THE FMAP

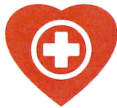
The Federal Medical Assistance Percentage

WHAT IS THE FMAP?

The Federal Medical Assistance Percentage (FMAP) rates are used in determining the amount of federal matching funds for state expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures.

AT DHS, THESE RATES APPLY TO:

Traditional Medicaid Services



Long-Term Care Services*

Medicaid Wavier Services**

Child Welfare/ IV-E Foster Care & Subsidized Adoption

*Excluding state programs SPED (Service Payments to Elderly and Disabled) and expanded SPED.

**Including Home and Community Based Services, Developmental Disabilities Services and 1915(i) Services.

BY THE NUMBERS

Federal Matching Assistance Percentage (N.D.)

FMAP follows the federal fiscal year from Oct-Sept	Rate
Oct. 1, 2015 - Sept. 30, 2019	50%
Oct. 1, 2019 - Sept. 30, 2020	50.05%
Oct. 1, 2020 - Sept. 30, 2021	52.4%
Oct. 1, 2021 - Sept. 30, 2022	53.59%

COVID FMAP Increase of 6.2% to FMAP	Rate
Jan. 1, 2020 - Sept. 30, 2020	56.25%
Oct. 1, 2020 - June 30, 2021 ***	58.60%

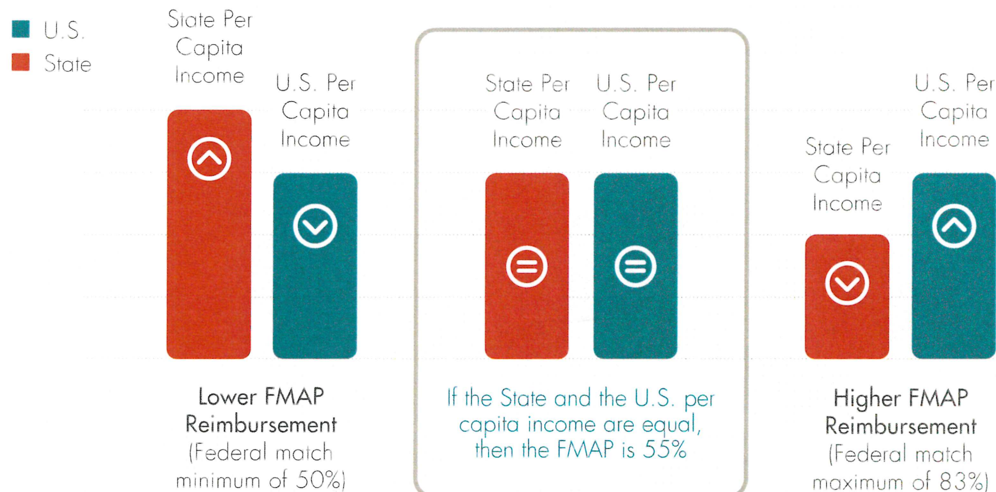
***This date may change pending extension of public health emergency.

FEDERAL FISCAL YEAR EFFECTIVE DATES:

The FMAP is calculated each federal fiscal year and is effective Oct. 1 through Sept. 30 each year.

HOW FMAP WORKS...

The FMAP formula compares a state's three year average per capita income relative to the U.S. three year average per capita income.



Jan. 21, 2021

North Dakota Be Legendary.™ | Human Services

MEDICAL SERVICES
Medicaid Expansion Quality KPIs

NORTH Dakota | Human Services
Be Legendary.™

North Dakota Medicaid Expansion Performance Measurement Scorecard Data for Sanford Health Plan Measurement Year (MY) 2017 – 2019

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Adult Body Mass Index Assessment	93.40	93.33	94.17	♦♦♦
Flu Vaccinations for Adults, Ages 18-64	41.75	38.93	38.60	♦
Breast Cancer Screening	50.35	54.97	54.69	♦
Cervical Cancer Screening	42.61	43.60	44.79	♦
Chlamydia Screening in Women, Upper Age Stratification, Ages 21-24	37.50	40.52	46.03	♦
Comprehensive Diabetes Care: Blood Pressure Controlled <140/90 mm Hg	77.86	76.86	73.97	♦♦♦
Comprehensive Diabetes Care: Eye Exam	50.09	51.12	49.64	♦
Comprehensive Diabetes Care: HbA1c Control (<8%)	55.01	55.96	60.83	♦♦♦♦
Comprehensive Diabetes Care: HbA1c Poor Control (>9%) *Lower is better*	30.58	32.12	28.71	♦♦♦
Comprehensive Diabetes Care: HbA1c Testing	92.62	92.57	90.27	♦♦
Comprehensive Diabetes Care: Medical Attention for Nephropathy	91.21	93.61	89.05	♦
Controlling High Blood Pressure	73.43	68.37	70.00	♦♦♦

MEDICAL SERVICES
Medicaid Expansion Quality KPIs

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Asthma Medication Ratio: Ages 19-50	NR	NR	55.00	♦♦
Asthma Medication Ratio: Ages 51-64	NR	NR	51.72	♦
Asthma Medication Ratio: Ages 19-64 (Total)	NR	NR	53.93	♦
PQI 01: Diabetes Short-Term Complications Admission Rate (denominator is total member months x100,00 for ages 18-64, Rate is numerator events/100,000 member months)* *Lower is better*	45.07	40.85	46.53	♦
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (denominator is total member months x100,00 for ages 40-64, Rate is numerator events/100,000 member months)* *Lower is better*	45.26	28.97	48.58	♦♦♦
PQI 08: Congestive Heart Failure (CHF) Admission Rate (denominator is total member months x100,00 for ages 18-64 and 65+, Rate is numerator events/100,000 member months)* *Lower is better*	23.91	29.07	27.11	♦♦
PQI 15: Asthma Admission Rate in Younger Adults (denominator is total member months x100,00 for ages 18-39, Rate is numerator events/100,000 member months)* *Lower is better*	8.29	3.47	2.90	♦♦♦

MEDICAL SERVICES
Medicaid Expansion Quality KPIs

NORTH Dakota | Human Services
Be Legendary.™

Measure	MCO MY 2017 Rate (%)	MCO MY 2018 Rate (%)	MCO MY 2019 Rate (%)	MY 2019 MCO Rate Compared to Benchmarks^
Plan All-Cause Readmissions Rate: Ages 18-44* *Lower is better* ^^	NR	NR	1.5441	NC
Plan All-Cause Readmissions Rate: Ages 45-54* *Lower is better* ^^	NR	NR	1.5655	NC
Plan All-Cause Readmissions Rate: Ages 55-64* *Lower is better* ^^	NR	NR	1.1399	NC
Plan All-Cause Readmissions Rate: Total* *Lower is better* ^^	NR	NR	1.4182	♦
Antidepressant Medication Management: Effective Acute Phase Treatment	62.55	64.33	61.85	♦♦♦

^ - Benchmark data source: *Quality Compass 2019 (Measurement Year 2018 data) National Medicaid Average for HMOs*. This is the most current benchmark source at the time of report production
* - Benchmark data source: *Quality of Care for Adults in Medicaid: Findings from the 2018 Adult Core Set Chart, September 2019*, a product of the Medicaid/CHIP Health Care Quality Measures Technical Assistance and Analytic Support Program, sponsored by the Centers for Medicare & Medicaid Services. This is the most current benchmark available at the time of report production
^^ - In 2020, the PCR measure reporting is based on the O/E Ratio (Observed Readmissions/Expected Readmissions) and not the Observed Readmission Rate like the previous measurement years
NA - Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate
NC - No Comparison made due to no rate or/and no benchmark available
♦♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile
♦♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile
♦♦ MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile
♦ MCO rate is below the NCQA Quality Compass National Average.
↑ Positive trend for three consecutive measurement years
↓ Negative trend for three consecutive measurement years

Memorandum

To: Caprice Knapp, Brendan Joyce, Erik Elkins

CC: Elrycc Berkman
Scott Campbell

From: Tim Doyle, FSA, MAAA

Date: December 18, 2020

Re: Pharmacy Savings Analysis

Background and Scope

Beginning in January 2020, the State of North Dakota carved the pharmacy services out of the managed care program for the Medicaid Expansion population and started to deliver those services in fee-for-service (FFS). **Optumas** was tasked with determining if there were savings that result from the delivery system change. During the review, **Optumas** performed a risk analysis utilizing the UCSD Medicaid Rx tool to normalize any changes in acuity of the underlying data to ensure that potential savings between the two time periods were not distorted.

Data Sources

Detailed Data

As the State's actuary for the development and certification of the Medicaid Expansion Capitation Rates, **Optumas** relied on the latest CY19 Managed Care encounter data that was validated and used during the CY21 rate development. The State additionally provided emerging FFS pharmacy data from January 1, 2020 through November 19, 2020 and the October 2020 State eligibility Roster.

Supplemental Resources

Since costs contained in the Managed Care and FFS data provided by the State included total costs, gross of rebates, the State provided pharmacy rebate information by quarter from CY19 through Q3CY20. **Optumas** relied on this information to benchmark the CY19 encounter data as well as remove all Federal and supplemental rebates in order to ensure that the results reflect the State's final cost.

Results

Since the analysis was done before the end of 2020, **Optumas** relied on comparing the complete first three quarters of data from CY19 and CY20. Because of differences in FMAP for the IHS and 340b providers, **Optumas** limited the review to exclude the IHS/340b providers so that the results were not distorted. In addition, to ensure that the CY19 Q1-3 data was on a comparable time

period as the CY20 Q1-3 data, **Optumas** used a 7.3% trend as a projection factor. The trend was developed based on a number of years of pharmacy data from the Medicaid Expansion program.

Figure 1 below summarizes the findings from the raw detailed data and trending historical CY19 date to the CY20 time periods. Under this approach, **Optumas** estimates that there is a 13.9% savings switching delivery systems from Managed Care to FFS.

Figure 1. Estimated Savings of Delivery System Change (excluding risk adjustment)

Managed Care CY19 Q1-3				Fee-for-Service CY20 Q1-3		
Raw Data	Federal and Supplemental Rebate Removal	Trend	Trended to CY20 Q1-3	Raw Data	Federal and Supplemental Rebate Removal	Estimated Savings
$132.22	$43.52	7.3%	$46.69	$136.77	$40.20	-13.9%

*Excludes IHS and 340b

Figure 2 below summarizes the findings from the raw detailed data, normalizing the data sets for risk, and trending historical CY19 data to the CY20 time periods. After all appropriate normalization steps, **Optumas** estimates that there is a 13.0% savings switching delivery systems from Managed Care to FFS.

Figure 2. Estimated Savings of Delivery System Change (including risk adjustment)

Managed Care CY19 Q1-3					Fee-for-Service CY20 Q1-3			
Raw Data	Federal and Supplemental Rebate Removal	Medicaid Rx Adjusted	Trend	Trended to CY20 Q1-3	Raw Data	Federal and Supplemental Rebate Removal	Medicaid Rx Adjusted	Estimated Savings
$132.22	$43.52	$43.19	7.3%	$46.34	$136.77	$40.20	$40.30	-13.0%

*Excludes IHS and 340b

Please note that the analyses above only reflect pharmacy claims and do not reflect administration and profit that gets built into the managed care rates. In calendar year 2019, the administrative and profit loads were 3.2% and 1.0%, respectively. If those amounts were included, the savings shown in the tables above would increase even further.

If you have any questions or feedback regarding this memo, please feel free to contact us.

MEDICAL SERVICES
Budget Estimate Comparison

Differences Between DHS Estimate and OMB Estimate

OMB 12 Month Estimate

		Total Costs	State Share
Admin Estimated Cost (CY 2022 6 months)		$ -	-
Admin Estimated Cost (CY 2023 6 months)		$ -	-

ADMINISTRATIVE COSTS - DHS	Federal Match	Total Costs	State Share
Staff:	50% to 75%	1,860,126	731,147
Contracts:	50% to 75%	(151,160)	(71,270)
Other:	50% to 90%	81,937	40,969
TOTAL DHS Administration Expansion Expenses		1,790,903	$ 700,846

Projected Savings for MCO Admin and HIPF		$ -	$ -
Estimated DHS Administration Expense		$ 1,790,903	$ 700,846
Total Savings from Transferring Expansion from MCO to FFS		$ 1,790,903	$ 700,846

Savings of Expansion Transition from Commercial Rates to Traditional Fee Schedule for 2021 - 2023 Biennium			
	Total	Federal	State
Grants	$ (96,421,742)	$ (85,404,552)	$ (11,017,190)
Addition of Dental and Vision	11,697,179	10,527,465	1,169,714
Subtotal Grants	$ (84,724,563)	$ (74,877,087)	$ (9,847,476)
Savings to Transition from MCO Administration to DHS Administration			
MCO Admin	0	0	0
Primary Care Case Management	0	0	0
DHS Admin	1,790,903	1,090,058	700,846
Subtotal for DHS Admin.	$ 1,790,903	$ 1,090,058	$ 700,846
Total Savings			
Total to Move to FFS DHS Admin	$ (82,933,660)	$ (73,787,030)	$ (9,146,631)

DHS 12 Month Estimate

		Total Costs	State Share	State Share Difference Between OMB and DHS
Admin Estimated Cost (CY 2022 6 months)		$ (6,755,533)	(776,886)	
Admin Estimated Cost (CY 2023 6 months)		$ (6,924,317)	(796,296)	-$1,573,182

ADMINISTRATIVE COSTS - DHS	Federal Match	Total Costs	State Share	
Staff:	50% to 75%	1,448,082	568,234	
Contracts:	50% to 75%	252,790	79,520	
Other:	50% to 90%	93,328	46,664	
TOTAL DHS Administration Expansion Expenses		1,794,200	$ 694,418	$6,428

Projected Savings for MCO Admin and HIPF		$ (13,679,850)	$ (1,573,182)	
Estimated DHS Administration Expense		$ 1,794,200	$ 694,418	
Total Savings from Transferring Expansion from MCO to FFS		$ (11,885,650)	$ (878,764)	$1,579,610

Savings of Expansion Transition from Commercial Rates to Traditional Fee Schedule for 2021 - 2023 Biennium				
	Total	Federal	State	
Grants	$ (96,421,742)	$ (85,404,552)	$ (11,017,190)	
Addition of Dental and Vision	11,697,179	10,527,465	1,169,714	
Subtotal Grants	$ (84,724,563)	$ (74,877,087)	$ (9,847,476)	
Savings to Transition from MCO Administration to DHS Administration				
MCO Admin	(13,679,850)	(12,106,668)	(1,573,182)	
Primary Care Case Management	0	0	0	
DHS Admin	1,794,200	1,099,782	694,418	
Subtotal for DHS Admin.	$ (11,885,650)	$ (11,006,886)	$ (878,764)	
Total Savings				
Total to Move to FFS DHS Admin	$ (96,610,213)	$ (85,883,973)	$ (10,726,240)	$1,579,610

MEDICAL SERVICES
Medicaid Expansion In-House Strategic Plan

Overview
The North Dakota Department of Human Services, Medical Services Division, aims to restructure its Medicaid programs to promote better care and quality for members, reduced burden on providers, and continual attention to better stewardship of taxpayer dollars. This document contains detailed information about the goals, objectives, action steps, timelines, and indicators for the restructuring. This is a living document and will be revised and updated as restructuring activities continue to progress.

