

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

North Dakota Medicaid Expansion Quality Strategy Plan



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Section 1: INTRODUCTION

Program Background

In the State of North Dakota (ND) the Medicaid program has historically been fee-for-service (FFS). However, through House Bill 1362, the 2013 ND Legislative Assembly *directed* the Department of Human Services (DHS) to expand medical assistance as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], to individuals under sixty five years of age with income below one hundred thirty eight percent of the federal poverty level, based on modified adjusted gross income. This included implementing the expansion by bidding through private carriers or using the health insurance exchange which ND DHS, hereinafter referred to as STATE, chose the option of utilizing a private carrier, hereinafter referred to as Managed Care Organization (MCO).

On December 20, 2013 the Center of Medicare and Medicaid Services (CMS) granted authority through a 1915(b) Waiver allowing the STATE to provide Medicaid Expansion as a Managed Care Organization (MCO) Program. This allowed having mandatory enrollment of individuals, including Native Americans, eligible for the Medicaid Expansion into a health plan offered by a MCO. As the STATE was only able to award one statewide MCO contract, to ensure compliance with Federal Medicaid Managed Care regulations requiring enrollees to have a choice of plans in the Metropolitan Statistical Areas the STATE submitted an 1115 Waiver with authority granted by CMS on February 26, 2014. This allowed having one health plan choice for those Medicaid Expansion enrollees residing in urban areas of the state.

For the Alternative Benefit Plan (ABP) the STATE chose the section 1937 benchmark option of the commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state. In addition, the ABP incorporates the Essential Health Benefits and ensures compliance with Mental Health and Substance Abuse parity.

The STATE began operating the ND Medicaid Expansion on January 1, 2014 and those enrolled in the MCO is solely limited to those individuals eligible in the new adult group.

Objectives & Overview

The North Dakota Medicaid Quality Strategy Plan (Quality Strategy Plan) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to enrollees in the Medicaid Expansion program. The Quality Strategy Plan provides a framework for the STATE to communicate the vision, objectives, and monitoring strategies for attaining quality, timely access, and cost effectiveness.

Mission

The Quality Strategy Plan supports the mission of the STATE, which is:

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

The Medical Services Division will ensure that its enrollees receive high quality care by providing effective oversight of a MCO and other contracted entities to promote accountability and transparency for improving health outcomes. A MCO is defined as a health care 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 its enrollees to receive care that is:

- **Safe**: prevents medical errors and minimizes risk of patient harm;
- **Effective**: evidence-based services consistently delivered to the population known to benefit from them;
- **Efficient**: cost-effective utilization that avoids waste, including waste of equipment, supplies, ideas, and energy;
- **Patient-centered**: respectful of and responsive to individual patient preferences, needs, and values;
- **Timely**: medically appropriate access to care and health care decisions with minimal delay; and
- **Equitable**: providing programs/services and care without variation in quality due to gender, ethnicity, geographic location, 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;
- 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

Development & Review of Quality Strategy

Throughout the development of the Quality Strategy Plan, the 42 Code of Federal Regulations (CFR) Part 438 was utilized to ensure compliance with the rules governing Medicaid managed care. On May 6, 2016, CMS published the Final Rule for Medicaid Managed Care along with

guidance on implementation dates for certain provisions which allows states to be within compliance so long as the state comply with the corresponding standard(s) codified in 42 CFR Part 438 contained in 42 CFR Parts 430 to 481 edition revised as of October 1, 2015. Unless otherwise noted, the 42 CFR Part 438 referenced throughout the 2016 – 2017 Quality Strategy Plan correspond to the October 1, 2015 edition of the CFR.

Prior to adopting it as final, the Quality Strategy Plan will be made available for public comment. The 2016 - 2017 Quality Strategy Plan will be placed on the STATE's website at <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 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 at least bi-annually by the Quality Strategy Leadership Team (Leadership Team) and MCO. This process will include workgroups that will establish strategic partnerships among stakeholders to obtain input on the STATE's quality assessment and improvement strategies. After implementation of the Medicaid Expansion program, the STATE will participate in MCO's advisory committee composed of representatives from the provider community, enrollees, family caregivers of MCO enrollees, the advocacy community, and MCO staff. These committees will provide a forum to be actively engaged in MCO's quality of services, raise concerns and issues, and provide advice and recommendations on a wide range of discussion topics, including the Quality Strategy Plan.

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

Quality Strategy Implementation

The success of the Quality Strategy Plan requires effective implementation and coordination between the STATE and the MCO. The STATE will convene two to four Quality Assurance and Improvement face-to-face or teleconference/webinar meetings per year. These meetings will routinely bring the STATE and all of the MCO's quality teams together, take a population perspective on ND Medicaid program, and, to the greatest degree possible, harmonize quality initiatives across the MCO and ND Medicaid Program.

Standardized reporting and review tools have been developed to allow for improved oversight

and trending over time. The Medicaid Expansion Administrator, within the Medical Services Division, receives and reviews all monitoring and quality reports from MCO and the EQRO.

The Leadership Team will review and analyze all findings from the reports including data received, root causes, barriers, and improvement interventions. Feedback will be provided to the MCO and corrective action will be requested, if needed. Findings and recommendations will be adequately documented for public review.

The STATE and the MCO will continue to conduct weekly, bi-weekly, or monthly and *ad hoc* calls to provide a mechanism for dialogue on particular topics (i.e. information technology systems, third party liability, Patient Centered Medical Home, clinical practice standards, etc.), feedback and review of performance improvement projects (PIPs), and identification of best practices as the Medicaid Expansion program matures.

The Leadership Team will periodically make updates to reflect changes in policy and highlight recent activities. STATE has submitted a copy of the initial strategy and will provide a copy of any revised strategy to CMS whenever significant changes are made, including changes to enrollee cost sharing, benefits, or services.

Section II: ASSESSMENT

Quality and Appropriateness of Care

The STATE will assess how well the MCO program is meeting the objectives outlined in the Section I through analysis of the quality and appropriateness of care and services delivered to enrollees, the level of contract compliance of the MCO, and to individuals with special health care needs, as required by §438.204(b)(1).

The STATE assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through:

- STATE Internal monitoring,
- ND Medicaid Expansion Quality Indicators monitoring (Appendix A),
- PIPs,
- ND Medicaid Expansion MCO Compliance, Operations, and Quality Reporting (Appendix B), and
- EQRO activities, including ND Medicaid population analysis and the EQRO Report.

Enrollees with Special Health Care Needs

Enrollees with special health care needs are those who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by enrollees, generally. MCO shall ensure there is access and care coordination to all services to meet the health needs of

enrollees with special health care needs in accordance with the covered services, limitations, and exclusions.

