North Dakota Medicaid Expansion
Quality Strategy Plan

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Section 1: INTRODUCTION

Program Background

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

On December 20, 2013, the Centers for Medicare, and Medicaid Services (CMS) granted authority through a 1915(b) Waiver allowing State to provide Medicaid Expansion as a Managed Care Organization (MCO) Program. This allowed having mandatory enrollment of individuals, including Native Americans, eligible for the Medicaid Expansion into a health plan offered by an MCO. The initial 1915(b) waiver authority ended on December 31, 2015.

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

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

On October 8, 2019, the State submitted a 1915(b) Waiver renewal request to CMS with authority granted on December 16, 2019. The current 1915(b) waiver renewal waiver authority ends on December 31, 2021.

On November 29, 2021, the State submitted a 1915(b) Waiver renewal request to CMS. The current 1915(b) waiver renewal waiver authority ends on December 31, 2021.

As the State was only able to award one statewide MCO contract, to ensure compliance with Federal Medicaid Managed Care regulations requiring enrollees to have a choice of plans in the Metropolitan Statistical Areas that State submitted an 1115 Waiver, with authority granted by CMS on February 26, 2014. This allowed having one health plan choice for those Medicaid Expansion enrollees residing in urban areas of North Dakota. The initial 1115 waiver authority ended on December 20, 2015.

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

For the Alternative Benefit Plan (ABP), State chose the section 1937 benchmark option of the commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state. In addition, the ABP incorporates the Essential Health Benefits and ensures compliance with the Mental Health and Addiction Equity Act of 2008.

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

Through Senate Bill 2012, the 2019 ND Legislative Assembly directed DHS to continue ND Medicaid Expansion as implemented through a private carrier except for pharmacy services as of January 1, 2020. Thus, as of January 1, 2020, the MCO will administer and manage medical benefits to those individuals eligible for ND Medicaid Expansion; the pharmacy benefits for the ND Medicaid Expansion population will be administered and managed by the State through a fee-for-service (FFS) Medicaid administration.

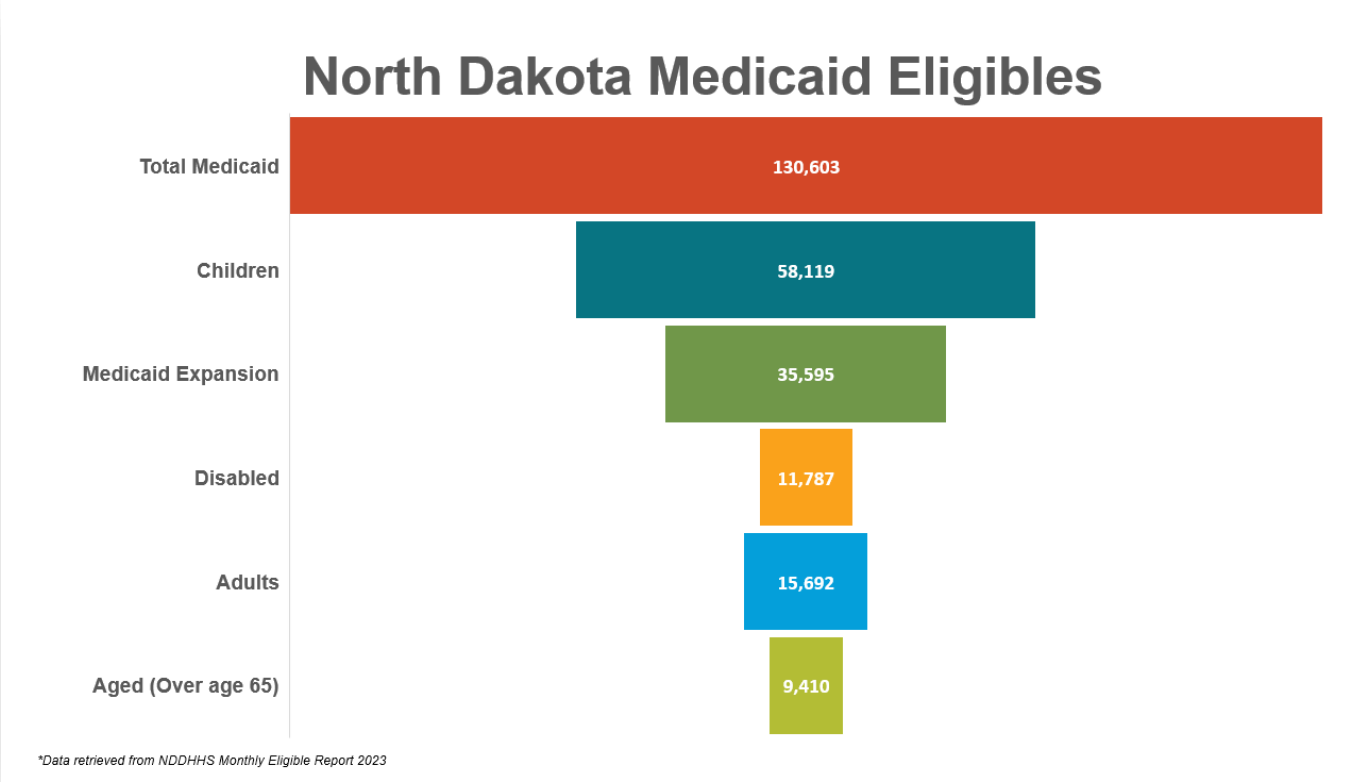
Through House Bill 1012, the 2021 ND Legislative Assembly directed DHS to change the 19- and 20-year-old Medicaid Expansion enrollees benefit to the traditional FFS benefit plan. Starting January 1, 2022, 19- and 20-year-old Medicaid Expansion enrollees will be receiving the State-administered FFS benefit which includes the Early and Periodic Screening, Diagnostic and Treatment program (EPSDT) benefits.

On January 1, 2022, Medicaid Expansion enrollees will be receiving services through Blue Cross Blue Shield of North Dakota (BCBSND) as the sole MCO for the ND Medicaid Expansion program.

