measure should not be reported; MCO rate was materially biased.

Results

Validation Results

Validation components receive a numeric audit score, confidence level rating, and reporting designation, based upon findings detailed under the following categories:

- Medical Record Over-Read Results
- Data Integration and Control Findings
- Data and Processes Used to Produce Performance Measure Findings
- Measure Validation Findings – Denominator
- Measure Validation Findings – Numerator
- Sampling Validation Findings
- Reporting Findings

Each audit element lists the information system standards and criteria, describes any compliance issues, and documents the potential impact of findings on performance measure reporting. An element is assessed as Met, Not Met, or Not Applicable. Results from SHP's MY 2021 PMV activities are displayed in Table 11.

Table 11. 2022 SHP Performance Measure Validation Results

Performance Measure Validation Results		
PMV Element	**SHP 2021**	**SHP 2022**
Data Integration and Control	100%	100%
Data and Process Used to Produce Measure	100%	100%

Performance Measure Validation Results		
Measure Validation - Denominator	100%	100%
Measure Validation - Numerator	100%	100%
Sampling Validation	100%	100%
Reporting	100%	100%
Overall Audit Score	**100%**	**100%**
Confidence Level	**SHP 2021**	**SHP 2022**
Level of Confidence in MCP Compliance	**High**	**High**
Reporting Designation	**SHP 2021**	**SHP 2022**
Designation	**Reportable**	**Reportable**

Qlarant's audit team determined SHP's information systems capabilities met requirements and SHP received an overall audit score of 100% for validation components. NDDHS and other stakeholders can have high confidence in SHP compliance and audit results. The denominator, numerator events, and calculated final rates for each measure reported by SHP was compliant with state specifications.

Medical Record Over-Read Results

Qlarant selects a random sample of 30 records, with an oversample of 3 records, from SHP's list of members who meet numerator requirements. Qlarant conducts a review (over-read) to verify the accuracy and validate the findings of SHP. To achieve a passing score, 90% percent of records selected for audit must be identified as meeting numerator requirements by Qlarant reviewers. In order to have confidence in SHP-reported results, at least two measures are required to achieve a passing score. If a measure has less than 30 numerator events, then all medical records are reviewed. When the reviewers do not agree with MCO findings, the record fails and is removed from the numerator events.

Two measures were selected for medical record over-read review to ensure SHP has an accurate and reliable medical record abstraction process. Table 12 displays the results of Qlarant's medical record over-read agreement.

Table 12. Performance Measure Medical Record Over-Read Results

Medical Record Over-Read Agreement			
Measure	**Record Sample Size**	**Compliant Records**	**SHP Agreement**
Comprehensive Diabetes Care - Eye Exams	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

The 2022 SHP performance measures validation includes HEDIS® [9] and non-HEDIS measures, per the 2021 North Dakota Medicaid Expansion Program Quality Strategy. SHP's rates are compared to 2022 (MY 2021) NCQA Quality Compass Medicaid benchmarks and the Fiscal Year 2020 Centers for Medicare & Medicaid Services Adult Core Set performance report. Table 13 shows comparisons made using a diamond rating system.

Table 13. Diamond Rating System Used to Compare SHP Performance to Benchmarks

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

Qlarant reviewers determined that SHP had appropriate systems in place to produce measure rates. SHP was compliant with each PMV element and all performance measures are "Reportable." Table 14 includes 2022 PMV results based on SHP calculation of MY 2021 measure rates. The results table includes 50 performance measures for MYs 2019 through 2021 and compares SHP performance to national benchmarks. In addition to the 50 measures, the table also includes 2 HEDIS measures retired by NCQA in MY 2020, and 4 CAHPS survey measures not reported for MY 2021. Green and red represent positive and negative trends for three consecutive measurement years, respectively.

Table 14. SHP Performance Measure Validation Results for MYs 2019 through 2021

Measure Name	MY 2019 Rate (%)	MY 2020 Rate (%)	MY 2021 Rate (%)	MY 2021 Diamond Rating^
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	**52.29**	**40.91**	**35.94**	♦
Adult Body Mass Index Assessment, Ages 19-64 (Retired)	94.17	NR	NR	NC
Adult Survey: Flu Vaccinations for Adults Ages 18-64†	38.60	34.38	NR	NC
Adult Survey: Medical Assistance With Smoking and Tobacco Use Cessation: Advised to Quit Smoking, Ages 19-64 (2 year rolling average)†	76.90	75.18	NR	NC
Adult Survey: Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Medication, Ages 19-64 (2 year rolling average)†	52.10	51.75	NR	NC
Adult Survey: Medical Assistance With Smoking and Tobacco Use Cessation: Discussing Cessation Strategies, Ages 19-64 (2 year rolling average)†	48.10	50.00	NR	NC

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

Measure Name	MY 2019 Rate (%)	MY 2020 Rate (%)	MY 2021 Rate (%)	MY 2021 Diamond Rating^
Antidepressant Medication Management - Effective Acute Phase Treatment	61.85	63.13	59.96	♦
Antidepressant Medication Management - Effective Continuation Phase Treatment	46.72	49.66	42.86	♦
Asthma Medication Ratio (19-50)	**55.00**	**73.28**	**88.20**	♦♦♦♦
Asthma Medication Ratio (51-64)	**51.72**	**73.58**	**87.69**	♦♦♦♦
Asthma Medication Ratio (Total)	**53.93**	**73.37**	**88.07**	♦♦♦♦
Breast Cancer Screening	**54.69**	**52.27**	**47.93**	♦
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NC
Cervical Cancer Screening	44.79	42.37	44.68	♦
Chlamydia Screening in Women (21-24)	46.03	46.69	41.80	♦
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	**73.97**	**72.75**	**70.56**	♦ ♦ ♦
Comprehensive Diabetes Care - Eye Exams	**49.64**	**48.42**	**45.50**	♦
Comprehensive Diabetes Care - HbA1c Control (<8%)	60.83	49.39	50.36	♦ ♦
Comprehensive Diabetes Care - HbA1c Testing	**90.27**	**89.05**	**85.40**	♦ ♦
Comprehensive Diabetes Care - Poor HbA1c Control (>9%) *Lower is better*	28.71	39.66	35.77	♦ ♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy, Ages 19-64 (Retired)	89.05	NR	NR	NC
Controlling High Blood Pressure	70.00	67.40	67.76	♦ ♦ ♦
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**85.15**	**79.70**	**79.47**	♦ ♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)	31.33	28.10	31.69	♦
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)	24.75	20.19	21.01	♦
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)	44.49	44.32	49.47	♦ ♦
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)	32.2	25.27	30.39	♦
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)	**34.45**	**43.55**	**51.99**	♦
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)	**19.62**	**25.12**	**31.24**	♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)	**14.57**	**15.58**	**17.78**	♦♦♦♦

Measure Name	MY 2019 Rate (%)	MY 2020 Rate (%)	MY 2021 Rate (%)	MY 2021 Diamond Rating^
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)	43.55	40.68	54.36	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)	**17.27**	**18.82**	**20.49**	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)	**18.52**	**19.81**	**22.80**	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)	**41.70**	**42.44**	**48.33**	♦ ♦ ♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)	62.50	57.97	72.82	♦♦♦♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)	41.97	41.05	47.30	♦ ♦ ♦
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)	44.31	44.31	49.35	♦ ♦ ♦
Plan All-Cause Readmissions Rate: Ages 19-44 *Lower is better*	**1.5441**	**1.1574**	**0.9320**	NC
Plan All-Cause Readmissions Rate: Ages 45-54 *Lower is better*	1.5655	0.7341	0.7904	NC
Plan All-Cause Readmissions Rate: Ages 55-64 *Lower is better*	**1.1399**	**1.0522**	**0.7826**	NC
Plan All-Cause Readmissions (18-64)	**1.4182**	**1.0214**	**0.8511**	♦ ♦ ♦
PQI 01: Diabetes Short-Term Complications Admission Rate* *Lower is better*	**46.53**	**42.41**	**31.50**	♦
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate* *Lower is better*	**48.58**	**29.83**	**24.74**	♦ ♦ ♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate* *Lower is better*	27.11	32.91	31.50	♦ ♦
PQI 15: Asthma Admission Rate in Younger Adults* *Lower is better*	**2.90**	**3.93**	**5.01**	♦ ♦
Use of Opioids at High Dosage *Lower is better*	**2.75**	**0.47**	**0.23**	♦♦♦♦
Use of Opioids From Multiple Providers – Multiple Pharmacies *Lower is better*	**5.02**	**4.64**	**3.18**	♦ ♦
Use of Opioids From Multiple Providers - Multiple Prescribers *Lower is better*	27.28	21.27	21.93	♦
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies *Lower is better*	**4.45**	**3.43**	**2.87**	♦

Due to the coronavirus pandemic, caution is advised when using MY 2020 and MY 2021 data.

^ SHP MY 2021 Rate Compared to the most current benchmark source at the time of report production: Benchmark sources include: *Quality Compass 2022 (Measurement Year 2021 data) National Medicaid Average for All Lines Business* and *Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set Chart Pack, January 2022.* A product of the Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, sponsored by the Centers for Medicare & Medicaid Services.

* The Agency for Healthcare Research & Quality (AHRQ) is the measure steward for this non-HEDIS measure. This report used the following benchmark source to assign the diamond rating: *Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set Chart Pack, January 2022*.
† SHP did not collect CAHPS Survey data for MY 2021.
NA Small Denominator: The organization followed the specifications, but the denominator was too small (<30) to report a valid rate
NC No Comparison: No Comparison made due to no rate or/and no benchmark available
NR Not Reported: Not reported in previous year(s) due to the measure being new, replaced, or retired.

Conclusion

Summary conclusions for the PMV activity are below. Specific SHP strengths, weaknesses, and recommendations are included in Table 36 within the **MCO Quality, Access, and Timeliness Assessment section**, later in the report.

- SHP received an overall PMV rating of 100%, providing High confidence in MCO measure calculations and reporting.
- Of the 48 measures (retired measures not included), an analysis of MY 2021 demonstrates:
  - 13% of rates (6 of 48 measures) decreased from MY 2020 to MY 2021.
  - 23% of rates (11 of 48 measures) increased from MY 2020 to MY 2021.
  - No comparison could be made for two (2) measures, due to small denominator (<30).
  - No comparison could be made for three (3) measures, due to no benchmarks available.
  - No comparison could be made for four (4) measures, due to MY 2021 CAHPS not completed.

Comparison to Benchmarks

- **Performance below Benchmarks.** Thirty-one percent (31%) of rates (15 of 48 measures) scored below national average benchmarks.
  - Adherence to Antipsychotic Medications for Individuals With Schizophrenia
  - Antidepressant Medication Management - Effective Acute Phase Treatment
  - Antidepressant Medication Management - Effective Continuation Phase Treatment
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening in Women (21-24)
  - Comprehensive Diabetes Care - Eye Exams
  - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)
  - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)
  - Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)
  - Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)
  - Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)
  - PQI 01: Diabetes Short-Term Complications Admission Rate *Lower is better*
  - Use of Opioids From Multiple Providers - Multiple Prescribers *Lower is better*
  - Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies *Lower is better*
- **Performance Meeting or Exceeding Benchmarks.** Fifty percent (50%) of rates (24 of 48 measures) compared favorably to the national average benchmark.

- Seventeen percent (17%) of rates (8 of 48 measures) met or exceeded national average benchmarks, but fell below 75th percentile benchmarks.
- Fifteen percent (15%) of rates (7 of 48 measures) exceeded 75th percentile benchmarks, but fell below 90th percentile benchmarks.
- Nineteen percent (19%) of rates (9 of 48 measures) met or exceeded the 90th percentile benchmarks:
  - Asthma Medication Ratio (19-50)
  - Asthma Medication Ratio (51-64)
  - Asthma Medication Ratio (Total)
  - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)
  - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)
  - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)
  - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)
  - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)
  - Use of Opioids at High Dosage *Lower is better*

Trend Analysis

- **Availability of Rates for Trending.** Eighty-eight percent (88%) of rates (42 of 48 measures) had rates available for MYs 2019 through 2021 and allowed for a trending analysis.
  - Fifteen percent (15%) of rates (7 of 48 measures) demonstrated a negative trend.
  - Thirty-five percent (35%) of rates (17 of 48 measures) demonstrated a positive trend.
  - The remaining 48% (23 of 48 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's review team conducts CRs in accordance with the *CMS EQR Protocol 3 – Review of Compliance with Medicaid and CHIP Managed Care Regulations*.[10] Qlarant reviews the following 42 CFR §438 standards:

[10] CMS EQR Protocols

- 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

Qlarant employs a systematic approach to completing the compliance review which includes three phases of activities: pre-site review, site review, and post-site review. Table 15 illustrates the three phases of CR activities.