Identify race, ethnicity, and primary language

Information about the race, ethnicity, and primary language of enrollees is collected by eligibility workers at local county social services offices and the medical facility staff during the enrollment process. This information is self-reported by the individual and optional on the application or redetermination form. As provided by the individual, county and state staff enter the information into the SPACES system (North Dakota's eligibility system) along with the individual's other enrollment application information.

MCO is required to determine prevalent non-English languages per the STATE's methodology that a language is prevalent when it is spoken as a primary language for 200 or more enrollees of the MCO within the service area. The MCO shall ensure that translation services are provided for written marketing and enrollee education materials for any prevalent non-English language. The STATE requires that MCO and any contractors have oral interpretive services for those who speak any foreign language.

North Dakota Medicaid Quality Indicators

Since CMS, in consultation with the states, has not mandated specific performance measures and topics for PIPs, the Medical Services Division has identified the current measure set to include selective CMS Adult Quality Indicators and Children's Core Set Quality Indicators (Appendix A). The measures are a selection of the latest standardized and validated measures from recognized and credible organizations, including CMS, the Agency for Healthcare Research and Quality (AHRQ), the HEDIS[®], and Consumer Assessment of Healthcare Providers and Systems - CAHPS[®] Health Plan Survey. To ensure the integrity, reliability, and validity of MCO encounter data, the STATE contracted with an EQRO to audit and validate encounter data and to provide technical assistance to MCO in collecting and submitting the requested information.

It is the STATE's intent that Appendix A may require modification based on the analysis of the identified quality measures as compared to the actual expansion population utilization and trending data. 2014 and 2015 serving as the baseline data with subsequent years used to provide comparative data. Analysis of the comparative data allows the Leadership Team to consider and implement the appropriate quality measure to drive quality improvement for Medicaid Expansion.

ND Medicaid Internal Monitoring & Contract Compliance

The success of the Quality Strategy Plan requires contract compliance with the standards of 42 CFR 438 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 (Appendix B), regular meetings with entities, 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 contract compliance and the standards are being appropriately implemented.

To assist with monitoring, the MCO has contractual reporting requirements with the STATE to allow for improved oversight and trending over time. The timeframe for reports due to the STATE are:

- **Monthly** reports will be due to the STATE on the fifth day of the following month, unless otherwise specified;
- **Quarterly** reports will be provided to the STATE 45-60 days following the end of each quarter;
- **Annual** reports will be submitted to the STATE 90-180 days following the end of the calendar year;

Exceptions to this schedule will be identified with the applicable report. Reports should be submitted electronically in a format approved by the STATE. In the event that a report requires revisions or format changes, the STATE shall provide written notice of such request to the MCO. MCO shall maintain a data gathering and storage system sufficient to meet the requirements of the contract.

In cooperation with other federal and/or State agencies, the MCO may be asked to produce additional *ad hoc* reports upon request of the STATE within a mutually agreed upon timeframe as established by the STATE and MCO. The STATE shall incur no expense in the generation of such reports. Additionally, MCO shall make revisions in the data elements or format of the reports required in the contract upon request of the STATE and without additional charge to the STATE.

The STATE reserves the right to request *ad hoc* meetings as needed.

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 Medicaid Expansion 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 Medicaid Expansion program as well as results of PIPs and

performance measures (PMs). The EQR report results will provide information regarding the effectiveness and performance of MCO by identifying strengths and weaknesses and by providing information about problems or opportunities for improvement. 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 enrollees or conducting other activities related to the oversight of the quality of the case management services, except for those specified in 42 CFR §438.354. 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 MCO, the EQRO, and the STATE with final approval by the STATE. 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 §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 the 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 consumer 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 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 MCO's strengths and opportunities for improvement;
- Recommendations for improving quality of health care;
- Comparative information across MCO programs; and
- An evaluation of how effectively MCO addressed the improvement recommendations made by the EQRO the prior year.

Each EQRO report will also include: information on trends in 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 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 MCO contract to evaluate existing program goals and inform new program goal development. The STATE will also use the report to inform 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, includes the elements described in the EQR results section, and results will be made available, as specified in the regulation.

Section III: STATE STANDARDS

NORTH DAKOTA STATE STANDARDS

The Quality Strategy Plan is organized to reflect the standards outlined in 42 CFR 438 Subpart D of the Medicaid Managed Care Rules and Regulations. The standards of North Dakota are at

least as stringent as those specified in 42 CFR §§438.200-438.242. Subpart D is divided into three standards: Access, Structure and Operations, and Measurement and Improvement. Each standard has multiple components as indicated in the following table and summarized below.

Standard	Regulatory Reference	Description
Access		
	§438.206	Availability of services
	§438.207	Assurances of adequate capacity and services
	§438.208	Coordination and continuity of care
	§438.210	Coverage and authorization of services
Structure and Operations		
	§438.214	Provider selection
	§438.218	Enrollee information
	§438.224	Confidentiality
	§438.226	Enrollment and disenrollment
	§438.228	Grievance systems
	§438.230	Subcontractual relationships and delegation
Measurement and Improvement		
	§438.236	Practice guidelines
	§438.240	Quality assessment and performance improvement program (PIP)
	§438.242	Health information systems

Access Standard

Availability of services (§438.206)

Availability of services ensures that services covered under contracts are available and accessible, in a culturally competent manner, to enrollees and address geographic, organizational, and equitable access. MCO must ensure that coverage is available to enrollees on a twenty-four hours a day, seven days a week basis. MCO must ensure that network providers offer hours of operation that are no less than those offered to commercial enrollees (or comparable to North Dakota Medicaid fee-for-service if a provider serves only Medicaid enrollees) (consistent with §438.206(c)(1)(ii)).

MCO must maintain a provider network sufficient to provide all enrollees with access to the full range of covered services required under the contract. MCO must ensure its providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations.

MCO must meet the following requirements:

- All covered services must be available to enrollees on a timely basis in accordance with the requirements of the contract and medically appropriate guidelines and consistent with generally accepted practice parameters.
- Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, MCO must consider the anticipated Medicaid enrollment, the expected utilization of services, and take in to consideration the characteristics and health care needs of specific Medicaid populations enrolled. MCO must also consider the numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, the number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and Medicaid enrollees. Distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees will be considered.
- The networks must be comprised of hospitals, practitioners, and specialists in sufficient numbers to make available all covered services in a timely manner.
- The primary care network must have at least one full-time equivalent Primary Care Provider (PCP) for every 2,500 patients, including Medicaid expansion enrollees.
- A ratio for each High Volume and High Impact Specialist type (see definition above) of one full time equivalent physician per 3,000 enrollees.
- A ratio for each High Volume Behavioral/Mental Health and Substance Use Disorder Practitioner type (see definition above) of one full time equivalent practitioner per 3,000 enrollees.
- MCO must incorporate access standards developed jointly by MCO and the STATE.