Vision Statement
All North Dakota Medicaid members have access to the same core services, delivered by health care providers who are incentivized to provide member-centered, comprehensive, high quality care.

Relevant Stakeholders
Because this is a large-scale program redesign effort, progress toward each goal will involve coordination and collaboration between a range of entities whose activities and missions are relevant to that goal. These agencies might include (but are not limited to):

North Dakota Department of Human Services (DHS)
- Behavioral Health Division (BHD)
- Aging Services Division
- Child and Family Services (CFS)
- Developmental Disabilities Division (DD)
- Division of Vocational Rehabilitation
- Field Services Division (FS)

Behavioral health service providers
Community Healthcare Association of the Dakotas (CHAD)
Family Voices of North Dakota
Federally Qualified Health Centers (FQHCs)
Human Service Zones (formerly Social Services)
Indian Health Services
Local Public Health Units
North Dakota Academy of Family Physicians (NDAFP)
Mental Health America of North Dakota
North Dakota Association of Community Providers (NDACP)
North Dakota Brain Injury Network (ND BIN)
North Dakota Chapter of the American Academy of Pediatrics (NDAAP)
North Dakota Dental Association (NDDA)
North Dakota Department of Health (NDDoH)
North Dakota Hospital Association (NDHA)
North Dakota Medical Association (NDMA)
North Dakota Optometric Association (NDOA)
Private health systems
Tribal Nations

December 2020
This plan is subject to change, based on actions that are implemented during the 2021 North Dakota Legislative Session.

Aim #1: Transition Medicaid Expansion from Managed Care to Managed Fee-for-Service.

1.1 Propose changes to state law that will enable DHS to administer the Medicaid Expansion program.

Objective	Action Step	Complete By
1. Develop a budget that outlines the cost savings and benefits that will be achieved through DHS administration of the Medicaid Expansion program.	1.1 Calculate savings that will be achieved through paying Medicaid Expansion providers the same rates as fee-for-service (FFS) Medicaid providers.	July 2020
	1.2 Calculate increases in expenditures for additional services that Medicaid Expansion members will receive once their benefit plan is the same as FFS (dental, vision, long term care, etc.).	July 2020
2. Develop communication materials for legislative session.	2.1 Develop PowerPoint presentation, handouts and talking points to explain the rationale for moving Medicaid Expansion to DHS administration.	December 2020
3. Present information to the Governor, legislature and stakeholders.	3.1 Present information to the Governor.	November 2020
	3.2 Present information to the House Appropriations committee.	January 2021
	3.2 Present information to the Senate Appropriations committee.	March 2021

1.2 Implement a well-defined, timely process that transitions Medicaid Expansion from Managed Care to Managed Fee-For-Service.

Objective	Action Step	Amount of Time Needed
1. Develop a timeline and action steps to transfer administration of Medicaid Expansion to DHS administration.	1.1 Develop timeline and action steps in coordination with the Medicaid Expansion managed care organization.	2 months
	1.2 Hold weekly meetings with managed care organization to ensure completion of timelines and benchmarks.	12 months
2. Provide progress updates to the Governor and interim legislative committees.	2.1 Provide regular progress updates to the Governor and interim legislative committees on the transition of Medicaid Expansion to DHS administration.	18 months

Aim #2 Implement a comprehensive quality strategy for North Dakota Medicaid.

2.1 Develop a primary care value based purchasing program for North Dakota Medicaid members with chronic conditions.

Objective	Action Step	Complete By
1. Develop a timeline and action steps to implement the Medicaid health homes program, as authorized by Section 1945 of the Social Security Act.	1.1 Develop timeline and action steps to implement a health homes program.	6 months
	1.2 Consult with CMS regarding health homes program requirements, including the 90 percent federal match that is available for health homes services for the first eight quarters of the program and the planning funds that may be available to states.	12 months
	1.3 Convene partner workgroups to provide input and direction for health homes program. Solicit input on: • Tiering system for members. • Provider payments. • Attributing members to a health home. • Quality measures and reporting. • How the program should be structured for children as compared to adults.	12 months
	1.4 Develop and submit state plan amendment to CMS for health homes program.	12 months
	1.5 Enroll members and providers with the health homes program and begin services.	6 months

2.2 Develop a hospital value-based payment program.

Objective	Action Step	Complete By
1. Develop a timeline and action steps to implement a value-based payment program for North Dakota hospitals.	1.1 Convene stakeholders to learn about three different value-based payment models that are used by other states.	2 months
	1.2 Convene partner workgroups to provide input and direction for value-based payment program. Input is needed on: • The model that is best suited for North Dakota hospitals. • Payment structure and quality incentives. • Quality measures and reporting.	12 months
	1.3 Develop timeline and action steps to implement a value-based payment program.	6 months

HOSPITAL NAME MEDICAID PAYER MIX	2017	2018	Medicaid Expansion 20% of Medicaid Enrollees	
ST ALEXIUS MEDICAL CENTER	7%	7%	1.4%	
TRINITY HOSPITALS/ST JOES	11%	13%	2.6%	
SANFORD MEDICAL CENTER - FARGO	8%	8%	1.6%	Average for PPS
SANFORD BISMARCK	7%	8%	1.6%	1.8%
ALTRU HEALTH SYSTEM - ALTRU HOSPTIAL	9%	8%	1.6%	
INNOVIS HEALTH	8%	6%	1.2%	
TIOGA MEDICAL CENTER	1%	1%	0.2%	
MOUNTRAIL COUNTY MEDICAL CENTER	3%	3%	0.6%	
MCKENZIE COUNTY HEALTHCARE SYSTEM	5%	4%	0.8%	
GARRISON MEMORIAL HOSPITAL	23%	22%	4.4%	
TURTLE LAKE COMMUNITY HOSPITAL	30%	11%	2.2%	
KENMARE COMMUNITY HOSPITAL	25%	19%	3.8%	
COOPERSTOWN MEDICAL CENTER	3%	6%	1.2%	
ST ANDREWS HEALTH CENTER	14%	17%	3.4%	
NELSON COUNTY HEALTH SYSTEMS-HO	1%	1%	0.2%	
SANFORD MAYVILLE	3%	3%	0.6%	
DAKAKAWEA MEDICAL CENTER	5%	6%	1.2%	
LISBON AREA HEALTH SERVICES	4%	7%	1.4%	
NORTHWOOD DEACONESS HEALTH CENTER	4%	5%	1.0%	
SOUTHWEST HEALTHCARE SERVICES	2%	1%	0.2%	
JACOBSON MEMORIAL HOSPTAL	20%	19%	3.8%	
OAKES COMMUNITY HOSPITAL	2%	8%	1.6%	Average for CAHs
PRESENTATION MEDICAL CENTER	28%	17%	3.4%	1.2%
CARRINTON HEALTH CENTER	2%	2%	0.4%	
PEMBINA COUNTY MEMORIAL HOSPITAL	14%	2%	0.4%	
UNITY MEDICAL CENTER	5%	4%	0.8%	
WISHEK COMMUNITY HOSPITAL	2%	2%	0.4%	
ASHLEY MEDICAL CENTER	2%	2%	0.4%	
CAVALIER COUNTY MEMORIAL HOSPITAL	8%	1%	0.2%	
MERCY HOSPITAL OF VALLEY CITY	4%	1%	0.2%	
ST LUKES HOSPITAL	1%	4%	0.8%	
FIRST CARE HEALTH CENTER	3%	3%	0.6%	
ST ALOISIUS MEDICAL CENTER	5%	4%	0.8%	
LINTON HOSPITAL	3%	4%	0.8%	
SANFORD HILLSBORO	2%	3%	0.6%	
WEST RIVER REGIONAL MEDICAL CENTER	3%	3%	0.6%	
TOWNER COUNTY MEDICAL CENTER	3%	3%	0.6%	
HEART OF AMERICA MEDICAL CENTER	30%	3%	0.6%	
MERCY HOSPITAL OF VALLEY CITY	10%	14%	2.8%	
MERCY MEDICAL CENTER	6%	3%	0.6%	
JAMESTOWN REGIONAL MEDICAL CENTER	13%	7%	1.4%	
ST JOSEPHS HOSPITAL AND HEATLH CENTER	7%	2%	0.4%	

Hospital Medicaid Share of Net Patient Revenues (approx)
Source: Horizon Government Affairs, HCRIS data via RAND Vintage 11-1-2020

Memorandum

To: Caprice Knapp, Erik Elkins

CC: Elrycc Berkman, ASA, MAAA

From: Tim Doyle, FSA, MAAA

Date: January 7, 2021

Re: Critical Access Hospital (CAH) Pricing Analysis

Background and Scope

Optumas was tasked with reviewing the cost of hospital services at North Dakota Critical Access Hospitals (CAHs) for the State's Medicaid Expansion population. **Optumas** performed a repricing analysis of detailed claims data to price the utilization commensurate with the reimbursement of the State's traditional Medicaid program. The corresponding results show the difference in reimbursement between the actual incurred costs in the Medicaid Expansion program and the costs that otherwise would have been incurred under the State's traditional Medicaid program.

Data Sources

As the State's actuary for the development and certification of the Medicaid Expansion capitation rates, **Optumas** relied on detailed claims and enrollment data for January 1, 2017 – December 31, 2018 (CY17 and CY18) with claims paid dates through June 30, 2019. This data was summarized and validated against reported financials during the development of the CY20 Medicaid Expansion capitation rates. Specifically, for this analysis, the data was limited to inpatient and outpatient claims incurred at any of the 36 CAHs in the State of North Dakota. These facilities are listed in the table below:

State of North Dakota CAHs	
Ashley Medical Center	Nelson County Health System
Carrington Health Center	Northwood Deaconess
Cavalier County Memorial Hospital	Oakes Community Hospital
Community Memorial Hospital	Pembina County Memorial Hospital
Cooperstown Medical Center	Presentation Medical Center
First Care Health Center	Sakakawea Medical Center
Garrison Memorial Hospital	Sanford Hillsboro Medical Center
Heart of America Medical Center	Sanford Mayville
Jacobson Memorial Hospital	Southwest Healthcare Services
Jamestown Hospital	St. Aloisius Hospital
Kenmare Community Hospital	St. Andrew's Health Center
Linton Hospital	St. Joseph's Hospital
Lisbon Area Health Services	St. Luke's Hospital
McKenzie County Medical Center	Tioga Medical Center
Mercy Hospital - Devils Lake	Towner County Medical Center
Mercy Hospital - Valley City	Unity Hospital
Mercy Medical Center	West River Regional Medical Center
Mountrail County Medical Center	Wishek Hospital

Methodology and Results

Optumas used historical reimbursement information from the State's traditional Medicaid program to reprice each claim in the CY17 and CY18 experience. Inpatient claims were repriced using per diems multiplied by the length of the inpatient stay in days. Outpatient claims were repriced using a cost-to-charge ratio multiplied by the charge amount for the claim. The overall results of the analysis are displayed in the table below:

Calendar Year	Incurred Dollars[1]	Repriced Dollars[2]	Implied % of State Traditional Medicaid Reimbursement
CY17	$22,941,857	$15,859,492	144.7%
CY18	$23,948,522	$16,662,009	143.7%
Two-Year Total	$46,890,379	$32,521,502	144.2%

1 – CAH Medicaid Expansion Program Reimbursement
2 – Repriced using State Traditional Medicaid Reimbursement

The results show, that on average over the two-year period, the CAH incurred dollars reflected reimbursement that was 144.2% times that of the reimbursement of the State's traditional Medicaid program. For CY17 this is a difference of approximately $7.1 million and for CY18 this is a difference of approximately $7.3 million.

Results do vary at the individual hospital level. There are hospitals where the Repriced Dollars are lower than the Incurred dollars. This typically occurs at hospitals that experience a lower volume of overall services. The tables below display the number and portion of hospitals by each year where the Repriced Dollars are Greater than or Less than the Incurred Dollars, and the volume and portion of Incurred Dollars by each of those categories:

	Number of Hospitals		Portion of Hospitals	
	CY17	CY18	CY17	CY18
Repriced Dollars Greater than Incurred Dollars	16	14	44.4%	38.9%
Repriced Dollars Less than Incurred Dollars	20	22	55.6%	61.1%

	Total Incurred Dollars[1]		Portion of Incurred Dollars[1]		Implied % of State Traditional Medicaid Reimbursement	
	CY17	CY18	CY17	CY18	CY17	CY18
Repriced Dollars Greater than Incurred Dollars	$2,479,638	$2,104,588	10.8%	8.8%	79.0%	68.6%
Repriced Dollars Less than Incurred Dollars	$20,462,220	$21,843,934	89.2%	91.2%	160.9%	160.7%
Total	$22,941,857	$23,948,522	100.0%	100.0%	144.7%	143.7%

1 – CAH Medicaid Expansion Program Reimbursement

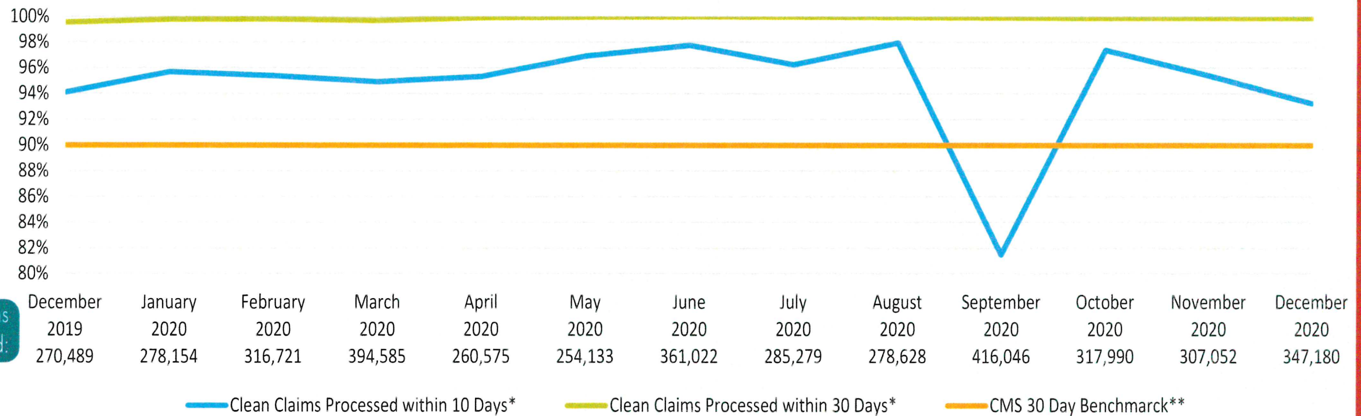
If you have any questions or feedback regarding this memo, please feel free to contact us.

