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Jack Dalrymple, Governor  
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September 2, 2015

Mr. Scott Davis  
Nd Indian Affairs Commission  
600 E Boulevard Avenue  
Bismarck ND 58505

Dear Mr. Davis:

This letter is regarding the Tribal Consultation between the North Dakota Department of Human Services and the North Dakota Indian Tribes. The consultation process was established to ensure Tribal governments are included in the decision making processes when proposed changes in the Medicaid or Children's Health Insurance Program(s) will directly impact the North Dakota Tribes and/or their Tribal members.

On February 4, 2009, President Barack Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA). Since that time the North Dakota Department of Human Services has been working with the Centers for Medicare and Medicaid Services (CMS) to implement the CHIPRA requirements.

This letter is specific to Managed Care Regulations at 42 Code of Federal Regulations (CFR) 438 relating to the Children's Health Insurance Program (CHIP), also known as Healthy Steps in North Dakota. The changes being implemented may directly impact the North Dakota Tribes or Tribal members by ensuring higher standards of quality for children enrolled in the Healthy Steps insurance plan. The intent of this change is to monitor quality within the Healthy Steps insurance plan.

This letter serves as prior notice of the proposed changes. The effective date of the proposed quality assurance strategy change is October 31, 2015. If you have any comments, questions or concerns, please contact Jodi Hulm, CHIP Administrator, Medical Services Division at [jmhulm@nd.gov](mailto:jmhulm@nd.gov), mailing a written response to 600 East Boulevard Avenue, Department 325, Bismarck, ND 58505 or by calling 701.328.2323. Please provide all input by October 1, 2015.

The Department appreciates the continuing opportunity to work collaboratively with The North Dakota Tribes to achieve the Department's mission, which is: "To provide quality, efficient, and effective human services, which improve the lives of people."

Sincerely,

A handwritten signature in black ink that reads "Maggie D. Anderson". The signature is fluid and cursive, written over a light blue horizontal line.

Maggie D. Anderson  
Executive Director

enclosure

THIS IS A DRAFT NORTH DAKOTA HEALTHY STEPS QUALITY STRATEGY PLAN AND IS SUBJECT TO CHANGE BASED ON THE REQUIRED OPEN PUBLIC COMMENT PERIOD AND CMS REVIEW.

North Dakota Healthy Steps  
Quality Strategy Plan



08-30-2015

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# **North Dakota Healthy Steps Quality Strategy**

## **Quality Strategy Introduction and Overview**

“Healthy Steps” is North Dakota’s Children’s Health insurance program (CHIP). Healthy Steps is delivered by a managed care organization. The State of North Dakota Department of Human Services Medical Services Division is required to develop and maintain a (CHIP) Quality Strategy, with requirements specified in 42 CFR 438.202. The Medical Services Division takes this opportunity to assess past and current quality efforts and build a cohesive quality strategy encompassing the division’s goals, objectives, interventions, and ongoing evaluation.

The Quality Strategy is comprehensive, systemic, and continuous. It will be amended as necessary to support the continuous quality improvement process, to reflect changes from state, federal or other regulatory authority, and to respond to any significant changes in membership or provider demographics. The purposes of the strategy include:

- Monitoring that the services provided to enrollees conform to professionally recognized standards of practice and code of ethics, and are culturally appropriate;
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, enrollee, stakeholder and provider satisfaction with care and service, safety, and equitability;
- Providing a framework for the division to guide and prioritize activities related to quality; and
- Assuring that an information system is in place to support the efforts of the quality strategy.

## **Mission**

The Quality Strategy supports the mission of the North Dakota Department of Human Services, which is:

**To provide quality, efficient and effective human services, which improve the lives of people.**

The Medical Services Division will ensure that its clients receive high quality care by providing effective oversight of managed care organizations (MCOs) and other contracted entities to promote accountability and transparency for improving health outcomes. A MCO is defined as a healthcare provider or a group or organization of medical service providers who offers managed care health plans. The Medical Services Division has adopted a framework of quality and strives for our clients to receive care that is:

- Safe – prevents medical errors and minimizes risk of patient harm;
- Effective – evidence-based culturally appropriate services consistently delivered to the population known to benefit from them;
- Efficient – cost-effective utilization that avoids waste, duplication of services, including waste of equipment, supplies, ideas, and energy;

- Patient-centered – respectful of and responsive to individual enrollee preferences, needs, and values;
- Timely – medically appropriate access to care and healthcare decisions with minimal delay; and
- Equitable – providing programs/services and care without variation in quality due to gender, race, ethnicity, geography, and socioeconomic status.

