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External Quality Review Annual Technical Report

Review Period: January 1, 2022 to December 31, 2023

North Dakota Department of Health and Human Services
Medical Services Division

April 2024

NORTH Dakota | Health & Human Services

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I. Executive Summary

Purpose of Report

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

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCO furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCO regarding health care quality, timeliness, and access, as well as making recommendations for improvement.

To comply with *Title 42 CFR § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the North Dakota (ND) Department of Health and Human Services (HHS) contracted with IPRO, an EQRO, to conduct EQR activities for Blue Cross Blue Shield of North Dakota (BCBSND) who is contracted to furnish Medicaid services to the Medicaid expansion population in the state. This report presents MCO-level results of these EQR activities for BCBSND conducted during the 2023 calendar year based on MY 2022 data. Some activities continued after the measurement year to December 31, 2023, including the PIPs, performance measure validation and the comprehensive administrative (compliance) review. Since this is the first year BCBSND provided Medicaid services future reports will contain trended data.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the four mandatory and one optional EQR activities that were conducted. It should be noted that validation of network adequacy of BCBSND was conducted at the state's discretion as activity protocols are not required to be reported until the April 2025 Annual Technical Report. IPRO utilized the CMS *External Quality Review (EQR) Protocols* published in February 2023 for this report. As set forth in *Title 42 CFR § 438.358 Activities related to external quality review* (b)(1), these activities are:

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

(ii) ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures (PM) reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.

(iii) ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4:* Validation of Network Adequacy –** This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population.

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

(v) ***CMS Optional Protocol 6:*** **Administration or Validation of Quality of Care Surveys –** This activity uses a member survey to measure satisfaction with care received, providers, and health plan operations. During the review period a CAHPS® satisfaction survey was conducted for adult members. The member survey measured satisfaction with care received, providers, and health plan operations.

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

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

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

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

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of MY 2022 EQR activity findings to assess the performance of the North Dakota Medicaid MCO in providing quality, timely, and accessible healthcare services to Medicaid members. Some activities continued after the measurement year to December 31, 2023, including the PIPs, performance measure validation and the comprehensive administrative (compliance) review. BCBSND was evaluated against state and national benchmarks, where available, for measures related to the quality, access, and timeliness domains.

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

Performance Improvement Projects

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

Overall, the COPD or Asthma in Older Adults PIP saw significant improvements in three indicators, demonstrating BCBSND's commitment to improving health outcomes in this area. IPRO noted a number of data reporting errors in the PIP reports and provided BCBSND with feedback to support continuous quality improvement.

Performance Measures

Reported HEDIS and non-HEDIS measures were validated and found to be reportable. Based on a review of the HEDIS MY 2022 FARs issued by BCBSND's independent auditor and on the ISCA review, IPRO found that BCBSND was *fully compliant* with all seven of the applicable NCQA information system (IS) standards. Of the 25 measures/submeasures that were benchmarked against NCQA Quality Compass data, eight were above the 75th percentile. There were seven measures/submeasures that fell below the 10th percentile.

Compliance Review

IPRO conducted a comprehensive administrative review of BCBSND in November 2023, consistent with *Title 42 CFR § 438* and *Title 42 CFR § 457*. The review covered the period from January 1, 2022, to December 31, 2022. Overall,

BCBSND achieved a high rate of compliance with the standards reviewed for the comprehensive administrative review with an overall compliance rate among the 16 domains of 95.1%. Rates of compliance for the different domains ranged from 58.8% to 100.0%. Standards for which BCBS achieved compliance scores of 100% were in the following areas: Disenrollment Requirements & Limitations, Emergency and Post Stabilization Services, Coordination of Care, Confidentiality of Health Information, Practice Guidelines and Quality Assessment and Performance Improvement (QAPI) Program.

Network Adequacy

IPRO conducted telephone surveys of primary care providers (PCPs) to determine if BCBSND members utilizing the provider directory to book a primary care appointment would be able to reach a PCP, and if the PCP were able to schedule an appointment in a time frame consistent with the BCBSND contract. Additionally, IPRO looked at time and distance reports and geographical access reports from BCBSND.

Overall, IPRO found the PCP provider directory to be 76.9% accurate; however, appointment timeliness did not meet standards outlined by HHS.

The BCBSND *Adherence to Provider Network Distance Standards* report for the fourth quarter of 2023 indicates that in North Dakota, five of the six top high-volume specialties, including behavioral health (BH), cardiology, obstetrics/gynecology (ob/gyn), orthopedic surgery, and surgery providers, met the state's requirement of 90% accessibility for BCBSND members within a 50-mile radius. However, medical oncology providers fell short of this goal with 74.9% of members able to access these providers within a 50-mile radius. The PCP to member ratio was 1:4.9 which met the standard of 1:2,500.

Quality of Care Surveys

BCBSND is required to conduct annually the adult, child, and child with chronic conditions CAHPS surveys of a sample of members. NCQA Quality Compass® was the tool used to examine quality improvement and benchmark BCBSND performance through online access to health plan Consumer Assessment of Healthcare Providers and Systems (CAHPS®) performance data. Measures performing at or above the 75th percentile were considered strengths: How Well Doctors Communicate (Q12), Customer Service (Q25), and Coordination of Care (Q17 and Q27).

NCQA/URAC Accreditation

Utilization Review Accreditation Commission (URAC)'s accreditation standards are focused on consumer protection and quality improvement. BCBSND is URAC-accredited, and the accreditation's benefits has helped the state to focus on policies and metrics, develop long-term process and system optimization plans, implement resources to check safety, meet privacy technology requirements and to have better health outcomes by focusing on key areas, such as patient access, value, and engagement.

Recommendations for BCBSND and HHS

Findings from this year's EQR activities highlight BCBSND's commitment to achieving the goals of the *North Dakota Medicaid Quality Strategy*. Strengths related to **quality** of, **timeliness** of, and **access** to care were observed; however, there were also important shortcomings in each that can be addressed through ongoing quality measurement, reporting, and improvement activities. HHS has developed a plan to increase BCBSND's focus on population health, care coordination, and addressing disparities. These priorities are described in HHS's new quality strategy, published in December 2023, which aligns with the recommendations in the following sections and is summarized in section 2 of this report.

II. North Dakota Medicaid Managed Care Program

Managed Care in North Dakota

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

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

On August 26, 2015, the state submitted a request to CMS for a 1115 waiver extension as the authority initially granted was to end December 20, 2015. The state received a letter from CMS on December 18, 2015, indicating the 1115 waiver extension request was approved. The 1115 waiver was allowed to expire, as the provisions of the *2016 Medicaid Managed Care Final Rule* (May 6, 2016) resulted in ND no longer having designated urban areas and considered rural statewide, thus, being exempt from having to provide a choice of MCOs and in compliance with *Section 1932(a)* of ACA and *Title 42 CFR § 438.52*.

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

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

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

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

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

On January 17, 2024, the state submitted a 1915(b) Waiver Extension request to CMS. On February 6, 2024 CMS granted the extension through June 30, 2024.

As the state was only able to award one statewide MCO contract, to ensure compliance with federal MMC regulations requiring enrollees to have a choice of MCOs in the metropolitan statistical areas the state submitted a 1115 waiver, with authority granted by CMS on February 26, 2014. This allowed having one MCO choice for those Medicaid Expansion enrollees residing in urban areas of North Dakota. The initial 1115 waiver authority ended on December 20, 2015.

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

pharmacy benefits for the ND Medicaid Expansion population will be administered and managed by the state through FFS Medicaid administration.

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

On January 1, 2022, Medicaid Expansion enrollees began receiving services through BCBSND as the sole MCO for the ND Medicaid Expansion program.

North Dakota Medicaid Quality Strategy

The Medicaid quality strategy supports the mission of the state, which is to provide quality, efficient and effective health services, which improve the lives of people. The Medical Services Division ensures that its enrollees receive high-quality care by providing effective oversight of its MCO to promote accountability and transparency for improving health outcomes.

Guiding principles and expected outcomes include:

- improved coordination of care;
- better health outcomes;
- increased quality of care as measured by metrics, such as HEDIS;
- greater emphasis on disease prevention and management of chronic conditions;
- earlier diagnosis and treatment of acute and chronic illness;
- improved access to essential specialty services;
- outreach and education to promote healthy behaviors;
- increased personal responsibility and self-management;
- reduction in the rate of avoidable hospital stays and readmissions;
- monitoring of and a decrease in fraud, abuse, and wasteful spending;
- greater accountability for the dollars spent; and
- a more financially sustainable system.