NORTH DAKOTA MEDICAID

Updated 1/20/2021

MONTHLY PAID CLAIMS REPORT
RADITIONAL MEDICAID

30 Day Prompt Pay Results

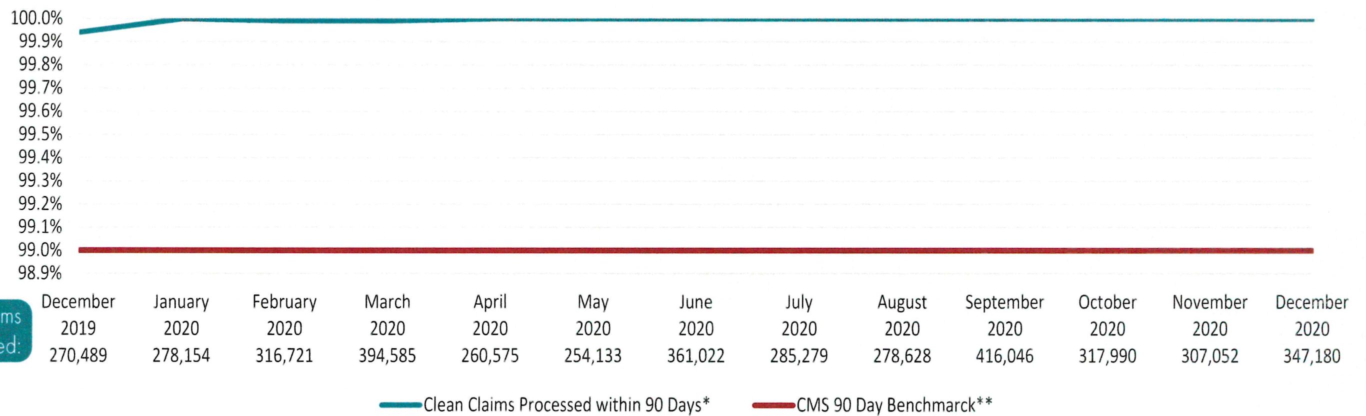


*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

**PER CFR 42 § 447.45 - TIMELY CLAIMS PAYMENT - STATE MUST PAY 90% OF CLEAN CLAIMS WITHIN 30 DAYS AND 99% OF CLEAN CLAIMS WITHIN 90 DAYS

HTTPS://WWW.GOVINFO.GOV/CONTENT/PKG/CFR-2011-TITLE42-VOL4/PDF/CFR-2011-TITLE42-VOL4-SEC447-45.PDF

90 Day Prompt Pay Results



*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

**PER CFR 42 § 447.45 - TIMELY CLAIMS PAYMENT - STATE MUST PAY 90% OF CLEAN CLAIMS WITHIN 30 DAYS AND 99% OF CLEAN CLAIMS WITHIN 90 DAYS

HTTPS://WWW.GOVINFO.GOV/CONTENT/PKG/CFR-2011-TITLE42-VOL4/PDF/CFR-2011-TITLE42-VOL4-SEC447-45.PDF

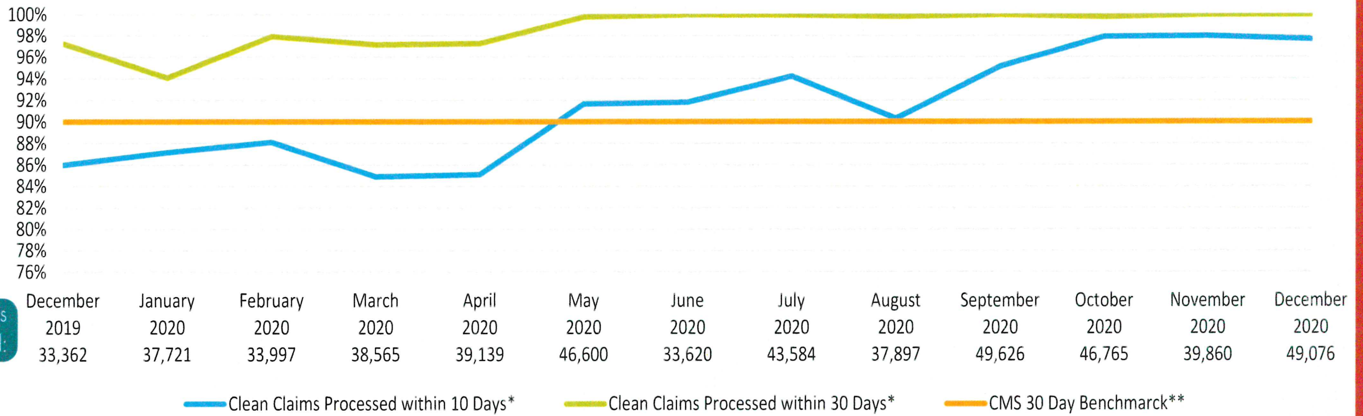
NORTH DAKOTA MEDICAID

Updated 1/20/2021

MONTHLY PAID CLAIMS REPORT

MEDICAID EXPANSION

30 Day Prompt Pay Results



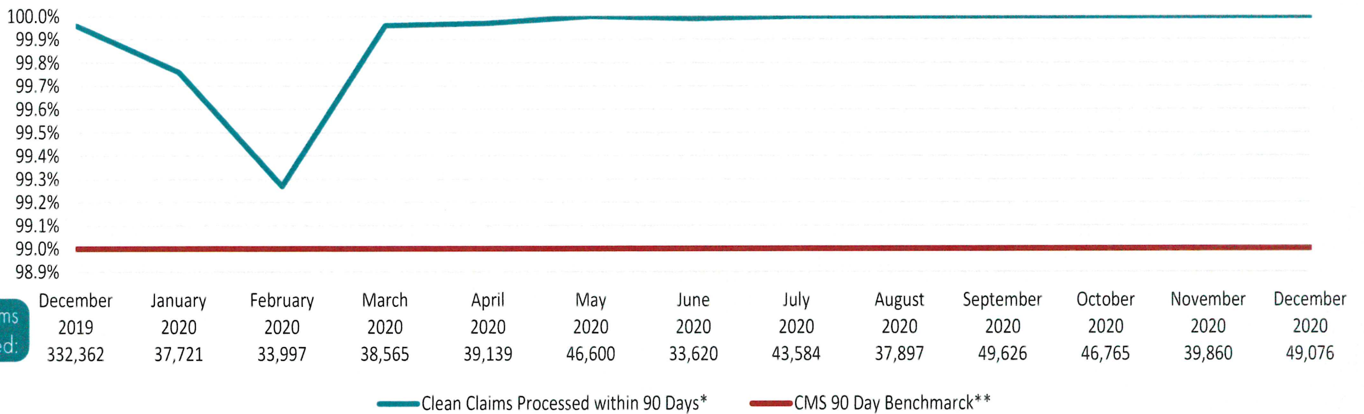
	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020
Clean Claims Processed:	33,362	37,721	33,997	38,565	39,139	46,600	33,620	43,584	37,897	49,626	46,765	39,860	49,076

*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

**PER CFR 42 § 447.45 - TIMELY CLAIMS PAYMENT - STATE MUST PAY 90% OF CLEAN CLAIMS WITHIN 30 DAYS AND 99% OF CLEAN CLAIMS WITHIN 90 DAYS

HTTPS://WWW.GOVINFO.GOV/CONTENT/PKG/CFR-2011-TITLE42-VOL4/PDF/CFR-2011-TITLE42-VOL4-SEC447-45.PDF

90 Day Prompt Pay Results



	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020
Clean Claims Processed:	332,362	37,721	33,997	38,565	39,139	46,600	33,620	43,584	37,897	49,626	46,765	39,860	49,076

*Clean Claims Processed means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

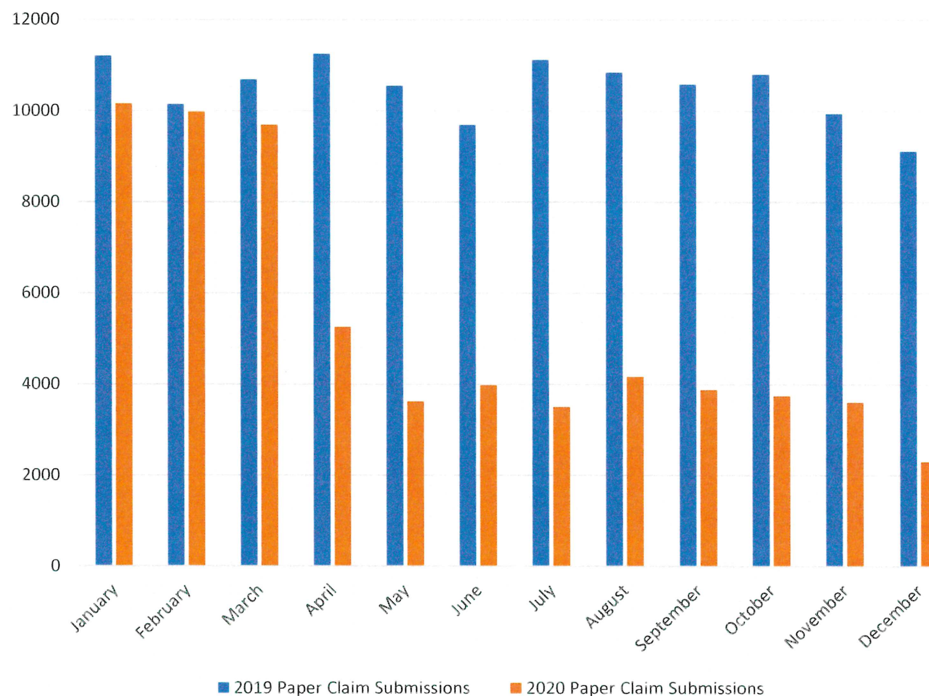
**PER CFR 42 § 447.45 - TIMELY CLAIMS PAYMENT - STATE MUST PAY 90% OF CLEAN CLAIMS WITHIN 30 DAYS AND 99% OF CLEAN CLAIMS WITHIN 90 DAYS

HTTPS://WWW.GOVINFO.GOV/CONTENT/PKG/CFR-2011-TITLE42-VOL4/PDF/CFR-2011-TITLE42-VOL4-SEC447-45.PDF

PAPER CLAIMS SUBMISSIONS

North Dakota | Human Services
Be Legendary.™

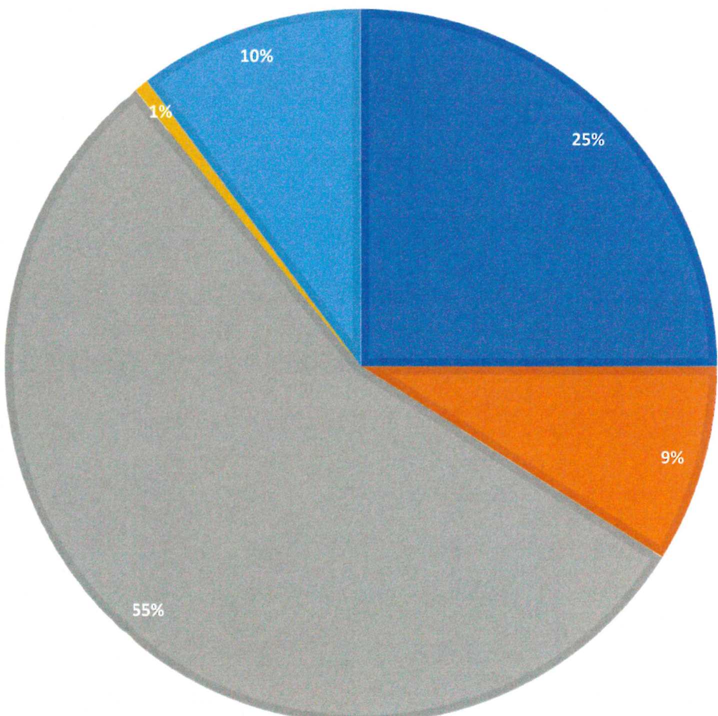
- As of April 15, 2020, paper claims are no longer being accepted by the department unless an exemption had been automatically granted or approved by North Dakota Medicaid.
- Exceptions were given to providers submitting less than 25 claims in a calendar year.
- LTC facilities where Medicaid is not the primary payer or PRTFs.
- Individual QSP providers and those providers that do not bill with an ICD-10 diagnosis code.
- 2019=125,944 paper claims
- 2020=63,829
- Decrease of 50.68%