### ***Guiding Principles and Expected Outcomes***

The guiding principles and expected outcomes have been developed and include the following:

- Improved coordination of care and services;
- Better health outcomes;
- Increased quality of care as measured by metrics, such as the Healthcare Effectiveness Data and Information Set (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;
- A 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; and
- Improved access to culturally appropriate services.

### ***Development & Review of Quality Strategy***

Prior to adopting it as final, the Quality Strategy Plan will be made available for public comment. The Quality Strategy Plan will be placed on the State's website at [www.nd.gov/dhs/info/pubs/medical.html](http://www.nd.gov/dhs/info/pubs/medical.html) and indicating a 30-day period for public input. Suggested revisions to the proposed Quality Strategy Plan and improvement goals will be considered as appropriate prior to submission of the final draft to the Centers for Medicare and Medicaid Services (CMS). Following approval, any amendments to the Quality Strategy Plan will be shared with CMS. The final Quality Strategy Plan will also be published on the State's website and will be available for ongoing public review and comment.

The Quality Strategy Plan will be reviewed and revised **annually** by the Quality Strategy Leadership Team (Leadership Team) and MCOs. This process will include workgroups that will establish strategic partnerships among stakeholders to obtain input on the State's quality assessment and improvement strategies.

The Leadership Team is a multidisciplinary group with representation from various program administrators within the Medical Services Division. Input is also incorporated from the External Quality Review Organization (EQRO), partner government agencies, providers, clients,

and advocates; all providing information useful in identifying quality activities important to the Healthy Steps population. The Medical Services Division has the overall responsibility for the quality oversight process that governs all Healthy Steps recipients. The Leadership Team serves as the unifying point by tracking trends and reporting information from MCOs and providing recommendations for improvement and corrective action.

### ***Clinical Practice Guidelines***

The application of evidence-based clinical practice guidelines has proven to reduce variation in treatment, resulting in improved quality. MCOs shall have the capability and established procedures that allow for utilization management based on:

- The application of evidence-based clinical practice guidelines and documentation that supports the medical necessity and appropriateness of setting;
- Consideration of unique factors associated with each patient care episode;
- Local healthcare delivery system infrastructure; and
- Clinical experience, judgment, and generally accepted standards of healthcare.

The use of evidence-based clinical practice guidelines and medical necessity criteria is expected, and guidelines must be based upon valid and reliable clinical evidence given the needs of the enrollees. The guidelines can be adapted or adopted from national professional organizations or developed in a collaborative manner with community provider input. All practice guidelines must be adopted in consultation with contracting healthcare professionals and reviewed and updated in a clinically appropriate manner. Clinical guidelines are expected to represent the range of health care needs serviced by the Healthy Steps population.

The application and definition of “medically necessary” is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions that are both medical and nonmedical and is required to meet the following North Dakota Administrative Code (NDAC) 75-02-02-03.2:

“Medically necessary” includes only medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the patient’s diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the patient or provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective.

MCOs will use clinical care standards and/or practice guidelines to objectively evaluate the care MCOs delivers, or fails to deliver, for the targeted clinical conditions. MCOs will utilize evidence-based clinical guidelines and identify the source of the guidelines. These clinical care standards and/or practice guidelines will be adopted by MCOs Quality Assurance/Quality Improvement (QA/QI) Committee. All clinical practice guidelines will be available to providers,

members, and potential members upon request. MCO clinical practice guidelines will be used to inform their coverage decisions, utilization management, and member educational activities.