Quality Strategy Overview

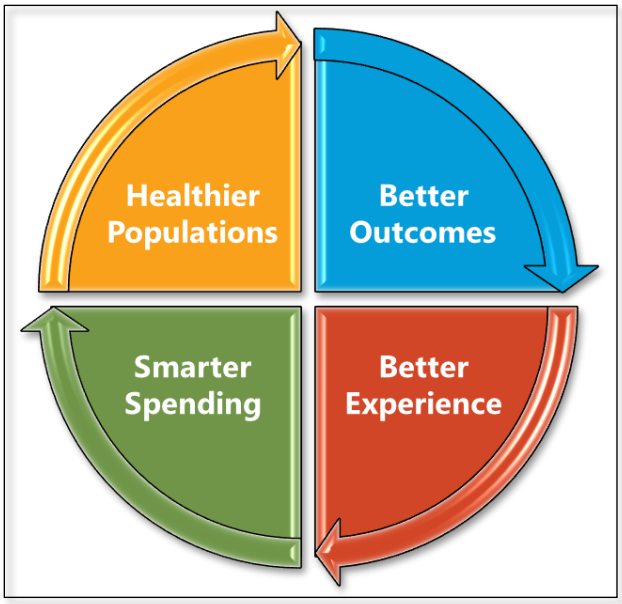
The Quality Strategy is intended to guide North Dakota Medicaid Expansion care management program by establishing clear aims and goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding the MCO accountable for desired outcomes.

The Medicaid Expansion population is the group being managed by the MCO, which is a subset of the entire FFS Medicaid population.



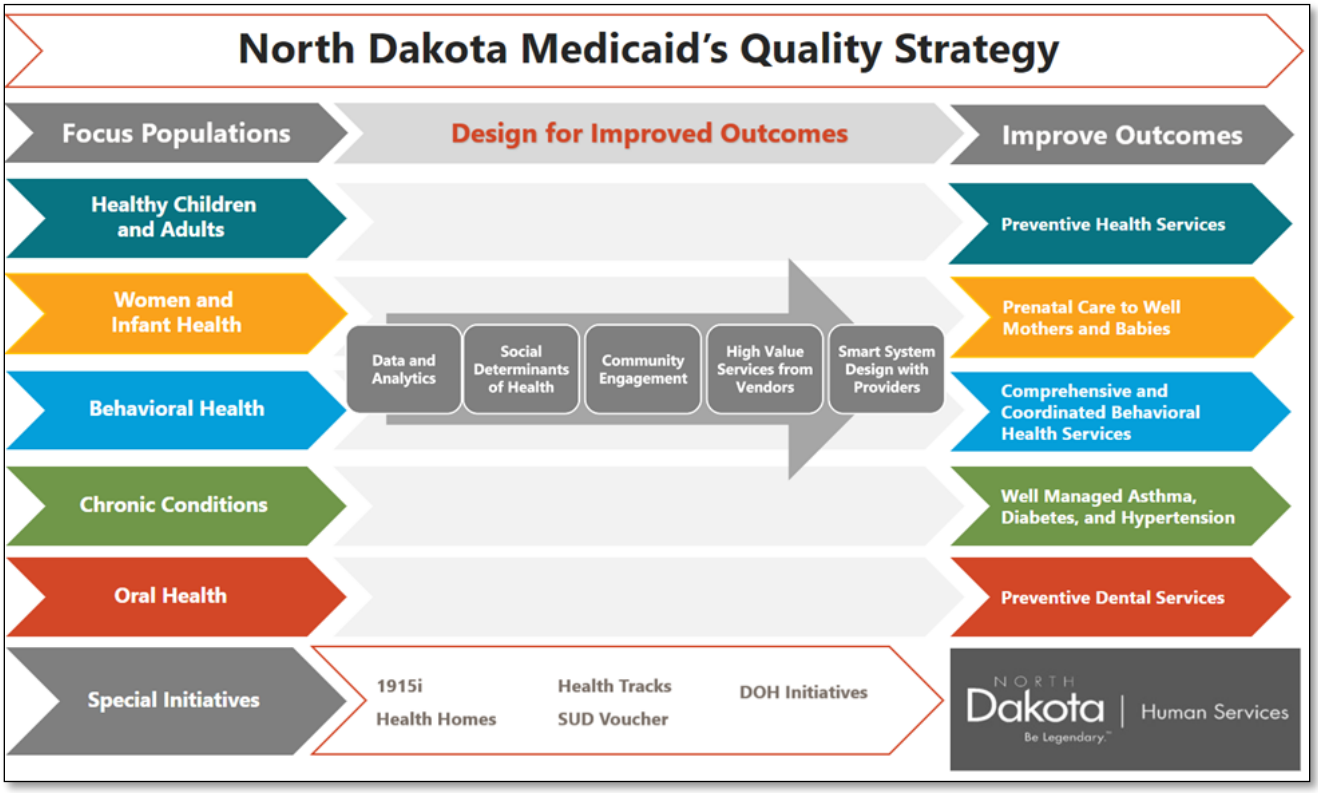
The Quality Strategy is a roadmap through which the State, in partnership with the MCO, will use the care management infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, health equity, provider supports, and steps to address health-related unmet resource needs. The vision is refined by using the Quadruple Aim to optimize performance by establishing clear aims and goals to drive quality improvements.

North Dakota's Quadruple Aim



Included within each of these four aims is a series of goals, intended to highlight key areas of expected progress and quality focus. Together, these aims create a framework through which North Dakota defines and drives the overall vision for advancing the quality of care provided to Medicaid Expansion members. These aims and goals were designed to align closely with CMS's Quality Strategy, adapted to address North Dakota's local priorities, challenges, and opportunities for its Medicaid program.

Quality Strategy



The Quality Strategy is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality of care and services to enrollees in the Medicaid and Medicaid Expansion programs. The Quality Strategy framework for the State to communicate the vision, objectives, and monitoring strategies is founded on the six dimension of healthcare quality. This framework drives data-driven decision-making that guide strategic business decisions that align goals, objectives, and initiatives to improve the quality of care for beneficiaries.

Framework for Quality Strategy

Mission

The Quality Strategy supports the mission of the State, which is:

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

The Medical Services Division will ensure that its enrollees receive high quality care by providing effective oversight of its MCO to promote accountability and transparency for improving health outcomes.