Figure 1 depicts North Dakota's Medicaid Quality Strategy, showing the conceptual linkages between healthcare needs, quality processes, and outcomes.

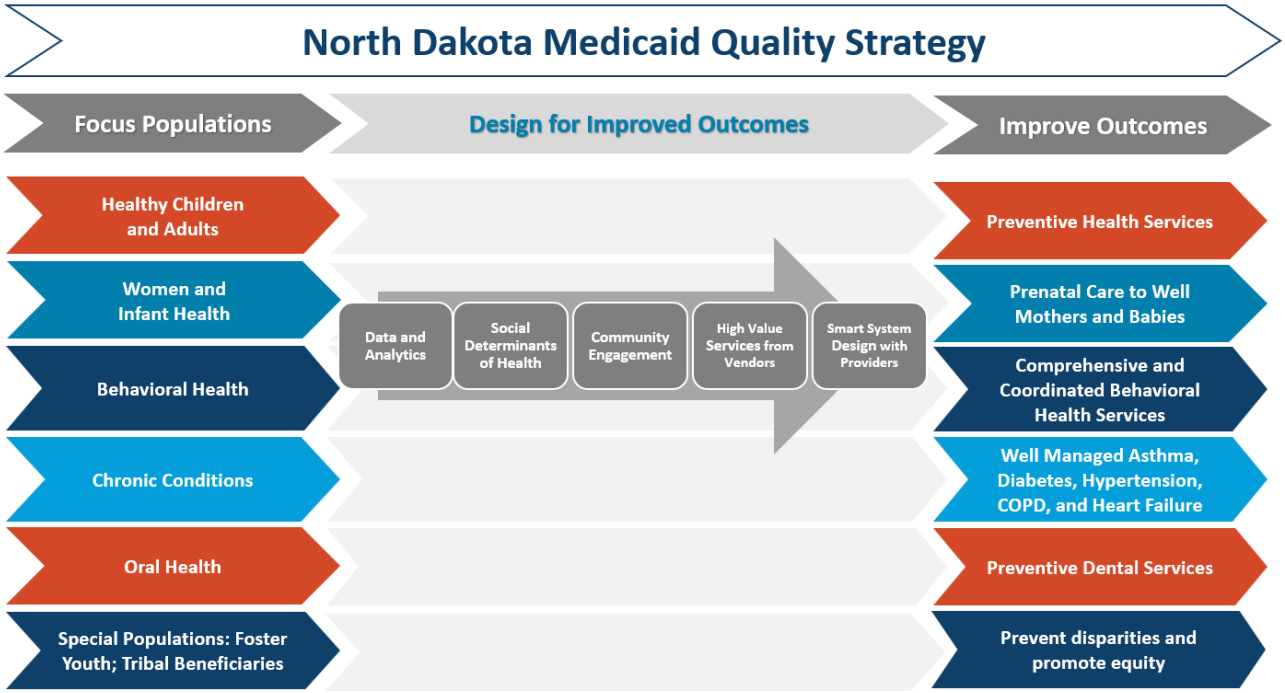

Figure 1: North Dakota Medicaid Quality Strategy. COPD: chronic obstructive pulmonary disease.

Figure 2, which is based on the Institute for Healthcare Improvement's quadruple aim, appears in the quality strategy as a guidepost to the scientific basis of quality improvement processes. Included within each of the four aims in **Figure 2** is a series of goals and corresponding objectives, intended to highlight key areas of expected progress and quality focus. Together, these aims create a framework through which ND defines and drives the overall vision for advancing the quality of care provided to the Medicaid program members. These aims, goals, and objectives were designed to align closely with Centers for Medicare & Medicaid Services' (CMS) Quality Strategy, adapted to address ND's local priorities, challenges, and opportunities for its Medicaid program.

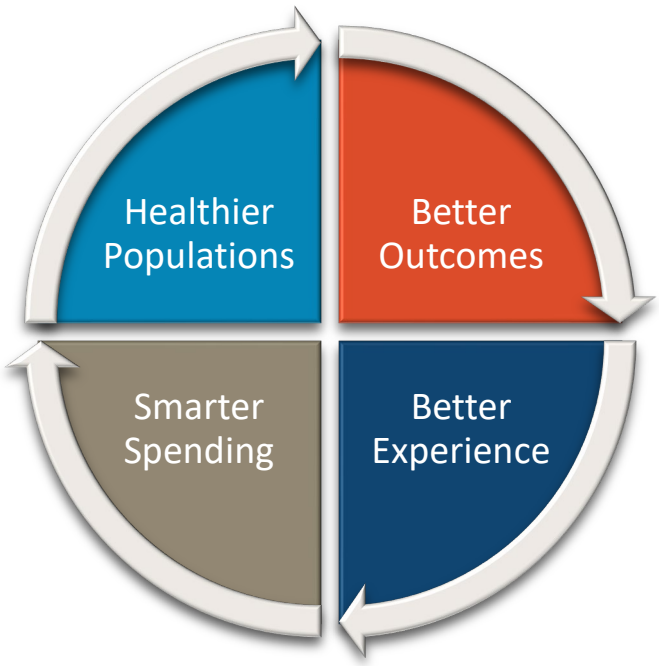

Figure 2: North Dakota's Quadruple Aim. Resource: IHI – Institute for Healthcare Improvement.

IPRO's Assessment of the North Dakota Medicaid Quality Strategy

Using the *CMS Managed Care Quality Strategy Toolkit* as a guide, IPRO has undertaken a complete evaluation of ND's 2023 *Medicaid Quality Strategy Plan.* The plan adheres to the recommendations provided by CMS for creating an effective strategy. EQR activities are incorporated into techniques for assessing and tracking MCO progress toward improving health outcomes, and goals and aims are well-defined and facilitated by well-planned interventions. HHS's extensive clinical and non-clinical activities and its implementation of MCO responsibility demonstrate how important it is to continue improving health outcomes. HHS intent is to align this quality strategy to include both MCO and FFS populations, and as such, IPRO took this under consideration during this evaluation. IPRO concluded that ND's strategy towards population health fits both MCO and FFS populations.

Recommendations to HHS

IPRO identified the following recommendations for BCBSND and HHS:

- HHS can expand their support of BCBSND's quality improvement (QI) initiatives by promoting ongoing education and training related to key clinical areas. For example, they can give BCBS feedback on HEDIS rate improvement by holding in-person or virtual conferences and trainings that draw on the knowledge gained from PIPs, focus studies, and national best practices. It can be instructive to contact other states and host webinars where they can discuss their QI projects.
- Support transparency to promote QI by releasing PIP reports and sharing quality performance data outcomes with key constituents, such as via the HHS website.
- Help BCBSND focus population health improvements by reducing the number of PIPs that are active each year.
- Use the quality strategy to highlight special programs that align with strategic initiatives across the state or with specific focus populations. Identify community-based programs that would help achieve outlined objectives to further describe the state's strategy towards population health .
- Ensure both FFS and MCO populations have equal representation throughout the quality strategy and program initiatives and goals are aligned across these populations.
- Ensure goal, objective, and measure alignment across both FFS and MCO populations.
- Add measures related to well-child visits as well as maternal, care and baby wellness measures in the first aim for healthier populations.
- Report quality measures on a statewide basis, averaging MCO and FFS across all measures/objectives, to give a holistic view of the state's achievements.

Quality Strategy Update

Following the evaluation of the state's quality strategy, ND undertook a process to update and incorporate the above recommendations into a new quality strategy. The main purpose of this update was to develop a strategy that comprehensively includes both FFS and MCO programs. The new strategy takes the core approach from the past strategy and aligns program goals across both FFS and MCO through goals, objectives, and strategic initiatives. This alignment allows ND to measure progress toward goals at the state level, while targeting disparities unique to each program's population. At the time of this report, the new quality strategy was available for public comment in December 2023.

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies that contract with MMC plans must conduct PIPs that focus on both clinical and non-clinical areas. According to CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by MCOs. *Title 42 CFR § 438.356(a)(1)* and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, HHS contracted with IPRO to validate the PIPs that were underway in 2023. PIP topics are displayed in **Table 1.**

Table 1: PIP Topics

PIP Topics
PIP 1: COPD or Asthma in Older Adults Admission Rate
PIP 2: Diabetes Care
PIP 3: Hypertension
PIP 4: Substance Use Disorder

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

Upon final reporting, a determination is made as to the overall credibility of the results of each PIP, with an assignment of one of three categories, as shown in **Table 2**.