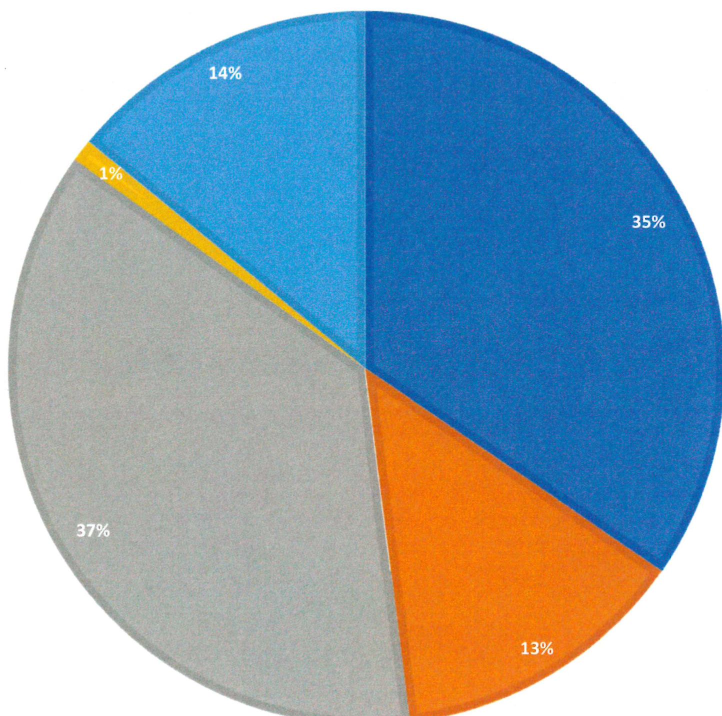
PAPER CLAIMS SUBMISSIONS

NORTH Dakota | Human Services
Be Legendary.™

2019

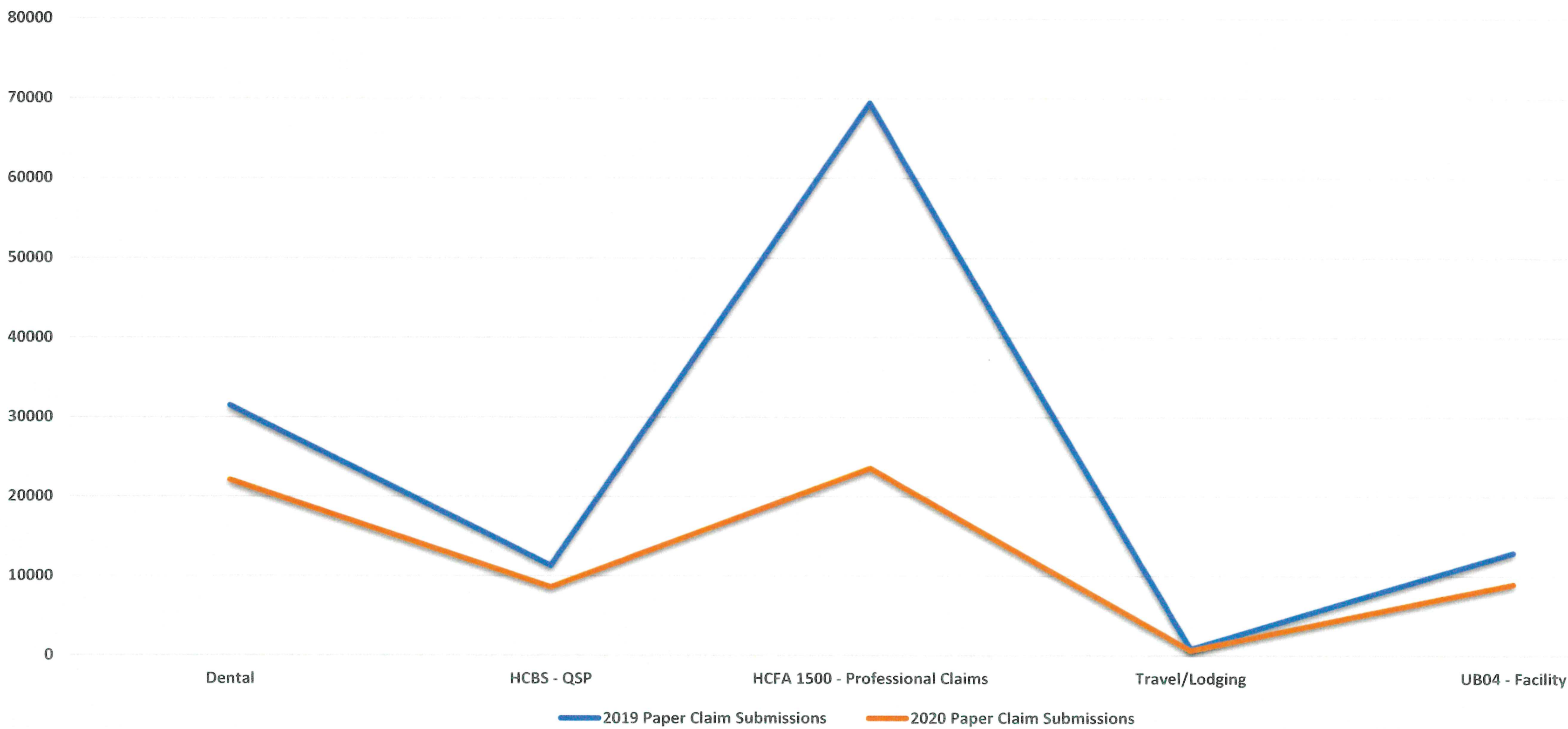


2020



PAPER CLAIMS SUBMISSIONS
2019-2020 Comparison

NORTH Dakota | Human Services
Be Legendary.™



PAPER CLAIMS SUBMISSIONS
Top 15 Providers Submitting Paper Claims in 2019

NORTH Dakota Be Legendary.™ | Human Services

Medical Providers

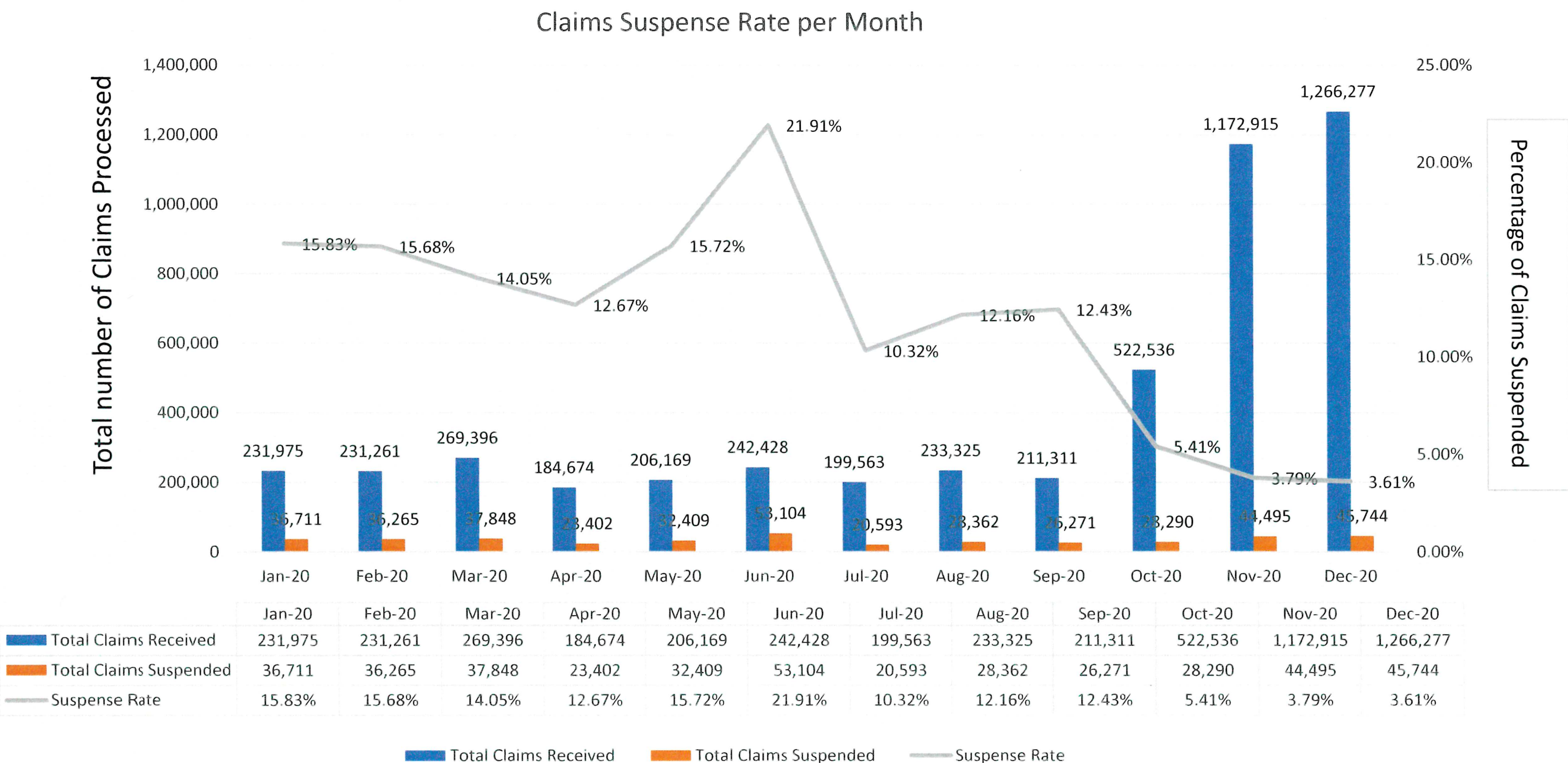
- Altru Health System
- FM Ambulance
- Metro Area Ambulance
- Community Ambulance
- Cass County Social Services
- North Central Human Service Center
- Altru Health Ambulance
- T&K Speech
- Trinity Medical Group(Physicians)

Dental Providers

- Bridging the Dental Gap
- High Plains Dental
- Valley Oral & Facial Surgery
- Bridge City Dentistry
- Pediatric Dentistry LTD
- Joy Dental Design

CLAIMS SUBMISSIONS
Claims Suspense Rate Per Month

NORTH Dakota | Human Services
Be Legendary.™



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Total Claims Received	231,975	231,261	269,396	184,674	206,169	242,428	199,563	233,325	211,311	522,536	1,172,915	1,266,277
Total Claims Suspended	36,711	36,265	37,848	23,402	32,409	53,104	20,593	28,362	26,271	28,290	44,495	45,744
Suspense Rate	15.83%	15.68%	14.05%	12.67%	15.72%	21.91%	10.32%	12.16%	12.43%	5.41%	3.79%	3.61%

SUSPENDED CLAIMS & TIMELY FILING

NORTH Dakota | Human Services
Be Legendary.™

- Claims that suspend in the MMIS system are monitored and tracked daily.
- Ensures Prompt Pay Requirements are being met.
- Assists providers with the timely filing process as they can view submitted claims via the web portal.
- There are several reasons that cause a claim to suspend for review
  - The recipient has a primary insurance.
  - The diagnosis code billed on the claim needs review by State Coding Staff.
  - The claim is an adjustment of an original claim.
  - Prior Authorization is needed.

DAILY CLAIM SUSPENSE REPORT

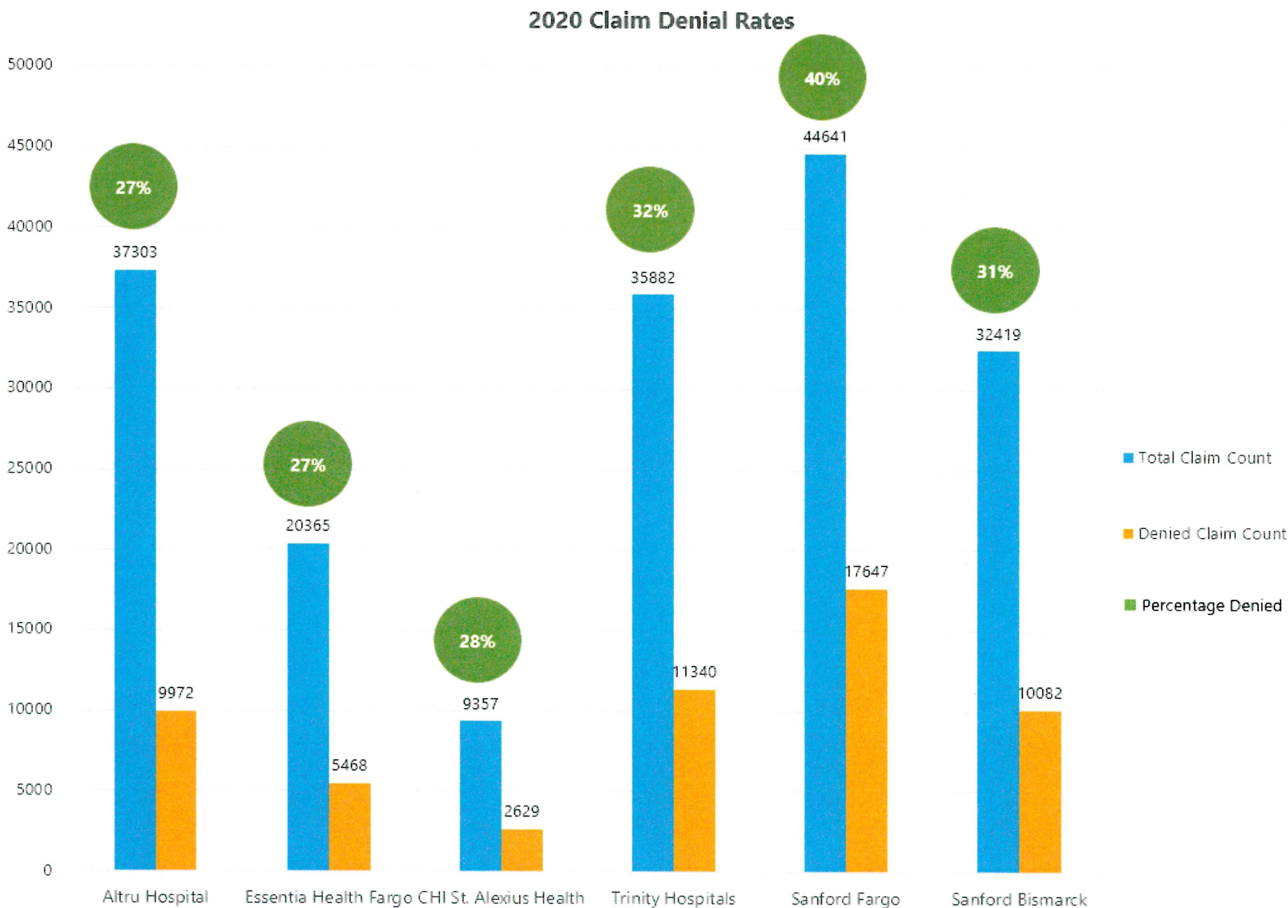
Claim Types	0 - 10 days	11 - 20 days	21 - 30 days	31 - 60 days	61 - 90 days	OVER 90 days	Total Claim Counts	Total Billed Charges	Percent of Total Claim Count
Inpatient	70	0	30	10	0	16	126	$2,810,635.86	4.00%
Lab & Xray	53	15	44	5	0	22	139	$64,638.54	5.00%
MC Cap	4	0	0	0	0	0	4	$19,991.86	0.00%
Lng Trm Cr	20	5	5	4	0	0	34	$299,488.77	1.00%
Outpatient	148	47	92	39	0	8	334	$1,225,755.72	12.00%
Pract/Phy	1173	261	350	307	12	37	2140	$983,604.50	74.00%
Med Sup	52	1	13	2	0	0	68	$86,731.24	2.00%
Transport	29	0	0	0	0	0	29	$1,025,864.75	1.00%
HCBS/DD	10	0	0	0	0	0	10	$57,495.08	1.00%
Totals	1559	329	534	367	12	83	2884	$6,574,206.32	100.00%

TIMELY PAYMENT TO PROVIDERS

- To increase the timeliness of payments to providers from NDMA is for providers to receive payment via the electronic fund transfer process(EFT).
- Currently 964 providers still receive paper checks
- Top Providers Still Receiving Paper Checks Weekly
  - Dakota Kids Dentistry
  - Valley Oral and Facial Surgery
  - Goebel DDS
  - CVS Pharmacy
  - Heart of America Medical Center-Rugby/Dunseith/Maddock
  - Nelson County Health System
  - Eventide Devils Lake Care Center
  - Alpha Opportunities
  - Sanford Health Care Accessories

CLAIM DENIAL RATE FOR TOP 6 PROVIDERS

NORTH Dakota | Human Services
Be Legendary.™



PROVIDER TRAININGS

North Dakota | Human Services
Be Legendary.™

- January 2020
  - Training to Hospital billing staff in Minot
- February 2020
  - Training to Hospital billing staff in Jamestown
- March 2020
  - Training/Meeting with CHI
- June 2020
  - Professional Web Portal Training via Teams
- July 2020
  - Dental Web Portal Training via Teams
- August 2020
  - Institutional Web Portal Training via Teams