MCO must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

MCO must also ensure that each enrollee has access to a second opinion regarding the use of any medically necessary covered service. A enrollee must be allowed access to a second opinion from a network provider or out-of-network provider if a network provider is not available. Other than allowable cost sharing, this service must be at no cost to the enrollee, in accordance with 42 CFR §438.206(b)(3).

MCO must establish mechanisms to ensure that network providers comply with the STATE standards of timely access requirements. MCO must meet and require its providers to meet STATE standards for timely access to care and services, taking into account the urgency of the need for services. Standards for access and timeliness are identified in the table below.

Appointment Standards			
General	Behavioral/Mental Health and/or Substance Use Disorder	High Volume and High Impact Specialty	Maternity
<ul style="list-style-type: none"> • <u>Emergency Services</u> - available 24 hours a day, seven days a week • <u>Urgent Care</u> – within 24 hours • <u>Non-Urgent Sick Care</u> - within 72 hours, or sooner, if conditions deteriorates into urgent or emergency condition • <u>Routine, Non-Urgent or Preventative Care Visits</u> – within six weeks of enrollee request 	<ul style="list-style-type: none"> • <u>Emergency Services, Life Threatening</u> – Immediate • <u>Emergency Services, Non-Life Threatening</u> – Within 6 hours • <u>Urgent Care</u> – within 48 hours • <u>Initial Visits, Routine Care</u> - within 10 working days • <u>Follow-Up Visits, Routine Care</u> – within 30 days 	<ul style="list-style-type: none"> • Consultation within one month of referral or as clinically indicated 	<ul style="list-style-type: none"> • <u>Emergency Services</u> – immediate • <u>Initial Prenatal Care- First trimester</u> - within 14 days of first Request • <u>Initial Prenatal Care- Second trimester</u> - within 7 calendar days of first request • <u>Initial prenatal care- Third trimester</u> – within 3 calendar days of first request • <u>Initial High Risk Pregnancy</u> – within 3 days of identification of high risk, or immediately if an emergency exists

MCO must provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services under the contract can be furnished to enrollees promptly and without compromise to the quality of care. MCO must monitor this regularly to determine compliance and take corrective action if there is a failure to comply.

Assurances of Adequate Capacity and Services (§438.207)

MCO shall provide an appropriate range of covered services adequate for the anticipated number of enrollees for the service and that MCO maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

MCO shall update network capacity data biennially and at any time there has been a significant change in MCO’s operations that would affect adequate capacity or services, including changes in services, benefits, payments, or enrollment of a new population.

Service Coordination (§438.208)

Modern health care delivery systems are multi-faceted and involve complex interactions

between many providers. Such delivery systems require coordination across the continuum of care. This standard requires that MCO implement procedures to deliver primary care to and coordinate health care services for all enrollees.

MCO must furnish a Service Coordinator to all Medicaid enrollees who request one. MCO should also furnish a Care Coordinator to an enrollee when MCO determines one is required through an assessment of the enrollee's health and support needs. MCO must provide a clinically appropriate primary care provider with the skills and experience to meet the needs of enrollees with special health care needs. MCO shall allow an appropriate specialist to be the PCP but only if the specialist has the skills to monitor the enrollee's preventative and primary care services. The PCP is responsible for overall clinical direction and, in conjunction with the Care Coordinator, serves as a central point of integration and coordination of covered services, including primary, acute care, and behavioral health services.

MCO shall maintain mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. In identifying enrollees with special health care needs, managed care entities may rely on information shared by the STATE. This includes Categories of Assistance, such as Supplemental Security Income (SSI) disabled only, to which enrollees are assigned by ND Medicaid, as well as information provided by other State agencies (consistent with §438.208(c)(1)). MCO must share with other health plans serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities (consistent with §438.208(b)(3)) and protect enrollee privacy when coordinating such care (consistent with §438.208(b)(4)).

For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with §438.208(c)(2)) to need a course of treatment or regular care monitoring, MCO must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs. The treatment plan must be approved by MCO in a timely manner, if approval is required. The treatment plan must conform to the STATE's quality assurance and utilization review standards. The process for requesting specialist's care shall be clearly described by MCO and explained to each enrollee upon enrollment.

If the contracted network is unable to provide necessary medical services covered under the contract to a particular enrollee, MCO must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them. This requires out-of-network providers to coordinate with MCO with respect to payment and to ensure that cost to the enrollee is no greater than it would be if the services were furnished within the network. Services provided outside of the United States are not allowed.

Continuity of Care (§438.208)

MCO, with its sub-contractors, must implement procedures to deliver primary care and coordinate health care for all beneficiaries. MCO must monitor continuity of care across all services and treatment modalities and ensure all services MCO furnishes to the enrollee coordinates with the services the enrollee receives from any other MCO/PHIP (consistent with §438.208(b)(2))

MCO must provide access to ensure that each enrollee has an ongoing source of primary care providers appropriate to his or her needs. Enrollees are encouraged to select their PCP but, the enrollee is not required to select a PCP.

MCO must ensure that the care of newly enrolled Medicaid enrollees is not disrupted or interrupted. It must take special care to provide continuity in the care of newly enrolled enrollees whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. If an enrollee moves out of a service area, MCO must provide or pay out-of-network providers in the new service area who provide medically necessary covered services to enrollees through the end of the period for which MCO received a capitation payment for the enrollee.

If covered services are not available within MCO's network, MCO must provide enrollees with timely and adequate access to out-of-network services for as long as those services are necessary and not available in the network, in accordance with 42 CFR §438.206(b)(4). MCO will not be obligated to provide an enrollee with access to out-of-network services if such services become available from a network provider.

Coverage (§438.210)

MCO must provide for all medically necessary services and appropriate Medicaid covered services in sufficient amount, duration, and scope to achieve the purpose of the service (consistent with §438.210(a)(1)). MCO must provide a comprehensive health care services benefit package. The covered services will include all services that North Dakota requires be made available to enrollees in North Dakota Medicaid expansion including, but not limited to:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services

- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

MCO may place appropriate limits on a service based criteria applied under the State plan, such as medical necessity or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. And specify what constitutes “medically necessary services” in a manner that:

- Is no more restrictive than that used in the State Medicaid program as indicated in State statutes and regulations, the State Plan, and other State policies and procedures and consistent with the ACA state-selected benchmark plan; and
- Complies with the Mental Health Parity and Addiction Equity Act;
- Addresses the extent to which MCO is responsible for covering services related to the following:
 - The prevention, diagnosis, and treatment of health impairments;
 - The ability to achieve age-appropriate growth and development; and
 - The ability to attain, maintain, or regain functional capacity.