Table 2: Overall Credibility of Results

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

The four current PIPs concluded their interim year on December 31, 2023. All of the PIPs will continue on until December 31, 2024 (except for the Hypertension PIP), after which IPRO will complete a final review. Findings below are preliminary.

Description of Data Obtained and Progress

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure (PM) calculations, targets, benchmarks, interventions (planned and executed), intervention tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

PIP 1: COPD or Asthma in Older Adults Admission Rate

Goal: Reduce inpatient admissions associated with COPD or asthma by building a connection with a healthcare provider and undergoing at least one ambulatory or preventive visit annually.

The following key interventions were implemented by BCBSND:

- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND.
- Case Management outreached members discharged from an inpatient admission with a diagnosis of COPD within 72 hours to assess post discharge needs.
- Case Management outreached members following an ED visit for a diagnosis of COPD to begin case management interventions, including scheduling medical appointments, and assisting with social or community needs.

There were four study indicators for this PIP:

- Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of COPD or asthma during the calendar year (CY).
- Indicator 2: The percentage of acute inpatient and observation stay discharges during the MY for a principal diagnosis of COPD or asthma during the CY.

- Indicator 3: The percentage of enrollees discharged from acute inpatient and observation stay for a principal diagnosis of COPD or asthma who also had a visit with a healthcare provider for a principal diagnosis of COPD or asthma during the CY.
- Indicator 4: The percentage of admissions with a principal diagnosis of COPD or asthma per 100,000 population, ages 40–64 years.

PIP 2: Diabetes Care

Goal: Reduce inpatient admissions associated with diabetes complications by establishing a connection with a healthcare provider and undergoing at least one ambulatory or preventive visit annually.

The following key interventions were implemented by BCBSND:

- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND.
- Case Management reached out to enrollees discharged from an inpatient admission with a diagnosis of diabetes within 72 hours to assess post discharge needs.
- Case Management conducted in-home hemoglobin A1c (HbA1c) labs for enrollees with a diabetes diagnosis (type 1 and 2).
- Case Management conducted in-home retinal eye exams on members with a diabetes diagnosis (type 1 and 2).
- Utilization Management sent daily reports with enrollees discharged from inpatient or observation settings and weekly reports on outpatient services approved for case management to engage with members and track the percentage of enrollees that required an inpatient and/or observation stay for a principal diagnosis of diabetes.
- Quality Management sent monthly gaps-in-care reports for diabetic enrollees to case management for review and intervention.
- Quality Management sent monthly reports on members with multiple admissions for diabetic complications for case management to conduct interventions and/or education.

There were eight study indicators for this PIP:

- Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of diabetes during the CY.
- Indicator 2. The percentage of acute inpatient and observation stay discharges during the MY for a principal diagnosis of diabetes.
- Indicator 3: The percentage of enrollees discharged from acute inpatient or observation for a principal diagnosis of diabetes, who also had a visit with a healthcare provider for a principal diagnosis of diabetes during the CY.
- Indicator 4: The percentage of admissions for a diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 member months (MM) for ages 21–64 years.
- Indicator 5: The percentage of diabetes admissions per 100,000 MM for enrollees ages 21–64 years.
- Indicator 6: The percentage of enrollees with diabetes whose HbA1c was in control (HbA1c < 8.0%).
- Indicator 7: The percentage of enrollees with diabetes whose HbA1c was in poor control (HbA1c > 9.0%).
- Indicator 8: The percentage of enrollees with diabetes who had a retinal eye exam.

PIP 3: Hypertension

Goal: Reduce inpatient admissions associated with hypertension complications by establishing a connection with a healthcare provider and undergoing at least one ambulatory or preventive visit annually.

The following key interventions were implemented by BCBSND:

- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND.
- Case Management reached out to enrollees discharged from an inpatient admission within 72 hours to assess post discharge needs.
- Case Management conducted in-home blood pressure checks for enrollees with a diagnosis of hypertension.
- Utilization Management sent daily reports of enrollees discharged from an inpatient or observation setting as well as weekly reports on outpatient services to case management for engagement with members.

There were five study indicators for this PIP:

- Indicator 1: The percentage of enrollees who have had at least one annual visit with a healthcare provider for a principal diagnosis of hypertension during the CY.
- Indicator 2: The percentage of acute inpatient and observation stay discharges with a principal diagnosis of hypertension during the CY.
- Indicator 3: The percentage of enrollees discharged from an acute inpatient or observational stay with a principal diagnosis of hypertension who also had a PCP visit for a principal diagnosis of hypertension during the CY.
- Indicator 4: The percentage of admissions with a principal diagnosis of hypertension per 100,000 population, ages 21–64 years.
- Indicator 5: The percentage of enrollees ages 21–64 years, who had a diagnosis of hypertension and whose blood pressure was adequately controlled at or below 140/90 mm Hg.

PIP 4: Substance Use Disorder

Goal: Reduce inpatient admissions associated with SUD for individuals enrolled in Medicaid Expansion by establishing a connection with a healthcare provider and undergoing at least one ambulatory or preventive visit annually.

The following key interventions were implemented by BCBSND:

- Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports, and participated in collaboration calls with BCBSND.
- Case Management received notifications for ED visits for enrollees and assisted with discharge follow-up, including, but not limited to, follow-up outpatient appointments.
- Utilization Management notified Case Management of all inpatient discharges, and Case Management outreached enrollees within 72 hours of discharge to assist with follow-up appointments and other needs.
- BCBSND implemented a peer support service which was covered.
- BCBSND enrolled members into the Coordinated Services Program to ensure close monitoring and care from an established PCP.

There were five study indicators for this PIP:

- Indicator 1: The percentage of Medicaid Expansion enrollees who have had at least one ambulatory or preventive care visit with a healthcare provider for a principal diagnosis of SUD or any diagnosis of drug overdose.
- Indicator 2: The percentage of ED visits for which the enrollee received follow-up within 7 days of the ED visit.
- Indicator 3: The percentage of ED visits for which the enrollee received follow-up within 30 days of the ED visit.
- Indicator 4: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- Indicator 5: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Conclusions and Comparative Findings

BCBSND submitted four interim PIP reports in November 2023, COPD or Asthma in Older Adults Admission Rate, Diabetes Care, Hypertension, and Substance Use Disorder, which are summarized in **Table 3–Table 7**.

Table 3: PIP Validation Results for PIP Elements – November 2023

BCBSND	PIP 1	PIP 2	PIP 3	PIP 4
Validation Element[1]	COPD/Asthma	Diabetes Care	Hypertension	SUD
Topic/Rationale	Met	Met	Met	Met
Aim	Met	Met	Met	Met
Methodology	Met	Partial	Partial	Met
Population analysis and stratification	Met	Met	Met	Met

BCBSND	PIP 1	PIP 2	PIP 3	PIP 4
Validation Element[1]	COPD/Asthma	Diabetes Care	Hypertension	SUD
Barrier analysis	Met	Met	Met	Met
Robust interventions	Partial	Partial	Met	Met
Results table	Partial	Partial	Met	Partial

[1] There are three levels of validation results: Met; Partial (Partially Met); and NM (Not Met).
PIP: performance improvement project; BCBSND: Blue Cross Blue Shield of North Dakota; COPD: chronic obstructive pulmonary disease; SUD: substance use disorder.

For the COPD/Asthma PIP (**Table 4**), IPRO indicated that BCBSND should consider linking all interventions and tracking measures to the actual barrier for that indicator. Some intervention tracking measures were not active with numerator, denominator, and rates documented. BCBSND should also review all denominators to ensure accuracy.

Table 4: BCBSND COPD or Asthma in Older Adults Admission Rate PIP Interim Results

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate
Indicator 1: % of enrollees with at least one annual visit for COPD/asthma	67.18% (350/521)	62.20% (204/328)	72%
Indicator 2: % of enrollee discharges for COPD/asthma	3.27% (26/795)	1.24% (3/242)	< 3.27%
Indicator 3: % of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma	53.85% (14/26)	66.67% (2/3)	60%
Indicator 4: % of admissions with a principal diagnosis of COPD/asthma per 100,000 population	13.96 (24 discharges/ 171,937 MM)	2.81 (6 discharges/ 705 MM)	< 41.9

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

For the Diabetes Care PIP (**Table 5**), IPRO determined that there was no evidence of estimated or true frequency, margin of error, or confidence intervals for the sampling used. Additionally, BCBSND should list their performance indicators and target rates as numerical values. Indicators #6 and #7 were missing rates.