North Dakota Department of Human Services

ACA MEDICAID INCOME ELIGIBILTY LEVELS Effective April 1, 2020

Family Size	(MAGI Equivalent of Approximately 50% of PL) Parents and Caretakers		Adults age 19 and 20 and Medically Needy for Pregnant Women (90% of PL)		Medically Needy Individuals up to age 21 (92% PL)		Medically Needy Parents, Caretakers and their Spouses (93% PL)		Adult Expansion Group (Ages 19 to 65) & Children (Ages 6 to 19) 138% of the PL		Children (Ages 0 to 6) 152% of the PL		Pregnant Women 162% of the PL	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$517	$6,204	$ 957	$11,484	$ 979	$ 11,739	$ 989	$ 11,867	$ 1,468	$ 17,609	$ 1,617	$ 19,395	$ 1,723	$ 20,671
2	694	8,328	1,293	15,516	1,322	15,861	1,337	16,033	1,983	23,791	2,184	26,205	2,328	27,929
3	871	10,452	1,629	19,548	1,666	19,982	1,684	20,200	2,498	29,974	2,752	33,014	2,933	35,186
4	1,048	12,576	1,965	23,580	2,009	24,104	2,031	24,366	3,013	36,156	3,319	39,824	3,537	42,444
5	1,226	14,712	2,301	27,612	2,353	28,226	2,378	28,532	3,529	42,338	3,887	46,634	4,142	49,702
6	1,403	16,836	2,637	31,644	2,696	32,347	2,725	32,699	4,044	48,521	4,454	53,443	4,747	56,959
7	1,580	18,960	2,973	35,676	3,040	36,469	3,073	36,865	4,559	54,703	5,022	60,253	5,352	64,217
8	1,757	21,084	3,309	39,708	3,383	40,590	3,420	41,032	5,074	60,886	5,589	67,062	5,957	71,474
9	1,934	23,208	3,645	43,740	3,726	44,712	3,767	45,198	5,589	67,068	6,156	73,872	6,561	78,732
10	2,111	25,332	3,981	47,772	4,070	48,834	4,114	49,364	6,105	73,250	6,724	80,682	7,166	85,990
+1	$178	$2,136	$ 336	$ 4,032	$ 344	$ 4,122	348	$ 4,166	$ 516	$ 6,182	$ 568	$ 6,810	$ 605	$ 7,258

Family Size	Optional Targeted Low-Income Children (CHIP) 175% of PL	
	Monthly	Yearly
1	$1,861	$22,330
2	2,515	30,170
3	3,168	38,010
4	3,821	45,850
5	4,475	53,690
6	5,128	61,530
7	5,781	69,370
8	6,435	77,210
9	7,088	85,050
10	7,741	92,890
+1	$ 654	$ 7,840

Maintenance of Effort – Medicaid

Family Size	111% of Federal Poverty Level		133% of Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly
1	$1,181	$14,164	$1,415	$16,971
2	1,595	19,110	1,911	22,929
3	2,010	24,109	2,408	28,888
4	2,424	29,082	2,904	34,846
5	2,838	34,055	3,401	40,804
6	3,253	39,028	3,897	46,763
7	3,667	44,000	4,394	52,721
8	4,082	48,973	4,890	58,680
9	4,496	53,946	5,387	64,638
10	4,910	58,919	5,884	70,596
+1	$ 415	$ 4,973	$ 497	$ 5,958

North Dakota Department of Human Services

NON-ACA MEDICAID INCOME ELIGIBILTY LEVELS Effective April 1, 2020

Family Size	SSI Effective 01-01-2021	Medically Needy 83% of Poverty	QMB 100% of Poverty	SLMB 120% of Poverty	QI-1 135% of Poverty	Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty	Children With Disabilities 250% of Poverty
1	$ 794	$ 883	$ 1,064	$ 1,276	$ 1,436	$ 2,127	$ 2,393	$ 2,659
2	1,191	1,193	1,437	1,724	1,940	2,874	3,233	3,592
3		1,503	1,810	2,172	2,444	3,620	4,073	4,525
4		1,813	2,184	2,620	2,948	4,367	4,913	5,459
5		2,123	2,557	3,068	3,452	5,114	5,753	6,392
6		2,432	2,930	3,516	3,956	5,860	6,593	7,325
7		2,742	3,304	3,964	4,460	6,607	7,433	8,259
8		3,052	3,677	4,412	4,964	7,354	8,273	9,192
9		3,362	4,050	4,860	5,468	8,100	9,113	10,125
10		3,672	4,424	5,308	5,972	8,847	9,953	11,059
+1		$ 310	$ 374	$ 448	$ 504	$ 747	$ 840	$ 934

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (Effective 01/01/2021)	Community Spouse Maximum Asset Allowance (Effective 01/01/2021)	Community Spouse Income Level (Effective 01/01/16)	Income Level for each Additional Individual
$26,076	$130,380	$2,550	$718 Eff 7/20 $703 Eff. 7/19

Average Cost of Nursing Care

Average Monthly Cost of Care (Effective 01/01/2021)	Average Daily Cost of Care (Effective 01/01/2021)	Nursing Care Income Level (Effective 10/01/2013)	Medicare Premium (Effective 01/2021)	Medicare Savings Program Asset Limit (Effective 01/01/2020)
$9,522.85	$313.08	LTC $65 ICF/IID $100	$148.50 premium for newly Medicare eligible in 2021	1 Person - $7,860 Couple - $11,800

North Dakota's Quality Strategy for Medicaid

Medical Services Division

January 2021

NORTH
Dakota | Human Services
Be Legendary.™

Table of Contents

I.	**Introduction and Overview**		**3**
	A.	History of North Dakota Medicaid	3
	B.	History of Medicaid Quality Improvement	4
	C.	Improving Health Care Quality and Safety	8
	D.	North Dakota's Quality Strategies for Medicaid	10
II.	**Alternative Payment Models and Payment Reform**		**16**
	A.	Value-Based Care	16
	B.	North Dakota Medicaid Current Models	17
	C.	Value-Based Purchasing Programs for Hospitals	18
		1. Episode of Care	18
		2. Pay-for-Performance	19
		3. Accountable Care Organization	20
		4. Pros/Cons Table	20
		5. Survey Results	22
	D.	Value-Based Purchasing Program for Primary Care	24
		1. Health Homes	24
		2. Measure Crosswalk	26
	E.	The Future of Quality in North Dakota	26
III.	**Conclusion**		**27**

North Dakota's Quality Strategy for Medicaid

I. Introduction and Overview

A. History of North Dakota Medicaid

Medicaid was established in 1965, authorized by Title XIX of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) administers and oversees Medicaid at the federal level. The Department of Human Services administers and oversees Medicaid in North Dakota.

Over the years, CMS and Congress have strengthened and enhanced Medicaid to ensure recipients would have access to cost-effective, high quality health care. Access has been expanded through legislative action. For example, in 1997 the Children's Health Insurance Program (CHIP) was created to provide health insurance and preventive care to millions of uninsured American children whose family's income are slightly higher than the Medicaid income levels. In 2013, North Dakota opted to accept federal funding to expand access under the Patient Protection and Affordable Care Act (ACA), which allowed for coverage to low-income adults without dependent children. In 2014, Medicaid Expansion coverage became effective through a private managed care organization in North Dakota.

Medicaid and CHIP offer health insurance and preventative care to low-income families, pregnant women, people of all ages with disabilities, and people who need long-term care. Table 1 provides historical enrollment information for the total North Dakota Medicaid population.

Medicaid and Medicaid Expansion

Monthly Average Number of Eligibles and Recipients by State Fiscal Year

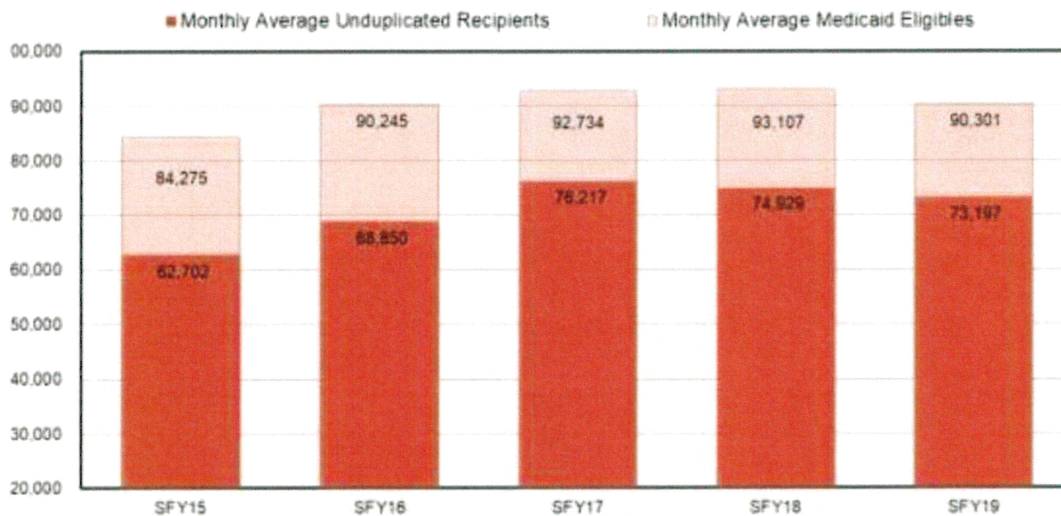


Table 1: *Total Eligible Medicaid Populations for FY 2020*

Funding for Medicaid is shared between states and the federal government. In North Dakota, the funding is approximately equal.

B. History of Medicaid Quality

Although states may have been addressing quality in their Medicaid programs, the first foray to address quality comprehensively at the national level occurred in 2009. The Children's Health Insurance Program Reauthorization Act of 2009 required CMS to develop a core set of children's health care quality measures to monitor the quality of care and health outcomes for children enrolled in Medicaid and CHIP. States were asked to voluntarily report on these measures. By 2010, an initial Child Core Set of measures were developed and published using existing quality of care measures, specifically focusing on:

- availability and effectiveness of preventive services,
- treatment and management of chronic conditions, and
- patient experiences with care.

The ACA required CMS to develop a core set of adult health care quality measures in

Medicaid. States were asked to voluntarily report on these measures. The initial Adult Core Set included quality of care measures that focused on:

- preventative care,
- management of chronic conditions,
- behavioral health treatment, and
- patient experiences with care.

Since 2009 the number of measures, and sometimes the specifications for the measures, have been refined. Currently, for federal fiscal year (FFY) 2020, there are 24 measures in the Child Core Set and 33 measures in the Adult Core Set (Appendix 1). The Child and Adult Core Sets are reviewed and updated annually for reporting feasibility and clinical relevance. The goals of the Child and Adult Core Sets are to facilitate standardized reporting by states on a uniform set of performance measures and encourages states to use results to drive quality improvements. The Child and Adult Core Sets also allow states, the public, and CMS to monitor trends in performance on standardized indicators of quality of care provided to Medicaid and CHIP members under both fee-for-service (FFS) and managed care arrangements and examine performance across states.

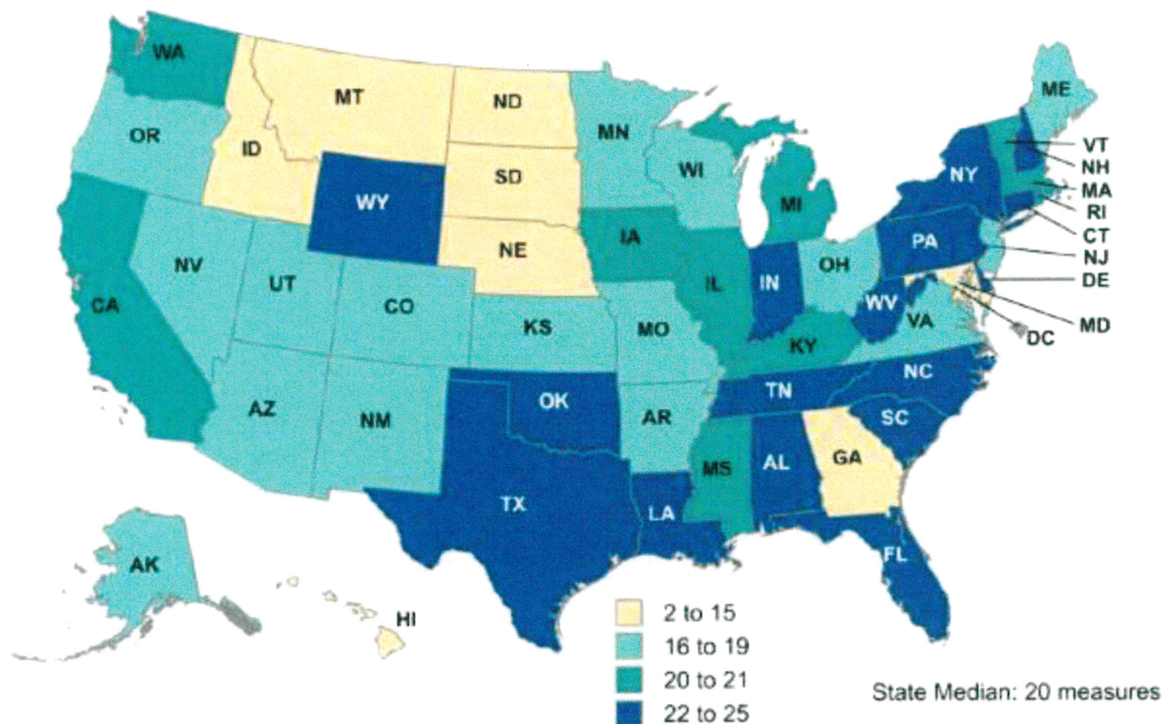
As part of the Balanced Budget Act of 2018 and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, states will be required to report on all measures in the Child Core Set for children enrolled in Medicaid and CHIP and on all the behavioral health measures in the Adult Core Set for adults enrolled in Medicaid. The behavioral health measures evaluate the quality of substance use disorder treatment services.

In 2018, CMS launched the Medicaid and CHIP Scorecard initiative to provide greater public transparency about the Medicaid and CHIP program administration and quality of care performance. The Scorecard aligns states' and CMS' efforts to drive quality improvements that improve health outcomes for Medicaid and CHIP members using standardized performance measures. The Scorecard is comprised of three pillars: (1)

State Health System Performance, (2) State Administrative Accountability, and (3) Federal Administrative Accountability.[1] Like the Child and Adult Core Sets, the Scorecard measures will continue to evolve over time.

From 2014 to 2018 North Dakota submitted one quality measure: access to preventive dental services for children aged 1 to 20. In 2019, North Dakota submitted 13 Child Core Set measures.

Geographic Variation in the Number of Child Core Set Measures Reported by States, FFY 2019



Sources: Mathematica analysis of MACPro reports for the FFY 2019 reporting cycle as of May 31, 2020; Form CMS-416 reports for the FFY 2019 reporting cycle as of July 1, 2020; and Centers for Disease Control and Prevention Wide-ranging ONline Data for Epidemiologic Research (CDC WONDER) for calendar year 2018.

Figure 1: *Geographic variation in the number of Child Core Set measures reported by States, FFY 2019*

In 2020, North Dakota reported on 21 Child Core Set measures, 14 Adult Core Set

[1] https://www.medicaid.gov/state-overviews/scorecard/index.html

measures for Traditional Medicaid and 22 Adult Core Set measures for Medicaid Expansion.