Services must be rendered in accordance with the medical necessity standard. All managed care programs operate under the same definition of medical necessity as North Dakota Medicaid fee-for-service. MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee (consistent with §438.210(a)(3)(ii)).

Utilization Management

MCO must have a written utilization management (UM) program description to maintain and follow written policies and procedures for processing requests for initial and continuing authorization of medically necessary covered services. The policies and procedures must conform to all applicable federal and state regulations, including specifically 42 CFR §438.210(b), which includes, at a minimum:

- Procedures to evaluate the need for medically necessary covered services;
- The evidence-based clinical review criteria used, the information sources, and the process used to review and approve the provision of covered services;
- The method for periodically reviewing and amending the UM clinical review criteria; and
- Duly-licensed clinical staff positions functionally responsible for the day-to-day management of the UM function, or delegation of, must be under the direction of a duly-licensed Medical Director.

MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, MCO must comply with the requirements of

42 CFR §456.111 (Hospitals) and 42 CFR §456.211 (Mental Hospitals), as applicable. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is to be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

MCO must provide written notification to the requesting provider and give the enrollee written notice of any decision by MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The written notice must meet the requirements of §438.404 and §438.210.

Notice of Adverse Benefit Determination (42 CFR §438.210(c))

Each contract must provide for MCO to notify the requesting provider and give the enrollee written notice of any decision by MCO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing.

Timeframe for Decisions (42 CFR §438.210(d)(1), (2)&(e))

MCO's contract must provide for the following decisions and notices:

- **Standard authorization decisions.** For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:
 - The enrollee, or the provider, requests extension; or
 - MCO justifies, to the State agency upon request, a need for additional information and how the extension is in the enrollee's interest.
- **Expedited authorization decisions.** For cases in which a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, MCO must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.
 - MCO may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension or if MCO justifies, to the STATE agency upon request, a need for additional information and how the extension is in the enrollee's interest.
- **Compensation for UM activities.** Each contract must provide that, consistent with §438.3(i), and §422.208 of this chapter, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

Grievance and Appeal Process

MCO must develop, implement, and maintain a system for tracking, resolving, and reporting enrollee grievances regarding its services, processes, procedures, and staff.

MCO must develop, implement, and maintain a system for tracking, resolving, and reporting enrollee appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, MCO must respond fully, and completely, to each appeal and establish a tracking mechanism to document the status and final disposition of each appeal.

MCO must ensure that individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.

If the individuals who are deciding an appeal of a denial that is based upon (a) lack of medical necessity or (b) grievance resolution regarding denial of expedited resolution of an appeal or (c) a grievance or (d) appeal that involves clinical issues, they must be health care professionals who have the appropriate clinical expertise as determined by the STATE, in treating the enrollees condition or disease.

An MCO shall have a grievance and appeal process for enrollees meeting all regulation requirements, including an enrollee grievance process, an enrollee appeal process, access to the STATE's fair hearing system, and a network provider appeal process. MCO shall maintain records of any grievance and appeal. The grievance and appeal process must be approved by STATE. The requirements are as follows:

Enrollee Grievance Process

MCO shall define a grievance as an expression of dissatisfaction about any matter other than an "adverse benefit determination". MCO shall explain to the enrollee that they are allowed to file a grievance with MCO only. An enrollee may file a grievance either orally or in writing.

MCO shall dispose each grievance and provide notice, as expeditiously as the enrollee's health condition requires, not exceeding 90 days from the day MCO received the grievance. MCO shall inform the enrollee, in writing, regarding the disposition of the grievance.

MCO is required to maintain records of grievances and appeals. Those records will include, at a minimum, a log of all grievances/appeals whether verbal or written. The log should include enrollee identifying information and a statement of the appeal and resolution, if affected. Log data should be analyzed monthly to identify trends and/or patterns for administrative use and review. Logs must always be available for STATE and CMS review.

Enrollee Appeal Process

MCO shall acknowledge receipt of each appeal and give enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and

toll-free numbers with TTY/TDD and interpreter capability.

MCO must ensure that the decision maker on an appeal was not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply:

- A denial appeal based on lack of medical necessity;
- The action involves the denial of expedited resolutions of an appeal; or
- Any appeal involving clinical issues.

MCO shall define appeal as the request for review of an "action". Either an enrollee or a network provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. The appeal must be filed no less than 30 calendar days from the date on the notice of action.

MCO shall allow the enrollee or provider to file an appeal either orally or in writing. Unless the enrollee requests an expedited resolution, an oral appeal must be following by a written, signed appeal. In addition, MCO shall:

- Ensure that oral inquiries seeking to appeal an action are treated as appeals and confirm those inquiries, in writing, unless the enrollee or the provider requests expedited;
- Provide a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
- Allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records and any other documents and records; and
- Consider the enrollee, representative, or estate representative of a deceased enrollee as parties to the appeal.

MCO shall resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, not exceeding 45 calendar days from the day the appeal is received. MCO may extend the timeframe once, by up to 14 calendar days, if the enrollee requests the extension and demonstrates that there is need for additional information and how the delay is in the enrollee's best interest. The enrollee must be given a written notice of the reason for the delay.

MCO shall provide written resolution notice of disposition. The written resolution notice must include:

- The reason and date of the appeal resolution.
- For decisions not wholly in the enrollee's favor:

- The right to request a STATE fair hearing;
- How to request a STATE fair hearing;
- The right to continue to receive benefits pending a hearing;
- How to request the continuation of benefits; and
- If the action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

MCO shall continue the enrollee's benefits if:

- The appeal is filed timely, meaning on or before the later of the following:
 - Within 10 calendar days of the mailing of notice of action.
 - The intended effective date of proposed action.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The authorization period has not expired; and
- The enrollee requests an extension of benefits.

If MCO continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The enrollee withdraws the appeal;
- The enrollee does not request a STATE fair hearing within 10 calendar days from when the adverse decision;
- A STATE fair hearing decision adverse to the enrollee is made; or
- The authorization expires or authorization service limits are met.

MCO may recover the cost of continuation of services from providers furnished to the enrollee while the appeal is pending if the final resolution of the appeal upholds in MCO's favor. When services are not furnished, MCO shall authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal is pending or the STATE Fair Hearing officer reverses a decision to deny, limit, or delay services.

MCO shall establish and maintain an expedited review process for appeals when MCO determines or the network provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard regulations for expedited requests except where differences are specifically noted in the regulation for expedited resolution.

- The enrollee or network provider may file an expedited appeal either orally or written.