Guiding Principles and Expected Outcomes

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

- Improved coordination of care;
- Better health outcomes;
- Increased quality of care as measured by metrics, such as the Healthcare Effectiveness Data and Information Set (HEDIS®);

- Greater emphasis on disease prevention and management of chronic conditions;
- Earlier diagnosis and treatment of acute and chronic illness;
- Improved access to essential specialty services;
- Outreach and education to promote healthy behaviors;
- Increased personal responsibility and self-management;
- A reduction in the rate of avoidable hospital stays and readmissions;
- Monitoring of and a decrease in fraud, abuse, and wasteful spending;
- Greater accountability for the dollars spent; and
- A more financially sustainable system

Quality Strategy Goals and Objectives

Goals & Objectives						
Objective	**Measure Name**	**Metric**	**Data Source**	**Measure Steward**	**Baseline MY 2020**	**NCQA Quality Compass Percentile**
AIM 1: Healthier Populations						
Goal 1.1: Improve Behavioral Health for Beneficiaries						
1.1a	Increase the percentage of follow-up after emergency department visit for alcohol and other drug abuse or dependence **at or above the HEDIS 50th percentile by the end of MY 2023**	FUA-AD	HEDIS	NCQA		
	7-day				20.19%	♦
	30-day				28.10%	♦
1.1b	Increase the percentage of follow-up after hospitalization for Mental Illness **at or above the HEDIS 50th percentile by the end of MY2023**	FUH-AD	HEDIS	NCQA		
	7-day				25.12%	♦
	30-day				43.55%	
1.1c	Increase the percentage of follow-up after emergency department visit for mental illness **at or above the HEDIS 50th percentile by the end of MY 2023**	FUM-AD	HEDIS	NCQA		♦
	7-day				25.27%	♦

Goals & Objectives						
Objective	**Measure Name**	**Metric**	**Data Source**	**Measure Steward**	**Baseline MY 2020**	**NCQA Quality Compass Percentile**
	30-day				44.32%	♦
Goal 1.2: Improve Outcomes for Members with Substance Use Disorders						
1.2a	Increase the percentage of adults ages 21-64 identified with a Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment within 14 Days or Engagement includes Initiation Treatment with Two Additional Services **at or above the HEDIS 75th percentile by the end of MY 2023**	IET-AD	HEDIS	NCQA		
	Alcohol Initiation				42.44%	♦♦
	Alcohol Engagement				15.58%	♦♦♦
	Opioid Initiation				57.97%	♦♦
	Opioid Engagement				40.68%	♦♦♦
	Other Drug Abuse Initiation				41.05%	♦
	Other Drug Abuse Engagement				18.82%	♦♦♦♦
	Total AOD Initiation				44.31%	♦♦
	Total AOD Engagement				19.81%	♦♦♦
Goal 1.3: Improve Health for Members with Chronic Conditions						
1.3a	Increase the percentage of adults ages 21-64 who had a diagnosis of hypertension and whose blood pressure was adequately controlled **at or above the HEDIS 75th percentile by the end of MY 2023**	CBP-AD	HEDIS	NCQA	67.40%	♦♦
1.3b	Decrease the percentage of adults ages 21-64 with diabetes who had hemoglobin A1c (HBA1c) in poor control (>9.0%) **at or above the HEDIS 75th percentile by the end of MY 2023** **lower rate is better*	HBD	HEDIS	NCQA		
	HbA1c Control (>9%)				39.66%	♦♦
	HbA1c Control (<8%)					
1.3d	Decrease the number of inpatient hospital admissions for diabetes short-term complications per 100,000 beneficiary months for beneficiaries	PQI01-AD	Adult Core Set	AHRQ	42.41	♦

Goals & Objectives						
Objective	**Measure Name**	**Metric**	**Data Source**	**Measure Steward**	**Baseline MY 2020**	**NCQA Quality Compass Percentile**
	ages 21 and older **by end of MY 2023** **lower rate is better*					
1.4e	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 **by end of MY 2023** **lower rate is better*	PQI05-AD	Adult Core Set	AHRQ	29.83%	♦♦♦
AIM 2: Better Outcomes						
Goal 2.1: Enhance Provider Support						
2.2a	Maintain provider engagement by rating of personal doctor	CPA-AD	Survey Q18	CAHPS	71.10%	
2.3b	Improve provider communication by personal doctors spent enough time	CPA-AD	Survey Q15	CAHPS	90.20%	
Goal 2.2: Ensure Access to Care						
2.2a	Getting Needed Care beneficiary got appointment with specialists as soon as needed	CPA-AD	Survey Q20	CAHPS	83.60%	
AIM 3: Better Experience						
Goal 3.1: Enhance Member Experience						
3.1a	Increase Timely Access to Care by beneficiary getting care quickly	CPA-AD	Survey	CAHPS	81.70%	
3.1b	Increase Member Satisfaction by beneficiary rating of health plan	CPA-AD	Survey	CAHPS	63.00%	
3.1c	Increase Member Satisfaction with Care rating of all health care	CPA-AD	Survey	CAHPS	52.80%	
AIM 4: Smarter Spending						
Goal 4.1: Focus on Paying for Value						
4.1a	Decrease the ratio of observed all-cause readmissions to expected readmissions (O/E Ratio) among adults ages 21-64 **at or above the HEDIS 50th percentile by the end of MY 2023** **lower rate is better*	PCR-AD	HEDIS	NCQA	1.02	♦

♦♦♦♦	MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.
♦♦♦	MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.
♦♦	MCO rate is equal to or exceeds the NCQA Quality Compass National Average, but does not meet the 75th Percentile.
♦	MCO rate is below the NCQA Quality Compass National Average.

Development & Review of Quality Strategy

Throughout the development of the Quality Strategy Plan, the 42 Code of Federal Regulations (CFR) Part 438.340 was utilized to ensure compliance with the rules governing Medicaid managed care.

In accordance with 42 CFR 438.340(c), following public comment and tribal consultation, the initial Quality Strategy Plan was submitted to CMS for comment prior to adopting it as final. It will be reviewed and updated as needed or upon a significant change, and no less than once every three years. For purposes of reviewing and updating the Quality Strategy Plan, "significant change" occurs when one of the following impacts the intent or content of the requirements within:

- New or amended State/Federal regulatory authority or legislation;
- State Medicaid program, policy, or procedure changes; or
- Analysis of quality performance data suggest the implementation of new or different approaches to improve the quality of care and health care services.