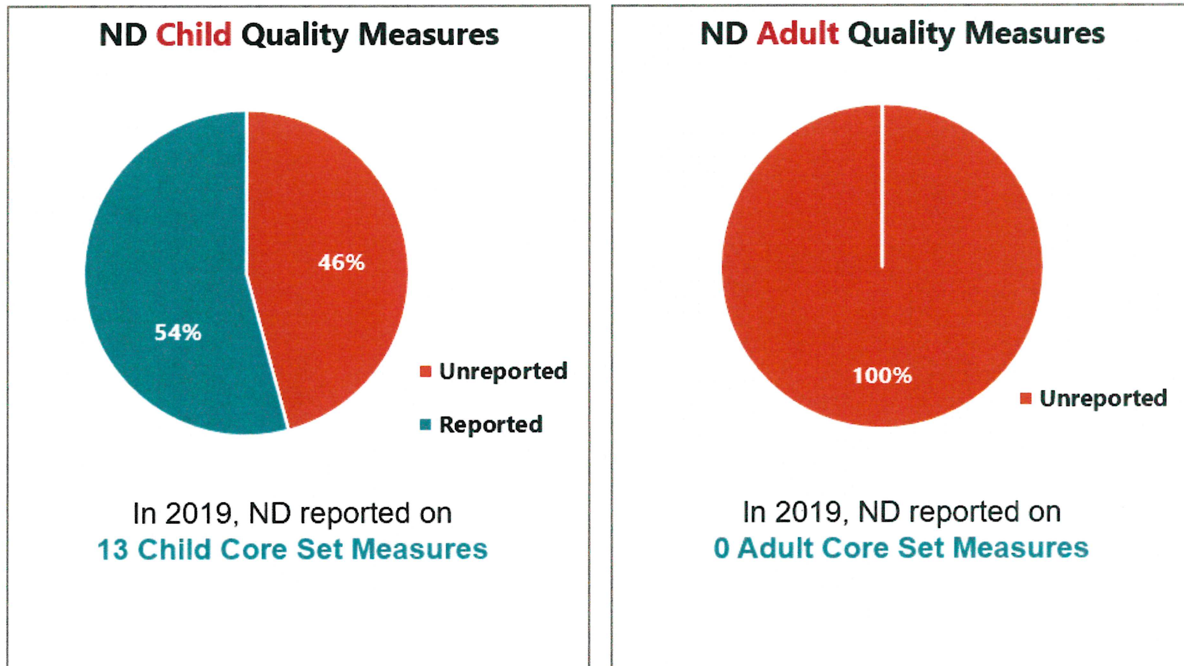


Figure 2: *North Dakota FFY 2019 Reported Measures*

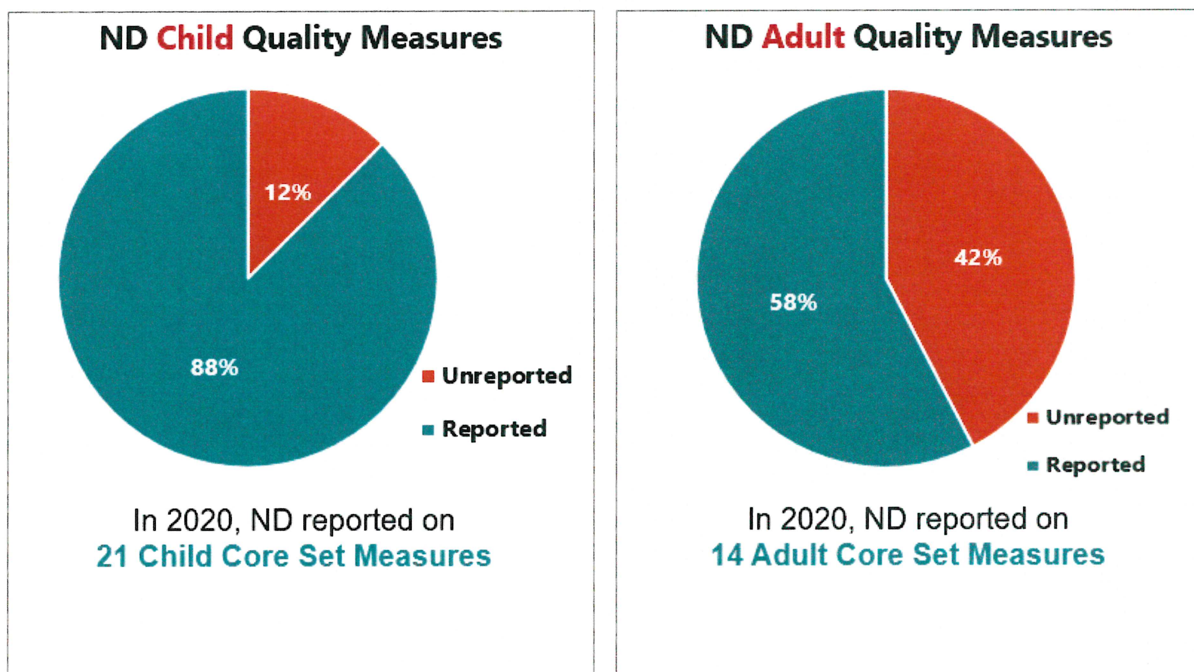


Figure 3: *North Dakota FFY 2020 Reported Measures*

C. North Dakota's Medicaid Quality Strategy

North Dakota's Medicaid Quality Strategy is designed to build healthier communities focusing on the health outcomes of target populations. Medicaid addresses both

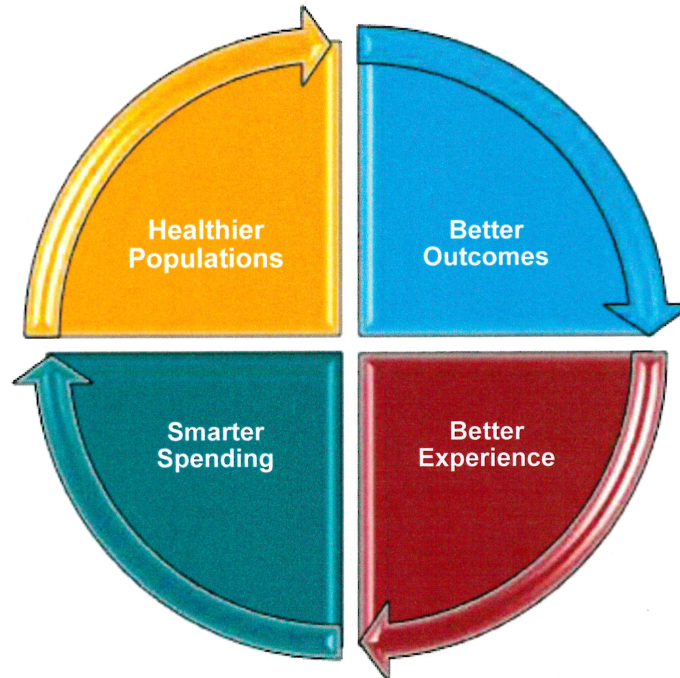


Figure 2: *Quadruple Aim for North Dakota Medicaid*

medical and non-medical health drivers to promote health equality by using the Quadruple Aim: (1) Healthier Populations, (2) Better Outcomes, (3) Smarter Spending, and (4) Better Experience.

Included in each of these four aims is a series of five goals and 10 objectives. As shown in Figure 2, these aims, goals, and objectives create the framework through which North Dakota defines the overall vision for improving quality of care for Medicaid members.

AIMS	GOALS	OBJECTIVES

Aim	Goal	Objectives
Healthier Populations	**Goal 1:** **Promote wellness and prevention**	**Objective 1.1:** Promote child health, development, and wellness **Objective 1.2:** Promote maternal health
	Goal 2: **Improve Chronic Condition management**	**Objective 2.1:** Improve behavioral health care **Objective 2.2:** Improve asthma management
Better Outcomes	**Goal 3:** **Ensure appropriate access to care**	**Objective 3.1:** Ensure timely access to care **Objective 3.2:** Link patients to appropriate care management services
Smarter Spending	**Goal 4:** **Pay for Value**	**Objective 4.1:** Report Medicaid Quality Measures **Objective 4.2:** Ensure high-value, appropriate care
Better Experience	**Goal 5:** **Enhance experience of care**	**Objective 5.1:** Promote patient engagement in care **Objective 5.2:** Maintain Medicaid provider engagement

Figure 3: *North Dakota's Quality Strategy Aims, Goals, and Objectives*

The development of the Quality Strategy aims, goals, and objectives reflect the opportunity for targeted quality improvement activities for Medicaid members. The Quality Strategy and objectives recognize that significant processes are aligned closely with the quality measures and activities that will drive improvement in the health of Medicaid members.

The objectives aligned with **Goal 1** (promote wellness and preventions) reflect an emphasis on improving the health of children and maternal health.

The objectives aligned with **Goal 2** (improve chronic condition management) focus on chronic conditions that significantly impact the North Dakota Medicaid populations, including asthma and behavioral health.

Many objectives tie to **Goal 3** (ensure appropriate access to care) which recognizes the need to maintain and expand access to appropriate care in a timely manner.

The objectives aligned with **Goal 4** (pay for value) reflect the importance of data transparency with public reporting of the quality measures and recognizes the importance of provider accountability to help drive high quality care to improve population health.

The objectives related to **Goal 5** (enhance experience of care) focus on member engagement in their health care, member satisfaction, provider engagement that drives patient-centered care, and ensuring members are linked to needed care management.

D. North Dakota's Quality Strategy for Medicaid

North Dakota Medicaid's Quality Strategy is based on a framework that can be used to facilitate the transformation of North Dakota's traditional fee-for-service Medicaid program to a value-based purchasing program. The Quality Strategy was designed and refined with stakeholder consideration, involvement, and feedback. The Quality Strategy is grounded in population health, which allows the Medicaid population to be categorized into targeted sub-groups and highlight specific care areas including: (1) prevention, (2) prenatal and postnatal care, (3) behavioral health, and (4) management of chronic conditions. The Quality Strategy is meant to be overarching. Individual

divisions within DHS such as Aging, Developmental Disabilities, and Behavioral Health might develop their own specific goals and objectives that fit into the overarching framework.

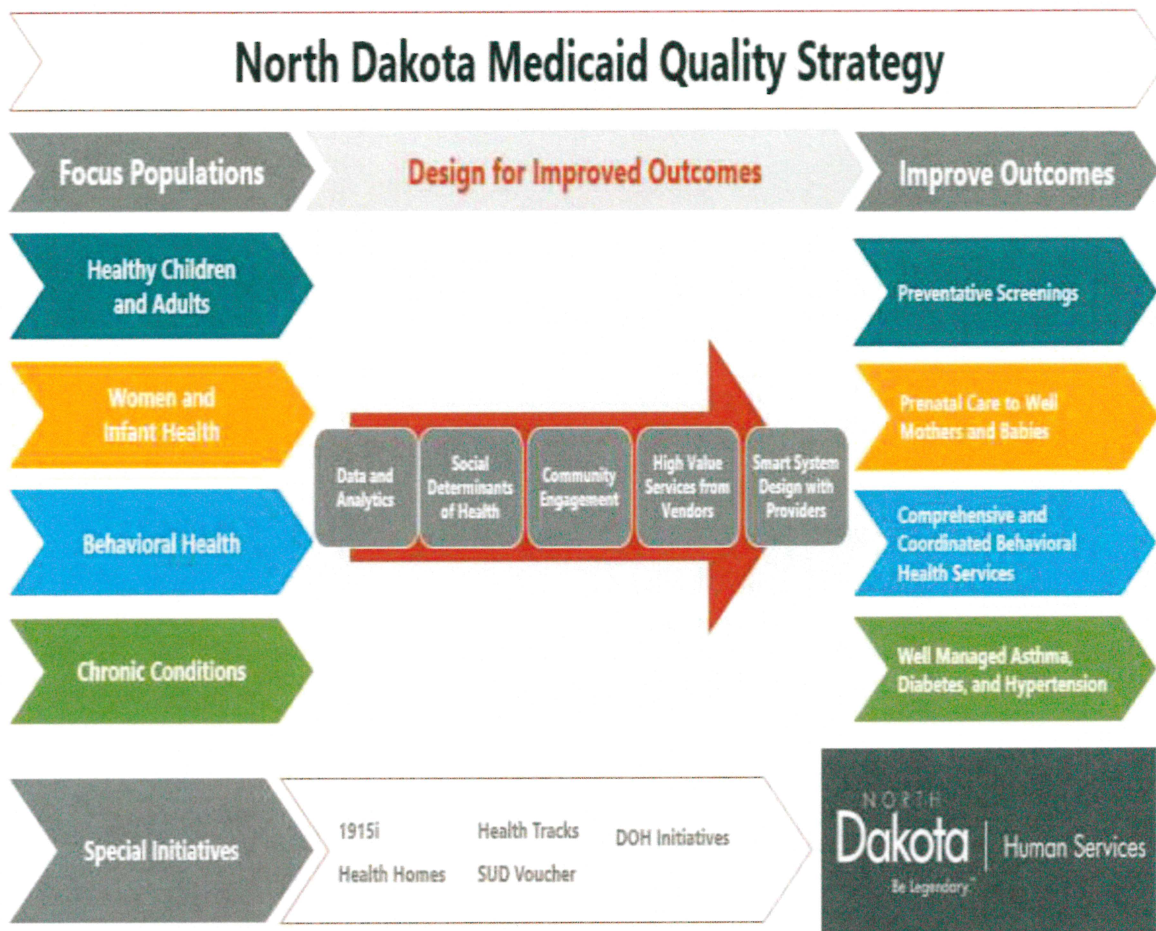


Figure 4: *North Dakota Medicaid Quality Strategy*

Through an emphasis on quality, North Dakota Medicaid aims to improve patient safety, health care outcomes, and add value in all care settings. North Dakota Medicaid aims to accomplish these through a collaborative process in which key stakeholders work together with Medicaid to promote strategies that:

- implement quality measures at the provider level.
- collect, aggregate, and report data in the most transparent way.
- report meaningful information to members, providers, and other stakeholders that can be used to inform decision-making and improve health outcomes.

Figure 5: *Medical Services Division Values*

Medicaid Expansion Quality Strategy

As part of the federal Managed Care Rule, Medicaid managed care organizations are required to have a quality strategy. North Dakota Medicaid has one managed care plan for the Medicaid expansion population. The quality strategy can be found in the Medicaid dashboard at http://www.nd.gov/dhs/services/medicalserv/medicaid/data.html. In addition to a quality strategy, the managed care plan is required to report on quality of care measures annually as well as engage in a performance improvement project. Highlights from the most recent quality of care data show that North Dakota Medicaid performs above the National Median on Child and Adolescent Immunizations.

The North Dakota Medicaid Quality team applied to participate in the Center for Medicaid and CHIP Services (CMCS) Oral Health affinity group. North Dakota Medicaid applied to participate in the Medicaid and CHIP Oral Health Affinity Group CMCS's Advancing Prevention and Reducing Childhood Caries in Medicaid and CHIP members. The Medicaid Quality and Health Tracks teams have formed a workgroup that is collaborating with CMCS to develop a performance improvement project that focuses on improving oral health through prevention that will reduce childhood caries. This project is in the development phase, that will focus on improving North Dakota Medicaid's

performance in the following two Child Quality measures: (1) Sealant Receipt on Permanent First Molars and (2) Percentage of Eligibles Who Received Preventive Dental Services.