Table 15. CR Activities

CR Activities	
Review Phase	**Audit Activities**
Pre-site Phase	• Qlarant develops CR standards and elements per DHS. • The standards and elements are distributed to the MCO. • The MCO updates Qlarant with organization changes within the last year by completing a pre-site survey. • The MCO posts required documents to Qlarant's secure web-based portal about 30 days before the site review. • Qlarant begins the document review.
Site Phase [11]	• Qlarant begins the site review with an opening conference. • Site review may consist of reviewing documentation, files, and records, conducting staff interviews, observing processes, and following up on Corrective Action Plans (CAPs), to ensure policies and procedures are followed and processes are consistent with the requirements. • Qlarant holds a closing conference, which provides general findings, identifies follow-up items, and reviews post-site activities.
Post-site Phase	• Qlarant generates an "exit" letter to the MCO, which outlines the standards that were not in full compliance during the review. • The MCO has 10 business days to respond by providing additional information to support compliance with the identified standards. • The information received is integrated for the final review.

Each standard is 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.

[11] Due to the COVID-19 public health emergency, Qlarant conducted the site visit virtually per DHS.

Aggregate points earned are reported by standard and receive a compliance score based on the percentage of points earned. All assessments are weighted equally, which allows standards with more elements and components to have more influence on a final score. Finally, an overall CR compliance score is calculated. Using the compliance scores, a level of confidence in the MCO's CR results is determined. Compliance ratings are defined in Table 16:

Table 16. CR Scoring

Compliance Score	Level of Confidence
95% - 100%	**High Confidence** in SHP compliance
85% - 94%	**Moderate Confidence** in SHP compliance
75% - 84%	**Low Confidence** in SHP compliance
<74%	**No Confidence** in SHP compliance

Results

SHP's results for each standard are displayed in Table 17. A detailed assessment including results of all elements and components are included with the narrative that follows. Specific recommendations on how to meet requirements are also included for any element or component that did not achieve full compliance for the MY 2021 compliance review. Below are the new standards for 2021, 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 Post-stabilization Services

Detailed findings and recommendations are included within the appendix that follows.

Table 17. SHP MY 2021 CR Results

Standards	Points Earned	Points Available	Compliance Score
Information Requirements	29	29	100%
Disenrollment Requirements and Limitations	0	11	0%
Enrollee Rights and Protections	15.5	18	86%
MCO Standards	65	67	97%
Quality Assessment and Performance Improvement Program	7	7	100%
Grievance and Appeal System	57	57	100%
Program Integrity	8	8	100%
Overall Weighted Compliance Score	181	197	92%
Confidence Level			**Moderate Confidence**

Table 18 displays SHP's results for MYs 2019 through 2021.

Table 18. SHP Results for MYs 2019 through 2021

Standards	MY 2019	MY 2020	MY 2021
Information Requirements	96%	98%	100%
Disenrollment Requirements and Limitations	NA	NA	0%
Enrollee Rights and Protections	100%	100%	86%
MCO Standards	98%	97%	97%
Quality Assessment and Performance Improvement Program	100%	100%	100%
Grievance and Appeal System	88%	100%	100%
Program Integrity	100%	100%	100%
Overall Weighted Compliance Score	95%	99%	92%

Conclusion

SHP's overall weighted compliance score was 92% for the MY 2021 CR with scores of 86% or greater for all standards. Qlarant found SHP had most systems, policies, and staff in place to support the core processes and operations necessary to deliver services to its managed care population. SHP did not have a policy to cover the Disenrollment Requirements nor updates to Enrollee Rights and Protections. If SHP is to be considered for future contracts for this program, Qlarant would recommend a preoperational assessment of the policy associated with the Disenrollment requirements. DHS and stakeholders should have a moderate confidence in SHP's compliance with all regulatory requirements based on its overall weighted compliance score as described in Table 3.

Network Adequacy Validation

Objective

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 members to care. NAV results provide DHS and other stakeholders with a level of confidence in provider compliance with the 24/7 requirement including directing members to care during nonbusiness hours.

Methodology

Qlarant completed all annual validation activities 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 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 members 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

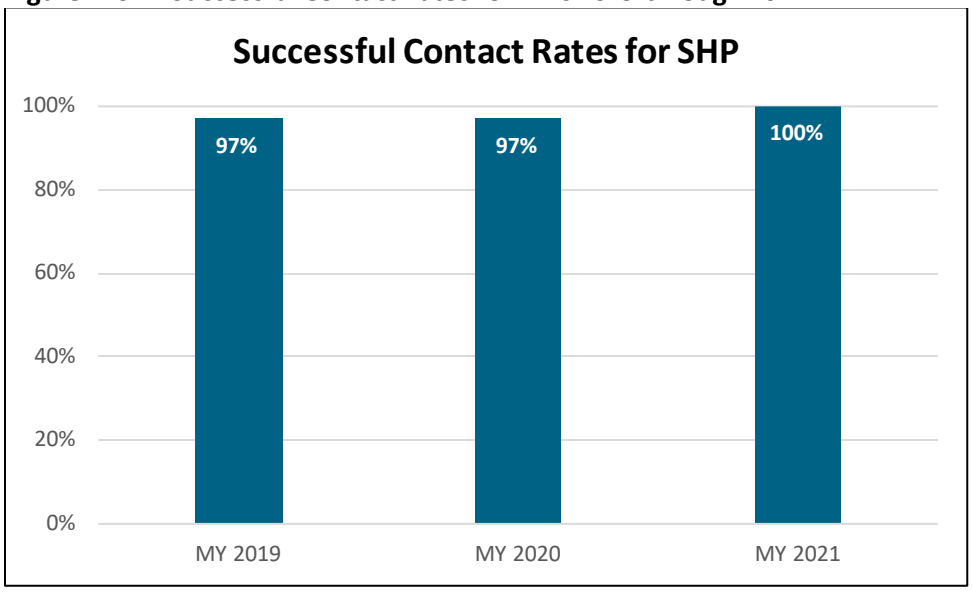
Table 19 includes the percentage of MY 2021 provider surveys resulting in successful contact for the MCO. Surveys were deemed successful if contact was made with a live person, answering service, on-call provider, or recorded/automated message. The MCO had a contact success rate of 100%.

Table 19. Successful Contact for SHP

2020 NAV	SHP
Successful Contact	100%

Figure 2 illustrates the percentage of provider surveys that resulted in successful contact for MYs 2019 through 2021.

Figure 2. SHP Successful Contact Rates for MYs 2019 through 2021



For MY 2021, SHP achieved a 100% in successful contact rate and exceeded both MYs 2020 and 2019 rates of 97%.

Figure 3 displays how successful contacts were answered. Most successful contacts (67%) were answered by recorded or automated message and followed by employee of the provider or practice (23%) with the remaining by answering service (10%).

Figure 3. How Successful Contacts Were Answered

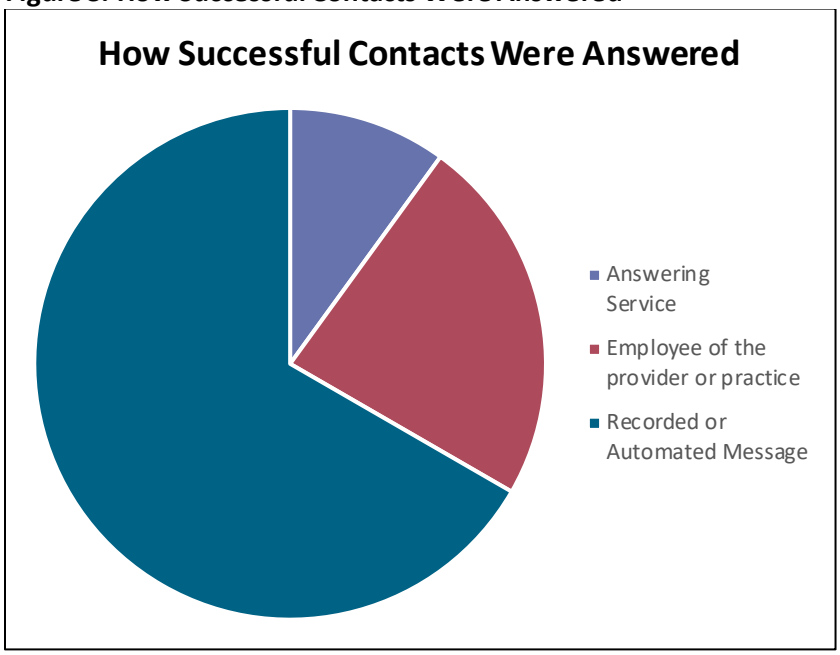
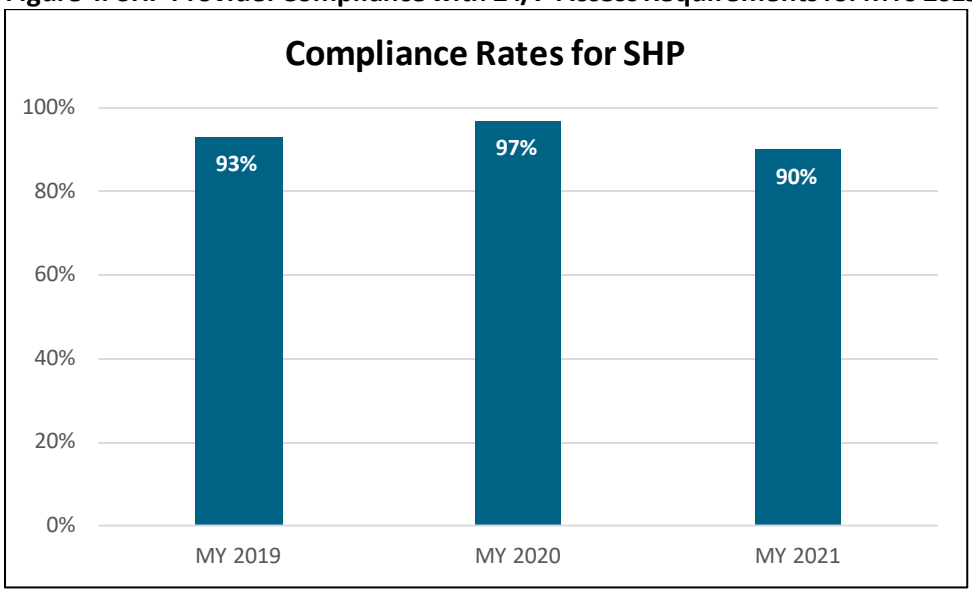


Figure 4 displays the MYs 2019 through 2021 SHP level of provider compliance with the 24/7 access requirements.

Figure 4. SHP Provider Compliance with 24/7 Access Requirements for MYs 2019 through 2021



Provider compliance with the 24/7 access requirements results:

- SHP's MY 2021 compliance rate declined by seven and three percentage points from MY 2020 (97%) and MY 2019 (93%), respectively

- All SHP provider noncompliance was due to a recorded/automated message not directing the member 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 36 within the **MCO Quality, Access, and Timeliness Assessment** section, later in the report.

- The MCO had a contact success rate of 100%.
- The MCO had a provider compliance rate of 90% with the 24/7 access requirements.
- Overall, the compliance rate shows SHP has an adequate provider network available to members 24 hours a day, 7 days a week, when medically necessary.

Encounter Data Validation

Objectives

States rely on valid and reliable encounter/claims data submitted by MCOs to make key decisions.[12] 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 conducted EDV in accordance with the *CMS EEQR Protocol 5, Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*[13]. To assess the completeness and accuracy of encounter data, Qlarant completed the following activities:

1. **Review state requirements for collecting and submitting encounter data.**
   Qlarant reviewed contractual requirements between DHS and SHP and 2021 Quality Strategy to ensure the MCO followed the State's encounter data collection and submission specifications in file format and types of encounters.

2. **Review the MCO's capability to produce accurate and complete encounter data.**
   Qlarant completed an evaluation of the MCO's Information Systems Capabilities Assessment (ISCA) and HEDIS®[14] Record of Administration, Data Management, and Processes (Roadmap) audit tools to determine whether the MCO's system is able to collect and report high quality encounter data. The

[12] Encounter data consists of claims; therefore, these terms, encounter data and claims, are used interchangeably in this report.
[13] **CMS EQR Protocols**
[14] HEDIS® – Health Care Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

assessment, which included a documentation review and interviews with key MCO staff, was conducted as part of the Performance Measure Validation (PMV) activity.

3. **Analyze MCO electronic encounter data for accuracy and completeness.**
   Qlarant's analysts examined the electronic encounter data for consistency, accuracy, and completeness. The activities include, but not limited to, examining critical fields to ensure data were in the correct format, data values were within the required ranges, and volume of data was consistent with the MCO's enrollment. To complete this activity, Qlarant obtained and analyzed an encounter/claims file from the MCO, which reflected the services that occurred during MY 2021. The analysis mainly emphasized on inpatient, outpatient, and office visit settings.