In the event that revisions to the Quality Strategy Plan are due to significant changes, it will be placed on the State's website at http://www.nd.gov/dhs/info/pubs/medical.html for public comment and tribal consultation. At the completion of the comment period, the State will incorporate comments, as appropriate, into the Quality Strategy Plan prior to the submission of the revised document to CMS for feedback. The final Quality Strategy Plan will also be published on the State's website.

The Quality Strategy Plan review process will include an evaluation of the effectiveness of the quality strategy conducted within the previous three years (or, at least the number of years since last review) and take into consideration the recommendations provided by the External Quality Review Organization (EQRO). The results of the Quality Strategy Plan review will be made available on State's website.

Quality Strategy Implementation

The success of the Quality Strategy Plan requires effective implementation and coordination between the State and MCO. The Leadership Team will convene two to four Quality Assurance and Improvement meetings per year. These meetings will routinely bring the State and MCO's quality team together, take a population perspective on ND Medicaid Expansion program, and,

to the greatest degree possible, harmonizes quality initiatives across MCO and the ND Medicaid Expansion Program.

Standardized reporting and review tools have been developed to allow for oversight and trending over time. The Medicaid Expansion Administrator, within the Medical Services Division, receives and reviews all monitoring and quality reports from MCO and the EQRO. The Leadership Team will review and analyze all findings from the reports including data received, root causes, barriers, and improvement interventions. Feedback will be provided to MCO and corrective action will be requested, if needed. Findings and recommendations will be adequately documented for public review.

The State and MCO will continue to conduct *ad hoc* calls to provide a mechanism for dialogue on particular topics feedback and review of performance improvement projects (PIPs), and identification of best practices as the ND Medicaid Expansion program matures.

Section II: ASSESSMENT

Quality and Appropriateness of Care

The State will assess how well MCO is meeting the objectives outlined in Section I through analysis of the quality and appropriateness of care and services delivered to enrollees, the level of contract compliance of MCO, and to individuals with special health care needs, as required by §438.340.

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

- State Internal monitoring,
- ND Medicaid Expansion Performance Measures monitoring (Appendix A),
- PIPs,
- ND Medicaid Expansion MCO Compliance, Operations, and Quality Reporting (Appendix B), and
- EQRO activities, including ND Medicaid Expansion population analysis and the EQRO Technical Annual Report.

Enrollees with Special Health Care Needs

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

Identify Race, Ethnicity, and Primary Language 42 CFR 438.340(b)(6)

Through the identification of an enrollee's race, ethnicity, and/or primary language, health disparities may be reduced or even eliminated by allowing the delivery of culturally competent healthcare. MCO shall have a process which allows for the following:

- Identification of an enrollee's race, ethnicity, and primary language; and
- Identification of a network provider's cultural and linguistic capabilities which then must be available to an enrollee in paper and electronic form upon request.

MCO shall utilize the top 15 languages spoken by individuals with limited English proficiency in North Dakota that indicate the availability of language assistance in accordance with guidance issued under Section 1557, CMS, HHS, and HHS OCR. MCO shall ensure that translation services are provided for written marketing and enrollee education materials for the top 15 languages spoken by individuals with limited English proficiency in ND, as applicable. The State requires that MCO and any contractors have oral interpretive services for those who speak any foreign language.

The State encourages delivery of services in a culturally competent manner to all recipients. Through performance measure data collection, the MCO shall examine data by race/ethnicity to identify health disparities and improve outcomes.

North Dakota Medicaid Expansion Performance Measures

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

It is the State's intent that Appendix A may require modification based on the analysis of the identified quality measures as compared to the actual ND Medicaid Expansion population utilization and trending data. Analysis of the comparative data allows the Leadership Team to consider and implement the appropriate quality measure to drive quality improvement for ND Medicaid Expansion.

Medicaid Contract Provisions

State Monitoring Requirements § 438.66

To assess the quality and appropriateness of care/services for members with routine and special health care needs, the STATE regularly reviews the MCO's routine reports and deliverables as required by the contract **(Appendix B)**. As described the State also contracts with its EQRO to conduct comprehensive IQAP compliance reviews. The implementation and compliance standards of the Quality Strategy Plan will be measured, monitored, and evaluated by internal and EQRO monitoring. The State monitors all aspects of the managed care program, including the performance of the MCO in at least the following areas:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services, including activities of the beneficiary support system
- Finance, including medical loss ratio reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including utilization management and case management
- Program integrity
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- Quality improvement
- Other contract provisions, as needed

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

- **Monthly** reports will be due by the twentieth day of the following month.
- **Quarterly** reports will be due the last day of the month following the end of each quarter.
- **Semi-annual** reports will be due within 90 days from the 30th of June and 31st of December in each year.
- **Annual** reports will be due the last day of the month or within 180 days, as applicable, following the end of the calendar year.

Exceptions to this schedule will be identified within report(s), as applicable. If reporting requirements cannot be met due to matters beyond the control of MCO, the State shall provide written documentation to MCO attesting to such matters, and grant allowances, as appropriate, for MCO to meet deadlines as required in contractual reporting requirements.

Reports should be submitted electronically in a format approved by the State. In the event that a report requires revisions or format changes, the State shall provide written notice of such

request to MCO. MCO shall maintain a data gathering and storage system sufficient to meet the requirements of the contract.

Arrangement for External Quality Review (42 CFR §438.340[b][4])

In accordance with 42 CFR §438.356, the State contracts with an EQRO to conduct *both the mandatory and optional EQR activities* as set forth in 42 CFR §438.358.

Mandatory EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, the State's EQRO conducts mandatory EQR activities for the North Dakota Medicaid Expansion program. The State has contracted with its EQRO to perform the following:

• ***Compliance monitoring evaluation.*** The State's EQRO conducts comprehensive, internal IQAP on-site reviews of compliance of the MCO at least once in a three-year period. The State's EQRO reviews MCO compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. These standards are as stringent as the federal Medicaid managed care standards described in 42 CFR §438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.