Table 5: BCBSND Diabetes Care PIP Interim Results

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate
Indicator 1: % of enrollees with at least one annual visit for diabetes	83.11% (1,550/1,865)	70.73% (1,160/1,640)	88%
Indicator 2: % of enrollee discharges for diabetes	5.52% (69/1,249)	9.34% (34/364)	5%
Indicator 3: % of enrollees discharged for diabetes with a healthcare provider visit for COPD/asthma	82.26% (51/62)	70.59% (24/34)	88%
Indicator 4: % of diabetes admissions with short-term complications per 100,000 member months (MM)[1]	1.92% (54/2,817)	7.01% (30/1,427)	1.9%
Indicator 5: % of diabetes admissions per 100,000 MM ages 21–64 years[1]	24.41 (96 discharges/ 393,239MM)	4.68 (10 discharges/ 1,427 MM)	The adult core set for the national median is the targeted rate for this indicator
Indicator 6: % of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (< 8.0%)	29.44% (121/411)	Not Reported	60.34%

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate
Indicator 7: % of enrollees with diabetes whose HbA1c was in poor control (> 9.0%)	65.21% (268/411)	Not Reported	29.44%
Indicator 8: % of enrollees with diabetes who had a retinal eye exam	30.21% (268/411)	20.17% (305/1,512)	63.33%

[1] Indicators 4 and 5 are reported in discharged per 100,000 MM.
BCBSND: Blue Cross Blue Shield of North Dakota; PIP: performance improvement project; CY: calendar year; COPD: chronic obstructive pulmonary disease. Source: BCBSND Quarterly Report.

For the Hypertension PIP (**Table 6**), IPRO determined that the sampling technique did not specify estimated or true frequency, margin of error, or confidence intervals.

Table 6: BCBSND Hypertension PIP Interim Results

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

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

For the Substance Use Disorder PIP (**Table 7**), IPRO indicated that BCBSND should consider linking all interventions and tracking measures to the actual barrier for that indicator and consider how the intervention is addressing the barrier to that indicator. IPRO also noted that BCBSND should review denominators for all measures to ensure accuracy.

Table 7: BCBSND Substance Use Disorder PIP Interim Results

Indicator	Baseline Period CY 2022	Interim Period CY 2023	Target Rate
Indicator 1: % of Medicaid Expansion enrollees who have had at least one preventive care visit for a principal diagnosis of SUD or drug overdose	37.63% (1,098/2,918)	34.29% (874/2,549)	42.63%
Indicator 2: % of ED visits for which the enrollee received follow-up within 7 days.	33.31% (393/1,180)	25.98% (172/662)	32.53%
Indicator 3: % of ED visits for which enrollee received follow-up within 30 days.	45.59% (538/1,180)	41.09% (272/662)	32.53%
Indicator 4: % of new SUD episodes resulting in treatment initiation within 14 days.	48.57% (442/910)	40.46% (666/1,646)	52.93%
Indicator 5: % of new SUD episodes that have evidence of treatment engagement within 34 days.	20.11% (183/910)	19.32% (318/1,646)	22.47%

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

Table 8 displays a summary of IPRO's improvement assessment for each project indicator by PIP topic for BCBSND. This table displays results through three quarters and final assessments will be made after the fourth quarter of data are received. IPRO's assessment of indicator performance was based on the following four categories:

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

Table 8: Assessment of BCBSND PIP Indicator Performance

Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim
COPD/Asthma in Older Adults Admission Rate PIP		
Indicator 1	% of enrollees with at least one annual visit for COPD/asthma	Target not met, and performance decline demonstrated. (Red)
Indicator 2	% of enrollee discharges for COPD or asthma	Target exceeded, and performance improvement demonstrated. (Green)
Indicator 3	% of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma	Target exceeded, and performance improvement demonstrated. (Green)
Indicator 4	% of admissions with a principal diagnosis of COPD or asthma per 100,000 population	Target exceeded, and performance improvement demonstrated. (Green)
Diabetes Care PIP		
Indicator 1	% of enrollees with at least one annual visit for diabetes	Target not met, and performance decline demonstrated. (Red)
Indicator 2	% of enrollee discharges for diabetes	Target not met, and performance decline demonstrated. (Red)
Indicator 3	% of enrollees discharged for diabetes with a healthcare provider visit for COPD/asthma	Target not met, and performance decline demonstrated. (Red)
Indicator 4	% of diabetes admissions with short-term complications	Target not met, and performance decline demonstrated. (Red)
Indicator 5	Rate of diabetes admissions per 100,000 member months ages 21–64 years.	Target not met, but performance improvement demonstrated. (Yellow)
Indicator 6	% of enrollees with diabetes whose hemoglobin A1c (HbA1c) was in control (< 8.0%)	Unable to evaluate performance at this time. (Gray)
Indicator 7	% of enrollees with diabetes whose HbA1c was in poor control (> 9.0%)	Unable to evaluate performance at this time. (Gray)
Indicator 8	% of enrollees with diabetes who had a retinal eye exam	Target not met, and performance decline demonstrated. (Red)
Hypertension PIP		
Indicator 1	% of enrollees with at least one annual visit for hypertension	Target not met, but performance improvement demonstrated. (Yellow)
Indicator 2	% of hospital discharges for a principal diagnosis of hypertension	Target not met, and performance decline demonstrated. (Red)
Indicator 3	% of enrollee hospital discharges for a principal diagnosis of hypertension who also had a PCP visit for hypertension	Unable to evaluate performance at this time. (Gray)
Indicator 4	% of admissions with a principal diagnosis of hypertension ages 21–64 years.	Unable to evaluate performance at this time. (Gray)
Indicator 5	% of enrollees ages 21–64 years with a diagnosis of hypertension whose BP was adequately controlled (< 140/90 mm Hg)	Target not met, and performance decline demonstrated. (Red)

Indicator #	Indicator Description	Assessment of Performance, Baseline to Interim
Substance Use Disorder PIP		
Indicator 1	% of Medicaid Expansion enrollees who have had at least one preventive care visit for a principal diagnosis of SUD or drug overdose	Target not met, and performance decline demonstrated. (Red)
Indicator 2	% of ED visits for which enrollee received follow-up within 7 days	Target not met, and performance decline demonstrated. (Red)
Indicator 3	% of ED visits for which enrollee received follow-up within 30 days	Target not met, and performance decline demonstrated. (Red)
Indicator 4	% of new SUD episodes resulting in treatment initiation within 14 days	Target not met, and performance decline demonstrated. (Red)
Indicator 5	% of new SUD episodes that have evidence of treatment engagement within 34 days	Target not met, and performance decline demonstrated. (Red)

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

Strengths and Opportunities for Improvement

Strengths

The COPD or Asthma in Older Adults PIP saw significant improvements in three indicators. BCBSND achieved an interim rate of 1.24% (down from 3.27%) of the percentage of enrollee discharges for COPD or asthma. They also achieved an interim rate of 66.67%, which exceeded their target goal rate of 60% of enrollees discharged for COPD/asthma with a healthcare provider visit for COPD/asthma. Lastly, they achieved 2.81 per 100,000 MM down from 13.96 per 100,000 MM of admissions with a principal diagnosis of COPD or asthma per 100,000 population, demonstrating BCBSND's commitment to improving health outcomes in this area. BCBSND demonstrated performance improvement in the rate of diabetes admissions per 100,000 MM for ages 21-64 years and percentage of enrollees with at least one annual visit for hypertension but did not reach the respective target rates.

Opportunities for Improvement

IPRO noted a number of data reporting errors in the PIP reports. To ensure the accuracy and reliability of the data reported by BCBSND, they should consider conducting a thorough review of their work. Addressing these discrepancies will not only enhance the credibility of the PIP reports but also contribute to the overall efficiency and effectiveness of their interventions.

