North Dakota Medicaid Expansion

Quality Strategy

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Disclaimer

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Section I: Introduction

Background and Structure of North Dakota's Medicaid Program

The North Dakota (ND) Medicaid Program has two parts: fee-for-service (FFS) and Medicaid Expansion. Before Medicaid Expansion started, ND Medicaid mainly worked as a fee-for-service program.

To help more people in North Dakota get affordable health insurance, preventive care, and financial protection if they get sick or injured, the North Dakota Department of Health and Human Services (HHS) started Medicaid Expansion on January 1, 2014. This was allowed under the federal Patient Protection and Affordable Care Act [Pub L 111-148] (ACA).

On January 1, 2022, people in Medicaid Expansion began receiving their health services through Blue Cross Blue Shield of North Dakota (BCBSND). BCBSND is the state's Medicaid managed care organization (MCO).

As of August 31, 2024, ND Medicaid served 106,324 people. This included:

- 50,262 children
- 24,537 people on Medicaid Expansion
- 10,713 individuals with disabilities
- 12,031 adults ages 21–64
- 8,781 people age 65 and older

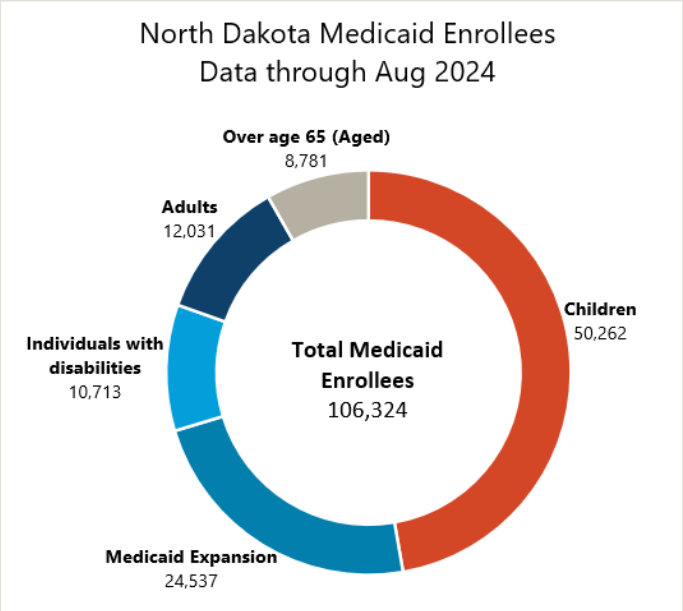


Figure 1: North Dakota State Medicaid Enrollees August 2024 Data

Our Vision

To make North Dakota the healthiest state in the nation

Our strategic priorities provide specifics for how we will achieve our vision and how we will measure our success:

- Support the advancement of strong, stable, healthy families and communities.
- Advance the foundations of well-being through access to high-quality services and supports closer to home.
- Optimize disaster and epidemic response and recovery.
- Advance excellence in agency infrastructure and operations.
- Deliver best-in-class customer-centered experiences.
- Foster a culture of excellence where every team member has a voice, adds value, and is empowered to make a difference.

HHS Guiding Principles

Continuous improvement and innovation

We embrace continuous improvement and innovation as ways to streamline the delivery of services, drive efficiencies and promote best-in-class customer-centered experiences.

Responsible stewardship

Our organizational effectiveness and impact are enhanced by our strategic and efficient management of agency funding, assets and resources.

Transparent and open communication

We prioritize transparent and open communication to facilitate trust, organizational and stakeholder awareness, collaboration and unity.

Engaged collaboration

We bring a spirit of teamwork and accountability to every interaction, using our combined strengths to drive solutions and success.

Data-centered decisions

Our decisions are grounded in data; we use facts and metrics to inform and guide our actions and evaluate outcomes.

To meet our strategic goals (Figure 2: North Dakota Medicaid Quality Strategy.), North Dakota uses a population health approach. This means we work to improve health for people at every stage of life.

The ND Medicaid program is designed with a clear vision and a data-driven plan to improve health outcomes for members. We focus on quality and performance improvement to make sure care is better for everyone.

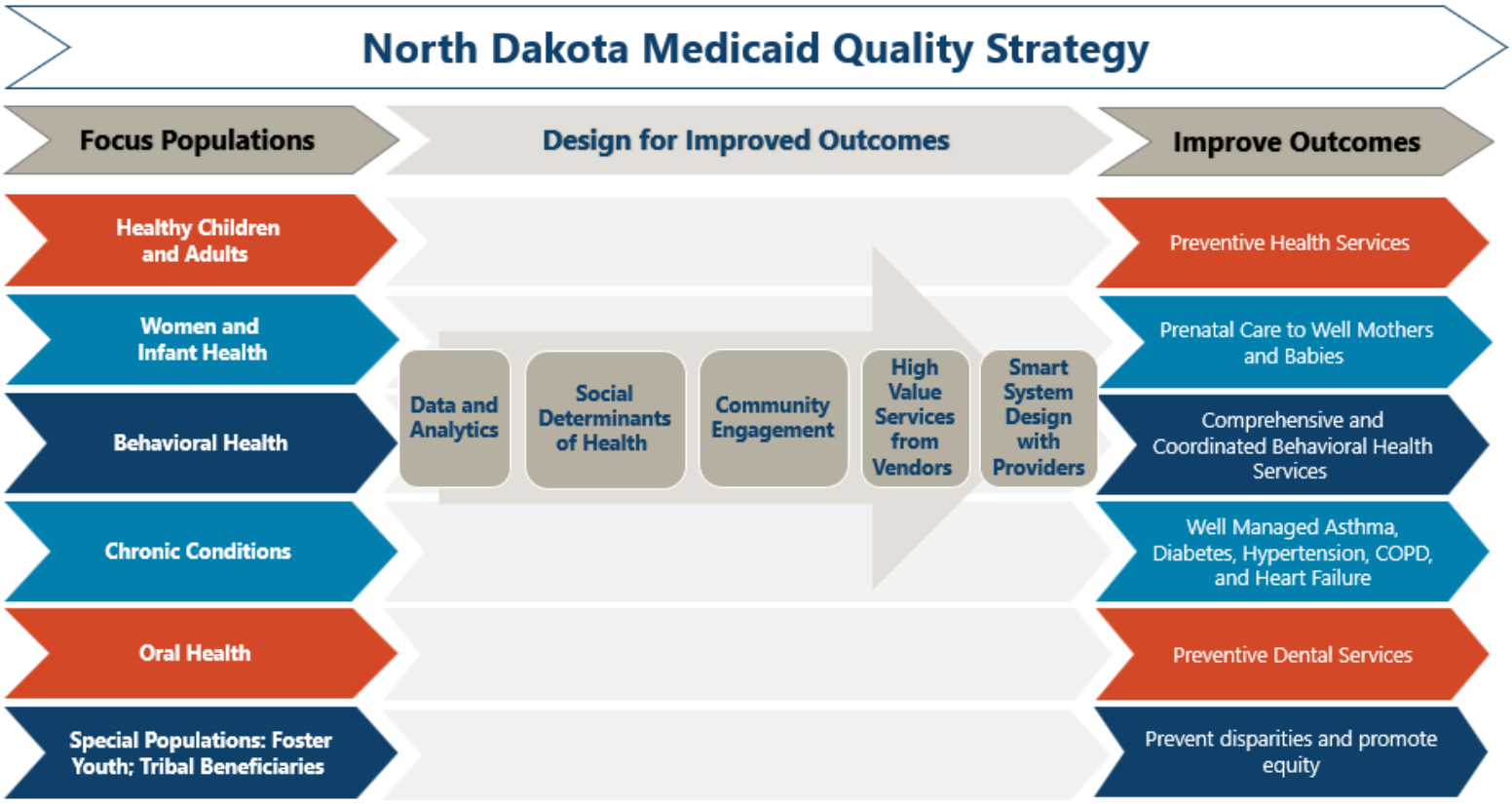


Figure 3: North Dakota Medicaid Quality Strategy

North Dakota Medicaid Quality Strategy purpose is to help focus populations:

- Healthy Children and Adults
- Women and Infant Health
- Behavioral Health
- Chronic Conditions
- Oral Health
- Special Populations such as Foster Youth and Tribal Beneficiaries.

The design for improved outcomes includes:

- Data and Analytics
- Social Determinants of Health
- Community Engagement
- High Value Services from Vendors
- Smart System Design with Providers

The goal is to improve outcomes:

- Preventive Health Services
- Prenatal Care to Well Mothers and Babies
- Comprehensive and Coordinated Behavioral Health Services
- Well managed Asthma, Diabetes, Hypertension, COPD (Chronic Obstructive Pulmonary Disease), and Heart Failure
- Preventive Dental Services
- Prevent disparities and promote equity

Quality Strategy Purpose

The purpose of ND Medicaid's Quality Strategy consists of four components:

1) **Healthier Populations**
    i) Improve the health status of North Dakotans by promoting healthy lifestyles, preventive care, disease management, and disparity elimination.
2) **Better Outcomes**
    i) Improve access to quality healthcare at an affordable price to improve outcomes.
3) **Better Experience**
    i) Enhance member and provider experience.
4) **Smarter Spending**
    i) Increase effectiveness and efficiency in the delivery of healthcare programs and ensure value in healthcare contracts.



Figure 4: North Dakota's Quadruple Aim

Source: Institute for Healthcare Improvement (IHI)

According to CMS, a quality strategy is part of a step-by-step plan to improve managed care. It works best when it is used along with other important tools and programs, such as:

- Medicaid and CHIP Adult and Child Core Set measure reporting
- NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys
- Performance Improvement Projects (PIPs) as part of Quality Assessment and Performance Improvement (QAPI) programs
- Annual External Quality Review (EQR)

Each of these tools supports the others. Together, they create a complete system for improving quality.