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

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

Results

State Requirements for Collecting and Submitting Encounter Data

DHS defined encounter data as "enrollee-specific, detailed claim-level records of individual single healthcare services, examinations, medical, and dental diagnostic and treatment services, all pharmaceuticals, supplies, and medical equipment dispensed for services provided to Medicaid Expansion enrollees" in the contract with the MCO.

Qlarant reviewed the MCO's contractual requirements for encounter data collection and submission. Below are some of the agreements, which the MCO must adhere:

- The encounter data-reporting format must follow the format, rules, and data elements as described in the most current HIPAA-compliant 837 Implementation Guide or the most current National Council for Prescription Drug Programs (NCPDP) Post Adjudication History Implementation Guide.
- DHS shall have access to detail transactional claims records of healthcare and related services.
- Records must include original claims, adjustments, and payment information.
- If SHP chooses to resubmit a claim previously paid or denied on its remittance advice, SHP must resubmit the claim as a replacement claim or a voided claim.
- The encounter data must contain all paid claims lines associated with the claim as well as those denied.
- If SHP uses a vendor to process encounter data or provide services, SHP must ensure the received data from the vendors are accurate and complete.

- SHP is required to submit all encounter claims no later than 25 calendar days after the date the MCO adjudicates the claim but no later than the 15th of the month following the month of payments included in the data file. Should DHS reject the file or claims, the MCO has 20 calendar days to resubmit the corrected file.
- Disallowed claims or overpayments must be reversed within 60 calendar days.
- SHP must attest to the accuracy and completeness of the submitted encounter data to DHS.

MCO's Capability to Produce Accurate and Complete Encounter Data

As a component of the PMV task conducted by Qlarant, SHP completed the 2021 ISCA and HEDIS Roadmap audit tools as part of the pre-site documentation review. The purpose of the ISCA and HEDIS Roadmap review was to assess the MCO's information systems capabilities to capture and assimilate information from multiple data sources. The documentation review determined if the system was vulnerable to incomplete or inaccurate data capture, integration, storage, or reporting. The findings were used to identify issues that may contribute to inaccurate or incomplete encounter data; for example, the MCO's use of non-standard codes or forms, inadequate data edits, or lack of provider contractual requirements that tie payment to data submission.

During the site review phase, Qlarant conducted interviews with the MCO's personnel to further review the MCO's information system and key processes to ensure the MCO has sufficient process and capabilities in producing accurate and complete encounter data. Results of the document review and interview process reveal:

- SHP's information system is capable of capturing and assimilating information from multiple sources.
- No significant issues were identified that may contribute to inaccurate or incomplete encounter data.
- SHP receives approximately 81.9% of facility claims and 89.3% of provider claims electronically. Remaining claims are paper-based and require manual entry into the claims system.
- SHP processes most Medicaid claims internally, and pharmacy claims are processed externally.
- SHP performs weekly post payment claims audit on approximately 2% of all Medicaid claims. SHP achieved an accuracy rate of 99%.
- SHP's goal for clean claims and encounters processing timeliness: 99% in 30 days. Results indicate 96% of claims and encounters are processed within 30 days.
- SHP applies edits to incoming claims data to screen for missing or invalid data fields. Claims are rejected if one or more required fields are missing or invalid.
- SHP uses standard claims/encounter forms. Only standard codes are utilized.
- SHP claims are all fee-for-service with no withhold or bonus.
- Global payments represent a very small number of claims and are used only for perinatal services.
- SHP requires providers to submit claims within 365 days of the date of service and late claims are denied.

Analysis of MCO Electronic Encounter Data for Accuracy and Completeness

In April 2022, SHP submitted two MY 2021 data files, encounter data and member data files, to Qlarant. Qlarant conducted an assessment evaluating data completeness and accuracy, below are the results:

- Encounter volume was substantially greater than MY 2020.
  - The volume (556,813) increase by 56% from last measurement year (357,815).
- Diagnosis and procedure codes were appropriate according to members' age and/or gender.
  - Less than 1% of claims had inappropriate coding and was removed from the analysis.
- Revenue codes for inpatient and outpatient settings are appropriate.
  - Less than 1% of claims had inappropriate coding and was removed from the analysis.

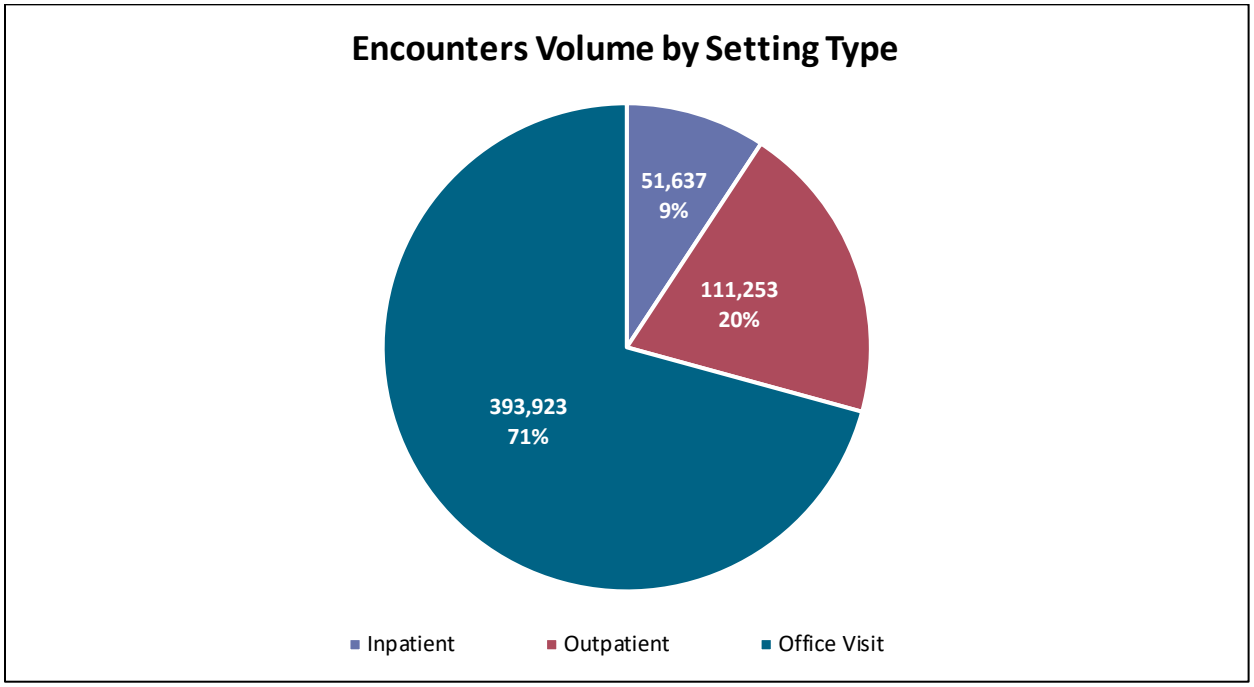
The MCO's member data file contains 38,124 unduplicated unique members. Of those members, 27,366 (72%) received at least one service in one (1) or more of the three settings during MY 2021. The utilization rate of 72% increased by three (3) percentage points from MY 2020 (71%). Table 20 and Figure 5 display the utilization rate by setting type.

Table 20. Utilization Rate by Setting Type

Setting Type	Unique Members with at Least One Paid Encounter	Unique Members	Utilization Rate
Any Setting*	27,366	38,124	72%
Inpatient	3,314	38,124	9%
Outpatient	15,433	38,124	40%
Office Visit	25,641	38,124	67%

*At least one (1) paid encounter was received in one (1) or more of the three (3) settings: Inpatient, Outpatient or Office Visit.

Figure 5. Encounters Volume by Setting Type



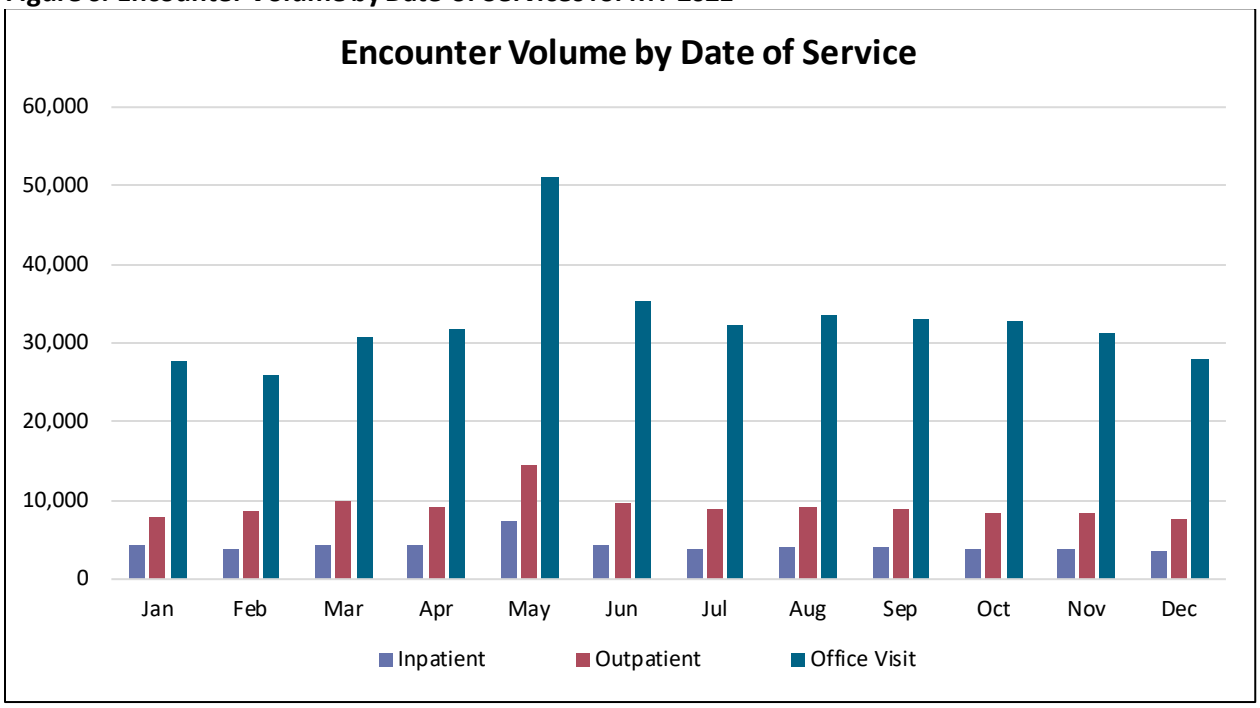
Analysis showed most encounters occurred in an office visit setting (71%), followed by outpatient (20%) with the remaining attributed to inpatient setting (9%).

Qlarant also examined monthly variation for each setting to identify potential gaps in data submission. Table 21 and Figure 6 display encounters volume by date of service (month) for MY 2021.

Table 21. Encounters Volume by Date of Services for MY 2021

Month	Inpatient	Outpatient	Office Visit	All Settings
January	4,222	7,985	27,724	39,931
February	3,792	8,597	26,000	38,389
March	4,249	9,913	30,885	45,047
April	4,441	9,152	31,913	45,506
May	7,280	14,443	51,255	72,978
June	4,364	9,787	35,333	49,484
July	3,938	8,804	32,193	44,935
August	4,216	9,252	33,646	47,114
September	3,970	8,841	32,968	45,779
October	3,750	8,338	32,757	44,845
November	3,911	8,445	31,180	43,536
December	3,504	7,696	28,069	39,269
Total	**51,637**	**111,253**	**393,923**	**556,813**

Figure 6. Encounter Volume by Date of Services for MY 2021



The claims volume by date of service for all three settings appeared reasonable. The volume for three settings combined, peaked in May 2021 with 72,978 claims and declined substantially in June 2021 with 49,484 claims, consistent with the lessening of the COVID-19 public health emergency stay restrictions.

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

Review of members' medical records offers another method to examine the completeness and accuracy of encounter data. Using the encounter/claims data file prepared by the MCO, Qlarant identified all members with an inpatient, outpatient, or office visit service claim. The sample size was selected to ensure a 90% confidence interval with a 5% +/- error rate for sampling. An oversample was added to ensure adequate numbers of records were received.

Records were requested directly from the billing providers. Qlarant mailed each sampled provider a letter with the specific record request, which included the patient name, patient account number, date of birth, date(s) of service, and treatment setting. Providers were asked to securely submit medical record information to Qlarant with the following instructions:

- Identify documentation submitted for each patient using: patient first and last name, medical assistance number (MA#), date of birth, age, gender, and provider name.
- Include all relevant medical record documentation to ensure receipt of adequate information for validating service codes (a list of recommended documentation was provided for reference).