IV. Validation of Performance Measures

Objectives

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

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

Technical Methods of Data Collection and Analysis

As part of the HEDIS MY 2022 Compliance Audit, BCBSND contracted with an NCQA-licensed audit organization to assess compliance with NCQA standards in the seven designated IS standards, as follows:

- **IS 1.0:** Medical Services Data – Sound Coding Methods and Data Capture, Transfer and Entry;
- **IS 2.0:** Enrollment Data – Data Capture, Transfer and Entry;
- **IS 3.0:** Practitioner Data – Data Capture, Transfer and Entry;
- **IS 4.0:** Medical Record Review Process – Training, Sampling, Abstraction and Oversight;
- **IS 5.0:** Supplemental Data – Capture, Transfer and Entry;
- **IS 6.0:** Member Call Center Data – Capture, Transfer and Entry; and
- **IS 7.0:** Data Integration – Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.

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

- **HD 1.0:** Denominator Identification;
- **HD 2.0:** Sampling;
- **HD 3.0:** Numerator Identification;
- **HD 4.0:** Algorithmic Compliance; and
- **HD 5.0:** Outsourced or Delegated HEDIS Reporting Functions.

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

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

In addition to the HEDIS measures, BCBSND calculated rates for non-HEDIS measures that were validated as one of the contracted tasks between IPRO and HHS. **Tables 11–13** present the HEDIS and non-HEDIS results.

PM validation activities included, but were not limited to:

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

Information System Capabilities

BCBSND was required to complete an ISCA. The purpose of the ISCA review was to provide IPRO with a baseline assessment of the BCBSND encounter data submission processes and the completeness and accuracy of encounter data submitted by BCBSND to the state. IPRO conducted the ISCA in accordance with Appendix A of the *CMS External Quality Review (EQR) Protocols* published in October 2019. This assessment posed standard questions to assess BCBSND's strengths with respect to the tasks outlined above. Responses to these questions assisted IPRO in assessing the extent to which BCBSND's information systems were capable of producing and tracking valid encounter data, PMs, and other data necessary to support quality assessment and improvement, as well as of managing the care delivered to their enrollees.

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

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

ISCA Findings and Recommendations

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

IPRO noted the following findings of the ISCA review as presented in **Table 9**.

Table 9: ISCA Findings

Category	Result	Comments
Completeness and accuracy of encounter data collected and submitted to the state	Met	BCBSND's information systems have a process in place that generates and submits encounter data to the HHS, Medical Services Division ND. BCBSND includes up to 25 ICD-10 diagnosis codes for institutional encounters and 12 ICD-10 diagnosis codes for professional encounters, including the primary diagnosis codes.
Validation and/or calculation PMs	N/A	BCBSND has been enrolling members into the Medicaid Expansion contract since January 1, 2022, BCBSND has not received any requirements from state for MY 2022 reporting. BCBSND plans to use Cotiviti® for PM and HEDIS MY 2022 reporting.

Category	Result	Comments
Utility of the information systems to conduct MCO quality assessment and improvement initiatives	Met	BCBSND's information systems support various data reporting requests, both internally and externally.
Ability of the information systems to conduct MCO quality assessment and improvement initiatives	Met	BCBSND's information systems can conduct quality assessments and conduct improvement initiatives.
Ability of the information systems to oversee and manage the delivery of health care to the MCO's enrollees	Met	BCBSND receives and processes the daily 834 files. The daily 834 enrollment roster files identify enrollees who have been re-enrolled for the current month. The member eligibility segment records are imported and processed into BCBSND's Enrollment Communication System (ECS), and the member tables are populated and loaded into the EDW, which is maintained by BCBSND's third-party vendor, enGen. BCBSND assigns every member a unique enterprise consumer identifier (ECI) in BCBSND's enrollment system, which remains the same for a member through all product changes.
Ability of the information systems to generate complete, accurate, and timely T-MSIS data	N/A	BCBSND does not submit encounter data directly to T-MSIS. BCBSND submits institutional and professional encounter data files to HHS, Medical Services Division ND on a weekly basis.
Utility of the information systems for review of provider network adequacy	Met	BCBSND utilizes Quest Analytics™ for assessing and reporting network adequacy.
Utility of the MCO's information systems for linking to other information sources for quality-related reporting (e.g., immunization registries, health information exchanges, vital statistics, public health data)	Met	BCBSND's information systems have processes in place to receive, validate, and incorporate claims data and produce internal and regulatory reports.

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

Description of Data Obtained

In addition to performing an ISCA, IPRO reviewed BCBSND's HEDIS MY 2022 FAR to determine compliance with ISCA standards. The FAR revealed BCBSND met all standards for successful reporting (**Table 10**).

Table 10: BCBSND Compliance with Information Systems Standards – MY 2022

IS Standard	Results
1.0: Medical Services Data	Met
2.0: Enrollment Data	Met
3.0: Practitioner Data	Met
4.0: Medical Record Review Processes	Met
5.0: Supplemental Data	Met

IS Standard	Results
6.0: Data Preproduction Processing	Met
7.0: Data Integration and Reporting	Met

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

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

Conclusions and Comparative Findings

BCBSND's independent auditors determined that the rates reported by BCBSND were calculated in accordance with NCQA's defined specifications, and there were no data collection or reporting issues identified. BCBSND did not submit their rates to NCQA for MY 2022, but plan to do so for MY 2023. IPRO also determined that the validated non-HEDIS measures were all reportable.

Table 11 displays the IPRO-validated non-HEDIS PMs for MY 2022 for BCBSND.

Table 11: IPRO-Validated Non-HEDIS Performance Measures – MY 2022

Measure	Rate
Screening for Depression and Follow-Up plan: Age 18 and Older (CDF-AD)	
Age 18-64 years	0.00%
Age 65+ years	0.00%
Total	0.00%
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	
Age 18-64 years	10.08%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	
Age 18-64 years	0.00%
Use of Pharmacotherapy for Opioid Use (OUD-AD)	
Total	64.44%
Buprenorphine	46.03%
Oral Naltrexone	2.86%
Long-Acting, Injectable Naltrexone	1.27%
Methadone	18.41%
Diabetes Short-Term Complications Admission Rate (PQI01-AD)	
Age 18 to 64 years	24.41%
Chronic Obstructive Pulmonary Disease (COPD)or Asthma in Older Adults Admission Rate (PQI05-AD)	
Age 40 to 64 years	25.41%
Heart Failure Admission Rate (PQI08-AD)	
Age 18 to 64 years	25.94%
Asthma in Younger Adults Admission Rate (PQI15-AD)	
Age 18 to 39 years	1.36%
Screening for Depression and Follow-Up plan: Age 18 and Older (CDF-AD)	
Age 18-64 years	0.00%
Age 65+ years	0.00%
Total	0.00%

Measure	Rate
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	
Age 18-64 years	10.08%
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	
Age 18-64 years	0.00%
Use of Pharmacotherapy for Opioid Use (OUD-AD)	
Total	64.44%
Buprenorphine	46.03%
Oral Naltrexone	2.86%
Long-Acting, Injectable Naltrexone	1.27%
Methadone	18.41%
Diabetes Short-Term Complications Admission Rate (PQI01-AD)	
Age 18 to 64 years	24.41%
Chronic Obstructive Pulmonary Disease (COPD)or Asthma in Older Adults Admission Rate (PQI05-AD)	
Age 40 to 64 years	25.41%
Heart Failure Admission Rate (PQI08-AD)	
Age 18 to 64 years	25.94%
HPCMI: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1c) Poor Control (>9.0%)	100.00%

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

Table 12 displays the NCQA Certified HEDIS Compliance Auditor audited HEDIS PMs for MY 2022 for BCBSND.