No additional enrollee follow-up is required. MCO shall inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

- A MCO shall resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, not exceeding three business days after MCO receives the appeal. An extension of up to 14 calendar days may be extended if the enrollee requests the extension or MCO shows that there is need for additional information and how the delay is in the enrollee's interest.
- In addition to written notice, MCO shall also make reasonable efforts to provide oral notice.
- MCO shall ensure that punitive action is not taken against a network provider who either requests an expedited resolution or supports and enrollee's appeal.

Access to STATE Fair Hearing

MCO shall include in enrollee and network provider information the STATE fair hearing description and how to obtain it. If MCO takes action and the enrollee requests a STATE fair hearing, the STATE will grant one. MCO will be a party as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Network Provider Appeal Process

MCO shall provide a network provider an appeal process to challenge the denial of MCO or to cover a service.

Structure and Operations Standard

Provider Selection (§438.214)

Service delivery by appropriately qualified individuals promotes patient safety and thus represents one essential structural component of a high quality delivery system. This standard ensures that MCO implements written policies and procedures for the selection and retention of providers.

MCO must establish documented processes to credential and re-credential providers with whom it has signed contracts or participation agreements. The STATE requires that the scope and structure of the processes for credentialing, at a minimum, be consistent with recognized industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant STATE regulations, including regulations issued by the Board of Registration of Medicine at 243 CMR 3.13.

- Nondiscrimination: Managed care entities, in establishing contractual relationships with providers, may not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

- **Excluded Providers:** Managed care entities may not contract with providers excluded from participation in federal health care programs under either §1128 or §1128A of the Social Security Act (42 U.S.C. 1320a-7). In addition, MCO may not authorize any providers terminated or suspended from MCO to treat enrollees and must deny payment to such providers. This does not preclude MCO from terminating or suspending providers for cause prior to action by the STATE. MCO is responsible for providing timely notification to enrollees when a provider has been terminated or suspended.

Enrollee Information (§438.218)

Good communication enhances access to care, appropriate use of services, and satisfaction. This standard delineates requirements for communicating with enrollees and potential enrollees. MCO must provide all enrollee notices, information materials, and instructional materials in a manner and format that may be easily understood, in accordance with 42 CFR §438.10. This includes ensuring capacity to meet the needs of non-English linguistic groups in their service areas and making available materials in alternative formats upon request. Materials and enrollee handbooks are designed to assist enrollees and potential enrollees in understanding the Health Plan programs, addressing program features, including: benefits, cost sharing, service areas, provider network characteristics, and policies and procedures concerning enrollee rights and protections. Materials must comply with both STATE and federal regulations/contract and must be approved by the STATE before they can be used.

On an annual basis, MCO must provide enrollees with notice of their right to request and obtain information on the various items required in 42 CFR §438.10(f) along with a list of all enrolled providers. In addition, managed care entities must provide enrollees with 30-calendar day prior written notification of any significant changes, including changes to enrollee cost sharing and benefits. MCO must make a good faith effort to provide written notice of termination of a contracted provider within 15 days after receipt or issuance of the termination notice to each enrollee who received his or her primary care from, or was seen on, a regular basis by the terminated provider.

Confidentiality (§438.224)

This standard requires that MCO and the STATE take appropriate steps to safeguard personal health information. Managed care entities may use and disclose individually identifiable health information only if done in a manner that is in accordance with the privacy requirements in 45 CFR parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable. Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies as well.

Enrollment and Disenrollment (§438.226)

This standard outlines requirements for the enrollment and disenrollment procedures of managed care entities. In accordance with 42 CFR §438.56, the Health Plan entity must follow certain specified procedures for enrollment and disenrollment of enrollees (voluntary as well as involuntary). MCO may not disenroll an individual because of any of the following:

- An adverse change in the enrollee's health status;
- Utilization patterns; or
- Behavior related to special needs.

In addition, managed care entities must accept all persons who voluntarily enroll or are assigned to their plan. Enrollees may switch health plans at any time without cause.

Grievance Systems (§438.228)

Once the first or second level of the Health Plan entity internal appeals process has been exhausted, when required, the STATE permits enrollees to request and obtain a STATE fair hearing, as detailed in STATE Standards – Member complaint and appeals process section.

Provider and Enrollee Suspected Fraud and Abuse

MCO must investigate and, if appropriate, report to the appropriate agency all suspected provider and enrollee fraud and abuse cases. MCO must report all suspected provider and enrollee fraud and abuse to the STATE within five business days.

MCO must provide a report to the STATE each quarter, which includes:

- A log of the suspected provider and enrollee fraud and abuse complaints received by MCO; and
- For each complaint, the following information must be supplied to the STATE:
 - Provider or enrollee name;
 - Provider or enrollee ID number;
 - Source of complaint;
 - Type of provider;
 - Nature of complaint;
 - Suspected duration or when the incident took place;
 - Approximate dollars involved; and
 - Any legal or administrative actions taken.

Subcontractual Relationships and Delegation (§438.230)

The Health Plan entity must oversee and remain accountable for any functions and responsibilities that are delegated to subcontractors. This entails ongoing monitoring and formal review of subcontractor performance and corrective action, given identification of deficiencies or areas for improvement. There must be a written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate (consistent with §438.230(b)(2)).

Measurement and Improvement Standards

Practice Guidelines (§438.236)

The application of evidence-based clinical practice guidelines has proven to reduce variation in treatment, resulting in improved quality. MCO 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 health care delivery system infrastructure; and
- Clinical experience, judgment, and generally accepted standards of health care.

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 health care 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 Medicaid Expansion 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.

MCO will use clinical care standards and/or practice guidelines to objectively evaluate the care MCO delivers, or fails to deliver, for the targeted clinical conditions. MCO 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 MCO’s Physician Quality Committee and/or the Pharmacy and Therapeutics Committee, and reviewed by MCO Quality Assurance/Quality Improvement (QA/QI) Committee. All clinical practice guidelines will be available on MCO’s website to providers, and enrollees and potential enrollees upon request. MCO clinical practice guidelines will be used to inform their coverage decisions, utilization management, and enrollee

educational activities.

MCO is 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 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, MCO 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.

Quality Indicators

The STATE requires the MCO to collect data on patient outcome performance measures, as defined by HEDIS[®], NCOA measures in the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators, CAHPS[®] or otherwise defined by the STATE, and reports the results of the measures to the STATE annually and included in the Medicaid Expansion Report Card. The report cards will be formatted and disseminated to key stakeholders as well as posted on the ND DHS website. EQR report results provide information regarding the effectiveness of the quality management organization's program, identify strengths and weaknesses and provide information about problems or opportunities for improvement. This information is utilized for input into the Quality Strategy Plan and for initiating and developing quality improvement projects.