MCOs are responsible for adopting, disseminating, and using clinical practice guidelines to the full range of covered services to support the program initiatives. The guidelines must stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified providers from appropriate specialties and, prior to adoption, have been reviewed by MCO Medical/Dental Director as well as other MCO practitioners and network providers, as appropriate.

Guidelines shall consider the needs of enrollees and be reviewed and updated, as appropriate, at least every two years. In addition, MCOs must develop explicit processes for monitoring adherence to guidelines, including ensuring that decisions regarding utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The Medical Services Division shall review the following:

- Quality Assurance/Quality Improvement (QA/QI) Plans and Evaluations of the previous year's activities;
- Utilization Management (UM) Plans, Practice Guidelines, and Evaluations; and
- Performance and Improvement Projects (PIPs) proposals and reports.

### ***ND Healthy Steps Internal Monitoring & Contract Compliance***

The success of the Quality Strategy Plan requires effective implementation and contract compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). The State will monitor contract compliance of the Quality Strategy Plan through routine reporting requirements, regular meetings with MCOs, and ongoing communications as appropriate and necessary. To ensure that the Quality Strategy Plan continues to embody the vision and values of the State, the Quality Strategy Plan will undergo reviews and updating as appropriate. The implementation and compliance standards of the Quality Strategy Plan will be measured, monitored, and evaluated by internal and EQRO monitoring. Monitoring activities will:

- Detect potential areas for improvement;
- Issue early warning of problems, fraud, and abuse; and
- Confirm that MCO contract compliance and the standards are being appropriately implemented.

### **Quality Flow Process**

The Healthy Steps Administrator from the Medical Services Division receives and reviews all monitoring and quality reports from the MCOs and the EQRO. Standardized reporting and review tools have been developed to allow for improved oversight and trending over time.

The Quality Strategy Leadership Team will review all findings from the reports. The Leadership Team will analyze the data received, root causes, barriers, and improvement interventions and provide feedback to the MCO. Corrective action will be requested, if needed. Findings and recommendations will be adequately documented for public review.

Semi-annually, the Leadership Team will meet collaboratively with the MCO. These meetings will allow an opportunity for dialogue, feedback, follow-up of corrective actions, and PIPs, exchange of information, and identification of effective practices.

### ***External Quality Review***

The State has contracted with an EQRO to perform, on an annual basis, an external, independent review of quality outcomes of timeliness and access to the services provided to Healthy Steps enrollees, as outlined in 42 CFR 438, Subpart E.

The External Quality Review (EQR) report will provide detailed information regarding the regulatory compliance of the Healthy Steps program as well as results of PIPs and performance measures (PMs). The EQR report results will provide information regarding the effectiveness and performance of MCOs by identifying strengths and weaknesses and by providing information about opportunities for improvement or problems. This information will be utilized for modifications to the Quality Strategy Plan and for the development and advancement of quality improvement projects.

The EQRO must meet the competency and independency requirements detailed in 42 CFR 438.354. To ensure competency, the EQRO must have staff with demonstrated experience and knowledge of the Medicaid program, managed care delivery systems, quality management methods, and research design and statistical analysis. The EQRO must have sufficient resources to conduct needed activities and other skills necessary to carry out activities or supervise any subcontractors. To ensure independence, the EQRO must not be: an entity that has Medicaid purchasing or managed care licensing authority; governed by a body in which the majority of its enrollees are government employees; reviewing a MCO in which the EQRO has a control position or financial relationship by stock ownership, stock options, voting trusts, common management, or contractual relationships; delivering any services to Medicaid recipients or conducting other activities related to the oversight of the quality of the case management services, except for those specified in 42 CFR 438.358. EQROs are permitted to use subcontractors; however, the EQRO is accountable for, and must oversee, all subcontractor functions, as mentioned in 42 CFR 438.356(c).