MCO Compliance Standards
Subpart A: Information Requirements
§438.10 Information Requirements
Subpart B: Disenrollment Requirements and Limitations
§438.56 Disenrollment Requirements and Limitations
Subpart C: Enrollee Rights and Protections
§438.100 Enrollee Rights
§438.102 Provider – Enrollee Communications
§438.114 Emergency and Post stabilization Services
Subpart D: MCO Standards
§438.206 Availability of Services
§438.207 Assurance of Adequate Capacity and Services

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

• ***Validation of performance measures.*** In accordance with 42 CFR §438.340(b)(3)(i), the State requires MCO to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with 42 CFR §438.358(b)(1)(ii), the State's EQRO validates the performance measures through NCQA HEDIS Compliance Audits for MCOs and performance measure validation audits. The NCQA HEDIS Compliance Audits focus on the ability of the MCO to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. The State's EQRO validates each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCO. As part of the NCQA HEDIS Compliance Audits and performance measure validation audits, the State's EQRO also explores the issue of completeness and accuracy of claims and encounter data to improve rates for the performance measures.

• ***Validation of PIPs.*** As described in 42 CFR §438.340(b)(3)(ii), the State requires the MCO to conduct PIPs in accordance with 42 CFR §438.330(d)(I-IV). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and enrollee satisfaction and must include the following elements:

- Measurement of performance using objective performance measures (Appendix A)
- Implementation of interventions to achieve improvement in the access to and quality of care.
- Evaluation of the effectiveness of the interventions based on the performance measures. Planning and initiation of activities for increasing or sustaining improvement.

In accordance with 42 CFR §438.358(b)(1)(i), the State's EQRO validates PIPs required by the State to comply with the requirements of 42 CFR §438.330(d). The State's EQRO validation determines if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction. The State requires the MCO to report the status and results of each project conducted of this section to the State in a semi-annual report, but not less than once per year as described in 42 CFR 438.330(d)(3).

• ***Network Adequacy Validation.*** In accordance with 42 CFR §438.358(b)(1)(iv), the State's EQRO performs validation of the MCO network adequacy. The analysis evaluates three dimensions of access and availability:

-*Capacity*—provider-to-recipient ratios for the State's provider networks as defined by MCO contract.

-*Geographic network distribution*—time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider as defined by MCO contract.

- *Appointment Availability*-average length of time (number of days) to see a provider as defined by MCO contract.

Optional EQR Activities

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

- Validation of encounter data reported by MCO for completeness and accuracy to industry standards to ensure timely receipt of provider claims, to assess provider claims submissions within 365 days of service, and to monitor timeliness in paying claims.
- Validation of quality-of-care surveys.
- Calculation of ND performance measures in addition to those reported by MCO and validated by an EQRO.
- Conduct PIPs in addition to those conducted by MCO and validated by an EQR.
- Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
- Assist with Quality Rating of Medicaid.
- Evaluate the effectiveness of the State's Quality Strategy and the MCO program achievement of goals and objectives identified in the strategy and provide an approach with updates to the quality strategy through creation of short-and-long term goals.
- Provide technical assistance to the State with activities to create alignment related to managed care and the Medicaid fee-for-service programs.

EQR Technical Reporting

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

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

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

The State will use the annual report to determine whether to apply sanctions or take other corrective action as designated in MCO contract to evaluate existing program goals and inform new program goal development. The State will also use the report to inform MCO of any needed contract amendments or revisions.

EQRO will meet these obligations by utilizing the EQR protocols developed by CMS to perform the mandatory activities required of EQROs, as mentioned in 42 CFR §438.352 and §438.358,

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

Accreditation and Duplication

MCO accreditation by a private independent nationally recognized accrediting entity is not required; however, MCO has the flexibility to attain such accreditation if it is obtained from a private accrediting organization recognized by CMS as applying standards at least as stringent as Medicare under the procedure in 42 CFR §422.158. If accreditation is obtained by MCO for the ND Medicaid Expansion population, the information from the review standards which are comparable to the EQR mandatory activities as described in 42 CFR §438.358(b)(1)(i-iii) may be utilized to avoid duplication.

Section III: STATE STANDARDS

North Dakota State Standards

The Quality Strategy Plan is organized to reflect the standards outlined in 42 CFR 438 Subpart D and E of the Medicaid Managed Care Rules and Regulations. The standards of North Dakota are at least as stringent as those specified in 42 CFR §438 and divided into three standards: Access, Structure and Operations, and Measurement and Improvement. Each standard has multiple components as indicated in the following table and summarized below.

Standard	Regulatory Reference	Description
Access		
	§438.68	Network Adequacy
	§438.206	Availability of services
	§438.207	Assurances of adequate capacity and services
	§438.208	Coordination and continuity of care
	§438.210	Coverage and authorization of services
Structure and Operations		
	§438.214	Provider selection
	§438.10	Enrollee information
	§438.224	Confidentiality
	§438.54 & §438.56	Enrollment and disenrollment
	§438.228	Grievance systems
	§438.230	Sub contractual relationships and delegation

Measurement and Improvement		
	§438.236	Practice guidelines
	§438.330	Quality assessment and performance improvement program (PIP)
	§438.242	Health information systems

Access Standard

The following access standards pertaining to network adequacy were developed taking into consideration the aspects as outlined within 42 §438.68(c) including:

- Anticipated Medicaid enrollment;
- Expected utilization of services;
- Characteristics and health care needs of specific Medicaid populations covered;
- Numbers and types of network providers required to furnish the contracted Medicaid services;
- Number of providers not accepting new Medicaid Patients;
- Geographic location of network providers and Medicaid enrollees, considering distance, travel time, and means of transportation ordinarily used by Medicaid enrollees;
- Ability of network providers to communicate with limited English proficient enrollees in their preferred language;
- Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities; and
- Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

Availability of services (§438.206)

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

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

MCO must meet the following requirements:

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

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

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

MCO must establish mechanisms to ensure that network providers comply with the State standards of timely access requirements. MCO must meet and require its providers to meet the

State standards for timely access to care and services, considering the urgency of the need for services. Standards for access and timeliness are identified in the table below.