These goals form a plan that guides North Dakota's vision for improving care for Medicaid members. The aims, goals, and objectives were created to match the CMS Quality Strategy. They also focus on North Dakota's specific priorities, challenges, and opportunities.

Each of the four aims shown in Figure 3 includes its own goals and objectives. These point out the main areas where we expect progress and want to improve quality.

Quality Strategy Goals

The Quality Strategy is guided by the goals and objectives listed in Tables 1 - 4. This strategy gives North Dakota Medicaid a clear plan to improve health and health care. It focuses on new programs, whole-person care, health equity, supporting providers, and helping people with unmet health-related needs.

The measures in Tables 1 - 4 focus on key objectives that help track progress toward these goals. All of the measures align with the MCO's QAPI Plan.

In the following tables, baseline rates represent Measurement Year 2022, and the target rates for Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are set for the current measurement year Medicaid Quality Compass (QC) percentile or Medicaid National median rates.

The tables outline the measure stewards which include the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), and Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Table 1: Quality Strategy Goals and Objectives Aim 1: Healthier Populations

Goal	Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
1.1: Improve Preventive Health	1.1a	Increase the percentage of women receiving Breast Cancer Screening: Ages 50 to 74	BCS-AD	HEDIS	NCQA	30.4%	NCQA 50th percentile
1.1: Improve Preventive Health	1.1b	Increase the percentage of beneficiaries receiving colorectal cancer screening: Ages 50 to 64	COL-AD	HEDIS	NCQA	14.0%	NCQA 50th percentile
1.2: Improve Postpartum Care	1.2	Increase the percentage of women delivering a live birth who had a timely postpartum care visit	PPC-AD	HEDIS	NCQA	39.5%	NCQA 50th percentile
1.3: Improve Behavioral Health Care for Beneficiaries	1.3a	Increase the percentage of follow-up after emergency department visit for mental illness (7-day)	FUM-AD	HEDIS	NCQA	35.9%	NCQA 50th percentile
1.3: Improve Behavioral Health Care for Beneficiaries	1.3b	Increase the percentage of follow-up after emergency department visit for mental illness (30-day)	FUM-AD	HEDIS	NCQA	51.5%	NCQA 50th percentile

Table 2: Quality Strategy Goals and Objectives Aim 2: Better Outcomes

Goal	Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
2.1: Improve Outcomes for Members with Substance Use Disorders	2.1a	Increase the percentage of adults ages 18–64 identified with an Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment within 14 Days of Engagement includes Initiation Treatment with Two Additional Services. (Total alcohol and other drug (AOD) Initiation)	IET-AD	HEDIS	NCQA	51.1%	NCQA 90th percentile
2.1: Improve Outcomes for Members with Substance Use Disorders	2.1b	Increase the percentage of adults ages 18–64 identified with an Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment within 14 Days of Engagement includes Initiation Treatment with Two Additional Services. (Total alcohol and other drug (AOD) Engagement)	IET-AD	HEDIS	NCQA	28.0%	NCQA 95th percentile

Goal	Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
2.2: Improve Health for Members with Chronic Conditions	2.2a	Decrease the number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries ages 18 and older. (lower rate is better)	PQI08-AD	Adult Core Set	AHRQ	25.94	Medicaid Median
2.2: Improve Health for Members with Chronic Conditions	2.2b	Decrease the number of inpatient hospital admissions for diabetes short-term complications per 100,000 beneficiary months for beneficiaries ages 21 and older. (lower rate is better)	PQI01-AD	Adult Core Set	AHRQ	24.41	Medicaid Median
2.2: Improve Health for Members with Chronic Conditions	2.2c	Decrease the number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries ages 40 and older. (lower rate is better)	PQI05-AD	Adult Core Set	AHRQ	25.41	Medicaid Top Quartile

Table 3: Quality Strategy Goals and Objectives Aim 3: Better Experience

Goal	Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
3.1: Enhance Member Experience	3.1a	Increase Timely Access to Care by beneficiary getting care quickly	CPA-AD	Survey	CAHPS	79.5%	Medicaid Median
3.1: Enhance Member Experience	3.1b	Increase Member Satisfaction by beneficiary rating of health plan	CPA-AD	Survey	CAHPS	71.4%	Medicaid Median
3.1: Enhance Member Experience	3.1c	Increase Member Satisfaction with Care rating of all health care	CPA-AD	Survey	CAHPS	82.1%	NCQA 95th percentile

Table 4: Quality Strategy Goals and Objectives Aim 4: Smarter Spending

Goal	Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
4.1: Focus on Paying for Value	4.1	Decrease the ratio of observed all-cause readmissions to expected readmissions (O/E Ratio) among adults ages 18–64 (lower rate is better)	PCR-AD	HEDIS	NCQA	1.0213	NCQA 50th percentile

Section II: Assessment

Quality and Appropriateness of Care (§ 438.340)

North Dakota will check how well the MCO is meeting the goals in Section I.

The state will look at:

- the quality and appropriateness of care and services provided to members
- how well the MCO follows its contract
- how it serves people with special health care needs

The state measures the quality and appropriateness of care for Medicaid managed care members through:

- State internal monitoring
- Performance Measurement
- Performance Improvement Projects (PIPs)
- ND Medicaid Expansion MCO Compliance, Operations, and Quality Reporting (Table A1-A15)
- External Quality Review (EQR): The Department of Health and Human Services hires an independent reviewer to evaluate MCO performance, as required by federal regulations.

Members with Special Health Care Needs (§ 438.340(b)(8)

Members with special health care needs are people who have, or may be more likely to have, long-term physical, developmental, behavioral, or emotional health conditions.

The MCO must make sure these members can get the services they need. The MCO must also make sure their care is planned and coordinated. All services must follow the program rules, including any limits or services that are not covered.

Disparities Plan (§ 438.340[b][6])

To follow federal rules about age, sex, race, ethnicity, disability, and primary language (Title 42 CFR § 438.206–438.210), the Department of Health and Human Services (HHS) requires the MCO to help North Dakota provide services in a respectful and culturally

aware way. This includes helping members who have limited English skills or come from different cultural backgrounds.

By collecting information about a member's race, ethnicity, and main language, the MCO can help reduce health differences and improve care. This makes health care better for each person's needs.

The MCO must have a process to:

- Find out a member's race, ethnicity, and main language.
- Find out the cultural and language skills of providers in the network and share this information with members if they ask (on paper or online).
- Follow disability decisions made by North Dakota Disability Determination Services (DDS), which uses Social Security Administration (SSA) rules. Learn more at: North Dakota Disability Determination Services.

The MCO must use the top 15 languages spoken by people in North Dakota who have limited English skills. It must let members know that language help is available, following federal rules under the Affordable Care Act Section 1557 and guidance from CMS, HHS, and the Office for Civil Rights. The MCO must also translate written marketing and member education materials into these top 15 languages, when needed.

The state requires the MCO and its contractors to provide spoken interpreter services for members who speak any foreign language.

HHS gives the MCO information about members' age, sex, race, ethnicity, disability status, and primary language. The MCO must use this information to look for possible differences in care and improve quality. When collecting performance data, the MCO must review information by age, race, ethnicity, sex, primary language, and disability status to find health gaps and improve health outcomes.

Medicaid Contract Provisions - State Monitoring Requirements (§ 438.66)

To check the quality and appropriateness of care for members with routine and special health needs, North Dakota (ND) regularly reviews the MCO's reports and deliverables as required by Appendix D of the contract (Table A1). ND also works with its External Quality Review Organization (EQRO) to do full compliance reviews through the

Interlaboratory Quality Assurance Program (IQAP). ND and the EQRO measure, monitor, and evaluate how well the Quality Strategy is being followed.

The state monitors how the MCO performs in these areas:

- Administration and management
- Appeals and grievances
- Claims management
- Member materials and customer service, including beneficiary support
- Finance, including medical loss ratio reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including utilization and case management
- Program integrity
- Provider network management, including provider directory standards
- Use of practice guidelines based on reliable clinical evidence and member needs
- Availability and access to services, including network adequacy
- Quality improvement
- Other contract requirements, as needed

To help with monitoring, the MCO must send reports to the state as required by the contract. This allows better oversight and tracking overtime. Report deadlines follow Appendix D: MCO Compliance, Operations, and Quarterly Reporting (Table A1). If there are exceptions to this schedule, they must be noted in the report. If the MCO cannot meet a deadline for reasons beyond its control, the state will provide written documentation and allow extra time as needed.

Reports must be submitted electronically in a format approved by the state. If a report needs changes or a new format, the state will send a written request to the MCO. The MCO must have a system to collect and store data that meets the contract requirements.

Sanctions (§ 438.340[b][7])

The Quality Strategy is based on continuous quality improvement. North Dakota (ND) believes in working closely and proactively with the MCO to improve the care provided to Medicaid Expansion members.

However, if improvement efforts are not effective, the state's quality management process includes penalties and possible contract termination. Any sanctions must meet federal requirements under Title 42 CFR Part 438, Subpart I, as well as state requirements.

The Medical Services Division has the authority to:

- Impose penalties or sanctions.
- Arrange for temporary management of the MCO.
- Immediately terminate the MCO's contract under certain conditions.

If the state decides that the MCO is not providing one or more required core benefits or services, it may allow members to receive those services from another provider. If the MCO does not maintain a required and adequate provider network, the state may impose a monetary penalty for each incident.

The state may also apply penalties and sanctions if the MCO or its related entities fail to meet program integrity and sanction requirements under North Dakota Administrative Code (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 the state, the MCO must implement the initial or revised CAP within the timeframes specified by the state.

Arrangement for External Quality Review (§ 438.340[b][4])

According to § 438.356 and § 438.358, North Dakota (ND) hires an External Quality Review Organization (EQRO) to complete both the mandatory and optional EQR activities.