Medical records received were verified against the sample listing and member demographics information from the data file to ensure consistency between submitted encounter data and corresponding medical records. If a medical record could not be verified against the encounter data by patient name, gender, date of birth, or date(s) of service, the reviewer ended the review process. The medical record was then considered invalid.

Table 22 displays the summary of total claims, sample sizes, and number of completed reviews for each setting.

Table 22. EDV Sample Size by Encounter Type

Encounter Type	MY 2021				
	Total Claims	% of Claims	Sample Size	Oversample size*	Reviews Completed
Inpatient	52,502	9%	26	52	27
Outpatient	112,485	20%	55	110	55
Office Visit	395,825	71%	192	384	192
Total	560,812	100%	273	546	274

*An oversample of 200% was selected to provide adequate reviews in each setting type to meet the required sample.

Qlarant conducted a full review of 274 medical records to confirm the accuracy of encounter data (including diagnosis, procedure, and revenue codes) compared to medical record documentation. Overall results of this validation process for all three settings are displayed in Table 23 and Figure 7. MY 2019 and MY 2020 results are included for comparative purposes.

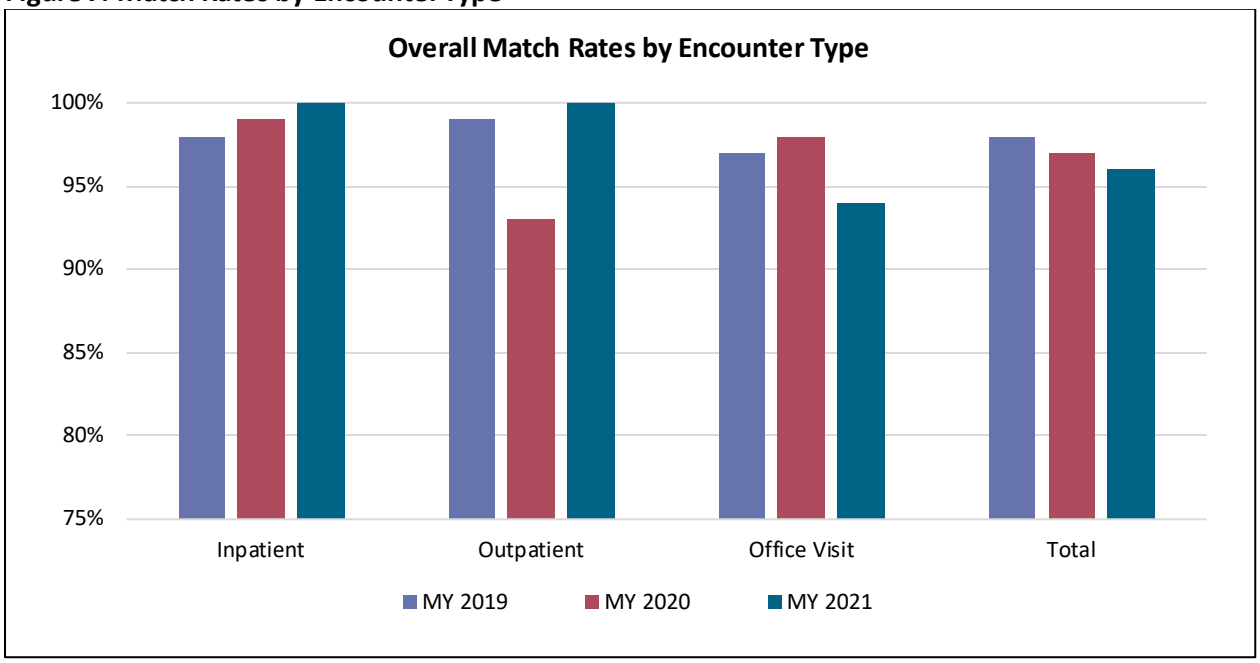
Table 23. EDV Results by Encounter Type

Encounter Type	Valid Records Reviewed			Total Available Elements*			Total Matched Elements			Percentage of Matched Elements		
	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021
Inpatient	32	50	27	182	339	160	179	336	160	98%	99%	100%
Outpatient	63	70	55	638	334	344	634	312	344	99%	93%	100%

Encounter Type	Valid Records Reviewed			Total Available Elements*			Total Matched Elements			Percentage of Matched Elements		
	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021
Office Visit	190	155	192	831	615	882	810	605	833	97%	98%	94%
Total	**285**	**275**	274	**1,651**	**1,288**	**1,386**	**1,623**	**1,253**	**1,337**	**98%**	**97%**	**96%**

* The available elements include diagnosis, procedure, and revenue codes

Figure 7. Match Rates by Encounter Type



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

- MY 2021 overall match rate (96%) declined by one (1) percentage point from MY 2020 (97%).
- Inpatient match rate demonstrated a year over year improvement.
- Outpatient match rate improved by seven (7) percentage points from MY 2020.
- Office visit match rate decreased by four (4) percentage point from MY 2020.

Results by Review Element

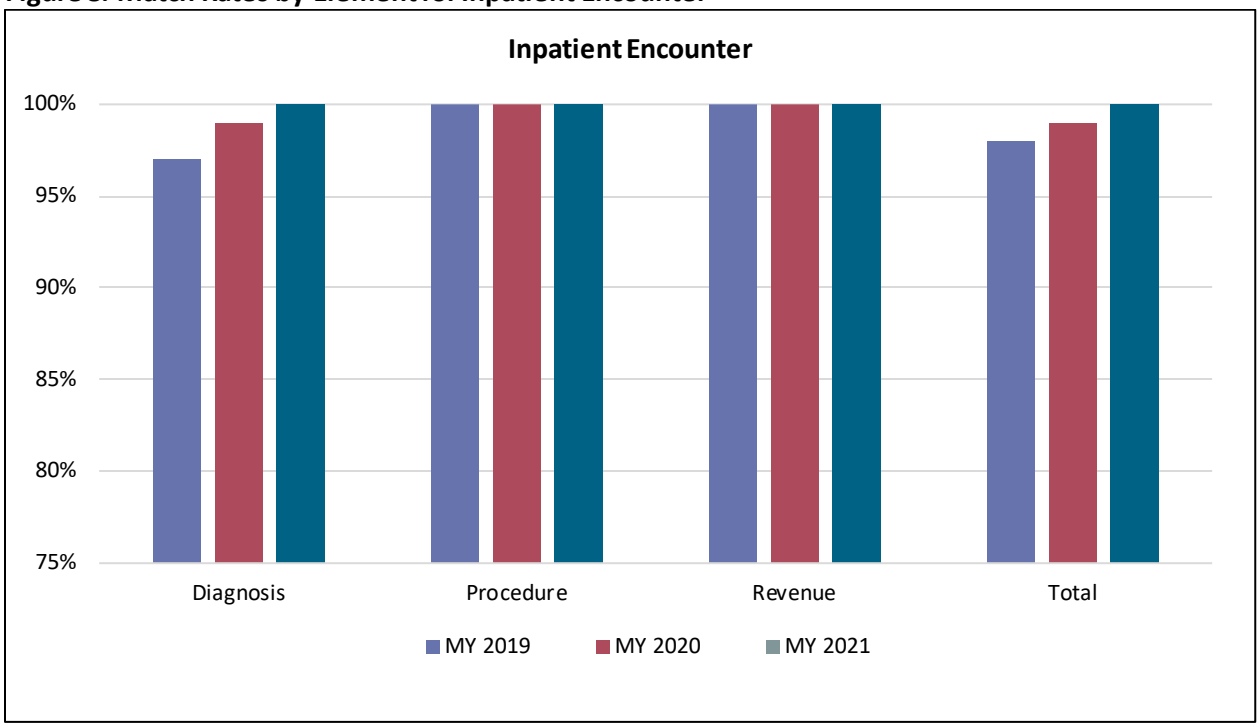
Match rates and reason for "no match" errors for diagnosis code, procedure code, and revenue code elements were analyzed for inpatient, outpatient, and office visit encounter types. Revenue codes, however, are not applicable for office visit encounters.

Tables 24 through 26 and Figures 8 through 10 illustrate EDV results by review element for each encounter type.

Table 24. EDV Results by Element for Inpatient Encounter

Inpatient Encounter	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021
Match	111	263	116	42	44	44	26	29	21	179	336	160
No Match	3	3	0	0	0	0	0	0	0	3	3	0
Total Elements	114	266	116	42	44	44	26	29	21	182	339	160
Match %	**97%**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**98%**	**99%**	**100%**

Figure 8. Match Rates by Element for Inpatient Encounter



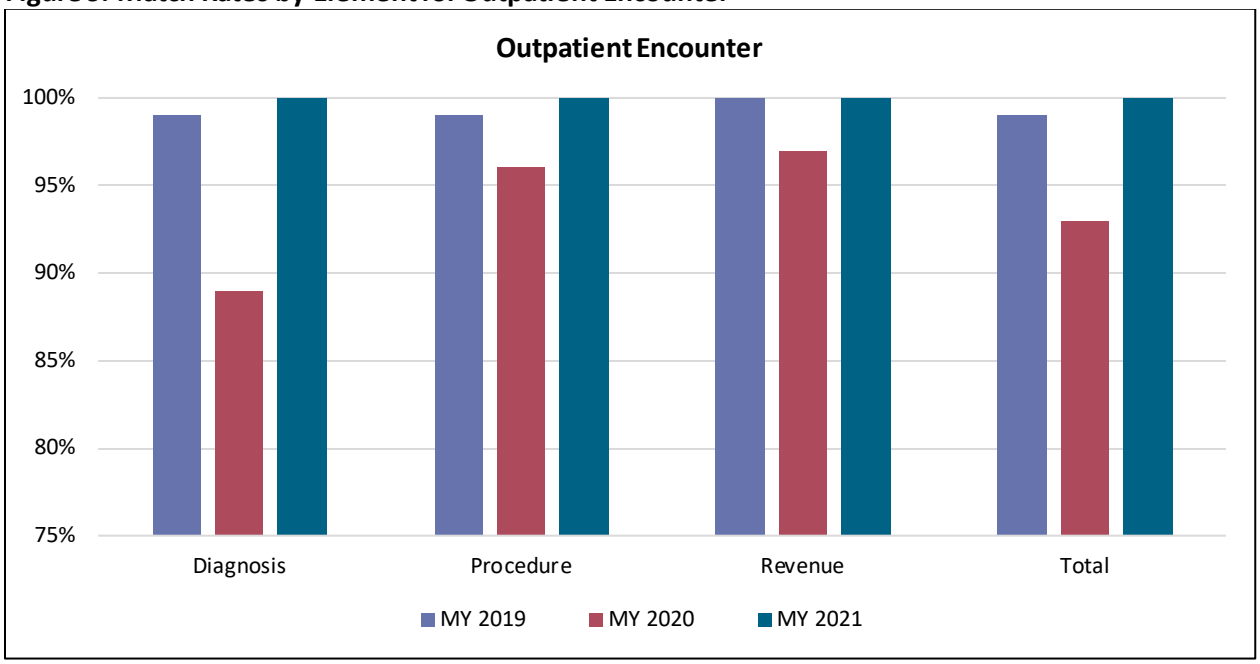
For MY 2021 inpatient records:

- Diagnosis codes match rate demonstrated a year over year improvement with 100% match for MY 2021.
- All procedure codes matched, maintaining a 100% match rate from MY 2019 through MY 2021.