Appointment Standards		
General	**Behavioral/Mental Health and/or Substance Use Disorder**	**High Volume and High Impact Specialty**
• Emergency Services - available 24 hours a day, seven days a week • Urgent Care – within 24 hours • Non-Urgent Sick Care - within 72 hours, or sooner, if conditions deteriorates into urgent or emergency condition • Routine, Non-Urgent or Preventative Care Visits – within six weeks of enrollee request	• Emergency Services, Life Threatening – Immediate • Emergency Services, Non-Life Threatening – Within 6 hours • Urgent Care – within 48 hours • Initial Visits, Routine Care - within 10 working days • Follow-Up Visits, Routine Care – within 30 days	• Consultation within one month of referral or as clinically indicated

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

Assurances of Adequate Capacity and Services (§438.207)

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

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

Service Coordination (§438.208)

Modern health care delivery systems are multi-faceted and involve complex interactions between many providers. Such delivery systems require coordination across the continuum of

care. This standard requires that MCO implement procedures to deliver primary care to and coordinate health care services for all enrollees.

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

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

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

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

Continuity of Care (§438.208)

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

MCO must provide access to ensure that each enrollee has an ongoing source of primary care providers appropriate to his or her needs. Enrollees are encouraged to select their PCP; if they do not select one MCO will assign one within their location. Enrollees are allowed to switch their PCP as often as they would like.

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

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

Another aspect to consider with regard to continuity of care pertains to ensuring continued access to services during transitions of care between ND Traditional FFS Medicaid and an MCO for ND Medicaid Expansion. In accordance to 42 CFR §438.62, if the absence of continued services would result in serious detriment to an enrollee's health or risk hospitalization, the State and MCO maintain and comply with a transition of care policy which includes the following:

- Provide instructions on how to access continued services upon transition within the MCO Enrollee Handbook;
- For a period of time, allow enrollees access to medically necessary covered services consistent with previous access and be permitted to retain current provider if not within the MCO network;
- Refer enrollees to appropriate providers of services that are in the MCO network;
- Share historical utilization data, upon request, in compliance with Federal and State law;

and
- Provide copies of enrollee's medical records, upon request, as consistent with Federal and State law.

Coverage (§438.210)

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

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs (to be provided through ND DHS's FFS system, effective 01/01/2020)
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management

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

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

Services must be rendered in accordance with the medical necessity standard. All managed care programs operate under the same definition of medical necessity as North Dakota Medicaid fee-for-service. MCO may not arbitrarily deny or reduce the amount, duration, or scope of a

required service solely because of diagnosis, type of illness, or condition of the enrollee (consistent with §438.210(a)(3)(ii)).

Utilization Management

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

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

MCO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, MCO must comply with the requirements of 42 CFR §456.111 (Hospitals) and 42 CFR §456.211 (Mental Hospitals), as applicable. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is to be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

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

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

MCO shall define an adverse benefit determination as being any of the following:

- Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of an MCO to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals;

- Denial of an Enrollee's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network for a resident of a Rural/Frontier or Area with only one MCO ; or
- Denial of Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

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

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

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

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

Grievance and Appeal Process

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

MCO must develop, implement, and maintain a system for tracking, resolving, and reporting

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

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

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

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

Enrollee Grievance Process

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

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

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

Enrollee Appeal Process

For an adverse benefit determination, MCO shall provide an enrollee or provider one level of appeal which must be exhausted prior to requesting a State fair hearing. If the MCO fails to adhere to the appeal process notice and timing requirements, enrollee is deemed to have exhausted the MCO's appeal process and an enrollee may initiate a State fair hearing. MCO shall acknowledge receipt of each appeal and give enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and

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

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

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

MCO shall define appeal as the request for review of an adverse benefit determination. Either an enrollee or a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file an appeal. The appeal must be filed within 60 calendar days from the date on the MCO's notice of adverse benefit determination.

MCO shall allow the enrollee or provider to file an appeal either orally or in writing. Provider's request must be accompanied by written consent of enrollee for provider to appeal on enrollee's behalf. In addition, MCO shall:

- Provide a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing;
- Allow the enrollee and representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records and any other documents and records; and
- Consider the enrollee, representative, or legal representative of a deceased enrollee as parties to the appeal.

MCO shall resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, not exceeding 30 calendar days from the day the appeal is received. MCO may extend the timeframe once, by up to 14 calendar days, if the enrollee requests the extension or MCO demonstrates that there is need for additional information including how the delay is in the enrollee's best interest. The enrollee must be given a written notice of the reason for the delay.

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

- The reason and date of the appeal resolution.
- For decisions not wholly in the enrollee's favor:
    - The right to request a State fair hearing;
    - How to request a State fair hearing;

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

MCO shall continue the enrollee's benefits if:

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

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

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

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

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

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

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

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

Grievance Systems (§438.228)

Once MCO's internal appeals process has been exhausted, the State permits enrollees to request and obtain a State fair hearing. MCO may only have one internal appeal level.

Access to State Fair Hearing

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

Network Provider Appeal Process

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

Structure and Operations Standard

Provider Selection (§438.214)

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

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

of Medicine at 243 CMR 3.13.

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

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

Enrollee Information (§438.10)

Good communication enhances access to care, appropriate use of services, and satisfaction. This standard delineates requirements for communicating with enrollees and potential enrollees.

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

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

Confidentiality (§438.224)

This standard requires that MCO and the State take appropriate steps to safeguard personal health information. Managed care entities may use and disclose individually identifiable health

information only if done in a manner that is in accordance with the privacy requirements in 45 CFR parts 160 and 164, Subparts A and E, to the extent that these requirements are applicable. Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies as well.

Enrollment and Disenrollment (§438.54 and §438.56)

This standard outlines requirements for the enrollment and disenrollment procedures of managed care entities. In accordance with 42 CFR §438.56, MCO may not disenroll an Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when the Enrollee's continued enrollment in MCO's Health Plan seriously impairs MCO's ability to furnish services to the Enrollee or other Enrollees).