Mandatory EQR Activities

To check the quality, timeliness, and access to services under the MCO contract, ND's EQRO performs mandatory EQR activities for the ND Medicaid Expansion program. The state contracts with its EQRO to do the activities shown in Figure 4, Compliance Monitoring Evaluation, Validations of Performance Measures, Validation of PIPS and Network Adequacy Validation.



Figure 5: External Quality Review Activities

Review of Compliance with Medicaid and CHIP Managed Care Regulations

ND's EQRO does full site reviews of the MCO's compliance at least once every three years. The EQRO checks if the MCO meets state standards for access to care, structure and operations, and quality measurement and improvement. These standards are as strict as the federal Medicaid managed care rules in Title 42 CFR Part 438, which cover access, operations, and quality improvement. Compliance is also checked by reviewing individual files to see if the standards are being followed. Table 5 lists relevant Title 42 CFR Part 438 regulations and MCO compliance standards.

Table 5: Title 42 CFR Part 438 and MCO Compliance Standards

Subpart	Regulation	Description
A: Information Requirements	§ 438.10	Information Requirements
B: Disenrollment Requirements and Limitations	§ 438.56	Disenrollment Requirements and Limitations
C: Enrollee Rights and Protections	§ 438.100	Enrollee Rights
C: Enrollee Rights and Protections	§ 438.102	Provider – Enrollee Communications
C: Enrollee Rights and Protections	§ 438.114	Emergency and Post-stabilization Services
D: MCO Standards	§ 438.206	Availability of Services
D: MCO Standards	§ 438.207	Assurance of Adequate Capacity and Services
D: MCO Standards	§ 438.208	Coordination and Continuity of Care
D: MCO Standards	§ 438.210	Coverage and Authorization of Services

Subpart	Regulation	Description
D: MCO Standards	§ 438.214	Provider Selection
D: MCO Standards	§ 438.224	Confidentiality
D: MCO Standards	§ 438.228	Grievance and Appeal Systems
D: MCO Standards	§ 438.230	Sub-contractual Relationships and Delegation
D: MCO Standards	§ 438.236	Practice Guidelines
D: MCO Standards	§ 438.242	Health Information Systems
E: Quality Measurement and Improvement	§ 438.330	Quality Assessment and Performance Improvement Program
F: Grievance and Appeal System	§ 438.402	General Requirements
F: Grievance and Appeal System	§ 438.404	Timely and Adequate Notice of Adverse Benefit Determination
F: Grievance and Appeal System	§ 438.406	Handling of Grievances and Appeals
F: Grievance and Appeal System	§ 438.408	Resolution and Notification: Grievances and Appeals
F: Grievance and Appeal System	§ 438.410	Expedited Resolution of Appeals
F: Grievance and Appeal System	§ 438.414	Information About the Grievance and Appeal System to Providers and Subcontractors
F: Grievance and Appeal System	§ 438.416	Recordkeeping Requirements
F: Grievance and Appeal System	§ 438.420	Continuation of Benefits While the MCO, PIHP, or PAHP Appeal and the State Fair Hearing are Pending
F: Grievance and Appeal System	§ 438.424	Effectuation of Reversed Appeal Resolutions
H: Program Integrity Requirements Under Contract	§ 438.608	Program Integrity Requirement – Fraud, Waste, and Abuse (FWA)

Validation of Performance Measures (§ 438.340(b)(3)(i))

ND requires the MCO to send performance measurement data as part of their Quality Assessment and Performance Improvement (QAPI) programs. To meet §438.332, the state's EQRO checks these performance measures through NCQA HEDIS Compliance Audits for MCOs and performance measure validation audits.

The NCQA HEDIS Compliance Audits look at how well the MCO handles claims, encounter data, pharmacy data, lab data, enrollment data, and provider data. The EQRO ensures that each performance measure chosen by the state is reported accurately.

As part of these audits, the EQRO also checks if claims and encounter data are complete and accurate. This helps improve the rates for performance measures.

Validation of Performance Improvement Projects (PIPs) (§ 438.340(b)(3)(ii))

ND requires the MCO to conduct PIPs following § 438.330(d). These projects must aim for major and lasting improvements in both clinical and nonclinical care. They should use ongoing measurement and actions to improve health outcomes and member satisfaction.

According to § 438.358(b)(1)(i), the state's EQRO checks (validates) PIPs to make sure they meet the requirements of § 438.330(d). The EQRO looks at whether the PIPs are designed to improve care and have a positive effect on health outcomes and member satisfaction.

The state requires the MCO to report the status and results of each PIP in a semi-annual report, but at least once a year, as described in § 438.330(d)(3).

Network Adequacy Validation (§438.68, §438.206, and §438.207)

ND's EQRO checks (validates) whether the MCO's provider network meets the rules in Title 42 CFR § 438.68 and § 438.14(b)(1).

The validation process includes:

- Making sure the network meets standards set by HHS, such as provider-to-member ratios, travel time or distance to providers, and timely appointment standards.
- Reviewing the data and methods the MCO uses to measure network adequacy.
- Confirming the results, giving a validation rating, and reporting the findings to HHS and the MCOs.

The analysis looks at three areas of access and availability:

Capacity

This means the number of providers compared to the number of members (provider-to-member ratios) as defined in the MCO contract. The North Dakota EQRO 2022 Compliance Review checked these ratios, such as the PCP-to-Enrollee Ratio Report. See also Availability of Services (§ 438.206).

Geographic Network Distribution

This measures how far members must travel to see providers. It includes time and distance for different provider types and the average miles to the closest provider, as defined in the MCO contract. The 2022 Compliance Review looked at tables showing access for adult PCPs, outpatient behavioral health, and specialists, such as the PCP Providers Accepting New Patients Geographic Access Report.

Appointment Availability

This measures how long it takes to get an appointment. The 2022 Compliance Review checked time standards, such as:

- Emergency services: 24/7 availability
- Routine care: within 6 weeks of request
- Urgent care (not life-threatening): within 24 hours
- Sick care (non-urgent): within 72 hours or sooner if condition worsens
- PCP ratio: 1 full-time PCP for every 2,500 members

The FY 2023 PCP Access Telephone Survey Report also checked appointment standards:

- Routine well-check visits: within 6 weeks
- Sick visits: within 3 days

Optional EQR Activities

North Dakota (ND) has chosen to have its EQRO perform the following optional activities allowed by CMS:

Validation of Encounter Data (§ 438.358(c)(1))

The EQRO conducts an Encounter Data Validation (EDV) study that checks if the MCO's encounter data is valid, accurate, and complete, meeting the 95% standard required by the contract. It also ensures:

- Provider claims are received on time
- Claims are submitted within 365 days of service
- Claims are paid promptly

Other Available EQR Activities

- Help with Medicaid Quality Ratings by evaluating the state's Quality Strategy, tracking progress toward goals, and suggesting updates.
- Provide technical assistance to align managed care with Medicaid fee-for-service programs.
- Quality Strategy evaluation

EQR Technical Reporting (§ 438.364)

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule-requires states to prepare an annual technical report. This report explains how data was collected and analyzed and how conclusions were made about the quality, timeliness, and access to care provided by MCOs.

North Dakota's EQRO creates this report, which includes all mandatory and optional EQR activities completed in the past 12 months. It also includes outcomes, data, results from quantitative assessments, and validation information.

The report must include:

- An assessment of quality, timeliness, and access to the care for each MCO
- Objectives of each activity
- Methodes used to collect and analyze data
- Description of data obtained.
- Conclusions drawn from the data.
- Strengths and weaknesses of each MCO
- Recommendations for improving care and aligning with the Quality Strategy
- Comparative information about MCO performance
- How well the MCO addressed last year's recommendations

HHS uses this report to make changes to the Quality Strategy and improve programs. The report also includes the EQRO's evaluation of the Quality Strategy,

The executive summary and full report will be posted on the ND Department of Health and Human Services Medicaid website. Past reports can be found at:
North Dakota Medicaid Expansion

The state uses the report to decide if sanctions or corrective actions are needed, as designated in the MCO contract. It evaluates existing program goals and informs new program goal development. The state will also use the report to inform the MCO of any contract amendments or revisions needed.

The EQRO follows the latest CMS protocols to complete its tasks. This includes collecting accurate data, analyzing it, and interpreting results, as required by § 438.352 and § 438.358. The state makes sure the EQRO has all the necessary information from mandatory and optional EQR-related activities, as stated in § 438.350. This information is gathered using approved methods and includes all elements listed in the EQR results section. Results will be shared as required by regulation.

Accreditation and Duplication (§ 438.340[b][9])

The MCO must be accredited by a nationally recognized independent accrediting organization, as required in contract section 2.13.3. The MCO must have accreditation from NCQA or URAC for its Medicaid product.

When the MCO is accredited for the ND Medicaid Expansion population, the information from the accreditation review—if it matches the EQR mandatory activities described in Title 42 CFR § 438.358(b)(1)(i-iii) and § 457.1250 – can be used to avoid doing the same work twice.

Section III: State Standards

The Quality Strategy is organized based on standards in Title 42 CFR Part 438 Subparts D and E of the Medicaid Managed Care Rules and Regulations. North Dakota's standards are at least as strict as those in Title 42 CFR Part 438.

The standards are divided into three main areas:

- Access
- Structure and Operations
- Measurement and Improvement

Access Standards

Network Adequacy (§ 438.68)

The access standards were developed based on § 438.68(c) and include:

- Expected Medicaid enrollment
- How often services will be used
- Health needs of different Medicaid populations
- Numbers and types of providers needed to deliver services
- Number of providers not accepting new Medicaid patients
- Location of providers and members, considering distance, travel time, and transportation options
- Providers' ability to communicate in members' preferred language
- Providers' ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with disabilities
- Availability of triage lines, screening systems, telemedicine, e-visits, and other new technology

Under new CMS rules (§ 438.68[f] and § 438.10[d][2]) the state contracts with its EQRO to do annual secret shopper surveys. These surveys check:

- If managed care plans meet appointment wait time standards
- If provider director information is accurate

To comply with § 438.10(h)(3)(iii) the secret shopper survey is available in all languages.