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles
Red	Below the national Medicaid 10th percentile.
Orange	At or above the national Medicaid 10th percentile but below the 25th percentile.
Yellow	At or above the national Medicaid 25th percentile but below the 50th percentile.
Light Blue	At or above the national Medicaid 50th percentile but below the 75th percentile.
Blue	At or above the national Medicaid 75th percentile but below the 90th percentile.
Green	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

Table 12: NCQA Certified HEDIS Compliance Auditor Audited HEDIS Performance Measures – MY 2022

Measure	Rate	NCQA Quality Compass MY 2022 Comparison
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	56.20%	P25-P50
Antidepressant Medication Management— Acute	73.80%	P75-P90
Antidepressant Medication Management— Continuation Phase	60.63%	≥P90
Asthma Medication Ratio—Total	93.10%	≥P90
Breast Cancer Screening	30.41%	<P10
Controlling High Blood Pressure	47.93%	<P10
Cervical Cancer Screening	16.90%	<P10
Chlamydia Screening in Women—Total	41.50%	<P10
Colorectal Cancer Screening	12.97%	NC
Eye Exam for Patients With Diabetes	32.17%	<P10
Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	38.06%	P75-P90

Measure	Rate	NCQA Quality Compass MY 2022 Comparison
Follow Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30 days—Total	51.19%	P75-P90
Follow Up After Hospitalization For Mental Illness—7 days	28.83%	P10-P25
Follow Up After Hospitalization For Mental Illness—30 days	51.17%	P25-P50
Follow Up After Emergency Department Visit for Mental Illness—7 days—Total	35.92%	P25-P50
Follow Up After Emergency Department Visit for Mental Illness—30 days—Total	51.46%	P25-P50
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8%)	39.40%	P10-P25
Hemoglobin A1c Poor Control Rate[1]	52.80%	P10-P25
Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total	27.98%	≥P90
Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total	51.10%	P75-P90
Plan All-Cause Readmissions—Expected Readmission <65 Rate[1]	1.02%	P25-P50
Pharmacotherapy for Opioid Use Disorder—Total	64.44%	≥P90
Prenatal and Postpartum Care—Timeliness of Prenatal Care	31.97%	<P10
Prenatal and Postpartum Care—Postpartum Care	39.46%	<P10
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	44.91%	P10-P25
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.38%	P25-P50

[1] Lower is better.

BCBSND: Blue Cross Blue Shield of North Dakota; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; MY: measurement year; P10: 10th percentile; P25: 25th percentile; P50: 50th percentile; P75: 75th percentile; P90: 90th percentile; NC: no comparison, as no NCQA Quality Compass benchmark comparison is available; HbA1c: hemoglobin A1c; SUD: substance use disorder.

Table 13 displays the NCQA-Certified HEDIS Compliance Auditor audited non-HEDIS PMs for MY 2022 for BCBSND.

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles
Red	Less than the Bottom Quartile
Green	Equal or greater than the Top Quartile.
White	No benchmarks available for this measure.

Table 13: NCQA Certified HEDIS Compliance Auditor-Audited Non-HEDIS Performance Measures – MY 2022

Measure	Rate	Bottom Quartile	Top Quartile	Ranking[1]
ACCA Contraceptive Care- Percentage of Women at Risk for Unintended Pregnancy Provided a Long-Acting Reversible Method of Contraception: Ages 21 to 44	2.96%	3.60%	6.10%	<Bottom Quartile
ACCA Contraceptive Care- Percentage of Women at Risk for Unintended Pregnancy Provided a Most Effective or Moderately Effective Method of Contraception: Ages 21 to 44	15.89%	23.00%	28.60%	<Bottom Quartile
ACCP Contraceptive Care - Percentage of Postpartum Women Provided a Long-Acting Reversible Method of Contraception Within 3 Days of Delivery: Ages 21to 44	0.00%	0.70%	2.70%	<Bottom Quartile

Measure	Rate	Bottom Quartile	Top Quartile	Ranking[1]
ACCP Contraceptive Care - Percentage of Postpartum Women Provided a Long-Acting Reversible Method of Contraception Within 60 Days of Delivery: Ages 21to 44	5.52%	9.50%	15.60%	<Bottom Quartile
ACCP Contraceptive Care - Percentage of Postpartum Women Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery: Ages 21 to 44	7.36%	8.70%	13.00%	<Bottom Quartile
ACCP Contraceptive Care - Percentage of Postpartum Women Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery: Ages 21to 44	25.15%	35.20%	46.00%	<Bottom Quartile
PQI01:DCA Diabetes Short-Term 18-64	24.41%	26.70%	15.40%	<Bottom Quartile
PQI05:COPD Chronic Obstructive Pulmonary Disease 18-64[2]	25.41%	85.20%	41.30%	≥Top Quartile
PQI08:CFHA Heart Failure Admission Rate 18-64[2]	25.94%	34.50%	19.40%	>Bottom Quartile
PQI15:AAR Asthma in Younger Adults Admission Rate[2]	1.36%	7.80%	3.90%	<Bottom Quartile
VLS HIV Viral Load Suppression	0.00%	N/A	N/A	NA
UODP Opioids in Persons Without Cancer	0.00%	9.60%	3.90%	<Bottom Quartile
CUOB Concurrent Use of Opioids and Benzodiazepines[2]	10.06%	21.60%	11.20%	≥Top Quartile
SCDF Screening for Depression and Follow-up Plan	0.00%	N/A	N/A	NA
HPCMI Diabetes Care PPL w MH >9[2]	100.00%	47.80%	34.90%	<Bottom Quartile
POUD Pharmacotherapy For Opioid Use Disorder	64.44%	N/A	N/A	NA

[1] Quality of Care for Adults in Medicaid: Findings from the 2020 Adult Core Set.

[2] Lower is better.

N/A: not applicable. NA: benchmark not available.

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

Objectives

HHS annually evaluates the MCO performance against contract requirements and state and federal regulatory standards through its EQRO contractor. In an effort to prevent duplicative review, federal regulations allow for use of the accreditation findings that are determined equivalent to regulatory requirements. In November 2023, BCBSND participated in a compliance review for the review period January 1 –June December 31, 2022.

Technical Methods of Data Collection and Analysis

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

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

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

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

Pre-review Activities

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

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

Review Activities

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

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

The standard determinations and assigned point values are shown in **Table 14.**

Table 14: North Dakota Medicaid Managed Care Compliance Monitoring Standard Designations

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

[1] Elements determined to be nonapplicable were not included in the overall determination calculation.
MCO: managed care organization; NCQA: National Committee for Quality Assurance.

Description of Data Obtained

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

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

Conclusions and Comparative Findings

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

Table 15: Compliance Review Findings

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

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

VI. Validation of Network Adequacy

Objectives

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

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

Technical Methods of Data Collection and Analysis

Provider Access Survey Study

A total of 381 PCPs were randomly sampled for the survey study. The sample included 10% of providers serving the Indian Health Services (IHS) Medicaid population, and 10% of providers serving non-IHS Medicaid members. The project assessed the ability of PCPs to accommodate four types of appointments: new patient well-care visits, new patient sick visits, existing patient well-care visits, and existing patient sick visits.

Survey responses were used to assess both access to providers and the validity of the Primary Care Provider Directory (PCPD) data across three domains:

- New and Existing Patient Access: information on whether the provider could be contacted via telephone, was still contracted with BCBSND, and whether the provider was accepting new patients; information on the soonest-available appointment with any provider at the location for sick and well-care visits among new and existing Medicaid members.
- PCPD File Validation – Provider Information: the degree to which survey responses aligned with PCPD data for provider's telephone number, office location, BCBSND contract status, and new patient acceptance status.

Survey calls took place Monday–Friday, 8:30 a.m.–5:30 p.m. EST. Up to three attempts were made to reach a live respondent for each provider sampled. The three attempts to reach office personnel were generally made on different days and/or at different times of the day.

The sample selection process allowed for multiple providers in the same practice, selected independently but for whom the telephone number was the same. For efficiency, IPRO grouped sampled providers by location based on address and telephone number. This process enabled IPRO to ask about multiple sampled providers at a given location during the same call, with the intent of minimizing the burden of the survey on the providers' office staff.

Provider Inclusion

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

1. Contact was made with the provider's office.
2. The provider was practicing as a PCP.
3. The provider accepted BCBSND.
4. Office personnel were willing to participate in the survey.

Of the 381 providers called, 156 providers successfully met all four criteria (**Table 16**). These providers were used as the final sample size for the remainder of the survey. None of the BCBSND IHS providers met the inclusion criteria (**Table 16**).

Table 16: Included Providers per Plan Type

Plan Type	Providers Surveyed (n)	Inclusion Criteria Met (n)	Rate (%)
BCBSND	376	156	41.5%
BCBSND IHS	5	0	0.0%

BCBSND: Blue Cross Blue Shield of North Dakota; IHS: Indian Health Services.

The total sample loss is described in **Figure 3**. The biggest contributor to the loss of respondents was the provider being unreachable.