In addition, managed care entities must accept all persons who are assigned to their plan via the State and may not initiate or authorize the disenrollment of any Enrollee's participation in the Health Plan. However, MCO shall provide information to the State if one or more of the following reasons for disenrollment occurs:

- Upon termination or expiration of this contract;
- Death of the Enrollee;
- Confinement of the Enrollee in an institution when confinement is not a Covered Service under this contract;
- MCO has received information indicating that an Enrollee may not be eligible for coverage under the Health Plan; or
- MCO has received an oral or written request from an Enrollee requesting disenrollment from the Health Plan.

At which point, the State shall determine individuals continued eligibility and enrollment or disenrollment.

Provider and Enrollee Suspected Fraud and Abuse

MCO must investigate and, if appropriate, report to the appropriate agency all suspected provider and enrollee fraud and abuse cases. MCO must report all suspected provider and enrollee fraud and abuse to the State within 5 (five) business days.

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

- A log of the suspected provider and enrollee fraud and abuse complaints received by MCO; and
- For each complaint, the following information must be supplied to the State:
    - Provider or enrollee name;
    - Provider or enrollee ID number;

- Source of complaint;
- Type of provider;
- Nature of complaint;
- Suspected duration or when the incident took place;
- Approximate dollars involved; and
- Any legal or administrative actions taken.

Sub contractual Relationships and Delegation (§438.230)

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

Measurement and Improvement Standards

Practice Guidelines (§438.236)

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

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

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

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

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

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

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

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

Performance Measure Reporting (42 CFR §438.330)

The State requires the MCO to collect data on performance measures, as defined by HEDIS®and the CMS Adult Core Set by reporting performance measure results to the State **annually** and included in the ND Medicaid Expansion Performance Measure Report. The State uses HEDIS® and the CMS Adult Core Measure Set whenever possible to measure the MCO performance with specific indicators of quality, timeliness, and access to care. The State's EQRO conducts CMS Core Measure Sets validation audits of the MCO annually and reports the results to the State. The State is implementing processes and requires the MCO to report all CMS Adult Core Measure Set by 2024. The State relies on annually validated performance measures to report

data in relation to the Quality Strategy. The State may add or remove reporting requirements with 30 days advance notice.

The State tracks, trends, and analyzes each measure. The State then compares its performance to national benchmarks and determines which measure to prioritize based on its Quality Strategy goals. The MCO may be subject to monthly state trending reports to monitor MCO's progress on achieving Quality Strategy goals and objectives. The State may also request PIPs based on a root cause analysis and driver diagrams for the metrics the State hopes to improve.

Low performance on any measure requires the MCO to implement remedial or corrective actions that are approved and monitored by the State. When the MCO corrective action includes an action plan, and the State/EQRO will conduct performance monitoring and review to assess for the implementation and effectiveness of the action plan. As part of the annual EQR technical report, the EQRO trends MCO rates over time and also performs a comparison of the CMOs' rates to selected national benchmarks. The EQRO uses trending to compare rates year-over-year when national benchmarks are not available to determine if improvement in the related measures is occurring. The State posts the quality measures and performance outcomes annually online.

Quality Assessment and Performance Improvement Program (§438.330)

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

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

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

MCO will be subject to **semiannual** comprehensive QAPI report to tell the story of the impact and effectiveness of the MCO quality assessment and performance improvement program plan in meeting defined goals and objectives and achieving improved health outcomes for the North Dakota Medicaid Expansion population, including but not limited to:

- Performance on the required standard performance measures; and
- The outcomes and trended results of MCO's performance improvement projects.
- The results of any efforts by the MCO to support community integration for enrollees using long-term services and supports.

Performance Improvement Projects (PIPs)(42 CFR 438.330(d))

As described in 42 CFR §438.330(b)(1), the State requires the MCO to conduct PIPs annually, in accordance with 42 CFR §438.330(d). MCO's QAPI program must also include at least two performance improvement projects, approved by the State, at least one of which must have a behavioral health focus. PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention and to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR §438.358(b)(1)(i), the State's EQRO validates PIPs required by the State and 42 CFR §438.330(b)(1) on an annual basis.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.330(b)(1) and 42 CFR §438.330(d)(2)(i-iv), including:

- Measurement of performance using objective Performance Measures (Appendix A).
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The table below lists the North Dakota PIPs to be completed annually.

PIP Topic	PIP AIM
Comprehensive Diabetes	By establishing a relationship with a health care provider and having at least one visit ambulatory or preventive visit with that provider each year, there will be a decrease in inpatient admission related to diabetes complications for Medicaid Expansion Enrollees during the calendar year.
Hypertension	By establishing a relationship with a health care provider and having at least one visit ambulatory or preventive visit with that provider each calendar year, there will be a decrease in inpatient admissions related to hypertension for Medicaid Expansion Enrollees.
COPD or Asthma in Older Adults Admission Rate	By establishing a relationship with a health care provider and having at least one visit ambulatory or preventive visit with that provider each year, there will be a decrease in patient admissions related for COPD or Asthma for Medicaid Expansion Enrollees during the calendar year.
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 ED visits for Medicaid Expansion Enrollees for a principle diagnoses of substance use disorder or any diagnosis of drug overdose.

Health Information Systems (§438.242)

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

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

- Collect data on enrollee and provider characteristics, as specified by STATE, and on services furnished to enrollees through an encounter data system or other methods as specified by the State; and
- Ensure that data received from providers is accurate and complete by:
    - Verifying the accuracy and timeliness of reported data;
    - Screening the data for completeness, logic, and consistency;
    - Collecting service information in standardized formats to the extent feasible and appropriate; and
    - Making all collected data available to the State and, upon request, to CMS.

Section IV: Improvements and Interventions

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

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

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

Sanctions

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

The Medical Services Division will have the right to impose penalties and sanctions, arrange for temporary management, as specified below, or immediately terminate MCO contract under conditions specified below.

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

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

> *Where these violations are documented, the State will require a corrective action plan (CAP) be developed and submitted within thirty (30) calendar days of the date of receipt of notification of the violation or non-compliance this authority is based on NDAC §75-02-05-05(16).*
>
> *Upon approval by the State, MCO must implement the initial or revised CAP within the timeframes specified by the State.*

Strategy Effectiveness

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

The comprehensive assessment and recommendations for improvement as provided by the EQRO review and analysis are within the Annual Technical Report. The State is committed to making information readily available to the public through public reporting and posted on the North Dakota Department of Human Services website.