Other Quality Information: Nursing Facilities

In addition to the Child and Adult Core Sets and the Medicaid expansion quality of care measures, North Dakota Medicaid has other quality of care information. Consumers can compare the quality of care in long-term services and supports or specifically for nursing facilities (NF). For general state comparisons consumers can use the long-term care services and supports scorecard as produced by the SCAN Foundation.[2] Based on the SCAN scorecard, North Dakota ranks 37th in the country on its performance in measures for affordability and access; choice of setting and provider; quality of life and quality of care; support for family caregivers; and, effective transitions. The scorecard measures specific to NFs are presented in Table 2 below.

Performance Measures	North Dakota rank out of 50 states **2017**	North Dakota rank out of 50 states **2020**
Median annual nursing home private pay cost as a percentage of median household income age 65+	**48**	**48**
Percent of high-risk nursing home residents with pressure sores	**8**	**1**
Percent of nursing home residents who are receiving antipsychotic medication	**37**	**44**
Percent of nursing home residents with low care needs	**38**	**41**
Percent of long-stay nursing home residents hospitalized within a 6-month period	**17**	**22**
Percent of people with 90+ day nursing home stays successfully transitioned back to community	**50**	**48**

[2] http://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/North%20Dakota%20Fact%20Sheet.pdf

Percent of nursing home residents with one or more potentially burdensome transitions at end of life	**9**	**5**

Table 2: *North Dakota's rank on performance measures*

For more NF specific quality of care information consumers can utilize Nursing Home Compare, a website sponsored by Medicare.[3] The website provides information on all Medicare and Medicaid certified NFs and on state survey agencies, ombudsman, and guidance for consumers. ND NFs are rated on a 5-star continuum for overall rating (5 is the highest), health inspections, staffing, and quality measures. Data comes from state surveys conducted by DOH, payroll-based journal, MDS, and Medicare claims. Medicare recently added a new feature to the website to denote facilities that have been cited for potential issues related to abuse.

Nationally, the percentage of NFs with a 5-star rating has increased over time indicating that the program is having a positive impact.[4] Table 3 shows the percentage of 1- and 5-star facilities for ND and surrounding states from 2009 to 2013.[5]

	Percent of 1-star facilities in 2009	Percent of 1-star facilities in 2013	Percent of 5-star facilities in 2009	Percent of 5-star facilities in 2013
North Dakota (n=80)	**8.4%**	**3.7%**	**14.5%**	**33.3%**
South Dakota (n=104)	**14.7%**	**6.4%**	**15.6%**	**24.5%**
Minnesota (n=367)	**14.5%**	**5.0%**	**16.0%**	**29.4%**
Wyoming (n=36)	**20.5%**	**7.9%**	**12.8%**	**31.6%**
Montana (n=70)	**14.3%**	**4.8%**	**15.4%**	**24.1%**

Table 3: *The percentage of 1- and 5-star facilities*

On Nursing Home Compare quality of care is reported separately for short and long stay

[3] https://www.medicare.gov/nursinghomecompare/search.html
[4] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/NHC-Year-Five-Report.pdf
[5] Ratings for January 2009 and December 2013 by state. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/NHC-Year-Five-Report.pdf

residents. Short stay residents typically have a goal to improve their health and return to their homes whereby long stay residents will likely stay in the facility. Short stay quality measures used to calculate the star rating include:

- Percentage of residents re-hospitalized
- Percent of residents with an outpatient emergency department visit
- Percentage of residents who got an antipsychotic medication
- Percent of residents with new or worsened pressure ulcers
- Percent of residents whose ability to move improved

Long stay quality measures used to calculate the star rating include:

- Number of hospitalizations per 1,000 days
- Number of outpatient emergency department visits per 1,000 days
- Percentage of residents who got an antipsychotic medication
- Percent of residents with 1 or more falls
- Percent of residents with pressure ulcers
- Percent of residents with urinary tract infection
- Percent of residents with a catheter
- Percent of residents whose inability to move worsened
- Percent of residents whose need for help with daily living increased

There are several other quality measures that do not contribute to the star ratings for short- and long-term stays.

Other Quality Information: Hospitals

Hospitals in North Dakota each have an overall star rating on the Hospital Compare website. The Hospital Compare website is a consumer-oriented website that allows consumers to compare hospitals' data on patients' experiences, outcome of care measures, use and overuse of medical procedures, and the volume of Medicare payments. The Overall Hospital Compare Star Rating is a 5-star rating that summarizes hospital performance based on indicators of quality, patient satisfaction survey, and volume of Medicare payments. Table 4 represents the Overall Star Rating for North

Dakota hospitals.

Star Rating	Hospital
★★★★	CHI St. Alexius Health Bismarck
★★★★	Essentia Health Fargo
★★	Altru Hospital Grand Forks
★★	Sanford Medical Center Bismarck
★★	Sanford Medical Center Fargo
★★	Trinity Hospital Minot

*Rating based on current data collection periods from Hospital Compare, last updated on July 22, 2020

Table 4: *Overall Star Rating for North Dakota Hospitals*

Finally, North Dakota Medicaid does collect and report on several quality of care measures for hospitals through a contracted quality improvement organization (QIO) vendor. The QIO's annual report reviewed the volume of Medicaid claims payment per hospital, reported the highest billed Diagnosis-Related Group (DRG) claims for Medicaid, and reviewed prior authorization claims.

II. Value-Based Purchasing Models and Payment Reform

A. Value-Based Purchasing

Developing a quality strategy and documenting quality of care through reporting helps to provide a clearer picture of where the Medicaid program can target areas for improvement. States use different approaches to improve quality of care including

Category	Description
Category 1	• fee-for-service with no link to payment quality
Category 2	• fee-for-service with a link of payment to quality and value
Category 3	• alternative payment models build on a fee-for-service architecture
Category 4	• population-based payment

performance improvement plans, public-private quality collaboratives, and value-based purchasing models. There are several value-based purchasing models Medicaid programs can implement. These are best described in the U.S. Department of Health and Human Services (DHHS) and the Health Care Payment Learning and Action Network (LAN) framework for value-based purchasing. The framework describes Alternative Payment Models (APM) that are meant to align with public and private stakeholders in the shared goal of shifting away from the current Fee-For-Service (FFS), volume-based payment system to a model that pays for value. Figure 6 describes the LAN APM categories. Currently, North Dakota Medicaid is in Category 1.

Figure 6: *LAN APM Model*

A 2018 Health Care Payment LAN APM study revealed the following:

- 39.1% of health care dollars in Category 1
- 25.1% of health care dollars in Category 2
- 35.8% of health care dollars in a composite of Categories 3 & 4

The results highlight a continued movement away from a fee-for-service system that reimburses only on volume, and towards value-based purchasing APMs. In North Dakota, commercial insurers as well as Medicare have made more progress moving to higher categories than Medicaid. For example, Blue Cross Blue Shield of North Dakota has the Blue Alliance program which is a tiered APM system and there are seven areas in the State that participate in a Medicare ACO program.[6]

B. North Dakota Medicaid Current Models

The current delivery of care model for the traditional North Dakota Medicaid population is generally a FFS payment model. The Medicaid agency establishes the FFS reimbursement rates for covered services and pays participating providers directly for each service provided to Medicaid members. In a FFS payment model the providers do not bear any finical risk and they receive full payment for delivering the service regardless of the outcome. In the FFS delivery of care model, there is no organized

[6]http://www.longtermscorecard.org/~/media/Microsite/State%20Fact%20Sheets/North%20Dakota%20Fact%20Sheet.pdf

provider network or coordinating entity.

North Dakota's Medicaid Expansion population receives care though a private managed care organization (MCO). The MCO is a health plan that contracts with the State to provide members with a set of Medicaid benefits for a prospectively set per member per month premium. The MCO is a comprehensive risk-based MCO that has both clinical and financial accountability for covered services provided to its members during their period of enrollment. The flow of funds in a risk based MCO arrangement is the State agency pays the MCO the negotiated per member per month premium times the number of enrollees then the health plan negotiates and pays providers directly through a FFS arrangement or a APM. Currently, the contracted managed care organization pays FFS.

In fall 2020, North Dakota Medicaid along with its stakeholders began exploring different value-based purchasing models. A working group of primary care providers is investigating the Health Homes model for beneficiaries with chronic conditions.

A working group of inpatient providers, including large hospitals and three large critical access hospitals, are investigating the following value-based purchasing delivery of care models through presentations and discussions.

C. Value-Based Purchasing Program for Hospitals

1. Episodes of Care

Episodes of Care is a value-based purchasing model that focuses on the total cost of care related to an episode. Providers or facilities that can deliver an episode below the benchmark cost can share in the realized savings. Providers or facilities that deliver an episode above the benchmark cost may be required to reimburse the State for the loss. Episodes are defined by a triggering event and may include services that are delivered pre and post the triggering event. Examples of triggering events are knee replacement surgery or emergency department visit related to asthma. Episodes are defined by the timeframe and settings. Building on the knee replacement example, the episode could

include post-acute rehabilitation provided by a physical therapist who may or may not be employed by the same health system as the physician financially responsible for the bundle. Clinical expertise is required to define an episode and several state Medicaid programs have their defined bundles available online such as Arkansas and Tennessee.

Benchmarks are needed for each episode so that facilities and providers understand not only what the clinical expectations are, but also the expected total costs. Providers bill the Medicaid program like they normally do under fee-for service. They are not paid in advance for the episode. At the end of the reporting period, typically one year, a reconciliation occurs, and the facility's total costs are compared to the benchmark. If the facility or provider manages the patient's care well and provides full care for less than the benchmark than the facility or provider can share the upside savings. If the cost of care exceeds the benchmark, no additional reimbursement will be received from Medicaid and in some states the facility or provider must pay the state back for the loss. To ensure patient care does not decline in the Episode of Care model, facilities or providers are required to meet specific minimum quality thresholds to ensure cost is not the only consideration while managing members' care.

2. Pay-for-Performance

Pay-for-Performance (P4P) is a delivery of care model that focuses on improving the quality and efficiency of care by incentivizing providers to report on and in some cases improve their performance. The P4P payment model attaches financial incentives and disincentives to provider performance by tying reimbursements to metric-driven outcomes, proven best practice, and patient satisfaction. This allows payers to align payments with outcomes and provider performance. P4P is the most common payment model used to drive quality and add value to health care programs across all types of payers. As a result, providers are often subject to more than one set of performance measures that may or may not conflict with one another. Additionally, P4P programs need to address the social determinant of health by including health equity measures to produce fair provider comparisons and reward providers who performance will among socioeconomically disadvantaged patient populations to offset the additional financial

risk associated with care for these groups.

During value-based discussions with hospitals, Wisconsin Medicaid presented on its P4P program. For instance, the goal for the measurement year 2020, is to reduce FFS Potentially Preventable Readmissions (PPR) in the Wisconsin Medicaid Program by 7.5 percent. A withhold of 3 percent of inpatient, FFS claims will be applied for the Withhold P4P, which will apply to claims with dates of service from 1/1/2020 to 12/31/2020. Withheld funds will be returned to hospitals consistent with the incentive/penalty methodology, and payouts will occur based on 2020 performance.

3. Accountable Care Organizations

An Accountable Care Organization (ACO) is a network of doctors and hospitals that share financial and medical responsibility for the health care delivery and outcomes to a defined attributed population. Providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency. In an ACO there is a shared risk arrangement that includes both incentives payments based on quality performance, as well as shared savings. The structure of an ACO requires significant time, energy, and resources to develop. For rural areas, providers may need to seek out appropriate partnerships to participate fully in ACO models.

During value-based discussion with hospitals, Caravan Health presented on its ACO program that is operational in seven areas in North Dakota. This program is financed through Medicare.

4. Value-Based Purchasing Models: Pros and Cons

Based on the presentations and a review of literature, the following table describes the pros and cons for each value-based purchasing program that was reviewed.

VBP Programs	Pros	Cons
Episode of Care	▪ Potential to improve coordination among multiple caregivers ▪ Ability to support flexibility in how and where care is delivered ▪ Incentive to efficiently	▪ Need clinical input on episodes ▪ Patient behavior could impede results ▪ Providers may not want to coordinate pre and post trigger care

	manage an episode (reduce treatment/manage costs) ▪ Simplicity from a billing perspective and no provider reporting required ▪ Clear accountability for care for a defined episode ▪ Can be done with small facilities/ populations	
P4P	▪ Potential to improve coordination among multiple caregivers ▪ Ability to support flexibility in how and where care is delivered ▪ Incentive to efficiently manage an episode (reduce treatment/manage costs) ▪ Simplicity from a billing perspective (one bill instead of many) ▪ Clear accountability for care for a defined episode	▪ Difficulty of defining the boundaries of an episode (what care falls within and outside of the episode) ▪ Potential to increase barriers to patients' choice of provider and/or geographic preferences for care accountability for care for a defined episode
ACO	▪ It creates better communication throughout the entire exchange ▪ There are cost advantages to consider when joining an ACO ▪ It provides an opportunity to offer more comprehensive care ▪ Physician-driven treatment ▪ There is already evidence to suggest that the ACO model can be successful It can eliminate extra expenses for the patient ▪ There is full availability of a patient's medical history	▪ The cost of the IT infrastructure can be daunting to medical providers ▪ Sharing everything means that you also concede some decision-making opportunities ▪ There can be challenges with data security for your patients ▪ Medical providers must start to adapt to new ways of doing things ▪ There will be more patients that come through your medical practice ▪ ACOs do not offer a guarantee of success ▪ There is a time element to consider with ACOs ▪ Difficult implementation;

		for organizations that are already using some sort of EMR this task could be easier, but for those who have not then the financial and resource cost could prove to be more than a practice is willing to incur

Table 4: *Pros and Cons Table for VBP Models*

4. Survey Results

North Dakota Medicaid administered a Value-Based Purchasing (VBP) Model Survey to North Dakota Hospital Association (NDHA) members who attended the three VBP presentations that were hosted by North Dakota Medicaid. NDHA members were informed during the presentations that States that incorporate a VBP model into their Medicaid program can increase quality and possibly reduce or maintain costs. DHS administered the survey to understand NDHA member's preferred VBP model. DHS received a total of seven surveys from both Prospective Payment System (PPS) Hospitals and Critical Access Hospitals (CAHs). The six PPS Hospitals that submitted the survey were: Essentia, CHI St. Alexius, Altru, and Trinity. Sanford Bismarck and Sanford Fargo did not complete the survey. The three participating CAHs responded to the survey.

VBP Models	Top Pro	Top Con
Episode of Care	No changes to current billing procedures	If cost is above an acceptable threshold, the provider owes a payment back to the state.
Pay-For-Performance	Simplicity from a billing perspective (one bill instead of many).	Any non-claims based measures will take additional funds to calculate.
Accountable Care Organization	Provides an opportunity to offer more comprehensive care.	Number of patients in the ACO - fewer Medicaid patients can mean more difficulty for providers to manage care and spread risk.