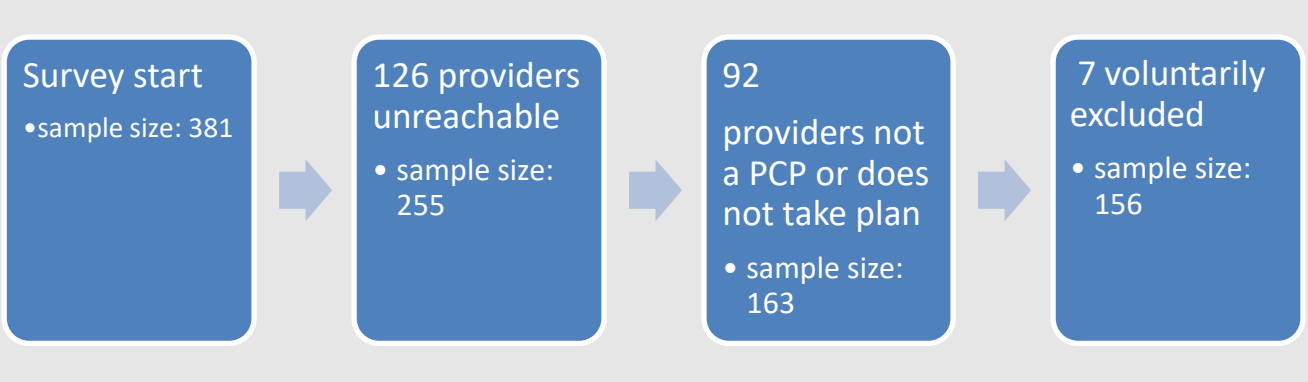

Figure 3: Sample Loss The starting sample size (blue box) and following nested subsamples (blue boxes for unreachable providers, providers who are not primary care providers [PCPs] or not taking BCBSND, and providers who asked to be excluded) are shown with the progression of sample loss indicated by light blue arrows between each sample box.

Table 17 shows the number of voluntary exclusions, which are the respondents who refused (including those who disconnected the call or left the surveyor on hold for 5 minutes or longer), needed a member identification (ID) to access their scheduling system, or did not provide specific information about their eligibility (incomplete surveys). Further, providers were excluded from the sample when respondents could not confirm they accepted BCBSND or did not confirm they were a PCP.

Table 17: Voluntary Exclusions

	Refused to Participate	Need Patient ID Information	Total
BCBSND	5	2	7
Percentage of total sample (n = 381)	1.3%	0.5%	1.9%

ID: identification; BCBSND: Blue Cross Blue Shield of North Dakota.

Review of Network Adequacy Standards

IPRO conducted a provider directory validation survey to determine the accuracy of BCBS's provider directory.

Description of Data Obtained

Provider Access Survey Study

Directory Accuracy Findings

Table 18 breaks down directory issues for the total sample (n = 381). Within the 381 PCP sample, 57.2% had directory issues with 126 providers who were unreachable, 89 not practicing as PCPs, and 3 not accepting BCBSND.

Table 18: Directory Issues by Plan Type

Plan Type	Unreachable	Not Practicing as PCP	BCBSND Not Accepted	Total
BCBSND	121	89	3	213

Plan Type	Unreachable	Not Practicing as PCP	BCBSND Not Accepted	Total
BCBSND IHS	5	0	0	5
Percentage of sample	33.1%	23.4%	0.8%	57.2%

PCP: primary care provider; BCBSND: Blue Cross Blue Shield of North Dakota; IHS: Indian Health Services.

Unreachable providers included PCPs where the phone number provided in the directory resulted in no contact with a live provider representative. These issues are detailed in **Table 19**.

Table 19: Unreachable Providers by Plan Type

Reason No Contact Made	BCBSND	BCBSND IHS	% (of Total Sample)
Non-working telephone number	6	0	1.6%
Answering machine/Voicemail[1]	10	0	2.6%
No answer[1]	6	0	1.6%
Provider not at location	99	5	27.3%
Total	121	5	33.1%

[1] These dispositions are based on the 3rd attempt since these reasons required multiple attempts.
BCBSND: Blue Cross Blue Shield of North Dakota; IHS: Indian Health Services.

Surveyors making the calls asked if the provider was accepting new patients, and this response was compared to the PCPD for accuracy. **Table 20** presents results for PCPD accuracy for contacted PCPs still participating in BCBSND and accepting new patients for BCBSND.

Table 20: PCPD Accuracy for Accepting New Patients

	Providers (n)	Verified Accepting (n)	Accuracy Rate (%)
BCBSND	156	120	76.9%

PCPD: Primary Care Provider Directory; BCBSND: Blue Cross Blue Shield of North Dakota.

Appointment Availability Findings

Table 21 displays appointment availability results that pertain to the 120 providers participating in BCBSND that were confirmed to be accepting new patients. For existing patients, 156 providers confirmed to be participating in the plan.

Table 21: Appointment Availability for New and Existing Patients by Appointment Type

BCBSND	Responses – Routine n	Available for Well-Care Visit	Responses – Sick n	Available for Sick Visit
New patients[1]	108	90.0%	101	84.2%
Existing patients[2]	139	89.1%	141	90.4%

[1] A total of 120 providers confirmed accepting new patients.
[2] A total of 156 providers confirmed participating in BCBSND.
BCBSND: Blue Cross Blue Shield of North Dakota.

Appointments were considered timely when the visit was within 6 weeks of the call for routine well-care visits and within 3 calendar days for sick visits. Providers had the availability to schedule well-care visit appointments within 6 weeks at a rate of 66.0% for existing patients, and 65.8% for new patients. Sick visit appointment availability within three days was 34.0% for existing patients, and 25.0% for new patients (**Table 22**).

Table 22: Timely Appointments by for New and Existing Patients by Appointment Type

BCBSND[1]	Responses – Routine n	Timely Well-Care Visit	Responses – Sick n	Timely Sick Visit
New patients[2]	79	65.8%	30	25.0%
Existing patients[3]	103	66.0%	53	34.0%

[1] Wait times within 6 weeks for routine well-care visits and within 3 calendar days for sick visits.
[2] A total of 120 providers confirmed accepting new patients.
[3] A total of 156 providers confirmed participating in the BCBSND.
BCBSND: Blue Cross Blue Shield of North Dakota.

Review of Network Adequacy Standards

Provider to Member Ratio Findings

Each quarter, BCBSND is required to calculate and report the PCP-to-member ratio to HHS. IPRO validated the BCBSND-calculated ratios for the 4th quarter of 2023. **Table 23** displays the validated BCBSND ratio for CY 2023. BCBSND met the provider to member ratio standard for CY 2023 of one PCP to 2,500 members.

Table 23: BCBSND Provider to Member Ratio, CY 2023

Specialty	Provider:Members	Ratio Providers to Members
PCPs	1,691:8,279	1:4.9

Data Source: PCP to Enrollee Ratio Report, Medicaid Expansion, December 11, 2023.
BCBSND: Blue Cross Blue Shield of North Dakota; CY: calendar year; PCP: primary care provider.

Network Adequacy Distance Standards Findings

North Dakota requires that at least 90% of BCBSND's membership has access to providers within the established distance standards. IPRO analyzed *Top-Six High-Volume Specialists Geographic Access Report* produced for the 4th quarter of 2023 by BCBSND to determine if they were compliant with the HHS distance requirements (**Table 24**).

Table 24: BCBSND Adherence to Provider Network Distance Standards for the Top-Six High-Volume Specialties

Specialty[1]	Standard	% with Access
Behavioral health providers	1 in 50 miles	100.0%
Cardiology providers	1 in 50 miles	96.1%
Medical oncology providers	1 in 50 miles	74.9%
Ob/Gyn providers	1 in 50 miles	97.5%
Orthopedic surgery providers	1 in 50 miles	95.0%
Surgery providers	1 in 50 miles	99.9%

[1] Provider types that were top-six high-volume specialties in the 4th quarter of 2023.
BCBSND: Blue Cross Blue Shield of North Dakota; Ob/Gyn: obstetrician/gynecologist.

Recommendations

- BCBSND should increase timely appointment rates for PCPs to ensure members are able to access primary care and obtain appointments in a timely manner.
- BCBSND should undertake measures to enhance the accuracy and accessibility of its PCPD.
- BCBSND should continue to monitor access to its top specialties and work on recruiting additional providers for these specialties where access is decreasing.

VII. Administration or Validation of Quality-of-Care Surveys – CAHPS Member Experience Survey

Objectives

HHS requires that the MCO conduct an annual assessment of member satisfaction with the quality of and access to services using the CAHPS surveys.