The EQR report will be conducted by the EQRO with the advice, assistance, and cooperation of a planning team composed of representatives from MCOs, the EQRO, and State with final

approval by State. The MCO shall:

- Designate an individual to serve as a liaison with the EQRO for routine communication with the EQRO.
- Designate a minimum of two representatives (unless one individual can serve both functions) to serve on the planning team for each PIP. Representatives will include a quality improvement representative and a data representative. The planning team is a joint collaboration between State staff, the EQRO, and MCO. The role of the planning team is to participate in the process and completion of focused studies.
- Be responsible for obtaining copies of enrollee information and facilitating on-site access to enrollee information as needed by the EQRO. Such information will be used to plan the EQR. Any associated copying cost is the responsibility of MCO. Enrollee information includes: medical records, administrative data such as enrollment information and claims, nurses' notes, medical logs, etc. of MCO or its providers.
- Provide enrollee information in a mutually agreed upon format compatible for the EQRO's use, and, in a timely fashion, allow the EQRO to select cases for its review.
- Provide data requests to the EQRO within 15 working days of the written request from the EQRO and provide medical records that meet the requirements of 42 CFR 456.111 and 42 CFR 456.211 within 30 working days of the written request from the EQRO. Requests for extensions of these time frames will be reviewed and approved or disapproved by State on a case-by-case basis.
- Assure that the EQRO staff and consultants have adequate work space and access to a telephone and copy machines at the time of review. The review will be performed during agreed-upon hours.
- Assign appropriate personnel to assist the EQRO personnel during on-site visits and to participate in an informal discussion of screening observations at the end of each on-site visit, if necessary.
- For information received from the EQRO, MCO will comply with the Department of Health and Human Services regulations relating to confidentiality of data and information.

The EQRO is responsible to perform mandatory and optional activities as described in 42 CFR 438.358. **Mandatory activities** for each MCO include:

- Validation of PIPs;
- Validation of performance measures reported as required by the State of North Dakota;
- A review, conducted within the previous three year period, to determine compliance with standards established by the State with regards to access to care, structure and operations, and quality measurement and improvement; and
- Preparation of an EQRO report for each Medicaid managed care plan.

**CMS Optional EQRO** activities that the State has elected to have the EQRO perform include:

- Validation of encounter data reported by MCO;
- Administration or validation of enrollee or providers survey on quality of care;
- Calculation of ND performance measures in addition to those reported by MCO and validated by an EQRO;
- Conduct PIPs in addition to those conducted by MCO and validated by an EQRO; and
- Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

For the EQR activities conducted, the State's EQRO will submit an **annual** detailed report that describes data aggregation and analysis and the conclusions that were drawn regarding the quality, timeliness, and access to the care furnished by MCO adherent to the CMS protocols found in 42 CFR 438.364 for EQR reports. The EQRO report will include:

- An overview of MCO activities, including:
  - A description of the manner in which MCO data was aggregated and analyzed;
  - The conclusions drawn from the data on the quality, timeliness, and access to care provided by the MCO;
  - For each MCO activity reviewed, the EQRO will address:
    - The objective of the MCO activity and the objective of the EQRO oversight function;
    - The technical methods of data collection and analysis;
    - A description of the data obtained; and
    - The conclusions drawn from the data;
  - An assessment of each MCO's strengths and opportunities for improvement;
  - Recommendations for improving quality of health services;
  - Comparative information across MCO programs; and
  - An evaluation of how effectively MCOs addressed the improvement recommendations made by the EQRO the prior year.

Each EQRO report will also include: information on trends in MCO health plan enrollment, provider network characteristics, complaints and grievances, identification of special needs populations, trends in utilization, statements of deficiencies, and other on-site survey findings and financial data, in addition to the scope of work outlined above on projects, performance measures, the quality of the encounter data, and any requested EQRO measures or focused clinical study findings. The EQRO will then compile an executive summary of each MCO, including a summary of MCO's strengths and weaknesses. The executive summary and full report will be made available on the North Dakota Department of Health and Human Services Medicaid public website.

The State will use the annual report to determine whether to apply sanctions or take other corrective action as designated in a MCO contract to evaluate existing program goals and

inform new program goal development. The State will also use the report to inform a MCO of any needed contract amendments or revisions.