Availability of Services (§ 438.206)

The MCO must make sure services are available and accessible to members in a culturally competent way. This includes addressing geographic, organizational, and fair access.

Key Requirements:

1. Services must be available 24/7
2. Provider hours must be at least the same as those offered to commercial patients or comparable to ND Medicaid fee-for-service if the provider only serves Medicaid members (consistent with § 438.206[c][1][ii])
3. The MCO must have enough providers to offer all covered services under the contract.
4. Providers and subcontractors must meet all state and federal rules and reporting requirements

Access Standards:

- Services must be provided on time and follow medical guidelines.
- The MCO must maintain a network of providers with written agreements to ensure access to all covered services.
- When building the network, the MCO must consider:
  - Expected enrollment and service use
  - Health needs of Medicaid Expansion members
  - Number and types of providers needed
  - Providers not accepting new patients
  - Location of providers and members, including travel time and transportation options
  - Physical access for members with disabilities

- Networks must include enough hospitals, doctors, and specialists to provide timely care.
- Ratios:
    - Primary Care: 1 full-time PCP for every 2,500 members
    - High-Volume Specialists: 1 full-time physician for every 3,000 members
    - Mental Health/Substance Use Specialists: 1 full-time practitioner for every 3,000 members
- Female members must have direct access to a women's health specialist for routine and preventive care.
- Members must be able to get a second opinion at no cost (except for allowed cost-sharing).
- The state's EQRO checks network adequacy every year. HHS also monitors through quarterly GeoAccess reports and grievance reports.
- The MCO must ensure providers meet state standards for timely access to care.

Standards for timeliness are listed below:



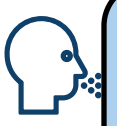
Emergency Services

- available 24 hours a day, 7 days a week
- immediate for Life Threatening Mental Health and/or Substance Use Disorders
- within 6 hours for Non-Life-Threatening Mental Health and/or Substance Use Disorders



Urgent Care

- within 24 hours



Non-Urgent Sick Care

- within 72 hours, or sooner if condition deteriorates into urgent or emergency condition



Routine, Non-Urgent or Preventative Care Visits

- within 6 weeks of member request



Mental Health and/or Substance Use Disorder

- Within 10 working days for Routine Care Initial Visits
- Within 30 days for Routine Care Follow-up Visits



High-Volume and High-Impact Specialty

- Consultation within one month of referral or as clinically indicated

The MCO must make sure there are providers to give members timely care without lowering quality. The MCO must check this regularly and fix any problems if standards are not met.

To check if appointment standards are being met, the state's EQRO does an annual secret shopper survey. This survey looks at how easy it is to get appointments and access services across the MCO's provider network, based on the standards in the state's contract.

Assurances of Adequate Capacity and Services (§ 438.207)

The MCO must provide a full range of covered services that meet the needs of the expected number of members. It must also keep a provider network that has enough providers, with the right mix of specialties and locations, to serve members in the service area.

The MCO must update its network capacity data twice a year and at any time there is a major change that could affect access to care. This includes changes in services, benefits, payments, or adding a new group of members.

Coordination and Continuity of Care (§ 438.208)

Modern health care systems are complex and involve many different providers working together. These systems need good coordination to make sure patients get the care they need at every stage. This standard requires the MCO to have processes in place to provide primary care and coordinate all health services for its members.

The MCO must help all North Dakota Medicaid Expansion members choose a Primary Care Provider (PCP). The MCO must make sure the PCP has the right skills and experience, especially for members with special health care needs. In some cases, a specialist can be a PCP, but only if they can also manage routine and preventive care. The PCP is in charge of the member's overall care and works with a care coordinator to organize all services, including primary care, urgent care, mental health care, and substance use treatment. The MCO must also provide a care coordinator when a member needs extra support based on their health needs.

The MCO must have a system to identify members with special health care needs and assess their conditions. This helps make sure they get the right treatment and ongoing care. The MCO can use information from North Dakota Medicaid, such as disability status or other program categories, as well as information from other state agencies. The MCO must also share assessment results with other health plans that serve the same member to avoid repeating the same work, while still protecting the member's privacy.

For members with special health care needs who require ongoing treatment or monitoring, the MCO must allow direct access to specialists when needed. This may include standing referrals or a set number of visits. Treatment plans must be approved quickly when required and must follow state quality and review standards. The MCO must clearly explain how members can request specialist care when they enroll.

If the MCO's network cannot provide needed covered services, it must arrange for those services outside the network in a timely way. The member should not pay more than they would for in-network care. Out-of-network providers must work with the MCO on payment and care coordination. Services provided outside of the United States are not covered.

The MCO and its subcontractors must have procedures to provide primary care and coordinate health care for all members. The MCO must monitor continuity of care across all services and treatments. It must also make sure the services it provides work together with any services the member gets from another MCO or private health insurance plan (PHIP; consistent with § 438.208[b][2]).

Key Requirements:

- Ensure all ND Medicaid Expansion members have a Primary Care Provider (PCP). Members are encouraged to choose their own PCP. If they don't choose one, the MCO will assign a PCP near their location. Members can change their PCP as often as they want.
- Provide a PCP with the right skills for members with special health needs. A specialist can serve as a PCP if they can manage preventive and primary care.
- The PCP works with a care coordinator to manage all covered services, including primary care, acute care, and mental health/substance use disorder services.
- Provide a care coordinator when needed, based on an assessment of the member's health and support needs.
- The MCO must make sure that care for new ND Medicaid Expansion members is not interrupted. Special attention must be given to members who are seeing specialists or whose health could be at risk if their care is disrupted.
- If a member moves out of the service area, the MCO must pay for or arrange care with out-of-network providers in the new area for medically necessary services until the end of the period covered by the MOC's capitation payment for that member

Medically Necessary

"Medically necessary" is a legal term that defines when a service can be approved. It imposes parameters and restrictions that are both medical and nonmedical. Under North Dakota Administrative Code (NDAC) 75-02-02-03.2, medically necessary services must:

- Treat an illness, injury, disease, or impairment.
- Match the patient's diagnosis or symptoms.
- Follow generally accepted medical standards.
- Not be provided only for convenience.
- Not be experimental or unproven.
- Be appropriate in scope, length, intensity, and setting.
- Be delivered at the safest and most effective level of care.

Special Health Care Needs:

- The MCO must identify members with special health needs and monitor ongoing conditions.
- The MCO can use information from ND Medicaid and other state agencies to identify these members.
- Share assessment results with other health plans serving the same member to avoid duplication, while protecting privacy.
- Members with special health needs must have direct access to specialists when needed (through standing referrals or approved visits).
- Treatment plans must be approved quickly if required and meet state quality and review standards.
- Explain the process for requesting specialist care to members when they enroll.

Out-of-Network Care:

- If the MCO's network cannot provide needed services, the MCO must cover these services out-of-network promptly and at no extra cost to the member (other than allowed cost-sharing) in accordance with § 438.206(b)(4)
- The 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.
- Out-of-network providers must coordinate with the MCO for payment.
- Services outside the United States are not allowed.

Another important part of making sure care continues is keeping access to services when people switch between ND Traditional Fee-for-Service (FFS) Medicaid and the MCO for ND Medicaid Expansion. According to § 438.62, if stopping services could seriously harm a person's health or cause them to need hospital care, ND and the MCO must follow a transition of care policy that includes:

- Giving clear instructions in the MCO Enrollee Handbook on how to keep getting services after the switch
- Allowing people to keep getting needed medical services for a certain time, even if their provider is not in the MCO network
- Helping people find providers in the MCO network
- Sharing past service use information when asked, following federal and state laws
- Providing copies of medical records when asked, as allowed by federal and state laws

Coverage and Authorization of Services (§ 438.210)

The MCO must provide all medically necessary services and appropriate ND Medicaid Expansion covered services in the right amount, for the right length of time, and with enough detail to meet the purpose of the service (consistent with § 438.210[a][1]). The MCO must offer a full health care benefit package. The covered services will include all services that ND requires to be made available to members in ND Medicaid Expansion including, but not limited to:

- Outpatient (ambulatory) care

- Emergency services
- Hospital care
- Maternity and newborn care
- Mental health and substance use treatment
- Prescription drugs (provided through ND DHHS's FFS system since 01/01/2020)
- Rehabilitation and habilitation services and devices
- Lab test
- Preventative care, wellness services, and chronic disease management

The MCO can set limits based on medical necessity or to manage use of services, as long as the services still meet their purpose. The MCO must clearly define "medically necessary services" in a way that:

- Is no stricter than ND Medicaid rules and follows state laws, the state plan, and ACA benchmark standards
- Meets the Mental Health Parity and Addiction Equity Act
- Explains coverage for:
  - Preventing, diagnosing, and treating health problems
  - Helping people grow and develop at the right age level
  - Helping people gain, keep, or get back normal function

All services must follow the medical necessity standard. Managed care programs use the same definition of medical necessity as ND Medicaid Fee-for-Service. The MCO cannot deny or reduce services just because of a person's diagnosis, illness type, or condition (§ 438.210[a][3][ii]).

Utilization Management (§ 438.210(b), § 438.210[d][1], [2] and [e])

The MCO must have a written utilization management (UM) program description that explains how it reviews requests for new services or continued services that are medically necessary. These written policies must follow all federal and state rules, including § 438.210(b). At a minimum, this includes:

- Procedures for deciding if a person needs medically necessary covered services

- The clinical review criteria, evidence, and information used to approve services
- How the MCO reviews and updates its UM criteria over time
- Licensed clinical staff who manage day-to-day UM activities, under the supervision of a licensed medical director

The MCO may create methods to keep service quality high and control costs, as long as these methods still meet its responsibilities to members (Title 42 CFR 438.12[b][3])

The MCO must make every effort to gather all needed information, including important clinical details, and talk with the treating provider when appropriate. When making UM decisions, the MCO must follow § 438.236(c), § 456.111 (Hospitals), § 438.910(d) (Mental Health and Substance Use Parity), and § 456.211 (Mental Hospitals), when they apply.