Conclusion

The Quality Strategy Plan allows the State to think strategically about quality data and management intervention activities. The cohesive plan regularly guides reviewers and recommends corrective action/follow-up; additionally, guides the Leadership Team, to ensure the implementation of quality activities. There has also been significant improvement in the collaboration between the State and health plans as well as between other Medical Service programs on quality activities. The plan to institute formal quality strategies on a regular basis will strengthen these collaborations and assure a forum for dialogue, review of interim results, follow-up of corrective action, sharing of best practices, and identification of systems changes. The State promotes and supports ongoing efforts of transparency and sharing.

Appendix A

ND Medicaid Expansion Performance Measures

MCO will follow current year CMS Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) as published by CMS for each applicable Measurement Year (MY), except for the age range differences in relation to the ND Medicaid Expansion population.

Care Domains	Measure Name	
Primary Care Access and Preventive Care	CCS-AD	Cervical Cancer Screening
	CHL-AD	Chlamydia Screening in Women Ages 21 to 24
	COL-AD	Colorectal Cancer Screening
	FVA-AD	Flu Vaccinations for Adults Ages 21 to 64
	BCS-AD	Breast Cancer Screening
Care of Acute and Chronic Conditions	CBP-AD	Controlling High Blood Pressure
	AAB-AD	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 21 and Older
	HBD-AD	Hemoglobin A1c Control for Patients With Diabetes
	PQI01-AD	Diabetes Short-Term Complications Admission Rate
	PQI05-AD	COPD or Asthma in Older Adults Admission Rate
	PQI08-AD	Heart Failure Admission Rate
	PQI15-AD	Asthma in Younger Adults Admission Rate
	PCR-AD	Plan All-Cause Readmission
	AMR-AD	Asthma Medication Ratio: Ages 21 to 64
	HVL-AD	HIV Viral Load Suppression
	OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
	COB-AD	Concurrent Use of Opioids and Benzodiazepines
Behavioral Health	IET-AD	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
	MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
	AMM-AD	Antidepressant Medication Management
	CDF-AD	Screening for Depression and Follow-Up Plan: Age 21 and Older
	FUH-AD	Follow-Up After Hospitalization for Mental Illness: Age 21 and Older
	SSD-AD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications
	HPCMI-AD	Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)
	OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder
	FUA-AD	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
	FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness
	SAA-AD	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Experience of Care	CPA-AD	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid)

APPENDIX B

MCO Compliance, Operations, and Quality Reporting

MCO shall provide STATE with all reports described in this Contract including Article 2.15.8, and the table below. MCO shall also provide STATE with any ad hoc reports requested by STATE within thirty (30) days of STATE's request or a longer timeframe as agreed upon by STATE.

Report Title	Description
Administration and Contract Management	
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 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
Enrollment	
Enrollment Discrepancy Report	Weekly report of Enrollees identified on NDMA's file but not enrolled in MCO's plan, Enrollees not identified on NDMA's file but enrolled in MCO's plan, and 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 twenty-four (24) hours of receipt from STATE and timeline for completion of transactions
Enrollee Services	
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
Covered Services	
Mental Health and Substance Use Parity	Annual report documenting compliance with the Mental Health Parity and Addiction Equity Act of 2008
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
Provider Networks, Contracts and Related Responsibilities	
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
Provider Suspensions and Termination Report	Annual list of Providers that MCO suspended or terminated upon notice of suspension or termination MCO, and list of provides

Report Title	Description
	suspended or terminated by MCO independently
Certification of Suspended/Terminated Providers	Weekly certification 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
Provider Complaints Report	Annual report on the number and type of the top ten (10) Provider complaints received, and MCO actions to address them
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
Network Adequacy	
PCP Geographic-Access Report	Semi-annual report of percent of Enrollees by County with access to open PCPs within the network accessibility standards in Appendix C.
PCP to Enrollee Ratio Report	Semi-annual report of open PCPs per number of Enrollees by geographic region as defined by STATE (includes data collection methodologies)
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
Significant Changes in Provider Network Report	Immediate notice and Semi-Annual Summary report 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)
Care Management	
Care Management	Annually report on care management program
Utilization Management	
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 ED visits and the volume of distribution by ED with top ten (10) diagnosis codes
Potentially Preventable ED visits	Quarterly report on potentially preventable hospital ED visits and

Report Title	Description
and Inpatient Readmissions	inpatient readmissions.
Provider Preventable Conditions	Annual report on Provider Preventable Conditions
Grievance Systems	
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 Enrollees	Monthly report of complaints and Appeals, including reporting on how and in what time frame the complaints were resolved
Quality Management and Quality Improvement	
HEDIS® Clinical Topic Review (CTR)	Annual report, prepared by an external contractor of Performance Measurement
HEDIS® Clinical Topic Review (CTR) Satisfaction Survey	Annual report, prepared by an external contractor of Performance Measurement
CAHPS® Survey	Annual report of CAHPS® survey results
Quality Assessment and Program Improvement goal report	Semiannual 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
Performance Evaluation and External Quality Review	
Report of mandatory EQR activities Program	Validation of performance improvement projects, Validation of Performance Measures, and Compliance with strategy standards
Data Management and Information Systems	
Encounter data	Monthly by the fifteenth (15th) of the following month for all claims paid in the previous month
Program Integrity and Operational Audits	
Fraud & Abuse Report	Immediate reporting of Provider and Enrollee Fraud and Abuse
Fraud & Abuse Report	Quarterly report regarding any areas of Provider and Enrollee Fraud and Abuse
Coordination of Benefits/Third Party Liability	
Benefit Coordination Plan	As relevant, benefit coordination plan and proposed changes submitted for review and approval
Financial	
MLR Reports	Annually, within twelve (12) months of the end of the MLR Reporting Year as defined in in this Contract.
Managed Care Reporting Template	Semi-annual
Cash Flow Statement	Annually and upon request, cash flow statements to demonstrate compliance with requirement to maintain sufficient cash flow and liquidity to meet obligations
Audited Financial Statements	Annual copies of NDID financial reports
Third Party Liability	Monthly report indicating the claims where MCO has billed or made a

Report Title	Description
	recovery of a claim subject to TPL
Alternative Payment Methodology 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