Table 25. EDV Results by Element for Outpatient Encounter

Outpatient Encounter	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021
Match	154	127	115	225	110	154	255	75	75	634	312	344
No Match	2	16	0	2	4	0	0	2	0	4	22	0
Total Elements	156	143	115	227	114	154	255	77	75	638	334	344
Match %	**99%**	**89%**	**100%**	**99%**	**96%**	**100%**	**100%**	**97%**	**100%**	**99%**	**93%**	**100%**

Figure 9. Match Rates by Element for Outpatient Encounter



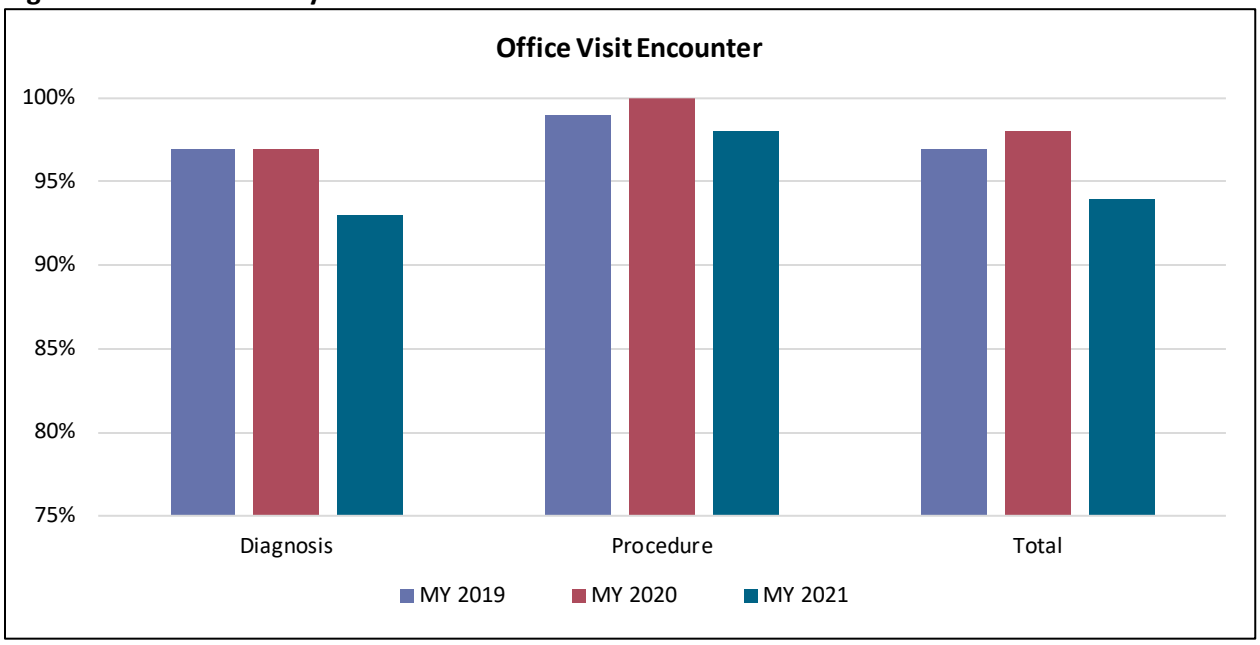
For MY 2021 outpatient records:

- Diagnosis code match rate increased substantially from MY 2020 by eleven (11) percentage points.
- Procedures code match rate increased from MY 2020 by four (4) percentage points.
- Revenue codes registered 100% match rate, increasing by three (3) percentage points from MY 2020.

Table 26. EDV Results by Element for Office Visit Encounter

Office Visit Encounter	Diagnosis Codes			Procedure Codes			Total		
	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021
Match	476	372	511	334	233	322	810	605	833
No Match	16	10	41	5	0	8	21	10	49
Total Elements	492	382	552	339	233	330	831	615	882
Match %	**97%**	**97%**	**93%**	**99%**	**100%**	**98%**	**97%**	**98%**	**94%**

Figure 10. Match Rates by Element for Office Visit Encounter



For MY 2021 office visit records:

- Diagnosis codes decreased in match rate by four (4) percentage points from MY 2020.
- Procedure codes decreased in match rate by two (2) percentage points from MY 2020.

"No Match" Results

Tables 27 through 29 illustrate the principle reasons for "no match" errors.

Reasons for determining a "no match" for the diagnosis code element include:

- Lack of medical record documentation
- Incorrect diagnosis codes

Table 27. EDV "No Match" Diagnosis Code Results by Encounter Type

Encounter Type		Lack of Medical Record Documentation	Incorrect Diagnosis Codes	Total "No Match" Diagnosis Elements
Inpatient	Element Counts	0	0	0
	Percentage	NA	NA	NA
Outpatient	Element Counts	0	0	0
	Percentage	NA	NA	NA
Office Visit	Element Counts	40	1	41
	Percentage	98%	2%	100%

- There were no inpatient "no match" diagnosis codes or outpatient mismatch diagnosis lacking documentation.
- The office visit "no match" diagnosis codes were resulted by lack of medical record documentation (40 or 98%) and incorrect diagnosis codes (1 or 2%).

Reasons for determining a "no match" for the procedure code element include:

- Lack of medical record documentation
- Incorrect procedure codes

Table 28. EDV "No Match" Procedure Code Results by Encounter Type

Encounter Type		Lack of Medical Record Documentation	Incorrect Procedure Codes	Total "No Match" Procedure Elements
Inpatient	Element Counts	0	0	0
	Percentage	NA	NA	NA
Outpatient	Element Counts	0	0	0
	Percentage	NA	NA	NA
Office Visit	Element Counts	6	2	8
	Percentage	75%	25%	100%

- There were no mismatches for inpatient or outpatient settings in procedure codes.
- The "no match" procedure codes found in office visits were contributed by lack of medical record documentation (6 or 75%) and incorrect procedure codes (2 or 25%).

Reasons for determining a "no match" for the revenue code element include:

- Lack of medical record documentation

Table 29. EDV "No Match" Revenue Code Results by Encounter Type

Encounter Type		Lack of Medical Record Documentation	Incorrect Revenue Codes	Total "No Match" Revenue Elements
Inpatient*	Element Counts	NA	NA	NA
	Percentage	NA	NA	NA
Outpatient	Element Counts	0	0	0
	Percentage	NA	NA	NA

*There were no revenue elements to review with the sample of inpatient claims for MY2021

- There were no mismatches for outpatient setting in revenue codes.

Conclusion

Qlarant completed an EDV study for SHP based on an assessment of encounters submitted during MY 2021. Qlarant reviewed the MCP's information system and concluded it has the capability to produce accurate and complete encounter data. The decrease in COVID-19 public health emergency restrictions appeared to have affected the claim volume of MY 2021 (556,813 claims) positively with 56% increase from MY 2020 (357,815 claims).

Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters to confirm the accuracy of codes. SHP achieved a total match rate of 96%, meaning 96% of claims submitted were supported by medical record documentation. SHP achieved a match rate for each encounter setting: 100% for inpatient, 100% for outpatient, and 94% for office visit.

CAHPS

Objectives

CAHPS survey is a study that measures how well SHP meets enrollee expectations and captures SHP enrollee experiences, while receiving health care services. Strengths and opportunities for improvement are identified to further help SHP improve enrollee quality of care.

Methodology

In 2021, SHP contracted with a NCQA-Certified survey vendor to administer the Adult CAHPS survey. SHP followed NCQA HEDIS protocols, identified in *HEDIS MY 2020 Volume 3: Specifications for Survey Measures*. The methodology met requirements of *CMS EQR Protocol 6 – Administration or Validation of Quality of Care Surveys*[15]. The NCQA Survey Vendor Certification Program and annual HEDIS accreditation audit ensure the survey vendor follows HEDIS protocols in sample frame and selection, data collection, and survey results calculation.

SHP did not administer the Adult CAHPS survey for MY 2021. The following CAHPS report contains survey results from MY 2020. In 2021, SHP's survey vendor successfully 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 MY and continuously enrolled in the MCO, for at least five of the last six months of the measurement year. Surveys were distributed to sampled, eligible enrollees by mail. Collection of completed surveys was completed by mail, phone, and internet.

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. The established scale was 0 through 10, where 0 indicated the worst possible assessment and 10 indicated 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.

[15] CMS EQR Protocols

In addition, four effectiveness of care survey measures were collected by SHP's survey vendor using NCQA's *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, prepared by the survey vendor. CAHPS survey results were compared to the 2020 NCQA Quality Compass Medicaid HMO benchmarks in 2021. Due to CAHPS surveys not being administered in 2022, a comparison to national benchmarks could not be competed.

Table 30 trends SHP's CAHPS results for MYs 2018 through2021. Green and red represents positive and negative trends for three consecutive measurement years, respectively.

Table 30. SHP CAHPS Results

Measure	MY 2018 Rate	MY 2019 Rate	MY 2020 Rate	MY 2021 Rate
Getting Care Quickly Composite	78.94%	NA	NA	ND
Getting Needed Care Composite	80.46%	89.60%	NA	ND
How Well Doctors Communicate Composite	92.28%	96.50%	NA	ND
Customer Service Composite	NA	NA	NA	ND
Coordination of Care Composite	NA	NA	NA	ND
Rating of All Health Care (8+9+10)	75.61%	81.00%	74.07%	ND
Rating of Personal Doctor (8+9+10)	85.71%	90.30%	85.94%	ND
Rating of Specialist Seen Most often (8+9+10)	NA	NA	NA	ND
Rating of Health Plan (8+9+10)	**74.38%**	**80.30%**	**81.48%**	ND
Flu vaccination: Had flu shot or spray in the nose since July 1, 2020	**38.93%**	**38.60%**	**34.38%**	ND
Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers To Quit (rolling 2 year average)	**78.22%**	**76.90%**	**75.18%**	ND
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications (rolling 2 year average)	**54.19%**	**52.10%**	**51.75%**	ND
Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Strategies (rolling 2 year average)	52.23%	48.10%	50.00%	ND

Interpret and trend results with caution due to survey methodology changes for COVID-19 public health emergency.
NA Small Response Rate: Response rate of less than 100 (<100) observations; too small to calculate a reliable rate.
ND No Data

Conclusion

Summary conclusions for the CAHPS activity are below. Specific MCO strengths, weaknesses, and recommendations are included in Table 36 within the **MCO Quality, Access, and Timeliness Assessment section**, later in the report.

- SHP's CAHPS survey response rate for MY 2021 was 12.4%, a 6.6% decrease from MY 2019 (19%).
- Four (4) of 13 measures had rates available for MYs 2018 through 2020 and allowed for a trending analysis. Performance of trended rates demonstrated positive and negative improvements:
    - Seventy-five percent (75%) (3 of 4 measures) demonstrated a negative trend.
    - Twenty-five percent (25%) (1 of 4 measures) demonstrated a positive trend.
    - Remaining measures did not produce a trend.

Focused Study

Objectives

On October 26, 2017, the US Department of Health and Human Services declared the "opioid crisis" a public health emergency and identified five priorities in an attempt to combat the crisis, which include:[16]

- Improve access to prevention, treatment, and recover support services
- Target the availability and distribution of overdose-reversing drugs
- Strengthen public health data reporting and collection
- Support cutting-edge research on addiction and pain
- Advance the practice of pain management

Despite of the opioid crisis declaration, opioid prescribing and dispensing rates continue to climb in ND, consistent with the rest of the country. According to "Substance Use in North Dakota" data book, the number of opioid prescriptions dispensing rate increased by 10.6 percent points between 2010 and 2017 and a rate of 9.2 drug overdose deaths per 100,000 ND residents was reported for 2017.[17]

Qlarant identifies the top 10 encounter diagnoses during the encounter data validation task each year since measurement year (MY) 2016. Through time, the F11.20 or opioid dependence, uncomplicated diagnosis (F11.20), has become substantially prevalent within the ND Medicaid Expansion population. A three-year lookback of opioid dependence encounters analysis for physician office visits (POV) setting was conducted and the results were shown in Table 31.

[16] 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
[17] North Dakota State Government. (2019). Substance Use in North Dakota. Accessed on September 25, 2019 from prevention.nd.gov.

Table 31. Three-Year Lookback – Opioid Dependence Encounters

MY	F11.20 Diagnosis Made into the Top 10 Diagnoses List	Frequency of F11.20 Diagnosis Appears in the Encounter Data[18]	Total Number of Members with At Least One POV Claim
2016	No	Not applicable	20,866
2017	Yes	2,628	21,640
2018	Yes	8,390	21,330

- For MY 2016, the frequency of F11.20 diagnosis appeared in the claim data was not calculated due to F11.20 was not in the top 10 encounter diagnoses.
- In MY 2017, F11.20 made the top 10 encounter diagnoses for the first time in the POV setting. F11.20 appeared 2,628 times in the encounter data.
- In MY 2018, F11.20 remained in the top 10 encounter diagnoses. F11.20 appeared 8,390 times in the encounter data, more than three times the amount of MY 2017.

The infiltration of opioid dependency in MY 2017 and alarming increase in MY 2018 prompted DHS to collaborate with Qlarant in spearheading a focused study solely on opioid dependency within the ND Medicaid Expansion members. The objective of this focused study is to explore or attempt to identify factors that cause the upward trends in opioid dependency and develop preventative initiatives to fight this public health emergency effectively.

Qlarant completed a three-year focused study (MYs 2019 through 2021) in accordance with the *CMS EQR Protocol 9, Conducting Focus Studies of Health Care Quality*, with the following study questions:[19]

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

This report includes opioid dependency study-related findings for SHP for the reporting period, January 1, 2020 through December 31, 2020 for MY 2020, which is the second year of three-year study.

Methodology

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

In April 2021, SHP submitted two MY 2020 data files, encounter data and member data files, to Qlarant. As previous years, Qlarant utilized the two data files to analyze encounter data that contains F11.20 diagnosis in a physician office visit (POV) or in-person visit setting.