Technical Methods of Data Collection and Analysis

BCBSND contracted with NCQA-certified survey vendor, SPH Analytics™, to conduct the member satisfaction survey for the adult (aged 18 years and over) member population in order to assess satisfaction with BCBSND and with participating providers. BCBSND's vendor followed NCQA HEDIS protocols, identified in *HEDIS MY 2022 Volume 3: Specifications for Survey Measures*. The methodology met requirements of *CMS EQR Protocol 6 – Administration or Validation of Quality-of-Care Surveys*. The NCQA Survey Vendor Certification Program and annual HEDIS accreditation audit ensure the survey vendor follows HEDIS protocols in sample frame and selection, data collection, and survey results calculation.

The adult member satisfaction surveys were sent to a random sample of members (as of December 31, 2022) who were continuously enrolled for at least 5 of the last 6 months of 2022 and who were enrolled at the time the survey was completed.

Description of Data Obtained

IPRO received the MY 2022 CAHPS results reported by BCBSND. The CAHPS data included deidentified member-level data and the *SPH Analytics Summary Report*.

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement for BCBSND, IPRO compared the CAHPS rates for adults (**Table 25**) to the national Medicaid benchmarks presented in the *Quality Compass* 2023/MY 2022. Measures performing at or above the 75th percentile were considered strengths; measures performing at the 50th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement. Eighteen questions were below average, two questions were average, and eight questions were above average when compared to Quality Compass.

Color Key	How Rate Compares to the NCQA HEDIS MY 2022 Quality Compass National Percentiles
Red	Below the national Medicaid 10th percentile.
Orange	At or above the national Medicaid 10th percentile but below the 25th percentile.
Yellow	At or above the national Medicaid 25th percentile but below the 50th percentile.
Light Blue	At or above the national Medicaid 50th percentile but below the 75th percentile.
Blue	At or above the national Medicaid 75th percentile but below the 90th percentile.
Green	At or above the national Medicaid 90th percentile.
White	No national benchmarks available for this measure or measure not applicable (N/A).

Table 25: BCBSND CAHPS Performance – Adult Member

CAHPS Measure	Rate	Percentile Ranking
Getting Needed Care (usually + always)	81.2%	P25-P50
Q9. Ease of getting necessary care, tests, or treatment needed	84.8%	P50-P75
Q20. Getting appointments with specialists as soon as needed	77.6%	P25-P50
Getting Care Quickly (usually + always)	79.5%	P25-P50
Q4. Got care as soon as needed when care was needed right away	82.9%	P25-P50
Q6. Got check-up/routine care appointment as soon as needed	76.1%	P25-P50
How Well Doctors Communicate (usually + always)	90.1%	<P10
Q12. Personal doctor explained things in an understandable way	95.6%	P75-P90

CAHPS Measure	Rate	Percentile Ranking
Q13. Personal doctor listened carefully to you	88.2%	<P10
Q14. Personal doctor showed respect for what you had to say	91.2%	<P10
Q15. Personal doctor spent enough time with you	85.3%	<P10
Customer Service (usually + always)	89.0%	P25-P50
Q24. Customer service provided information or help	81.3%	P10-P25
Q25. Customer service treated member with courtesy and respect	96.8%	P75-P90
Coordination of Care (Q17) (usually + always)	88.4%	P75-P90
Ease of Filling out Forms (Q27) (Summary Rate = 8 + 9 + 10)	97.3%	P75-P90
Rating Items (Summary Rate = 8 + 9 + 10)		
Rating of Health Care (Q8)	82.1%	≥P90
Rating of Personal Doctor (Q18)	86.2%	P75-P90
Rating of Specialist (Q22)	87.0%	≥P90
Rating of Health Plan (Q28)	71.4%	P10-P25
Rating Items (Summary Rate = 9 + 10)		
Rating of Health Care (Q8)	53.8%	P25-P50
Rating of Personal Doctor (Q18)	64.4%	P25-P50
Rating of Specialist (Q22)	76.1%	≥P90
Rating of Health Plan (Q28)	52.7%	<P10
Effectiveness of Care Measures (Current Year)		
Flu Vaccinations (Adults 18–64)	39.8%	P50-P75
Advising Smokers and Tobacco Users to Quit	64.9%	<P10
Discussing Cessation Medications	50.0%	P25-P50
Discussing Cessation Strategies	43.2%	P25-P50

[1] BCBSND percentile ranking in measurement year 2022 Quality Compass.

CAHPS: Consumer Assessment of Healthcare Providers and Systems; BCBSND: Blue Cross Blue Shield of North Dakota; P10: 10th percentile; P25: 25th percentile; P50: 50th percentile; P75: 75th percentile; P90: 90th percentile.

VIII. URAC Accreditation

Section 2.13.3 of the North Dakota state contract requires that BCBSND be accredited by NCQA or URAC for its Medicaid product. BCBSND holds full URAC accreditation for "Health Plan" and "Health Plan with Health Insurance Marketplace." URAC is an independent, non-profit health care accrediting organization that is dedicated to promoting health care quality through accreditation, education, and measurement.

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

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

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

Corrective action plans for each finding were implemented and provided to URAC. A return visit was scheduled on 3/21/24. The URAC reviewer was satisfied with the corrective actions implemented and found no findings with both standards passing.

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

Table 26 highlights the BCBSND's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of MY 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations

Table 26: BCBSND Strengths and Opportunities for Improvement, and EQR Recommendations

EQR Activity	Strengths	Opportunity for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
PIP	The COPD or Asthma in Older Adults PIP saw significant improvements in three indicators, demonstrating the plan's commitment to improving health outcomes in this area.	IPRO noted a number of data reporting errors in the PIP reports.	To ensure the accuracy and reliability of the data reported by BCBSND, BCBSND should consider conducting a thorough review of their work. Addressing the data discrepancies will not only enhance the credibility of the PIP reports, but also contribute to the overall efficiency and effectiveness of their interventions.	X	X	X
Performance Measures	Based on responses provided from the ISCA and in the remote meeting interviews and discussions, IPRO found BCBSND to have processes in place to produce and report performance measures. BCBSND was compliant with all seven Information Systems standards. Eight of the 25 reported HEDIS measures ranked	Eleven of the 25 HEDIS measures reported were less than the 25th percentile.	Focusing on the HEDIS quality-related measures that fell below the NCQA national 25th percentile, BCBSND should continue to identify barriers and consider interventions to improve performance, particularly for measures in the Prevention and Screening domain and the Overuse/ Appropriateness domain.	X	X	X

EQR Activity	Strengths	Opportunity for Improvement	EQRO Assessment/ Recommendation	Quality	Timeliness	Access
	above the 75th percentile.					
Compliance with Medicaid Standards	Six of the 15 domains were 100% fully compliant. The overall score across all domains was 95.1%.	Availability of Services, Assurances of Adequate Capacity & Services, and Provider Selection domains scored below 85%.	BCBSND should focus on the three domains that performed poorly: Availability of Services, Assurances of Adequate Capacity & Services, and Provider Selection.	X	X	X
Network Adequacy	IPRO found that five out of the top-six high-volume specialties were compliant with North Dakota's requirement that at least 90% of an BCBSND's membership has access to providers within the established distance standards. IPRO found that PCP to member ratio for PCPs is 1:4.9 which met contractual standards.	Sick visit appointment availability within 3 days was 34.0% for existing patients and 25.0% for new patients. Overall, 57.2% of PCP survey sample was unreachable, not practicing as a PCP, or no longer accepting BCBSND.	Survey results indicate a need for BCBSND to increase timely appointment rates for PCPs to ensure members are able to access primary care and obtain appointments in a timely manner. Based on the survey findings, there is a clear need for BCBSND to undertake measures to enhance the accuracy and accessibility of its provider directory.	X	X	X
Quality of Care Surveys – Member	BCBSND showed above average performance in measures of consumer satisfaction, with ten CAHPS measures at or above the national 50th percentile.	BCBSND had eight CAHPS measures performing below the national 25th percentile.	BCBSND should address all the measures that performed below the 50th percentile.	X	X	X

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

Conclusion

Overall, findings from MY 2022 EQR activities highlight BCBSNDs' continued commitment to achieving the goals of the North Dakota Medicaid quality strategy. Strengths related to **quality**, **timeliness**, and **access** were observed across all covered populations. However, numerous quality measures showed room for improvement. BCBSND will be required to take action to address the opportunities identified in this report, and those actions will be summarized in the SFY 2024 EQR technical report.