The STATE may add or remove reporting requirements with 30 days advance notice. The standards/measures in Appendix A shall be included in the Medicaid Expansion Report Card.

The STATE requires the use of the HEDIS[®] to develop, collect, and report data for most performance measures; most results reported were indicators of enrollees' use of services rather than absolute rates for how successfully MCO provided care. The STATE fully intends to take advantage of a unique opportunity to focus its Performance Measure requirements for all lines of business across the department to align with clinical, outcome, and satisfaction measures that are being implemented by CMS.

Although HEDIS[®] measures are reasonable indicators of health care accessibility, availability, and quality, thoughts on what is important to measure and how to measure have evolved and become more sophisticated. Focus has shifted from the importance of access to an office visit to the actual content of the visit: treatment of specific conditions, evidence-based care, care coordination, care outcomes, and patient safety.

The STATE Performance Measure sets will also support the health care communities' need for adoption of electronic health records (EHRs) and electronic data exchange capabilities. The health care system is changing in relation to how it measures quality. Traditional data sources such as claims, encounters, and medical chart reviews are no longer enough. The CMS Core Measures include methodologies that utilize data sources and data collection processes that are not yet fully developed or implemented but are progressing at a rapid rate. With this in mind, the course of action is anticipated to result in greater availability of data/information that will allow for:

- Increased efficiencies;
- Improved health care outcomes, including patient-specific outcomes;
- Improved patient satisfaction;
- Greater population health management capabilities; and
- Reduced costs.

This will be an incremental approach in order to provide needed flexibility for the methodologies as not all expected technologies/data sources (i.e.; EHRs, the Health Information Exchange (HIE), ICD-10, etc.) are currently operational. Each methodology will outline current measurement practices as well as expected practices once the data sources are in place and fully operational. The STATE fully intends to conduct ongoing reviews of the information systems to ensure support of the initial and ongoing operation of the STATE's quality strategy.

Quality Assessment and Performance Improvement Program (§438.240)

To complement the North Dakota Quality Strategy Plan, MCO shall develop, maintain, and operate a comprehensive Quality Assessment and Performance Improvement (QAPI) program that details the plans, tasks, initiatives, and staff responsible for improving quality and meeting the requirements and ND Medicaid services as required by 42 CFR §438.240. The QAPI is subject to the approval by the STATE. In addition to complying with contractual terms related to specific QI activities, processes, and reporting, MCO shall conform to all applicable federal and STATE regulations. The QAPI must have procedures that:

- Assess the quality and appropriateness of care and services furnished to all enrollees and to individuals with special health care needs;
- Implement mechanisms to detect the over-utilization and under-utilization of health care services;
- Regularly monitor and evaluate compliance with the STATE standards for MCOs;
- Comply with any national performance measures and levels that may be identified and developed by CMS in consultation with the Medical Services Division and other relevant stakeholders;
- Develop a Utilization Management Plan and annual work plan;
- Describe methodologies and mechanisms for monitoring and auditing provider

performance, identifying deficiencies, addressing deficiencies with corrective action, monitoring of corrective actions for intended results, and communication of all findings to providers;

- A full description of how clinical program initiatives will be addressed as specified by the STATE for the Medicaid population;
- Ongoing reports quarterly, semi-annually, and annually as specified in the reporting section. Additional reports as determined necessary by the STATE for quality assurance and improvement activities (Appendix B);
- Must measure and report to the STATE its performance using standard measures required by the STATE, including those developed in consultation with STATES and other relevant stakeholders (42 CFR §438.3204(c) and §438.240(a)(2)). The program must submit data specified by the STATE to enable the STATE to measure the program's performance; and
- Report the status and results of each project to the STATE upon request and annually as requested for the EQR process and must produce new information on quality of care every year.

MCO will be subject to **annual** review of the impact and effectiveness of their quality assessment and performance improvement program, including:

- Performance on the required standard measures; and
- Results of Performance Improvement Projects.

MCO's QAPI program must also include two performance improvement projects, approved by the STATE, at least one of which must have a behavioral health focus. The PIP will achieve demonstrable and sustained improvement over time incorporating performance improvement standards of measurement, including objective quality indicators, implementation, and evaluation and planning. The STATE and CMS may specify performance measures and topics for required MCO PIPs, which must be achieved through ongoing measurements and intervention, significant improvement, sustained over time, clinically and non-clinically, with favorable effect on health outcomes and member satisfaction.

Health Information Systems (§438.242)

MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this Section. The system must provide information on areas, including, but not limited to, utilization, grievances and appeals, and disenrollments for others than loss of Medicaid eligibility.

At a minimum, MCO is required to comply with the following:

- Collect data on enrollee and provider characteristics, as specified by the STATE, and on services furnished to enrollees through an encounter data system or other methods as

- specified by the STATE; and
- Ensure that data received from providers is accurate and complete by:
 - Verifying the accuracy and timeliness of reported data;
 - Screening the data for completeness, logic, and consistency;
 - Collecting service information in standardized formats to the extent feasible and appropriate; and
 - Making all collected data available to the STATE and, upon request, to CMS.

Section IV: Improvements and Interventions

Interventions for improvement of quality activities are varied and based on the ongoing review and analyses of results from each monitoring activity by the STATE and EQRO. 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. Improvement activities are central to any quality strategy and must include:

- Identifying current levels of quality;
- Identifying areas for improvement;
- Designing interventions to achieve improvement; and
- Charting progress towards quality goals.

The STATE's EQRO reports will include an assessment of MCO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, recommendations for improving the quality of health care services furnished by the MCO, and an assessment of the degree to which MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This information will be used to inform any needed benefit changes, ND MCO contract amendments, additional MCO quality improvement activities, sanctions, or other program changes. Additionally, the EQRO report will be used to inform the STATE of any needed oversight or regulatory support to improve managed care health care delivery.

Sanctions

The premise behind the Quality Strategy Plan process is one of continuous quality improvement. STATE strongly believes in working with MCO in a proactive manner to improve the quality of care received by ND Medicaid enrollees. However, should the need arise; part of STATE's quality management process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. The sanctions of MCO plan meet the federal requirements of 42 CFR §438 Subpart I, as well as STATE requirements for sanctions and termination.

The Medical Services Division will have the right to impose penalties and sanctions, arrange for

temporary management, as specified below, or immediately terminate MCO contract under conditions specified below.

Whenever the STATE determines that MCO is failing to provide one or more core benefits and services, it may authorize enrollees to obtain the covered service from another source. In the event that the Medical Services Division determines that MCO failed to maintain an adequate network of mandatory contracted provider/service types, a monetary penalty per incident may be assessed.