In this review cycle, Qlarant provided an introductory analysis, opioid dependence rate by measurement year, on a new setting - telehealth visit (TV). Telehealth has become more prominent as an alternate way for members to seek care during the COVID-19 public health emergency, which includes opioid use

[18] The number of encounter diagnoses does not represent unique members. For example, one member 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.
[19] CMS EQR Protocols

disorder treatment.[20] Consequently, Qlarant has noticed a surge in telehealth claims with F11.20 diagnosis within the ND Medicaid Expansion population.

The Qlarant analytic team analyzed the data to determine:

- Opioid dependence rate by measurement year (POV and TV)
  - the number of unique members who received F11.20 diagnosis
  - the volume of claims with F11.20 diagnosis by date of service
- Opioid dependence rate by age and gender (POV only)
- Opioid dependence rate by geographic distribution (POV only)
- Usage of F11.20 as primary diagnosis (POV only)

Results

ND state has reported the total drug overdose deaths during 2020 were 118, registering a 49% increase from 2019 (79), which surpassed the nationwide increase rate of 29%.[21,22] The health experts indicated the increase may be due to individuals that experienced an increase in feelings of depression, anxiety, and isolation during 2020, a year of uncertainties surrounding COVID-19 outbreaks.

Opioid Dependence Rate by Measurement Year

Table 32 demonstrates how Qlarant calculated opioid dependence rate per 1,000 members with POV claims for MY 2020. MYs 2018 and 2019 results are included for comparative purposes.

Table 32. Total Members, POV, and Opioid Dependence Rate per 1,000

MY	Members	Members with At Least One POV Claim		Members with F11.20 Diagnosis in POV Claim		POV Claims with F11.20 Diagnosis	
		Number	Percent	Number	Percent	Number[23]	Rate per 1,000 Members w/ POV
2018	33,595	21,330	63.49%	403	1.89%	8,390	393.34
2019	33,264	20,964	63.02%	531	2.53%	17,905	854.08
2020[24]	32,277	20,899	64.75%	694	3.32%	22,895	1,095.51
3-Year Average	**33,045**	**21,064**	**63.74%**	**543**	**2.58%**	**16,397**	**778.41**

Analysis revealed:

- Of the 20,899 members served in POV setting, 694 or 3.32% members with F11.20 diagnosis were identified, registering a 0.79 percentage point increase from MY 2019.

[20] https://www.ahrq.gov/news/blog/ahrqviews/telehealth-opioids.html
[21] https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20210714.htm
[22] https://www.kfyrtv.com/2021/07/20/drug-overdose-deaths-increased-nearly-50-north-dakota-2020/
[23] The number of encounter diagnoses does not represent unique members. For example, one member 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.
[24] Make comparison with caution. CMS removed Medicaid eligibilty redetermination rule due to the public health emergency in MY 2020.

- The identified members generated 22,895 claims with F11.20 diagnosis, a substantially higher number than MY 2019 (17,905) and MY 2018 (8,390), yielding a negative trend (lower rate is better).
- MY 2020 has the highest opioid dependence rate per 1,000 members with POV claim to date, registering at 1,095.51.

Table 33 demonstrates how Qlarant calculated opioid dependence rate per 1,000 members with TV claims for MY 2020. MYs 2018 and 2019 results are included for comparative purposes.

Table 33. Total Members, TV, and Opioid Dependence Rate per 1,000

MY	Members	Members with At Least One TV Claim		Members with F11.20 Diagnosis in TV Claim		TV Claims with F11.20 Diagnosis	
		Number	Percent	Number	Percent	Number	Rate per 1,000 Members w/ TV
2018	33,595	856	2.55%	23	2.69%	32	37.38
2019	33,264	710	2.13%	37	5.21%	66	92.96
2020[25]	32,277	5,359	16.60%	319	5.95%	2,507	467.81
3-Year Average	**33,045**	**2,308**	**6.99%**	**126**	**5.47%**	**868**	**376.17**

Analysis revealed:

- The total members with at least one telehealth claim has increased significantly in MY 2020 (5,359) from MY 2019 (710), which was largely due to the COVID-19 public health emergency.
- Of the 5,359 members served in TV setting, 319 or 5.95% members with F11.20 diagnosis were identified, registering a 0.74 percentage point increase from MY 2019.
- The identified members generated 2,507 claims with F11.20 diagnosis, a substantially higher number than MY 2019 (66) and MY 2018 (32), yielding a negative trend (lower rate is better).
- MY 2020 has the highest opioid dependence rate per 1,000 members with TV claim to date, registering at 467.81.

For MY 2020, Qlarant also examined claims with F11.20 diagnosis code by date of service (month) for POV and TV, as shown in Table 34 and Figure 11.

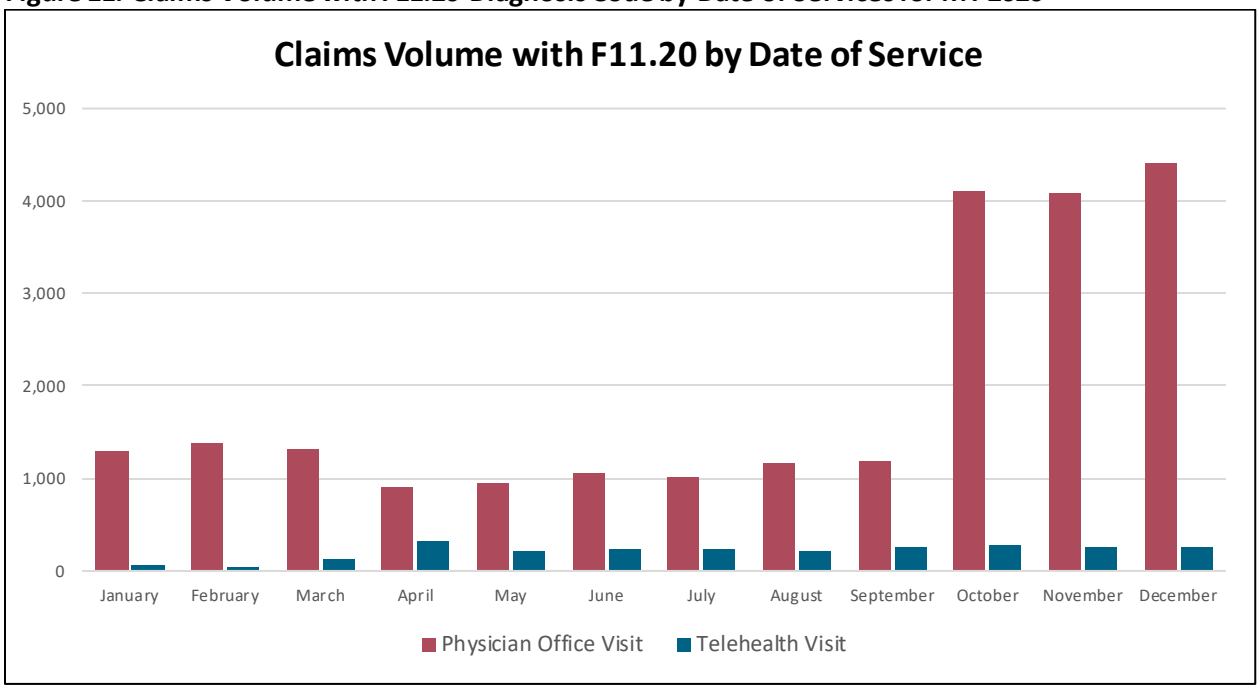
Table 34. Claims Volume with F11.20 Diagnosis Code by Date of Services for MY 2020

Month	Physician Office Visit	Telehealth Visit	POV and TV
January	1,290	56	1,346
February	1,388	40	1,428
March	1,328	130	1,458
April	900	331	1,231
May	955	213	1,168
June	1,065	232	1,297
July	1,023	237	1,260
August	1,162	216	1,378
September	1,181	257	1,438

[25] Make comparison with caution. CMS removed Medicaid eligibilty redetermination rule due to the public health emergency in MY 2020.

Month	Physician Office Visit	Telehealth Visit	POV and TV
October	4,114	280	4,394
November	4,092	261	4,353
December	4,405	255	4,660
Total	**22,903**	**2,508**	**25,411**

Figure 11. Claims Volume with F11.20 Diagnosis Code by Date of Services for MY 2020



Analysis revealed:

- In April 2020, the volume for POV setting hit the lowest point with 900 claims, whereas the volume for TV setting peaked with 331 claims, consistent with the COVID-19 public health emergency stay-at-home orders and limited operating hours and temporary closure of healthcare facilities. Ideal Option also opened its virtual clinic for opioid use disorder in April 2020.[26]
- The volume for TV setting stayed consistent from April 2020 through the rest of the year.
- The volume for both settings combined drastically surged in October 2020 with 4,394 claims and peaked in December 2020 with 4,660 claims, which was correlated with the following factors:
  - reopening of healthcare facilities and fulfilling backlog appointments.
  - more openings of the Ideal Option clinics
  - Ideal Option clinics' new requirement – members were required to attend office visit two or more times a week
  - the federal requirement for coverage of Opioid Treatment Program (OTP) services starting on 10/1/2020.
  - OTPs filed claims for their services on a daily basis

[26] https://www.minotdailynews.com/news/local-news/2020/04/ideal-option-opens-virtual-clinic-for-opioid-use-disorder/

Opioid Dependence Rate by Age and Gender

Table 35 and Figures 12 and 13 display the results of opioid dependence occurrences by age and gender in POV setting for MY 2020.

Table 35. Rate of Opioid Dependence Occurrences by Age and Gender for MY 2020

Age Group (Year)	Number of Members		Number of Opioid Dependence Claims		Rate Per Person	
	Female	Male	Female	Male	Female	Male
0 -19	0	1	0	5	0.0	5.0
20 - 24	40	24	909	824	22.7	34.3
25 - 29	72	110	2,379	3,552	33.0	32.3
30 - 34	65	104	1,411	3,760	21.7	36.2
35 - 39	79	75	2,718	2,128	34.4	28.4
40 - 44	27	44	879	1,222	32.6	27.8
45 - 49	14	14	477	497	34.1	35.5
50 - 54	22	17	754	296	34.3	17.4
55 - 59	21	12	569	254	27.1	21.2
60+	6	3	100	161	16.7	53.7
Total	**346**	**404**	**10,196**	**12,699**	**29.5**	**31.4**