If the MCO denies a service request or approves it for less than what was asked for, the decision must be made by a health care professional with the right clinical training for the enrollee's condition.

The MCO must send written notice to the provider and the member any time it denies a service request or approves less than what was requested. The written notice must follow the requirements in § 438.404 and § 438.210.

Structure and Operations Standards

Provider Selection (§ 438.214)

Making sure services are provided by properly qualified professionals helps keep patients safe. This is an important part of a high-quality health care system.

This standard requires the MCO to have written policies and procedures for choosing and keeping qualified providers

The MCO must have written and documented steps to check the qualifications of providers before they join the network and on an ongoing basis. This process is called credentialing and re-credentialing. It applies to providers who the MCO has contracts or participation agreements with.

ND requires these processes to follow recognized industry standards, such as those from the National Committee for Quality Assurance (NCQA), and all state rules. This also includes regulations from the Board of Registration of Medicine at 243 CMR 3.13.

- Nondiscrimination

        - The MCO cannot refuse to contract with providers just because they treat high-risk patients or specialize in costly conditions.
    - Excluded providers
        - The MCO cannot contract with providers who are excluded from federal health care programs under Sections 1128 or 1128A of the Social Security Act or under Title 42 U.S. Code § 1320a-7.
        - The MCO also cannot allow providers who have been terminated or suspended by the MCO to treat members, and it must not pay them for services. However, the MCO may suspend or terminate a provider for cause before the state takes action. The MCO must promptly notify members if their provider has been terminated or suspended.

Member Information (§ 438.10)

Good communication helps members get care, use services the right way, and feel satisfied with their health plan. This standard explains how the MCO must communicate with members and potential members.

The MCO must provide all notices, informational materials, and instructions in a way that is easy to understand, following § 438.10. The MCO must:

Meet the needs of people with limited English skills in its service area.

Provide materials in other formats (such as large print or other accessible formats) if requested.

Member materials and handbooks must help members and potential members understand the health plan. This includes information about:

- Benefits
- Cost sharing
- Service areas
- Provider network details
- Member rights and protections
- Plan policies and procedures

All materials must follow state and federal rules and must be approved by the state before they are used.

Each year, the MCO must notify members that they have the right to request and receive certain information listed in § 438.10(f). The MCO must also provide a list of all network providers.

The MCO must give members at least 30 calendar days' written notice before making any major changes, such as changes to benefits or cost sharing.

If a contracted provider is terminated, the MCO must make a good faith effort to send written notice within 15 days to each member who chose that provider as their primary care provider or saw that provider regularly.

Confidentiality (§ 438.224)

This standard requires the MCO and ND to take proper steps to protect members' personal health information.

MCOs may use or share a person's identifiable health information only if they follow the privacy rules in Title 45 CFR Parts 160 and 164, Subparts A and E, when those rules apply.

They must also follow the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Enrollment and Disenrollment (§ 438.54 and § 438.56)

This standard explains the rules for enrolling and disenrolling members in a managed care plan.

Under § 438.56, the MCO cannot disenroll a member because:

- The member's health gets worse.
- The member uses a lot of medical services.
- The member has reduced mental capacity.
- The member has uncooperative or disruptive behavior related to special needs.

The only exception is if the member's continued enrollment seriously affects the MCO's ability to provide services to that member or others.

The MCO must accept all individuals assigned to its plan by the state. The MCO cannot start or approve a member's disenrollment on its own. However, the MCO must notify the state if any of the following happens:

- The contract ends or expires.
- The member dies.
- The member is placed in an institution, and the stay is not covered under the contract.
- The MCO receives information that the member may no longer be eligible for coverage.
- The MCO receives a request (oral or written) from the member asking to disenroll.

The state will then decide whether the person remains eligible and enrolled or should be disenrolled.

Grievance and Appeal Systems (§438.228, §438.230 Subpart F, §438.400, §438.402, § 438.210[d][1], [2] and [e])

The MCO must have a grievance and appeal process that meets all state and federal rules. This must include:

- A process for member grievances (complaints),
- A process for member appeals,
- Access to ND's state fair hearing system, and
- A process for network providers to file appeals.

The MCO must keep records of all grievances and appeals. The state must approve the grievance and appeal process.

The MCO's contract must include the following rules for making decisions and sending notices:

- Standard authorization decisions:
  - The MCO must decide and send notice as quickly as the enrollee's health needs require, but no later than 14 calendar days after getting the request for service.
  - The MCO can extend this by up to 14 more days if:
    - The enrollee or provider asks for more time, or
    - The MCO explains to the state why more information is needed and how the delay benefits the enrollee.

When the member or provider has completed the MCO's appeal process, the MCO must give them information that includes a description of ND's state fair hearing and instructions on how to request one.

If the MCO takes an action and the member requests a state fair hearing, the state will allow the hearing. The MCO, the member, and the member's representative—or the representative of a deceased member's estate—will all be parties in the hearing.

Adverse Benefit Determination (ABD) (§ 438.210[c])

An adverse benefit determination includes any of the following actions by the MCO:

- Denying or limiting a requested service, including decisions about service type, level, medical necessity, appropriateness, setting, or effectiveness
- Reducing, stopping, or ending a service that was previously approved
- Denying payment for all or part of a service
- Not providing services within the time limits set by ND
- Not acting within the required timeframes for resolving grievances and appeals (§ 438.408[b][1] and [2])
- Denying an enrollee's request to get out of network services when allowed for rural/frontier areas or areas with only one MCO (§ 438.52[b][2][ii])
- Denying an enrollee's request to challenge financial charges, including cost sharing, copayments, premiums, deductibles, and other financial responsibilities

Every contract must require the MCO to notify the provider and give the enrollee written notice anytime a service request is denied or approved at a lower amount, duration, or scope than requested. The notice must follow § 438.404 requirements, although the provider's notice does not have to be in writing.

Member Grievance Process

The MCO must define a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. The MCO must tell members that they can file a grievance only with the MCO. Members can file a grievance either by phone (oral) or in writing.

The MCO must review and resolve each grievance as quickly as the member's health condition requires. This cannot take longer than 90 days from the date the MCO receives the grievance. The MCO must send the member a written notice explaining the final decision.

The MCO must keep records of all grievances and appeals. At a minimum, this must include a log of every grievance and appeal, whether made by phone or in writing. The log must include the member's identifying information, a summary of the complaint or appeal, and the final decision, if one was made.

The MCO must review this log every month to look for trends or patterns. The logs must always be available for review by the state and CMS.

Member Appeal Process

An appeal is a request to review an ABD.

- One level of appeal required before a state fair hearing
- Must be filed with the MCO within 60 days of the ABD notice
- May be filed by:
  - The member, or
  - A provider with written consent
- Can be submitted orally or in writing

If the MCO misses deadlines or notice requirements, the member may proceed directly to a state fair hearing.

MCO Responsibilities During Appeal:

- Acknowledge receipt of the appeal
- Provide assistance (forms, interpreters, TTY/TDD access)
- Ensure impartial reviewers (not involved in original decision)
- Use qualified clinical reviewers for medical-related appeals

Member rights:

- Submit evidence and arguments
- Access and review case files
- Be represented

Appeal Timeframes:

- Standard resolution: 30 days
- One extension (up to 14 days) allowed if:
  - Requested by the member, or
  - In the member's best interest

Written notice is required for any extension.

The Appeal Decision Notice must include:

- Decision, date, and reason

- If not fully favorable:
    - Right to a state fair hearing
    - How to request a hearing
    - Right to continue benefits
    - Potential financial liability if the decision is upheld

Benefits must continue if:

- Appeal is filed on time (within 10 days or before effective date)
- The appeal involves reduction/termination of approved services
- Services were authorized and within the approval period
- The member requests continuation

Benefits continue until:

- Appeal is withdrawn
- No timely request for a hearing
- Unfavorable hearing decision
- Authorization expires

Post-Appeal Requirements:

- If the MCO prevails, it may recover the cost of continued services (as allowed)
- If the decision is overturned, the MCO must promptly authorize or provide services

Expedited Appeal Process (§ 438.210[d][1], [2] and [e])

The MCO must have a fast (expedited) appeal process when the MCO or a network provider believes that waiting for a standard appeal could seriously harm the member's life, health, or ability to reach or maintain maximum function.

- The MCO must resolve each expedited appeal as quickly as the member's health requires, but no later than 3 business days after receiving the appeal.
- The MCO can extend this by up to 14 more days if:
  - The enrollee asks for more time, or
  - The MCO explains to the state why more information is needed and how the delay benefits the enrollee.
- Concurrent review is not required for inpatient hospital services under the DRG payment method.

Network Provider Appeal Process

The MCO must let a network provider appeal if the MCO denies coverage for a service.

Sub contractual Relationships and Delegation (§ 438.230)

The health plan must oversee and stay responsible for any work it gives to subcontractors. Even if duties are delegated, the health plan is still accountable.

The health plan must regularly monitor and formally review the subcontractor's performance. If problems or areas for improvement are found, the health plan must require corrective action.

There must be a written agreement that clearly explains:

- The tasks and responsibilities given to the subcontractor.
- The reporting requirements.
- The health plan's right to take back the delegated duties or apply other sanctions if the subcontractor does not perform adequately, as required by § 438.230(b)(2).

Standard for Measurement and Improvement

Practice Guidelines (§ 438.236)

Using evidence-based clinical practice guidelines helps reduce differences in treatment and improve quality of care.

The MCO must have clear procedures for utilization management (deciding what care is approved) based on:

- Evidence-based clinical guidelines and proof that services are medically necessary and appropriate.
- Each patient's unique needs and situation.
- The local health care system and available services.
- Clinical experience, professional judgment, and accepted standards of care.