The STATE may apply penalties and sanctions to MCO if any of the entities fail to comply with all program integrity and sanctions requirements as described by the authority of NDAC §75-02-05-05:

Where these violations are documented, the STATE will require a corrective action plan (CAP) be developed and submitted within thirty (30) calendar days of the date of receipt of notification of the violation or non-compliance this authority is based on NDAC §75-02-05-05(16).

Upon approval by STATE, MCO must implement the initial or revised CAP within the timeframes specified by the Department.

Strategy Effectiveness

The Quality Strategy Plan has contributed to the collaborative partnership between the STATE and MCO ensuring quality care and services for those within the Medicaid Expansion population. The data collection for 2014 and 2015 shall serve as the baseline with subsequent years used to provide comparative data. Upon review and analysis by the Leadership Team, the baseline data along with national benchmarks associated with the quality indicators will allow the development of program specific benchmarks in 2017.

Based on the initial data, the MCO shall monitor and implement the following PIPs:

- Prevention and Treatment of Chronic Conditions which relates to the coordination and continuity of care and services for those enrollees with chronic conditions including the aim of engaging the enrollee along with providers to take an active role in their health care. The MCO focused on chronic conditions as related to comprehensive diabetes care and controlling high blood pressure taking into consideration indicators related to Hemoglobin A1c Testing, Controlling High Blood Pressure, and Adult Body Mass Index Assessment.
- Follow-up for Mental Health which relates to access to behavioral health practitioners after hospitalization for mental illness by assessing the percentage of discharges for Medicaid enrollees age 21 and older that were hospitalized for selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge.

The comprehensive assessment and recommendations for improvement as provided by the EQRO review and analysis are within the Annual Technical Report. The STATE is committed to making information readily available to the public through public reporting and included within the quality section in the North Dakota Department of Human Services annual report.

Conclusion

The Quality Strategy Plan allows the Medical Services Division to think strategically about quality data and management intervention activities. The cohesive plan regularly guides reviewers and recommends corrective action/follow-up; additionally, guides the Leadership Team, to ensure the implementation of quality activities. There has also been significant improvement in the collaboration between the Medical Services Division and health plans as well as between other Medical Service programs on quality activities. The plan to institute 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 best practices, and identification of systems changes. The Medical Services Division promotes and supports ongoing efforts of transparency and sharing.

Appendix A

ND Medicaid Expansion Quality Indicators

Measure	Measure Steward (website)	Description	Data Source
ADULT MEASURES			
1. Flu Shots for Adults Ages 19 to 64	NCQA/HEDIS® (www.ncqa.org)	Rolling average represents the percentage of Medicaid enrollees ages 19 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS® survey was completed	Survey
2. Adult Body Mass Index (BMI) Assessment	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 65 that had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Administrative or hybrid
3. Breast Cancer Screening	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid-enrolled women ages 50 to 64 that received a mammogram any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year	Administrative
4. Cervical Cancer Screening	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid-enrolled women ages 21 to 64 who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> • Women age 21-64 who had cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. 	Administrative
5. Medical Assistance With Smoking and Tobacco Use Cessation	NCQA/HEDIS® (www.ncqa.org)	Rolling average represents the percentage of Medicaid enrollees age 19 and older that were current smokers or tobacco users and who received advice to quit, discussed or were recommended cessation medications, and discussed or were provided cessation methods or strategies during the measurement year	Survey

Measure	Measure Steward (website)	Description	Data Source
6. Plan All-Cause Readmission Rate	NCQA/HEDIS [®] (www.ncqa.org)	For Medicaid enrollees age 19 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	Administrative
7. PQI 01: Diabetes Short-Term Complications Admission Rate	AHRQ (www.qualityindicators.ahrq.gov)	Number of discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 19 and older	Administrative
8. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	AHRQ (www.qualityindicators.ahrq.gov)	Number of discharges for COPD per 100,000 Medicaid enrollees age 19 and older	Administrative
9. PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ (www.qualityindicators.ahrq.gov)	Number of discharges for CHF per 100,000 Medicaid enrollees age 19 and older	Administrative
10. PQI 15: Adult Asthma Admission Rate	AHRQ (www.qualityindicators.ahrq.gov)	Number of discharges for asthma per 100,000 Medicaid enrollees age 19 and older	Administrative
11. Chlamydia Screening in Women Ages 21 to 24	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrolled women ages 21 to 24 that were identified as sexually active and that had at least one test for Chlamydia during the measurement year	Administrative
12. Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of discharges for Medicaid enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative

Measure	Measure Steward (website)	Description	Data Source
13. Controlling High Blood Pressure	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 that had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year based on the following criteria: <ul style="list-style-type: none"> • Enrollees 19–59 years of age whose BP was <140/90 mm Hg. • Enrollees 60–64 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Enrollees 60–64 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. 	Hybrid
14. Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) that had a Hemoglobin A1c test	Administrative or hybrid
15. Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9%)	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) that had a Hemoglobin A1c level >9%	Administrative or hybrid
16. Comprehensive Diabetes Care: Hemoglobin A1c Control (<8%)	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) that had a Hemoglobin A1c level <8%	Administrative or hybrid
17. Comprehensive Diabetes Care: Hemoglobin A1c Control (<7%)	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) that had a Hemoglobin A1c level <7%	Administrative or hybrid
18. Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) that had either: <ul style="list-style-type: none"> • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. 	Administrative or hybrid
19. Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) that had a nephropathy screening or monitoring test or evidence of nephropathy	Administrative or hybrid

Measure	Measure Steward (website)	Description	Data Source
20. Comprehensive Diabetes Care: BP Control (<140/90)	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with diabetes (type 1 and type 2) whose most recent BP reading was <140/90	Administrative or hybrid
21. Antidepressant Medication Management	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid enrollees age 19 and older with a diagnosis of major depression, that were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) and for at least 180 days (6 months)	Administrative
22. Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	Administrative
23. Annual Monitoring for Patients on Persistent Medications	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid enrollees age 19 and older that received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and that received annual monitoring for the therapeutic agent during the measurement year	Administrative
24. CAHPS® Health Plan Survey 5.0H – Adult Questionnaire	AHRQ NCQA/HEDIS® (www.ncqa.org)	Survey on adult Medicaid enrollees' age 19 and older experiences with care	Survey
25. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS® (www.ncqa.org)	Percentage of Medicaid enrollees age 19 and older with a new episode of alcohol or other drug (AOD) dependence who: (a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis (b) Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Administrative or hybrid
26. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA/HEDIS® (www.ncqa.org)	The percentage of enrollees 19-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Administrative