Figure 12. Number of Members with F11.20 by Age and Gender for MY 2020

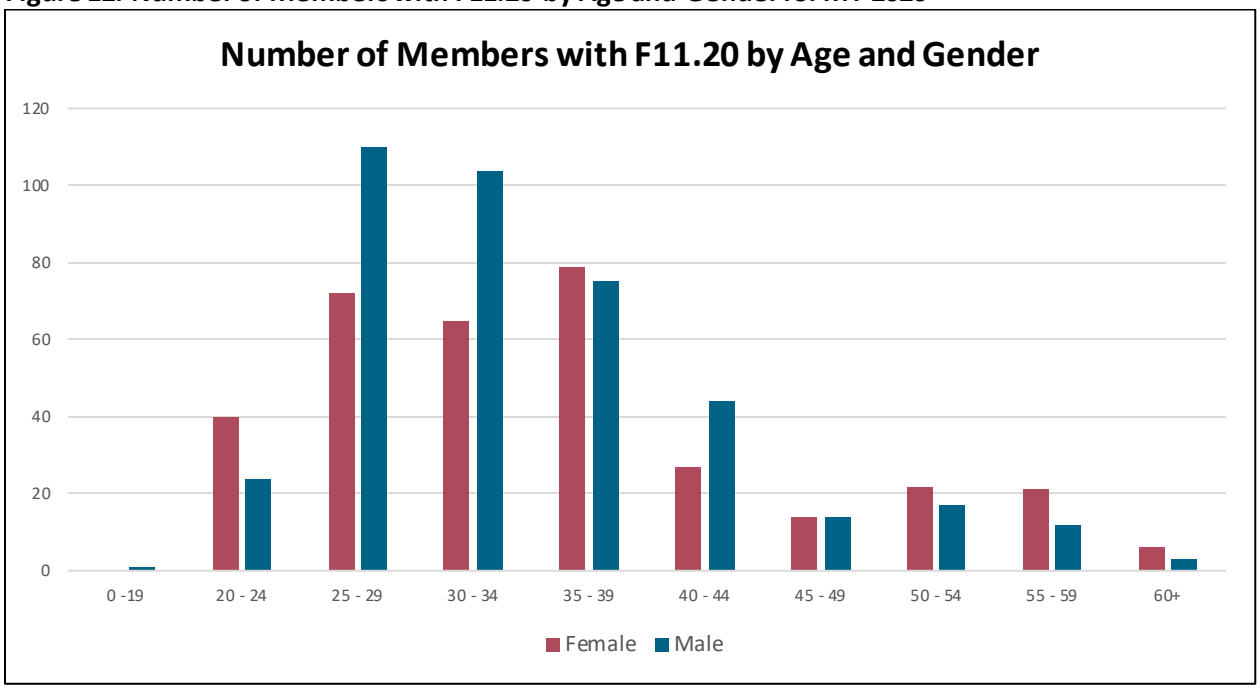
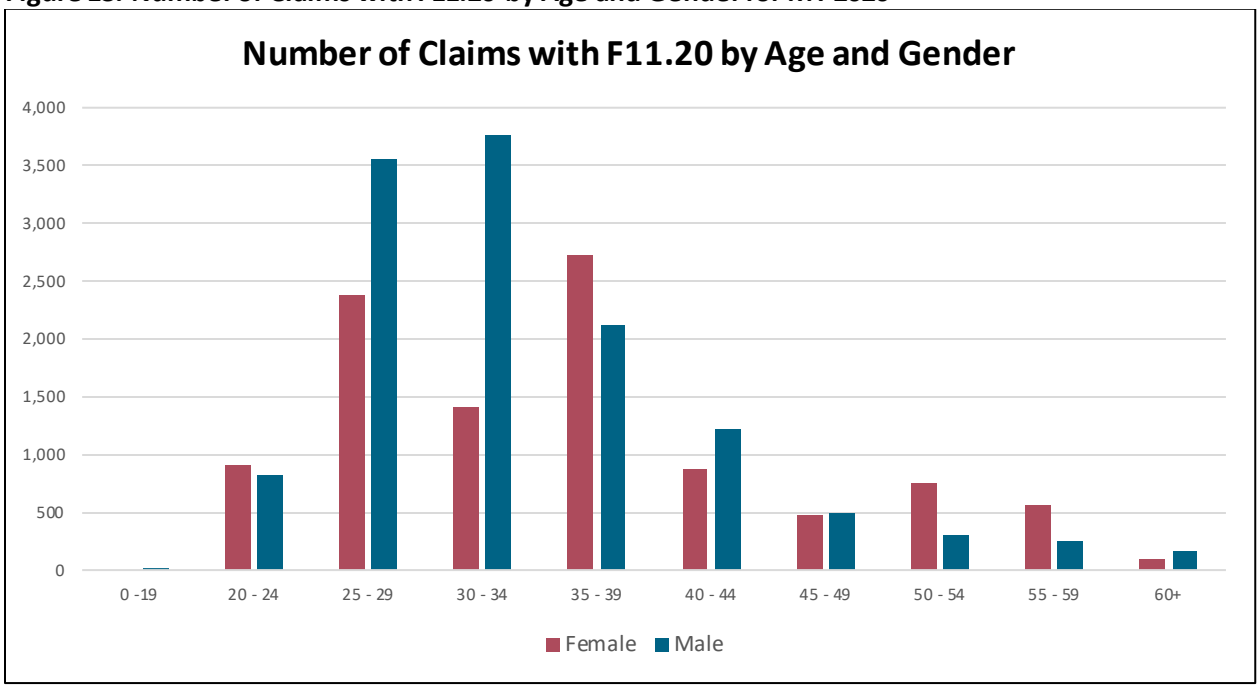


Figure 13. Number of Claims with F11.20 by Age and Gender for MY 2020



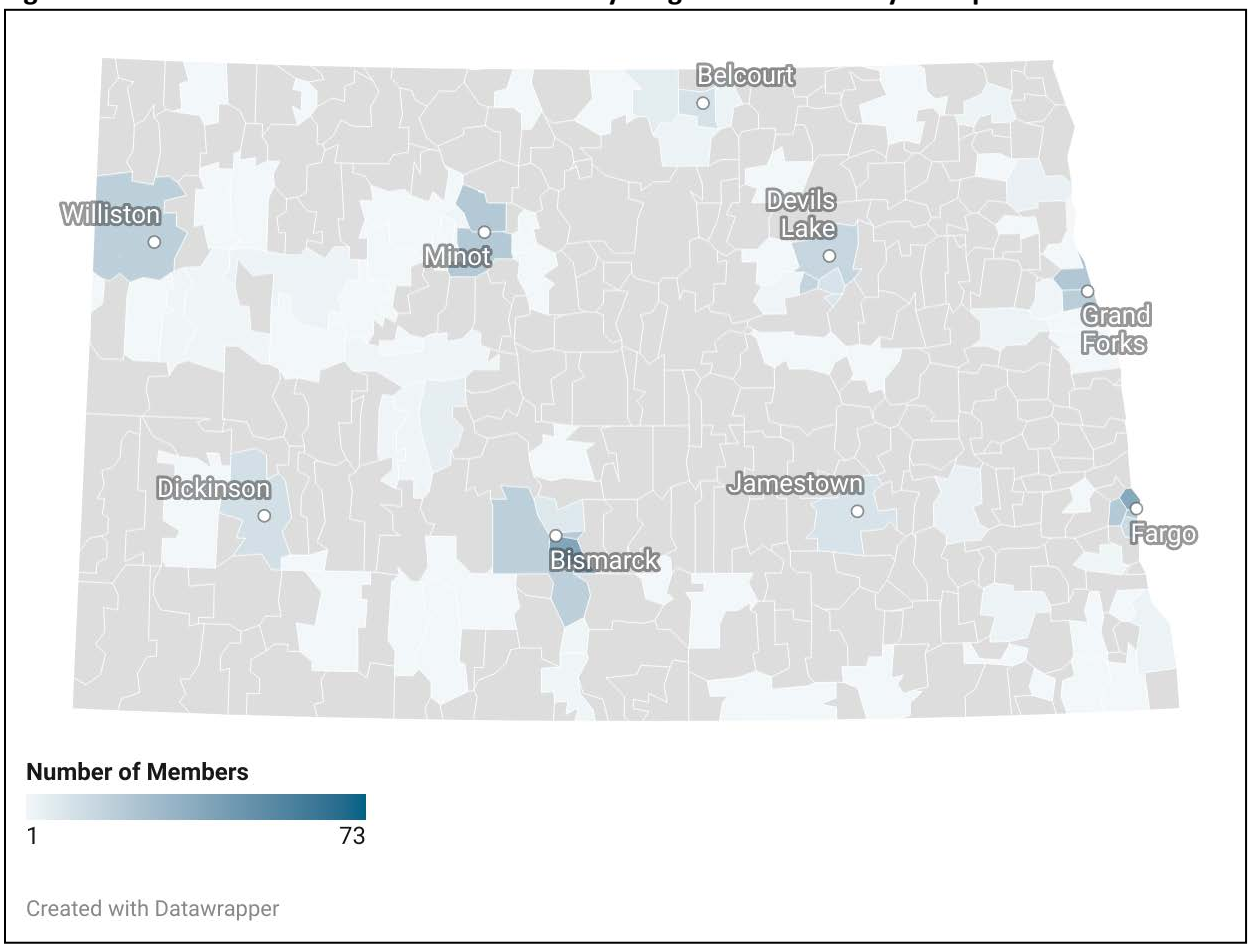
Analysis revealed:

- Of the 750 members with F11.20 diagnosis, 46% (346) is female and 54% (404) is male.
- Within the female gender:
  - 35 through 39 year old age group was the largest group with F11.20 diagnosis (79 or 23%).
  - 35 through 39 year old age group also generated the highest number of opioid dependence claims (2,718 or 27%).
- Within the male gender:
  - 25 through 29 year old age group was the largest group with F11.20 diagnosis (110 or 27%).
  - 30 through 34 year old age group generated the highest number of opioid dependence claims (3,760 or 30%).
- The male gender's rate per person of 31.4 is higher than the female gender (29.5).

Opioid Dependence by Geographic Distribution

The MY 2020 geographic distribution (ND zip codes only) of members who received a primary diagnosis of F11.20 in POV setting is shown in Figure 14. A comprehensive analysis can be found in Appendix 1's Table A1-1.

Figure 14. The Number of Members with a Primary Diagnosis of F11.20 by ND Zip Codes for MY 2020



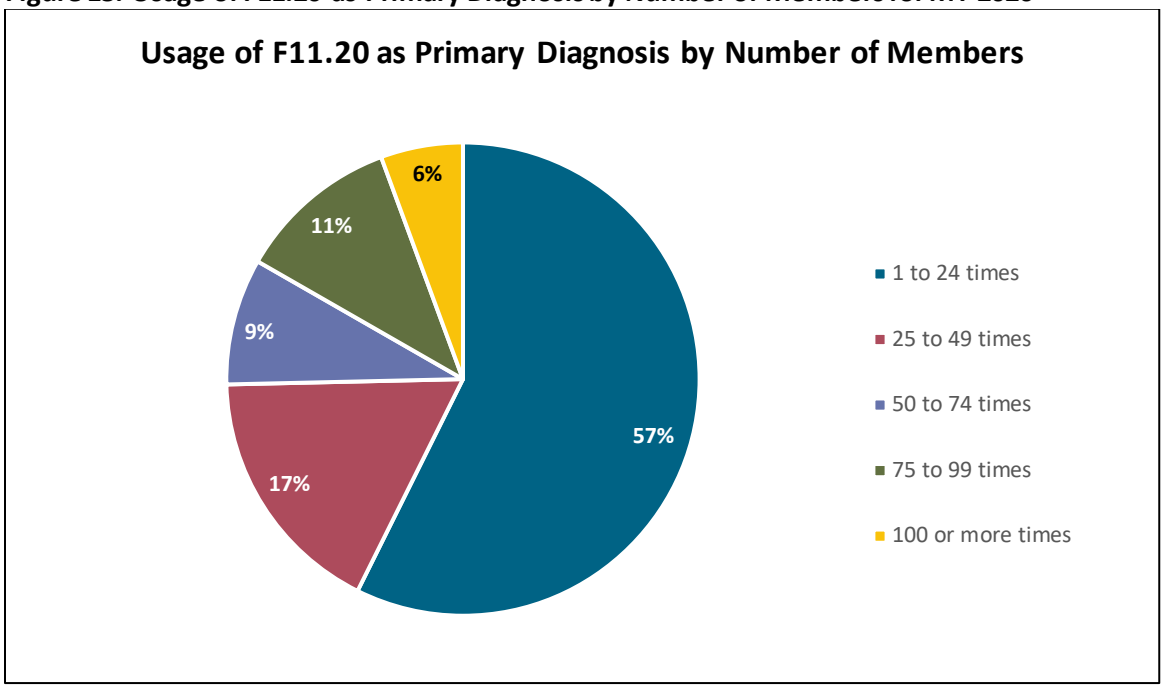
Analysis reviewed:

- The members with F11.20 diagnosis were generally residing in densely populated areas.
- The top four regions are:
    1. Fargo (132 or 19%)
    2. Bismarck (111 or 16%)
    3. Minot (86 or 13%)
    4. Grand Forks (72 or 11%)

Usage of F11.20 as Primary Diagnosis

Figure 15 displays the MY 2020 results of members who received F11.20 as primary diagnosis in POV setting. A comprehensive analysis can be found in Appendix 1's Table A1-2.

Figure 15. Usage of F11.20 as Primary Diagnosis by Number of Members for MY 2020

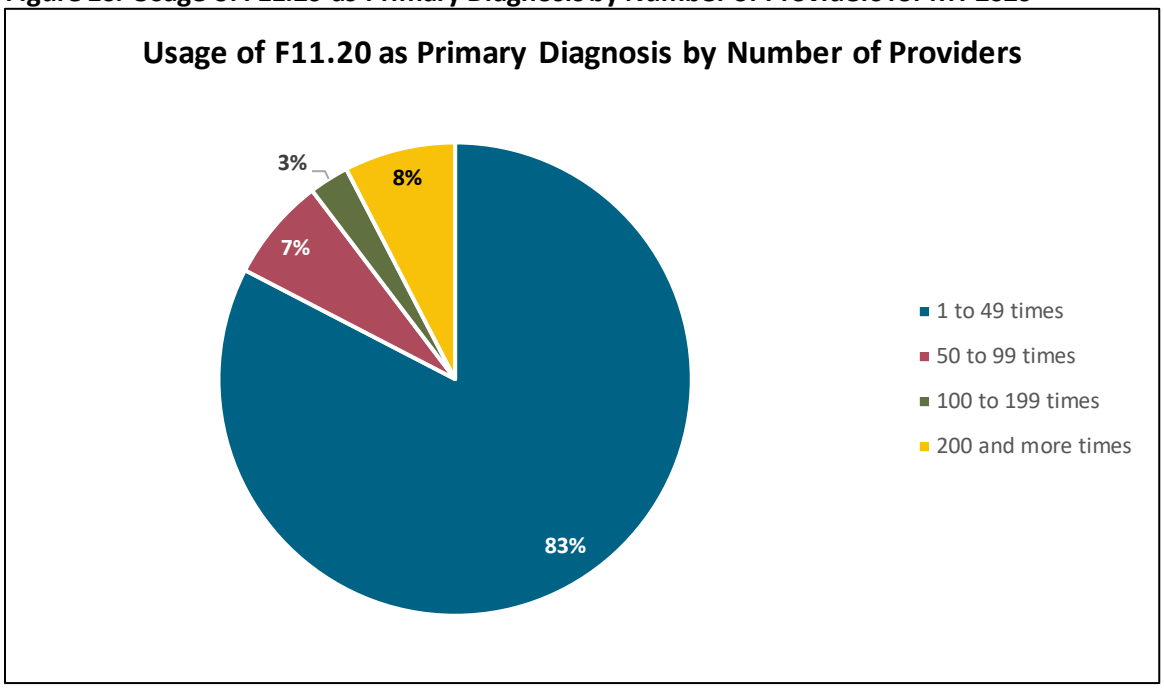


Analysis revealed:

- Of the 694 identified members, F11.20 diagnosis was given:
  - 1 to 24 times to 398 members (57%)
  - 25 to 49 times to 120 members (17%)
  - 50 to 74 times to 60 members (9%)
  - 75 to 99 times to 77 members (11%)
  - 100 or more times to 39 members (6%)
- The highest received amount of F11.20 as primary diagnosis by a single member was 184 times in MY 2020.