The MCO is expected to use evidence-based guidelines that are based on reliable clinical research and meet the needs of members. These guidelines may be adapted or adopted from national professional organizations or developed with collaborative input from local providers. All guidelines must be reviewed with contracted health care professionals and updated when appropriate. They must reflect the health care needs of the Medicaid Expansion population.

The MCO must use clinical care standards and guidelines to evaluate the care it provides or fails to provide, for the targeted clinical conditions. It must identify the source of the guidelines it uses.

The following are examples of clinical practice guidelines used by the MCO BCBS ND:

- The COPD or Asthma in Older Adults Admission Rate PIP provides a link to the Asthma Management Guidelines: Focused Updates 2020 (National Heart, Lung, and Blood Institute, 2021).
- The Diabetes Care PIP provides a link to the document Clinical Guidance for Diabetes (CDC, 2024).

These clinical care standards and/or practice guidelines will be adopted by the MCO's Physician Quality Committee and/or the Pharmacy and Therapeutics Committee and reviewed by the MCO Quality Assurance/Quality Improvement (QA/QI) Committee. All clinical practice guidelines will be available on the MCO's website to providers, and

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

The MCO is responsible for adopting, sharing, and using clinical practice guidelines for all covered services to support program initiatives. Guidelines must come from recognized organizations that develop evidence-based standards or be created with input from board-certified specialists. Before adoption, they must be reviewed by the MCO's medical director and other appropriate providers, as appropriate.

Guidelines must reflect members' needs and be reviewed and updated, as appropriate, at least every two years. The MCO must also have clear processes to monitor whether guidelines are being followed in utilization management, member education, coverage decisions, and related activities.

Additional examples of guideline sources include:

- Substance Abuse and Mental Health Services Administration (SAMHSA) and American Society of Addiction Medicine (ASAM) Treatment Improvement Protocols
- American College of Obstetricians and Gynecologists (ACOG) and U.S. Preventive Services Task Force (USPSTF) Practice Guidelines
- National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (Breast Cancer)

Quality Assessment and Performance Improvement Program (§ 438.330)

The MCO must have an ongoing Quality Assessment and Performance Improvement (QAPI) program to support the North Dakota (ND) Quality Strategy.

The QAPI program must regularly and carefully review the quality and appropriateness of the care and services members receive. It must include activities that measure quality and look for ways to improve services over time, as required by § 438.240. The state must review and approve the QAPI program.

In addition to meeting contract requirements for quality improvement (QI) activities, processes, and reporting, the MCO must also follow all federal and state laws and regulations.

The QAPI program must include the following procedures:

- Use quality measures, including HEDIS® data and CMS Adult Core Set measures, to regularly check how well the MCO is meeting the Quality Strategy goals.
- Combine results from yearly Performance Improvement Projects (PIPs), performance measure tracking, and reviews of federal and state requirements.
- Maintain a strong health information system that can collect, track, analyze, and report data.
- Use approved clinical care standards and practice guidelines.
- Have systems in place to find overuse or underuse of services.
- Review clinical care and create programs to reduce or remove differences in healthcare outcomes (health disparities).
- Regularly check that the MCO is meeting state standards.
- Follow any national performance measures or targets developed by CMS in partnership with the state and other stakeholders.
- Create a Utilization Management Plan and an annual work plan.
- Explain how the MCO will monitor and review provider performance, find problems, fix them through corrective action plans, track whether those fixes work, and share results with providers.
- Clearly describe how clinical program initiatives will be carried out for the North Dakota Medicaid Expansion population, as required by the state.
- Submit regular reports (monthly, quarterly, semi-annual, and annual), along with any additional reports the state requires for quality improvement activities (Table A1-A15).
- Measure and report expansion program performance to the state each year using standard measures required by the state (§ 438.3204[c] and § 438.240[a][2]). The MCO must provide all data the state needs to review program performance.
- Report the progress and results of each project to the state when asked and annually for the External Quality Review (EQR) process. The program must produce new information about quality of care every year.

The state will review how well the QAPI program is working and whether it is improving care.

The MCO must submit a detailed QAPI report every quarter. This report should clearly explain how the MCO's quality assessment and performance improvement plan is helping meet its goals and improve health outcomes for the North Dakota Medicaid Expansion population.

The quarterly report must include, but is not limited to:

- Results for required standard performance measures.
- The outcomes and trends of the MCO's Performance Improvement Projects (PIPs).
- The results of the MCO's efforts to help members who use long-term services and supports stay involved and active in their communities (community integration).

Performance Measure Reporting (§ 438.330)

Performance measurement is important for checking and improving quality. The North Dakota Department of Health and Human Services (HHS) uses national tools like HEDIS® and the Adult and Child Core Set measures to compare how well its Medicaid programs are doing compared to national results. This helps the state find areas that need improvement in both the Medicaid fee-for-service (FFS) program and the managed care program.

HHS uses national performance measures whenever possible. These measures have clear rules for how data is collected and reported. This makes sure the information is consistent and allows North Dakota to compare its results with other states and with Medicaid and CHIP programs across the country.

North Dakota requires its MCO to collect and report performance data each year using HEDIS® and the CMS Adult Core Set measures. The MCO must follow all required CMS reporting rules. The CMS Adult and Child core set measures can be found at : Medicaid Adult and Child Core Set Measures. The state supports CMS by collecting and reporting the CMS Adult Core Set and Child Core Set healthcare quality measures in a consistent way.

Each year, the state's External Quality Review Organization (EQRO) reviews and checks the MCO's reported data to make sure it is accurate. The state relies on annually

validated performance measures to report data in relation to the Quality Strategy. The state can change reporting requirements, but it must give 30 days' notice.

The state tracks and studies each measure over time. It compares its results to national benchmarks and decides which areas to focus on based on its Quality Strategy goals. The MCO may be subject to quarterly state trending reports to monitor the MCO's progress on achieving Quality Strategy goals and objectives. The state may also require Performance Improvement Projects (PIPs) to address problem areas after looking at the root causes.

Each year, the EQRO report will review the MCO's strengths and weaknesses in providing quality care, timely services, and access to care for ND Medicaid Expansion members. The report will also:

- Recommend ways to improve the quality of services.
- Review how well the MCO addressed the EQRO's recommendations from the previous year.

If the MCO performs poorly on a measure, it must take corrective action. The state must approve these actions and will monitor them. If a formal action plan is required, the state and the EQRO will review the plan to make sure it is carried out and is working effectively.

The state will use this information to decide if changes are needed. These changes could include benefit updates, contract changes with the MCO, new quality improvement activities, sanctions, or other program updates. The EQRO report may also help the state decide if additional oversight or regulatory support is needed to improve managed care services.

Public Posting of Quality Measures and Performance Outcomes (§438.10(c)(3))

Following federal rules (Title 42 CFR § 438.340(b)(3)(i) and § 457.1240(e)), HHS shares performance results with the public each year. These results are posted for each MCO and for the state as a whole in the yearly External Quality Review (EQR) technical report.

The EQR technical report includes all the measures listed in Tables 1-4: Quality Strategy Goals and Objectives, along with other measures that support the goals in the Quality Strategy. The annual EQR technical report for North Dakota Medicaid managed care members is available on the HHS website under the reports section.

HHS also posts yearly performance results for the state's Fee-for-Service (FFS) program and for each MCO in the North Dakota Annual Performance Report for both children and adults. This report can also be found on the HHS website under reports.

Performance Improvement Projects (§ 438.330[d])

North Dakota requires the MCO to complete Performance Improvement Projects (PIPs) each year, following § 438.330(d).

The MCO's QAPI program must start and maintain state-approved PIPs. At least one PIP each year must focus on mental health or substance use disorders. These projects must aim to create meaningful and lasting improvements in both clinical care (medical services) and nonclinical services (such as access or customer service). PIPs must use ongoing measurements and specific actions to improve health outcomes and member satisfaction.

Each year, the state's External Quality Review Organization (EQRO) reviews and validates the required PIPs, as required by § 438.358(b)(1)(i).

The main goal of PIP validation is to make sure the MCO is meeting federal requirements under § 438.330. This includes making sure the MCO:

- Measures performance using clear and objective quality indicators.
- Puts structured improvement strategies in place to improve quality.
- Reviews whether those strategies are working.
- Plans and starts new actions to improve or maintain progress over time.

Table 6: ND Annual Performance Improvement Projects (PIP)

PIP	PIP Aim	PIP Interventions
Comprehensive Diabetes	By establishing a relationship with a health care provider and having at least one ambulatory or preventive visit with that provider each year, there will be a decrease in inpatient admission related to diabetes complications for Medicaid Expansion members during the calendar year	• Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND. • Case Management reached out to members for the start of case management interventions, medical appointment needs including appointments with PCP and/or specialty care, and social/community needs. • Case Management conducted in-home hemoglobin A1c (HbA1c) labs for members with a diabetes diagnosis (type 1 and 2). • Quality Management sent monthly reports on members with multiple admissions to case management for follow for medical interventions, follow up appointment needs with PCP or specialty provider and community support.

PIP	PIP Aim	PIP Interventions
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	By establishing a relationship with a health care provider and having at least one ambulatory or preventive visit with that provider each year, there will be a decrease in patient admissions related to COPD or Asthma for Medicaid Expansion members during the calendar year.	• Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND. • Case Management made outbound engagement calls in order to reach members for start of case management interventions, medical • Appointment needs, including appointments with PCP and/or specialty care, and social/community needs. • Utilization management sent daily reports with enrollee discharges from inpatient or observation setting and sends weekly reports on outpatient services approved to case management to engage with members to assess healthcare needs including but not limited to appointments, medications, and services as well as assess and provide community support.