The EQRO will meet these obligations by utilizing the EQR protocols developed by CMS to perform the mandatory activities required of EQROs, as mentioned in 42 CFR 438.352 and 438.358, including: data to be gathered, data sources, activities to ensure accuracy, validity and reliability of data, proposed data analysis, and interpretation methods and documents and/or tools necessary to implement the protocol. The State will ensure the EQRO has sufficient information for the review from the mandatory and optional EQR-related activities described in the regulation, as mentioned in 42 CFR 438.350. This information will be obtained through methods consistent with established protocols and protections, includes the elements described in the EQR results section, and results will be made available, as specified in the regulation.

The Medical Services Division's quality approach aspires to the following:

### **Collaborative Partnerships**

To a large extent in North Dakota, the same providers deliver health services to enrollees who have public or private health insurance. Improving the quality of healthcare for Healthy Steps enrollees means improving the care for all North Dakota residents and requires collaboration among State Agencies, MCO's and private sector stakeholders. Quality measures alignment among CHIP, Medicaid and private health plans would promote evidence based care, simplify reporting and measurement for providers, and allow for an easier and more transparent comparison for enrollees. Measures will be evidence-based and follow the technical specifications outlined by the Centers for Medicare and Medicaid Services (CMS).

### **Transparency**

The Medical Services Division is committed to making information readily available to the public. Information about performance measures, including satisfaction, access, immunization, dental, behavioral health, etc., will be available through public reporting. In addition, the Medical Services Division will include a quality section in the North Dakota Department of Human Services annual report.

### **Access**

Ensure and support efforts to remove any barriers to health services and resources.

### **Cultural and Linguistic Competence**

Ensure that members have access to culturally appropriate services that are responsive and accessible to a diverse population. The State requires that MCO and any contractors have translation services for those who speak **any** foreign language.

### **Integrity**

Perform responsibilities with confidentiality, honesty, sincerity, courtesy and the highest quality of ethical and professional conduct.

## **History of Managed Care**

The rationale for the State of North Dakota to implement managed care for the CHIP population is improved access, quality and cost-efficiency. Using managed care systems improves the care delivered to CHIP enrollees by improving coordination of care, consistent application of managed care principles, high quality assurance programs, partnerships with providers, reduced stigma, and achieving cost-effective service delivery.

## **Objectives**

The Medical Services Division is focused on ensuring that clients receive high quality care that is safe, effective, efficient, patient-centered, timely, and equitable, by providing effective oversight of the health plan and to promote accountability and transparency for improving health outcomes.

Program Initiative Objectives:

- The MCO should aim to meet or exceed a two percentage point improvement each year for the next three years in the number of children receiving preventative dental services.
- The MCO should aim to meet or exceed the well child visit 2012 Medicaid national benchmark of 49.58%. At a minimum, the MCO must demonstrate an annual two percentage point improvement, each year for the next three years in the number of children ages 12 - 18 years of age that are compliant with the recommended number of well-child visit either with a primary care provider or a Gynecologist.
- The MCO should aim to meet or exceed the well child visit 2012 Medicaid national benchmark of 71.93%. At a minimum, the MCO must demonstrate an annual two percentage point improvement, each year for the next three years in the number of children in the third, fourth, fifth and sixth years of life that are compliant with the recommended number of well-child visits.

## **Assessment**

The Medical Services Division must implement an effective Quality Improvement (QI) system that monitors, evaluates performance measurements and implements strategies to improve the quality of care delivered by health providers rendering services on its behalf, regardless of setting. The Medical Services Division is also accountable for demonstrating: evidence of an internal QI system that includes governing body participation in QI activities, designated QI committee(s) with oversight and performance responsibility, and is in the development and performance review of the QI system.

The Medical Services Division has established the following strategies to monitor access, appropriateness and quality of care provided by the MCO and their network providers:

### **Enrollee Race, Ethnicity and Primary Language Data**

Information about the race, ethnicity and primary language information of enrollees is collected by eligibility workers at local county social services offices and the state office during the Healthy Steps enrollment process. The information is self-reported by the individual on the application or redetermination form. County and state staff enter the information into the eligibility system along with the individual's other enrollment application information.