Figures 16 displays the MY 2020 results of providers who issued F11.20 as primary diagnosis in POV setting. A comprehensive analysis can be found in Appendix 1's Table A1-3.

Figure 16. Usage of F11.20 as Primary Diagnosis by Number of Providers for MY 2020



Analysis revealed:

- Of the 184 identified providers, F11.20 diagnosis was used:
  - 1 to 49 times by 152 providers (83%)
  - 50 to 99 times by 13 providers (7%)
  - 100 to 199 times by 5 providers (3%)
  - 200 and more times by 14 providers (8%)
- The highest usage of F11.20 as primary diagnosis by a single provider was 6,796 times in MY 2020. The provider is a nurse practitioner who works at an addiction treatment center.

Conclusions

Qlarant concluded MY 2020 focused study with the below answers to the study questions:

- ***Is opioid dependence increasing within the North Dakota Medicaid Expansion population?***
  - The second year of three-year focused study shows the MY 2020 opioid dependence rate within ND Medicaid Expansion population continued to rise. The correlated factors could be found on page 6.
  - For physician office visit setting, both members with F11.20 diagnosis rate (3.32%) and opioid dependence rate per 1,000 members (1,095.51) increased from MYs 2018 and 2019.
  - For telehealth visit setting, both members with F11.20 diagnosis rate (5.95%) and opioid dependence rate per 1,000 members (467.81) for telehealth visit increased substantially from MYs 2018 and 2019.
- ***Do study results identify a specific subpopulation that should be targeted for interventions?***

- For physician office visit setting, most members with F11.20 diagnosis lived in urban area; for example, Fargo, Bismarck, Minot, and Grand Forks. The members who received F11.20 diagnosis were largely between the ages of 25 through 39 in both genders.
- No in-depth analysis was conducted in the introductory year for telehealth visit setting.

MCO Quality, Access, and Timeliness Assessment

Quality, Access, and 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.

Tables 36 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 365. MCO Strengths, Weaknesses, and Recommendations

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Performance Improvement Projects			
Comprehensive Diabetes Care PIP			
✓	NA	NA	**Strengths.** SHP met all requirements for Steps 1 to 6 of the Comprehensive Diabetes Care PIP.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
✓	NA	NA	**Recommendation.** SHP is encouraged to identify causes for performance and identify lessons learned to apply to the study during data analysis. SHP is encouraged to continue annual barrier analysis and also develop, modify, and implement targeted interventions to ensure they are consistently facilitating quality improvement. SHP is encouraged to use the Plan-Do-Study-Act, or similar approach, to test improvement strategies.
Follow-Up for Mental Health PIP			
✓	✓	✓	**Strength.** SHP completed a thorough analysis of three performance measures relating to follow-up for mental health. SHP showed improvement in all of the performance measures for MY 2021. The Follow-Up for Mental Health – Within 7 and 30 Days measures exceed the MCO's goal. SHP sustained improvement in all three measures: Follow-Up After Emergency Department Visit for Mental Health – 7 Day and 30 Day Follow-Up, and Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment.
✓	NA	NA	**Weakness.** SHP received a score of 89.47% (moderate confidence). SHP did not identify lessons learned that can be applied to the study. **Recommendation.** SHP is encouraged to specify the time period for the study. Qlarant recommends SHP to consider adding "within the next year," or similar time specification, to the aim statement. SHP is encouraged to identify causes for performance and identify lessons learned that can be applied to the study during data analysis. SHP is encouraged to continue annual barrier analysis and also develop, modify, and implement targeted interventions to ensure they are consistently facilitating quality improvement. SHP is encouraged to use the Plan-Do-Study-Act, or similar approach, to test improvement strategies.
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."
✓	NA	NA	**Strength.** Fifty percent (50%) of rates (24 of 48 measures) compared favorably to the national average benchmark. Eighty-eight percent (88%) of rates (42 of 48 measures) had rates available for MYs 2019 through2021 and allowed for a trending analysis. Thirty-five percent (35%) of rates (17 of 48 measures) demonstrated a positive trend.

Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
✓	NA	NA	**Weakness.** Thirty-one percent (31%) of rates (15 of 48 measures) scored below national average benchmarks. **Recommendation.** SHP should identify the 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 services, and how provider practices are following safety protocols.
Compliance Review			
✓	✓	✓	**Strength.** SHP received a high overall compliance score of 92% (moderate confidence). This is a 7% point decline from MY 2020 (99%).
✓	NA	NA	**Recommendation.** If SHP is to be considered for future contracts for this program, Qlarant would recommend a preoperational assessment of this element.
Information Requirements			
✓	✓	✓	**Strength.** SHP received a score of 100% in the Information Requirements standard.
Disenrollment Requirements and Limitations			
✓	NA	NA	**Weakness.** SHP largest identified opportunities included minor revisions to the active policies and failure to create a policy for disenrollment reflecting the new standards from the previous year. **Recommendation.** If SHP is to be considered for future contracts for this program, Qlarant would recommend a preoperational assessment of this element.
Enrollee Rights and Protections			
✓	NA	NA	**Strength.** SHP received a score of 100% in the Enrollee Rights Standard.
MCO Standards			
✓	✓	✓	**Strength.** SHP received a score of 97% in the MCO Standards.
NA	✓	✓	**Weakness.** SHP's 2021 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 North Dakota standard for timely access to care and services. SHP should require corrective action when providers fail to meet access standards. Qlarant recommends SHP to develop a process for monthly monitoring of corrective action plans and resurveying providers to ensure compliance with SHP-established requirements.
Quality Measurement and Improvement			
✓	NA	NA	**Strength.** SHP received a score of 100% in the Quality Assessment and Performance Improvement Program standard.

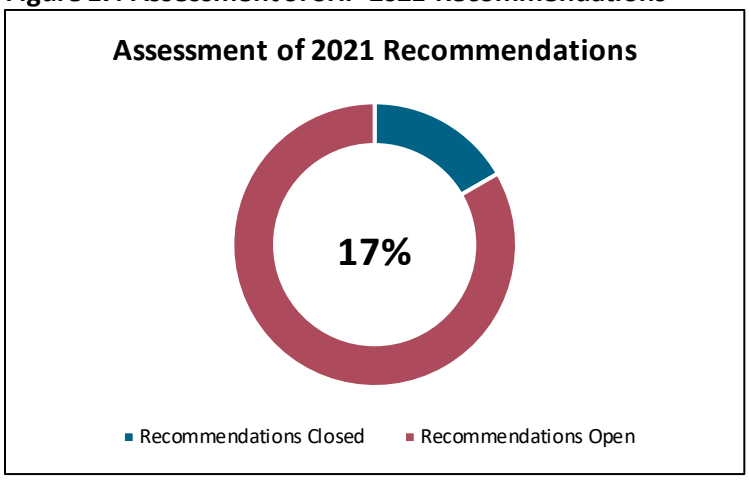
Quality	Access	Timeliness	Strengths, Weaknesses, Recommendations
Grievance and Appeal System			
✓	✓	✓	**Strength.** SHP received a score of 100% in Grievance and Appeal System standard.
Program Integrity Requirements Under Contract			
✓	NA	NA	**Strength.** SHP received a score of 100% in Program Integrity Requirements Under Contract standard.
Network Adequacy Validation			
NA	✓	✓	**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.
Encounter Data Validation			
✓	NA	NA	**Strength.** SHP has well documented data integration and claims processing procedures. SHP achieved a high total match rate at 96%. SHP scored 100% match rate in procedure codes for inpatient and outpatient encounters.
NA	NA	✓	**Weakness.** SHP had a substantial decline in MY 2021 office visit match rate (94%) from MY 2020 (98%) in outpatient encounters. **Recommendation.** SHP needs to investigate what causes the substantial decline in match rate, add a field to encounter data to document date claims are received and educate provider on participation requirements regarding the EDV assessment.
CAHPS Survey			
✓	NA	NA	**Weakness.** The survey results indicate SHP enrollees are not satisfied with their health care 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			
NA	✓	NA	**Weakness.** SHP's opioid dependence rate per 1,000 enrollees with a POV claim continues to rise. **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 2022 EQR activities, Qlarant evaluated the MCO's compliance in addressing 2021 recommendations.[27] Assessment outcomes are illustrated in Figure 17. MCO-specific recommendations and follow-up assessments are summarized in Table 37. Assessments identify whether the MCO adequately addressed 2021 recommendations. Green and red arrow symbols specify results:

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

Figure 17. Assessment of SHP 2021 Recommendations



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

Table. 37 Assessment of SHP's Previous Annual Recommendations

2021 Recommendations	2022 Assessment
Performance Improvement Projects	
Comprehensive Diabetes Care PIP	
Explore new ways or utilize existing outreach initiatives to communicate to members the importance of completing routine diabetes care, the availability of telehealth services, and how provider practices are following safety protocols.	**Continues to be an improvement opportunity.** SHP is encouraged to continue to assess, analyze, and develop interventions to ensure consistently facilitated quality improvement. SHP is encouraged to use the Plan-Do-Study-Act, or similar approach, to test improvement strategies.
Follow-Up for Mental Health PIP	
Explore why certain interventions did not work by using 5-Whys or similar methods. In addition, SHP should communicate to members the importance of continuous mental health care, the availability of telehealth services, and how provider practices are following safety protocols.	**Continues to be an improvement opportunity.** SHP is encouraged to continue to assess, analyze and develop interventions to ensure consistently facilitated quality improvement. SHP is encouraged to use the Plan-Do-Study-Act, or similar approach, to test improvement strategies.

[27] 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.

2021 Recommendations	2022 Assessment
Performance Measure Validation	
Identify barriers and explore ways to communicate to members the importance of personal health care, the availability of telehealth services, and how provider practices are following safety protocols.	**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 2021, thirty-one percent (31%) of rates (15 of 48 measures) scored below national average benchmarks. This is a slight improvement from the twenty-three (23) from MY 2020.
Compliance Review	
Information Requirements	
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.	**Compliant** Information Requirements section of the review received a 100% score.
MCO Standards	
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, which is well below DHS's threshold. Ensuring timely access to provider appointments continues to be a challenge for SHP.
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

Recognizing the MCO will be transitioning to a new organization, the following recommendations are more generic to the transitioning process.

- Continue to support, provide guidance, and work collaboratively with the MCO as the organization works to meet all requirements.
- Continue to work to overcome the challenges the MCO, providers, and enrollees face during transition and public health emergencies.
- Require the MCO to follow-up on recommendations made by the EQRO in the CR
- Continue to work with the EQRO and MCO to identify measures meaningful to the Medicaid Expansion population.
- Encourage MCO to identify barriers and interventions to help close the gap in Comprehensive Diabetes Care and Follow-Up for Mental Health PIP measures.
- Encourage MCO 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

Challenges associated with the COVID-19 public health emergency and the transition to a new MCO in the middle of this reporting year have presented many challenges to the North Dakota Medicaid Expansion program. With the larger population to be served and the lack of access due to the slow reopening of healthcare facilities, the respective measurement rates have been affected. The changes to the disenrollment process also affected the compliance rate for SHP. SHP did not update or alter their policies and procedures to reflect the new process due to the transitioning to a new MCO.
Even with the transitioning from one MCO to another, it would be advised to require appropriate policy and procedure implementation regardless of the length of the MCO contract. By implementing new policies, interventions and addressing the newest regulations and rules, the MCO will facilitate improvement in the areas of quality, access, and timeliness of care for the Medicaid Expansion population.