PIP	PIP Aim	PIP Interventions
Substance Use	By having a follow-up with a mental health provider or participation in an intensive outpatient or partial hospitalization program, there will be a decrease in rate of Emergency Department (ED) visits for Medicaid Expansion members for a principal diagnosis of substance use disorder or any diagnosis of drug overdose	• Participating providers with BlueAlliance Care+ received quality scorecards, gaps-in-care reports, and participated in collaboration calls with BCBSND. • Case Management made outbound engagement calls in order to reach members for start of case management interventions, medical appointment needs including appointments with PCP and/or specialty care, and social/community needs. • Case management receives alerts from BCBSND, local ER and HIN on members that have been treated in the ER or were admitted to acute inpatient. Case management addressed healthcare needs following receiving alerts such as follow up appointments, gaps in care, health education needs, home visits and social supports. • BCBSND provided case management vendor with list of members that fell into the denominator for the FUA and FUI measure, case management will review list to determine additional outreach and case management needs. • BCBSND implemented peer support services. • Enrolled members into the coordinated services program, to ensure close monitoring and care from an established PCP

Health Information Systems (§ 438.242)

The MCO must have a health information system that collects, analyzes, combines, and reports data. This system must meet the goals listed in federal rule § 438.242. It must provide information on areas such as service use (utilization), member grievances and appeals, and reasons for disenrollment other than losing Medicaid eligibility.

At a minimum, the MCO must:

- Collect data about members and providers, as required by North Dakota, and collect information about services provided to members. This must be done through an encounter data system or another method approved by the state.
- Make sure the data received from providers is accurate and complete by:
    - Checking that the data is correct and submitted on time.
    - Reviewing the data for completeness, logic, and consistency.
    - Collecting service information in standardized formats whenever possible and appropriate.
    - Sharing all collected data with the state and, if requested, with CMS.

Section IV: Process for Quality Strategy Development, Review, and Revisions

Development and Review of Quality Strategy

The purpose of the Managed Care Quality Strategy is to be used as a tool for assessing quality, timeliness, and access to care across the Medicaid Expansion population.

During the development of the Quality Strategy, the state followed Title 42 CFR § 438.340 to ensure compliance with Medicaid managed care rules. Appendix B provides a crosswalk showing where each required element from the 2021 CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit can be found in the Managed Care Quality Strategy.

Updates and Revision of the Quality Strategy

Updates to the Quality Strategy are part of North Dakota's continuous quality improvement process, as required by Title 42 CFR § 438.364(a)(4). Updates take into account recommendations from the EQRO to improve the quality of care provided by the MCO and help HHS focus on goals and objectives that support better quality, timeliness, and access to healthcare for Medicaid Expansion members.

The Quality Strategy will be reviewed and updated at least once every three years, and more often if significant changes occur. Before finalizing any revised or renewed Quality Strategy, North Dakota will submit a copy to CMS at least every three years and whenever major changes are made.

A "significant change" occurs when any of the following affects the purpose or content of the Quality Strategy requirements:

- New or updated state or federal laws or regulations.
- Changes to the state Medicaid program, policies, or procedures.
- Any change that requires public comment, tribal consultation, or input from North Dakota's Medicaid Member Advisory Committee (MMAC).
- Any change to the Quality Strategy goals, including adding or removing goals and objectives.

If updates are made due to significant changes, the draft will be posted on the ND HHS website at North Dakota Events for public comment. The final version will then be posted at North Dakota Medicaid Expansion.

Each updated Quality Strategy is made publicly available on the HHS website at: North Dakota Medicaid Expansion under the reports section.

Public Comment and Tribal Consultation (§ 438.340(c))

Following § 438.340(c), HHS seeks input from the public, the Medicaid Medical Care Advisory Committee (MMAC), and Tribal Nations. This is done through tribal consultation meetings, sharing the Draft Quality Strategy with the MMAC, and publishing it on the ND HHS website at North Dakota Events. Public comments received are also posted on the state's website.

After the public comment period ends and stakeholders—including the MMAC, members, and Tribal Nations—reach a consensus, the Quality Strategy is finalized. The final version is shared with all relevant stakeholders, submitted to CMS, and made publicly available on the HHS website at: North Dakota Publications.

Annual Evaluation of the Quality Strategy

HHS and its EQRO review how the Quality Strategy is being carried out and how effective it is. The results of this evaluation are published each year in the EQR technical report on ND's website at: North Dakota Medicaid Expansion under the Reports tab.

Throughout the year, HHS works closely with the EQRO to support, oversee, and monitor quality activities and track the Medicaid managed care program's progress toward achieving the goals and objectives in the Quality Strategy. The EQRO provides technical support to HHS in developing monitoring strategies and helps ensure that MCOs are aware of new state and federal requirements, as well as updates in quality measurement and reporting technologies.

Each year, HHS and the EQRO also conduct a formal evaluation of the Quality Strategy to assess its overall effectiveness and determine whether it has led to measurable improvements in the quality of services for members, providers, and other stakeholders.

The annual Quality Strategy evaluation includes a review of several key areas:

- Effectiveness of interventions
    - How well quality improvement actions and remediation strategies worked over the past year, shown by improvements in care and services, and trends in performance measure data.
- Program structure and objectives
    - Whether the program's design, processes, and goals are appropriate.
- Barriers to improvement
    - Identification of any limitations or obstacles that may affect performance.
- Internal activity findings
    - Review of results from quality improvement committees, work groups, member complaints, grievances and appeals, and provider complaints, especially when trends or focus areas are identified by HHS or other stakeholders.
- EQRO recommendations
    - How recommendations from the previous year's External Quality Review were addressed by the MCO and HHS.
- Stakeholder feedback
    - Input from HHS administration, the MCO, providers, advocacy groups, Medicaid members, and other internal and external stakeholders.
- Review of goals and objectives
    - Assessment of current Quality Strategy goals and objectives to determine if they continue to support program improvement.

HHS uses several tools to evaluate how well the Quality Strategy is working and whether goals are being met. These include:

- Findings from the annual EQR technical report.
- Results from validated Performance Improvement Projects (PIPs).
- Validated performance measure results.
- Validated network adequacy results (to ensure members have enough providers to choose from).
- Encounter Data Validation (EDV) results.
- Results from MCO compliance reviews.
- Ongoing review of required MCO contract deliverables.
- Information about member grievances and appeals.
- Review of the MCO's cultural competency and QAPI programs.
- Feedback from stakeholders.

The success of the Quality Strategy depends on strong collaboration between North Dakota (ND) and the MCO. To support this, the Leadership Team holds two to four Quality Assurance and Improvement meetings each year. These meetings bring together the state and the MCO's quality teams to:

- Track progress toward Quality Strategy goals.
- Review the ND Medicaid Expansion program from a population perspective.
- Align quality initiatives across ND Medicaid, the MCO, and the Medicaid Expansion programs as much as possible.

Standardized reporting and tracking tools help the state monitor progress and trends over time. The Medicaid Expansion administrator in the Medical Services Division reviews all monitoring and quality reports from the MCO and EQRO. The Leadership Team analyzes the reports, looking at data, root causes, barriers, and improvement actions. Feedback is given to the MCO, and corrective actions are required if needed. All findings and recommendations are documented for public review.

The state and MCO also hold ad hoc calls to discuss specific topics, provide feedback, review Performance Improvement Projects (PIPs), and share best practices as the Medicaid Expansion program evolves.

To further support the Quality Strategy goals, HHS encourages the MCO to align its QAPI program with these goals. Each year, HHS and the EQRO assess the MCO's QAPI program to ensure the MCO continuously monitors and evaluates its own progress in improving access, timeliness, and quality of services for ND Medicaid Expansion members.

Table 7 lists the evaluation dates and the measurement periods for each Quality Strategy update.

Table 7: Quality Strategy Evaluation Dates and Measurement Periods

Evaluation Date	Measurement Period
2024	Calendar Year (CY) 2023
2025	CY 2024
2026	CY 2025
2027	CY 2026

Appendix A: MCO Compliance, Operations, and Quality Reporting

According to the contract between the MCO and the state, including Article 2.15.8, the MCO shall provide the state with the reports described in Table A1-A15 (aligns with Appendix D of the contract). The MCO shall also provide ND with any ad hoc reports requested by the state within 30 days of the state's request, or a longer timeframe as agreed upon by the state.

Table A1: Administration and Contract Management

Report Title	Description
Notification of Termination	Within five (5) business days, notice of MCO's termination of any Material Subcontractor, or notice by any Material Subcontractor of intention to terminate a contract
Staffing	Annually by 31 December and upon request from STATE, a copy of the current organizational chart with reporting structures, names, and positions
Key Personnel Changes	As relevant, changes to MCO personnel in key positions

Table A2: Enrollment

Report Title	Description
Enrollment Discrepancy Report	Monthly report of Members identified on North Dakota Medical Association's (NDMA) file but not enrolled in MCO's plan, Members not identified on NDMA's file but enrolled in MCO's plan, and other information potentially impacting eligibility such as Enrollee's address, death, or obtaining pharmacy services outside of ND or its contiguous states
Enrollment Timeliness Report	Monthly report of outbound 834 transactions not processed within one business day of receipt from STATE and timeline for completion of transactions

Table A3: Enrollee Services

Report Title	Description
Telephone Statistics Report	Quarterly report detailing weekly telephone answer statistics (e.g., number of calls received, number/percentage of calls abandoned, number/ percentage calls answered w/in thirty (30) seconds, average speed of answer)
Enrollee Inquiries	Semiannual report identifying the number and type of the top ten (10) inquiries received, due 31 March and 30 September

Table A4: Covered Services

Report Title	Description
Mental Health and Substance Use Parity	Annual report documenting compliance with the Mental Health Parity and Addiction Equity Act of 2008 due 1 June
Value-Added Benefits	As relevant, any changes to value-added benefits offered
Value-Added Benefits	Annually, a report on the impact of its value-added benefits due 1 June