### **Clinical Standard and Guidelines**

The Medical Services Division uses clinical guidelines to guide its policy development. Guidelines are adapted or adopted from national professional organizations, such as the Centers for Disease Control/American committee on Immunization Practices from immunization recommendations, the American Academy of Pediatrics/Bright Futures for Early Periodic Screening Diagnosis and Treatment (EPSDT) periodicity of screening and diagnostic testing, and the American Academy of Pediatric Dentistry. The State and the MCO will use the 2013 CHIPRA Initial Core Set Technical Specifications Manual to pull all data.

### **Performance Measures**

Since CMS, in consultation with the States, has not mandated specific performance measures and topics for performance improvement projects (PIPs), the Medical Services Division has identified a set of performance measures and PIP topics that address a range of priority issues for CHIP enrollees. The measures have been identified through a process of analysis and trending data with the CHIP population, from MCO reports.

### **Regulatory Requirements and Contract Compliance**

Contract provisions established for the North Dakota Healthy Steps managed care plan incorporate specific standards for the elements outlined in 42 CFR 438.204: access to care, structure and operations, and quality measurement and improvement. Plans are responsible for communicating established standards to network providers, monitoring provider compliance and enforcing corrective actions, as needed.

- Access to care

The Provider Contractors and Education Consultants meet regularly with the large health systems as well as new clinics. And, our Member Services Division alerts them to any reported issues by enrollees. As issues arise, the MCO follows-up with the providers to provide the necessary education.

The MCO shall require that network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. The MCO shall ensure that services are available 24 hours a day, 7 days a week, when medically necessary.

The MCO shall request that network providers comply with the following benchmarks:

- Waiting Time for Appointments
- a. Primary Care Providers:
  - i. Within 21 calendar days for routine, non-urgent appointments
  - ii. Within 60 calendar days for school physicals
  - iii. Within 2 calendar days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)
- b. Specialist:
  - i. Within 30 calendar days for non-urgent care
  - ii. Within 2 calendar days for urgent, symptomatic, but not life-threatening care (care that can be treated in a doctor's office)

These benchmarks do not apply to appointments for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every three weeks.

- Provider Directory

Upon enrollment each enrollee will receive provider directories for health, dental and vision services. In addition, the enrollee can go to the MCO's website and obtain a list of participating providers. Enrollees may request and obtain a provider directory at anytime.

#### Enrollee Handbook

Every two years, the MCO must submit to the Medical Services Division the enrollee handbook for approval or, as needed, in order to comply with all Federal and State regulations. Upon enrollment, the MCO will mail the handbook on health, dental and vision, to each enrollee. The enrollees will also receive ID cards for the plans and a welcome letter.

At a minimum, the enrollee handbook must include the following information: a) enrollee services contact information; b) enrollee services; c) emergency services; and d) appeals process.

- Enrollee Satisfaction Survey (Consumer Assessment of Healthcare Providers and Systems CAHPS)

The MCO administers and analyzes the Consumer Satisfaction Survey each year. The survey is distributed annually to all families that have at least one child enrolled in the Healthy Steps plan. Survey results are compiled by the MCO and a final report is sent to the State.

- MCO Report Card

Annually, the MCO is required to compile a report card comparing the performance on selected measures. These measures will also be reported annually by the Medical Services Division to CMS.

- Health Information Technology

Data collection systems, such as registries, pay-for-performance tracking, profiling systems, electronic record information exchanges, regional Health Information Technology (HIT) collaborative activities, and telemedicine initiatives largely occur at the health plan level.

The Medical Services Division will continue to be a collaborative partner with the MCO and with providers and stakeholder groups to develop policies that support the adoption of HIT and health information exchange solutions to improve access and health care quality.

## **Improvement**

Interventions for improvement of quality activities are varied and based on the review and analyses of results from each monitoring activity. As results from assessment activities are produced, it is likely that the Medical Services Division will be able to further and more clearly define interventions for quality improvement as well as progress towards objectives.

### **State Agency Collaboration**

The Medical Services Division is in regular communication with other divisions and programs within the North Dakota Department of Human Services as well as the Department of Health. These include the Oral Health program, the Mental Health and Substance Abuse Division, the Maternal and Child Health Programs, and the Developmental Disabilities Division, among others. The MCO performance on measures may trigger discussion to collaborate on assisting the MCO in improving their performance. These programs often work together on common issues, such as early screening and intervention, mental health and access to dental care.