Measure	Measure Steward (website)	Description	Data Source
27. Diabetes Monitoring for People With Diabetes and Schizophrenia	NCQA/HEDIS [®] (www.ncqa.org)	The percentage of enrollees 19–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	Administrative
28. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NCQA/HEDIS [®] (www.ncqa.org)	The percentage of enrollees 19–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.	Administrative

Measure	Measure Steward (web site)	Description	Data Source
CHILDREN'S (19-20 YEAR OLD) MEASURES			
1. Adolescent Well-Care Visit	NCQA/HEDIS® (www.ncqa.org)	Percentage of adolescents ages 19 to 20 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Administrative or hybrid
2. Percentage Of Eligibles That Received Preventive Dental Services	CMS (www.cms.gov/MedicaidEarlyPeriodicScrn/03_STATEAgencyResponsibilities.asp)	Percentage of individuals ages 19 to 20 that are enrolled in Medicaid or Children's Health Insurance Program (CHIP) Medicaid Expansion programs, are eligible for EPSDT services, and that received preventive dental services	Administrative (Form CMS416)
3. Medication Management for People with Asthma	NCQA/HEDIS® (www.ncqa.org)	Percentage of children ages 19 to 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period Two rates are reported: <ul style="list-style-type: none"> • Percentage of children that remained on an asthma controller medication for at least 50 percent of their treatment period • Percentage of children that remained on an asthma controller medication for at least 75 percent of their treatment period. 	Administrative
4. Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS® (www.ncqa.org)	Percentage of discharges for children ages 19 to 20 that were hospitalized for treatment of selected mental health disorders and that had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative

Measure	Measure Steward (web site)	Description	Data Source
5. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS [®] (www.ncqa.org)	Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a 10 month period, one of which was within 30 days from the time the first ADHD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase	Administrative

Appendix B

ND Medicaid Expansion MCO Compliance, Operations, and Quality Reporting

Strategy Section	Report Title	Description
Availability of Services: delivery networks		
	PCP Geographic-Access Report	<u>Semi-annual</u> report and geo-access maps of adult and pediatric PCP geographic locations by service area
	PCP to Enrollee Ratio Report	<u>Semi-annual</u> report of open and closed adult, pediatric, and family PCPs per number of enrollees by Service Area (includes data collection methodologies)
	Top 5 High Volume Specialists Geographic Access Report	<u>Annual</u> report of geographic access to top 5 high volume specialty types, as defined by MCO, Behavioral Health Providers and OB/GYNs based on MCO-specific utilization
	Emergency Department (ED) Visits	<u>Annual</u> report on Emergency Department visits and the volume of distribution by ED with top 10 diagnosis codes
	Pharmacy Network Geographic-Access Report	<u>Annual</u> geo-access map of pharmacy network by service area
	Significant Changes in Provider Network Report	<u>Immediate notice and Semi-Annual Summary</u> report of significant changes in provider network that will affect the adequacy and capacity of services
	Summary Access and Availability Analysis Report	<u>Annual</u> report of key findings from all access reports and data sources(e.g. grievance system, telephone contacts with access /availability associated reason codes, provider site visits, use of out of network alternatives due to access/availability, care management staff experiences with scheduling appointments)
	Credentialing Policy	<u>As relevant</u> , changes to credentialing policies and procedures
	Service Area Expansions	<u>As relevant</u> , proposed service area expansions including, # /type of Providers included by specialty and town/city, rationale, quality and access standards used to select Providers, description of methods to assure compliance with federal/state laws and Contract, distance from city/town center to each PCP and Specialist by Specialty Type
	Provider Suspension and Termination Notification	<u>Immediate</u> notice of any independent action taken by MCO to suspend or terminate network provider
	Provider Suspensions and Termination Report	<u>Annual</u> list of providers that MCO suspended or terminated upon notice of suspension or termination MCO, and list of provides suspended or terminated by MCO independently
	Certification of Suspended/Terminated Providers	<u>Quarterly</u> certification of compliance with MCO Provider suspensions and terminations requirements and report

Strategy Section	Report Title	Description
	Provider Manual	<u>Annual</u> , provider manual which includes specific information about MCO covered services, non MCO covered services, and other requirements relevant to provider responsibilities
Availability of Services: Timely access	Telephone Statistics Report	<u>Quarterly</u> report of telephone answer statistics (e.g., number of calls received, number /percentage of calls abandoned, number/ percentage calls answered w/in 30 seconds , average speed of answer)
Coverage and authorization of services	Service Authorization and Utilization Review Report	<u>Quarterly</u> report regarding services authorized and denied
	Fraud & Abuse Report	<u>Quarterly</u> report regarding any areas of provider and enrollee fraud and abuse
	Network Provider Profiling	<u>Quarterly</u> utilization review of like specialists across provider network to determine if services billed are medically necessary
	Benefit Coordination Plan	<u>As relevant</u> , benefit coordination plan and proposed changes submitted for review and approval
Enrollment	Enrollment Discrepancy Report Unreachable Enrollees PCP Assignment Report	<u>Monthly</u> report of enrollees identified on NDMA's file but not enrolled in MCO's plan, enrollees not identified on NDMA's file but enrolled in MCO's plan, and enrollee changes of address
	Disenrollment Reasons	<u>Annual</u> report of mortality data
Grievance systems	Enrollee Inquiries	<u>Semiannual</u> report identifying the number and type of the top 10 inquiries received
	Enrollee Grievances	<u>Quarterly</u> report identifying the number and type of administrative grievances received from an enrollee or his/her appeal representative (quality of care, access, attitude/service, billing/finance) , the action taken for the grievances for which trends are observed, the average time frame for resolution of grievances in each category
	Report of number and types of complaints and appeals filed by enrollees	<u>Monthly</u> report of complaints, and appeals, including reporting on how and in what time frame the complaints were resolved
Sub contractual relationships and delegation	Notification of Termination	<u>Within five business days</u> , notice of MCO's termination of any material subcontractor, or notice by any material subcontractor of intention to terminate a contract
Quality assessment	HEDIS [®] Clinical Topic Review (CTR)	<u>Annual</u> report, prepared by an external contractor of performance measurement
	HEDIS [®] Clinical Topic Review (CTR) Satisfaction Survey	<u>Annual</u> report, prepared by an external contractor of performance measurement
	CAHPS [®] Survey	<u>Annual</u> report of CAHPS survey results
Performance improvement	Quality Assessment and Program Improvement goal report	<u>Semiannual</u> reports of progress toward QAPI goals
Information systems	Encounter data	<u>Monthly</u> , by the 25 th of the following month for all claims paid in the previous month

Strategy Section	Report Title	Description
EQRO activities	Report of mandatory EQR activities Program	Validation of performance improvement projects, Validation of performance measures, and Compliance with strategy standards