Table A5: Provider Networks, Contracts and Related Responsibilities

Report Title	Description
Credentialing Policy	As relevant, changes to credentialing policies and procedures
Service Area Expansions	As relevant, 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	Immediate notice of any independent action taken by MCO to suspend or terminate Network Provider

Report Title	Description
Provider Suspensions and Termination Report	Annual list of Providers that MCO suspended or terminated upon notice of suspension or termination MCO, and list of providers suspended or terminated by MCO independently due 15 January
Report of Suspended/Terminated Providers	Weekly report of compliance with MCO Provider suspensions and terminations requirements and report
Provider Handbook	Annual Provider Handbook which includes specific information about MCO Covered Services, non MCO Covered Services, and other requirements relevant to Provider responsibilities due 31 December
Provider Complaints Report	Annual report that includes all Provider complaints received, and MCO actions to address them due 1 June
Claims Summary Report	Monthly report on paid and denied claims by claim type
Claims Payment Accuracy Report	Monthly report on claims payment accuracy based on an audit conducted by MCO
Network Development and Management Plan	Annual plan describing MCO's Network development and Network management activities and results, including findings of Provider non-compliance and any corrective action plan and/or measures taken by MCO to bring Provider into compliance, and Enrollee access to Provider types where STATE has granted MCO an exception to a time or distance or appointment accessibility standard due 15 February

Table A6: Network Adequacy

Report Title	Description
PCP Geographic-Access Report	Semi-annual report of percentage of Members by County with access to open PCPs within the network accessibility standards in Appendix C of the contract due 31 March and 30 September
PCP to Enrollee Ratio Report	Semi-annual report of open PCPs per number of Members by geographic region as defined by STATE (includes data collection methodologies) due 31 March and 30 September

Report Title	Description
Top 5 High Volume Specialists Geographic Access Report	Semi-annual report of Enrollee's geographic access to top five (5) high volume specialty types by geographic region as defined by STATE due 31 March and 30 September
Significant Changes in Provider Network Report	Immediate notice and Semi-Annual Summary report due 31 March and 30 September of significant changes in Provider Network that will affect the adequacy and capacity of services
Summary Access and Availability Analysis Report	Annual 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, use of limited Provider agreements, care management staff experiences with scheduling appointments) due 1 July

Table A7: Care Management

Report Title	Description
Care Management	Annual report on care management program due 1 August

Table A8: Utilization Management

Report Title	Description
Service Authorization and Utilization Review Report	Quarterly report regarding services authorized and denied
Network Provider Profiling	Quarterly utilization review of like Specialists across Provider Network to determine if services billed are Medically Necessary
Emergency Department (ED) Visits	Annual report on Emergency Department (ED) visits and the volume of distribution by ED with top ten (10) diagnosis codes due 1 July

Report Title	Description
Potentially Avoidable ED visits and Inpatient Readmissions	Quarterly report on potentially avoidable hospital ED visits and inpatient readmissions.
Provider Preventable Conditions	Annual report on Provider Preventable Conditions due 1 July

Table A9: Grievance Systems

Report Title	Description
Enrollee Grievances	Quarterly 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 Members	Monthly report of complaints and appeals, including reporting on how and in what time frame the complaints were resolved

Table A20: Quality Management and Quality Improvement

Report Title	Description
HEDIS Final Audit Report	Annual report, prepared by an external contractor of Performance Measurement due 15 July
CAHPS AHRQ Dataset Submission	Annual file submission of CAHPS survey results to AHRQ database due 30 June
CAHPS Survey	Annual report of CAHPS survey results due 31 July
Quality Assessment and Program Improvement goal report	Quarterly reports of progress toward QAPI goals including status and outcomes of performance improvement projects
Health Plan Accreditation Report	As relevant, copy of final accreditation report for each accrediting cycle

Table A31: Performance Evaluation and External Quality Review

Report Title	Description
Report of mandatory EQR activities Program	External Quality Review Organization report of validation of performance improvement projects, Validation of Performance Measures, and Compliance with strategy standards. Due 1 July

Table A42: Data Management and Information Systems

Report Title	Description
Encounter data	Monthly by the fifteenth (15th) of the following month for all claims paid in the previous month

Table A53: Program Integrity and Operational Audits

Report Title	Description
Fraud and Abuse Report	Immediate reporting of Provider and Enrollee Fraud and Abuse
Fraud and Abuse Report	Quarterly report regarding any areas of Provider and Enrollee Fraud and Abuse

Table A64: Coordination of Benefits/Third Party Liability

Report Title	Description
Benefit Coordination Plan	As relevant, benefit coordination plan and proposed changes submitted for review and approval

Table A75: Financial

Report Title	Description
MLR Reports	Annually, within twelve (12) months of the end of the MLR Reporting Year as defined in this Contract.
Managed Care Reporting Template	Semi-annual due on 1 May and 1 August
Cash Flow Statement	Annually and upon request, cash flow statements to demonstrate compliance with the requirement to maintain sufficient cash flow and liquidity to meet obligations
Audited Financial Statements	Annual copies of NDID financial reports due 31 December
Third Party Liability	Monthly report indicating the claims where the MCO has billed or made a recovery of a claim subject to TPL
Alternative Payment Methodology (APM) Report	Annual report on use of APMs including a list of APM models used with Network Providers, list of APM Provider agreements and the Network providers, PCMHs and ACOs involved in such agreements, the quality measures and range of performance benchmarks used in APMs by Provider type, and total amount paid to Providers for all Provider agreements. Due on 30 June
Patient Access Application Programming Interface (API)	Annual report due July 1st of each year covering the previous calendar year indicating the total number of unique beneficiaries covered by the MCO whose data was transferred via the Patient Access API to a health application designated by the beneficiary. The report will include MCO specific numbers and a breakout for Multiple Data transfers.
Assurances of Adequate Capacity and Services; Provider Payment Analysis	Annual report due August 1st of each year covering Payment and Medicaid comparison for Primary Care, OB/GYN, and Outpatient Mental Health and Substance Use Disorder; Payment and Medicaid comparison for Homemaker Services, Home Health Aide, Personal Care, and Habilitation.

Appendix B: North Dakota Quality Strategy Crosswalk to CMS Toolkit

Each state contracting with an MCO, PIHP, PAHP, or PCCM entity must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, PAHP, or PCCM entity, per § 438.340(a) and § 457.1240(e). The following table lists the required elements and the processes for developing state quality strategies as required by Title 42 CFR § 438.340(b), § 438.340(c), § 438.340(d), and the June 2021 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit; and the corresponding sections in the North Dakota Quality Strategy that address each requirement.

Table B1: Crosswalk to CMS Toolkit

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(b)(1)	Network Adequacy and Clinical Practice Guidelines	The State's quality strategy includes the State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by § 438.68 and § 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with § 438.236.	Page 21 (network adequacy) and 41 (clinical practice guidelines)

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(b)(2)	Goals and Objectives	The State's quality strategy includes goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP, and PCCM entity described in § 438.310(c)(2).	Page 8
§ 438.340(b)(3)(i)	Quality Metrics and Performance Targets	The State's quality strategy includes a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with § 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website required under § 438.10(c)(3).	Page 8

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(b)(3)(ii)	Performance Improvement Projects	The State's quality strategy includes a description of the performance improvement projects to be implemented in accordance with § 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.	Page 46
§ 438.340(b)(4)	Annual External Independent Review	Arrangements for annual, external independent reviews, in accordance with § 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in § 438.310[c][2]) contract.	Page 18
§ 438.340(b)(5)	Transition of Care Policy	A description of the State's transition of care policy required under § 438.62(b)(3). Continued services to members: The State must make its transition of care policy publicly available and provide instructions to members and potential members on how to access continued services upon transition.	Page 28

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(b)(6)	Identifying, Evaluating, and Reducing Health Disparities	The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. For purposes of this paragraph (b)(6), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status.	Page 15 North Dakota Disability Determination Services
§ 438.340(b)(7)	Sanctions	For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	Page 18

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(b)(8)	Identification of Persons Needing Long-term Services and Supports and Persons with Special Needs	The mechanisms implemented by the State to comply with § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	Page 15

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(b)(9)	Non-duplication of EQR Activities	The information required under § 438.360(c) (relating to non-duplication of EQR activities). The State must identify in its quality strategy under § 438.340 the EQR activities for which it has exercised the option described in this section and explain the rationale for the State's determination that the Medicare review or private accreditation activity is comparable to such EQR activities.	Page 23-24
§ 438.340(b)(10)	Definition of Significant Change	The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section. A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	Page 52

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(c)(1)(i) (ii)	Public Comment	Make the strategy available for public comment before submitting the strategy to the CMS for review, including: i. Obtaining input from the Medical Services Fund Advisory Council (established by § 431.12 of this chapter), beneficiaries, and other stakeholders. i. If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.340(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy.	Page 53 North Dakota Events
§ 438.340(c)(2)(i) (ii)(iii)	Updating Quality Strategy	In drafting or revising its quality strategy, the State must review and update the quality strategy as needed, but no less than once every 3 years. This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years. The State must make the results of the review available on the Web site required under § 438.10(c)(3). Updates to the quality strategy must take into consideration the recommendations provided pursuant to § 438.364(a)(4).	Page 52 North Dakota Publications

Regulatory Reference Title 42 Code of Federal Regulations (CFR)	Required State Element	Description	Page or Link Reference within the Quality Strategy
§ 438.340(c)(3)(i)(ii)	Submitting Revised Quality Strategies to CMS	The State must submit to CMS the following: i. A copy of the initial strategy for CMS comment and feedback prior to adopting it in final. ii. A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	Page 53
§ 438.340(d)	Availability of the Final Quality Strategy on the Website	The State must make the final quality strategy available on the Web site required under § 438.10(c)(3). The State must operate a website that provides the content, either directly or by linking to individual MCO, PIHP, PAHP, or PCCM entity websites specified in paragraphs (g), (h), and (i) of this section.	Page 53 North Dakota Medicaid Expansion