### **Performance Measure Validation**

Performance measures will be tracked and trended. The information will be used to focus future quality activities and direct interventions for existing quality activities. If the MCO is performing poorly in certain performance measures, they are expected to conduct root cause analyses and causal barrier analyses to identify appropriate interventions. The EQRO, in the review of the performance measures, may offer recommendations for improvements to the MCO and provide follow-ups to make sure that these recommendations are implemented.

- 1) Childhood Immunization Status
- 2) Immunizations for Adolescents
- 3) Well-Child Visits in the First 15 Months of Life
- 4) Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> Years of Life
- 5) Adolescent Well-Care Visit
- 6) Ambulatory Care - Emergency Department Visits
- 7) Follow-up Care for Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
- 8) Follow-up After Hospitalization for Mental Illness
- 9) Child and Adolescent Access to Primary Care Practitioners
- 10) Medication Management for People with Asthma
- 11) Human Papillomavirus (HPV) Vaccine for Female Adolescents
- 12) Total eligibles receiving Preventive Dental Services
- 13) Total eligibles who received a dental treatment service

### **Performance Improvement Projects**

A PIP is intended to improve the care, services, or member outcomes in a focus area(s) of study. The Medical Services Division selects certain PIP topics to be performed by the MCO. The current mandatory PIP topics for the MCO are focused on children's utilization of preventative dental services, and children's well-child checks.

For each PIP, the MCO will submit data to the State along with a complete description of the methodology used to pull the data, background information on the topic, timeframes, any barriers identified and interventions taken. All PIP(s) will be measured at least annually.

### **Frequency of Reporting**

As described above, the Medical Services Division is establishing an annual review of any findings and recommendations related to the Quality Strategy that are included in the EQRO's annual report. This annual review process will include tracking and follow up on any recommended action items. In addition, every three years the Medical Services Division will conduct a comprehensive review of the Quality Strategy and release an updated strategy.

### **Strategy Effectiveness**

In preparing the annual report, which includes and evaluation of the Medical Services Division implementation of its most recent Quality Strategy, the EQRO considers the following documentation:

- Plans annual HEDIS scores (reported to State in July)
- Plans PIP proposals and annual status reports (reported periodically throughout each year as determined by each PIP's schedule)
- Plans Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results each year when the survey is administered (survey is administered annually)
- Other relevant documentation

These documents and activities each have specific schedules and performance targets, which are discussed throughout this document.

To periodically update the Quality Strategy document, the Medical Services Division will convene a workgroup representing all program areas and also include the EQRO, as appropriate.

## **Achievements and Opportunities**

### **Achievements**

The plan will regularly guide reviewers and recommend corrective action/follow-up, additionally, it will, guide the Leadership Team, which will be an important step to ensuring the implementation of quality activities.

The Medical Services Division continues to promote and support ongoing efforts of transparency and sharing. There has also been significant improvement in the collaboration between the Medical Services Division and the MCO as well as between the Medical Services Division and other programs on quality activities. The institution of formal quality strategies on a regular basis will strengthen these collaborations and assure a forum for dialogue, review of interim results, follow-up of corrective action, sharing of effective practices, and identification of systems changes.

### **Challenges and Future Plans**

It will be important to continuously assess and revise the quality process to ensure the successful implementation of the Quality Strategy. In addition, performance measures and targets will be continuously evaluated to ensure that the measures meet appropriate populations and domains of care. Plans for the future include the establishment of performance measures and improvement activities for Medicaid children.

The Medical Services Division has had no standardization amongst programs, with each program implementing its own quality activities and forming silos within the Medical Services Division. The Quality Strategy will focus on quality activities for the whole division, informed from analyses of previous performance data and input from a variety of sources, breaking down barriers to promote quality efforts within the Medical Services Division.

With the Quality Strategy, the Medical Services Division will ensure the implementation of quality improvement process from reporting to systems improvement.