Table 5: *VBP survey results for Top Pros and Top Cons*

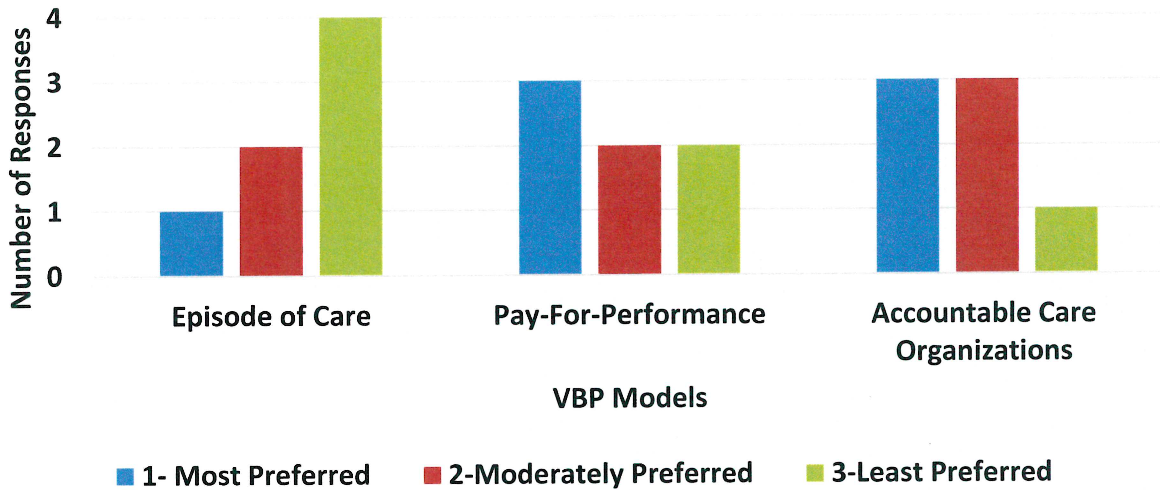


Figure 7: VBP survey result for Question 1

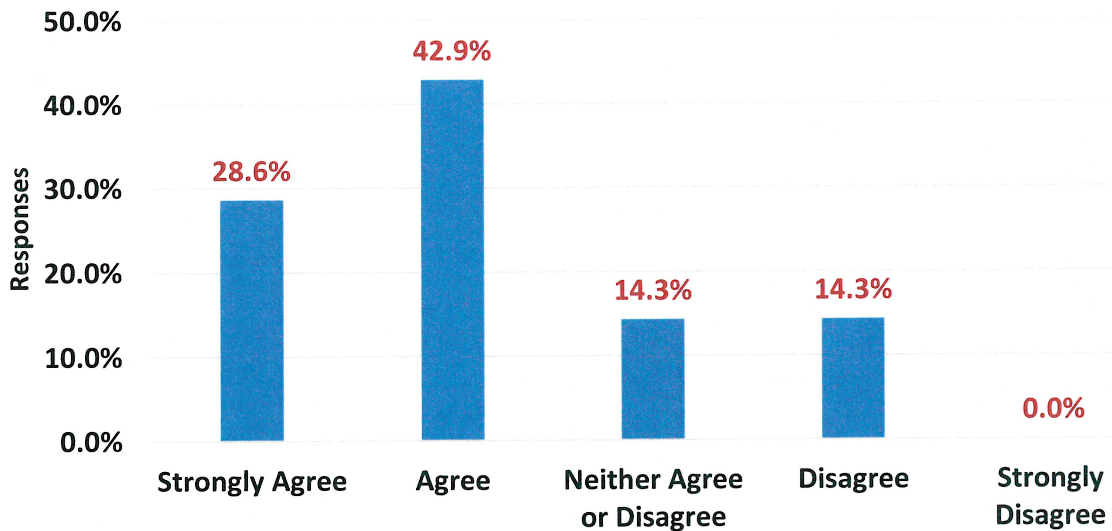


Figure 8: VBP survey result for Question 10

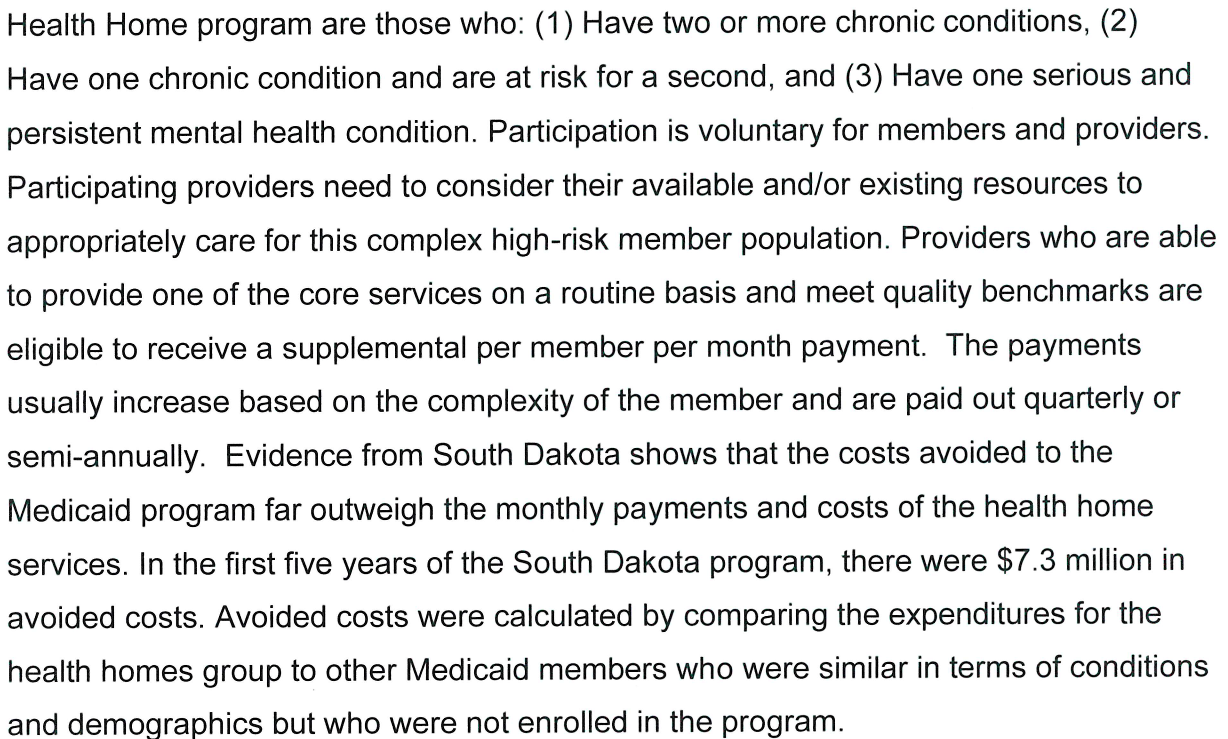
D. Value-Based Purchasing Model for Primary Care

The current delivery of care model using for primary care services in North Dakota Medicaid is the Primary Care Case Management (PCCM), which is a managed FFS arrangement with an additional $2 per member per month management fee. The PCCM model requires primary care providers to provide, locate, coordinate and monitor primary care service for Medicaid members.

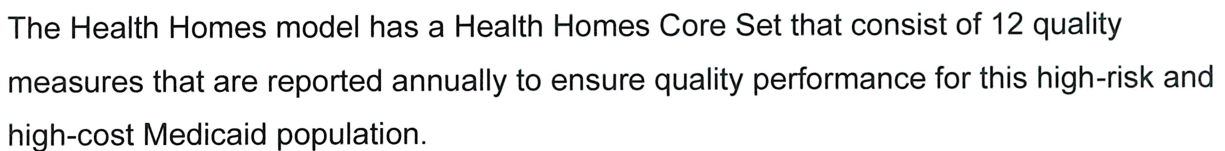
PCCM requires each traditional Medicaid member to choose a primary care provider, or if they do not, one is chosen for them. Primary care providers must provide referrals and approve acute, non-emergency care in inpatient settings. Although the PCCM program has been in place for some time, there is concern with the $2 incentive, the rules related to attribution, and the lack of effectiveness. In 2020 North Dakota Medicaid hosted presentations from several states on models for primary care other than PCCM. South Dakota, Connecticut, and Alabama presented on their programs and stakeholder feedback indicated that Health Homes which were presented by South Dakota were a model that North Dakota Medicaid should further explore. A working group was established to discuss the model, the parameters that need to be decided, and possible chronic conditions to target.

1. Health Homes

The Health Homes model, authorized in Section 1945 of the Social Security Act, is designed to coordinate healthcare and social services for Medicaid members with chronic conditions, including behavioral health conditions. Health Homes emphasize a whole-person approach for high-risk Medicaid members with chronic conditions through the integration and coordination of primary, acute, behavioral health, and long-term services and support. The Health Home services include: (1) Comprehensive Care Management, (2) Care Coordination, (3) Health Promotion, (4) Comprehensive Transitional Care and Follow-Up, (5) Patient and Family Support, and (6) Referral to Community and Social Support Services. The goals of Health Homes are to reduce the cost of care and improve quality. This is typically accomplished by reducing emergency department use, hospital admissions, and re-admissions of member with chronic conditions through improved disease management. Medicaid members eligible for the



Health Home program are those who: (1) Have two or more chronic conditions, (2) Have one chronic condition and are at risk for a second, and (3) Have one serious and persistent mental health condition. Participation is voluntary for members and providers. Participating providers need to consider their available and/or existing resources to appropriately care for this complex high-risk member population. Providers who are able to provide one of the core services on a routine basis and meet quality benchmarks are eligible to receive a supplemental per member per month payment. The payments usually increase based on the complexity of the member and are paid out quarterly or semi-annually. Evidence from South Dakota shows that the costs avoided to the Medicaid program far outweigh the monthly payments and costs of the health home services. In the first five years of the South Dakota program, there were $7.3 million in avoided costs. Avoided costs were calculated by comparing the expenditures for the health homes group to other Medicaid members who were similar in terms of conditions and demographics but who were not enrolled in the program.



The Health Homes model has a Health Homes Core Set that consist of 12 quality measures that are reported annually to ensure quality performance for this high-risk and high-cost Medicaid population.

2. Health Homes Core Set Cross Walk

Crosswalk Medicaid Quality Measures

Measure	Measure Abbreviation	Health Homes	Adult Core Set	Child Core Set	Blue Alliance	Medicare Shared Savings	Data Collection Method	Measure Steward
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	IET	X	X		X		Administrative or EHR	NCQA
Controlling High Blood Pressure	CBP	X	X		X	X	Administrative, hybrid, or EHR	NCQA
Screening for Depression and Follow-Up Plan	CDF	X	X	X	X	X	Administrative or EHR	CMS
Follow-Up After Hospitalization for Mental Illness	FUH	X	X	X			Administrative	NCQA
Plan All-Cause Readmissions	PCR	X	X		X*		Administrative	NCQA
Use of Pharmacotherapy for Opiod Use Disorder	OUD	X	X				Administrative	CMS
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	FUA	X	X				Administrative	NCQA
Adult Body Mass Index Assessment	ABA	X	X				Administrative or hybrid	NCQA
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite	PQI92	X					Administrative	NCQA
Admission to an Institution from the Community	AIF	X					Adminsitrative	CMS
Ambulatory Care: Embergency Department (ED) Visits	AMB	X			X		Administrative	NCQA
Inpatient Utilization	IU	X					Administrative	CMS

Figure 7: *North Dakota Medicaid's Roadmap to Drive Quality*

E. The Future of Quality in North Dakota Medicaid

The purposes of this document are to outline North Dakota Medicaid's current quality of care, present Medicaid's Quality Strategy, and describe models that can be pursued in the future that will transition the State from fee-for-service to value based purchasing. The figure below depicts this journey to improve the quality of care for Medicaid members and ensure that the State is a good steward of taxpayer dollars by purchasing the highest value care.

Road Map

HOSPITALS

- Research value-based payment models that could be implemented for ND Medicaid.
- Hold regular meetings with ND Hospitals and the ND Hospital Association
- Select the best value-based payment program for ND Medicaid

PRIMARY CARE

- Establish a Health Homes program to coordinate care for Medicaid members with chronic conditions.
- Review Quality Measure Crosswalk

PLANNING

- Develop ND Medicaid Quality Strategy
- Meet with Hospitals and primary care stakeholders
- Plan to report more Child and Adult Quality Core Measures

Figure 8: *North Dakota Medicaid's Roadmap to Drive Quality*

III. Conclusion

The North Dakota Quality Strategy is a living document that will continue to evolve as key health care stakeholders, as well as the executive and legislative branches, invest in and insist on high quality of care for Medicaid members. North Dakota can realize high quality for Medicaid members through cross-sector collaboration as multiple agencies and providers serve the same population. This critical collaboration will lead to investments and results that build a comprehensive quality program that will drive better health outcomes and promote a healthier population. North Dakota Medicaid, along with its partners, is committed to the quadruple aims of healthier populations, better outcomes, smarter spending, and better experiences.

Appendix 1: Child and Adult 2020 Core Sets

2020 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)*	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)*	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	Administrative or hybrid
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448**	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	Administrative or hybrid
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	Administrative or hybrid
Maternal and Perinatal Health			
0471	TJC	PC-02: Cesarean Birth (PC02-CH)	Hybrid
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1517**	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)*	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)*	Administrative
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)****	Administrative
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)*	Administrative
Dental and Oral Health Services			
2508**	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Administrative
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)

NQF #	Measure Steward	Measure Name	Data Collection Method
Experience of Care			
NA****	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

* This measure was modified for the 2020 Core Set. The Counseling for Nutrition and Counseling for Physical Activity indicators were added to this measure for the 2020 Child Core Set. Prior Core Sets included only the Body Mass Index (BMI) Percentile Documentation indicator.

** This measure is no longer endorsed by NQF.

*** This measure was added to the 2020 Child Core Set. More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

**** The Child Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006).

^ This measure is part of the Behavioral Health Core Set. The complete list of 2020 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf.

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)	Administrative or hybrid
Maternal and Perinatal Health			
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)^	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)^	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)^	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)^	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)^	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)^	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)^	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)**^	Administrative

NQF #	Measure Steward	Measure Name	Data Collection Method
3488***	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)^	Administrative
3489***	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)^	Administrative
NA****	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)^	Administrative
Experience of Care			
NA*****	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	Survey
Long-Term Services & Supports			
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)**	Survey

* This measure is no longer endorsed by NQF.

** This measure was added to the 2020 Adult Core Set. More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

*** The NQF number for the FUA-AD and FUM-AD measures was previously listed as 2605. These measures now have separate NQF numbers but are the same measures included in the FFY 2019 Adult Core Set.

**** The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879).

***** The Adult Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006).

^ This measure is part of the Behavioral Health Core Set. The complete list of 2020 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

References

History of Quality 2009 didn't have any directive at national level to come up with quality strategy chipper legislations, CHILD and Adult □ Score Card (2009-present)
Link for score card (how many submit) show measures direct them with links
https://www.macpac.gov/wp-content/uploads/2020/03/State-Readiness-to-Report-Mandatory-Core-Set-Measures.pdf

16 Pros and Cons of Pay for Performance Healthcare. Vittana. 2020. Retrieved on November 4, 2020, from https://vittana.org/16-pros-and-cons-of-pay-for-performance-healthcare