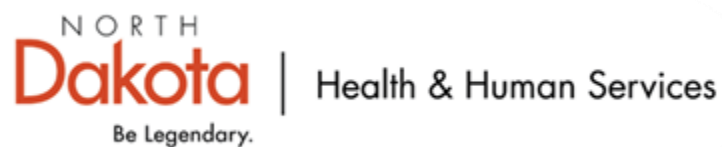


North Dakota Medicaid Quality Strategy



2025-2027

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Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA). Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Section I: INTRODUCTION

Background and Structure of North Dakota's Medicaid Program

The North Dakota (ND) Medicaid Program encompasses both the fee-for-service (FFS) and Medicaid Expansion programs. In the State of ND, the Medicaid program historically operated in an FFS environment prior to the adoption of Medicaid Expansion. To give more North Dakotans the opportunity to have affordable coverage, preventive services and greater economic security in the event of accidents or illness, the ND Department of Health and Human Services (HHS) implemented Medicaid Expansion on January 1, 2014, as authorized by the federal *Patient Protection and Affordable Care Act [Pub. L. 111-148]* (ACA). On January 1, 2022, Medicaid Expansion enrollees began receiving services through Blue Cross Blue Shield of North Dakota (BCBSND), the Medicaid managed care organization (MCO) for ND.

As of August 31, 2024, the ND Medicaid program served 106,324 North Dakotans, including 50,262 children, 24,537 individuals covered under the Medicaid Expansion, 12,031 adults ages 21 – 64 and 8,781 people over age 65 years.

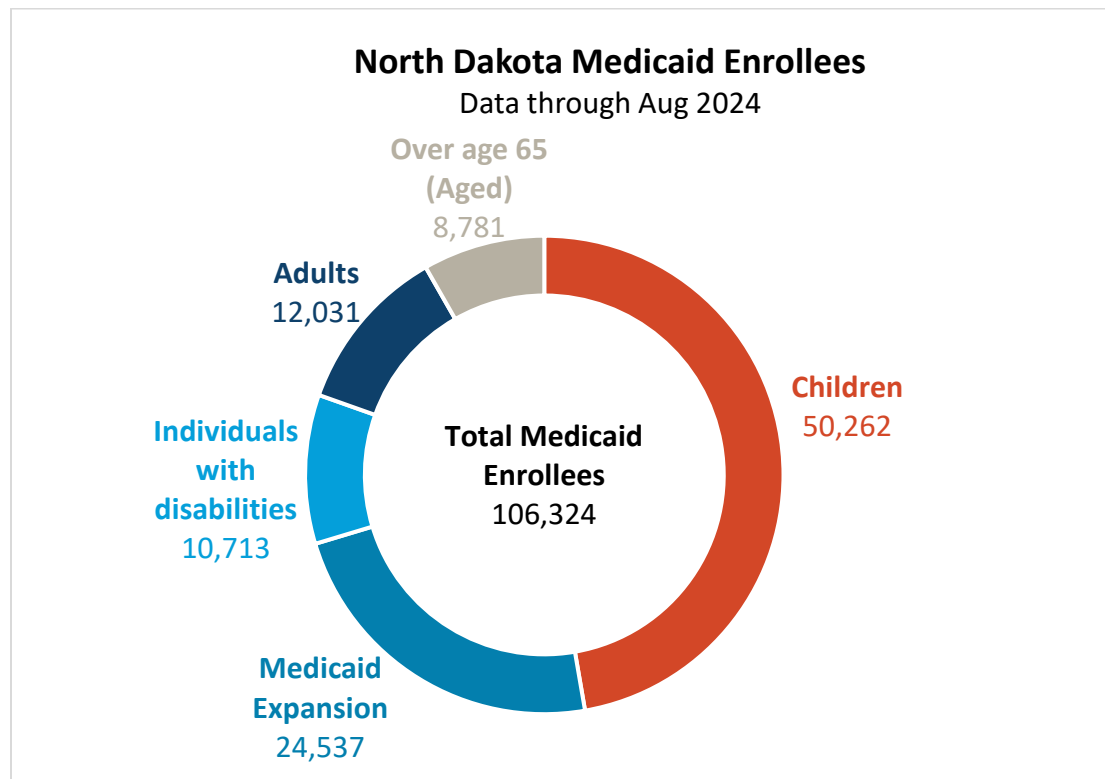


Figure 1: ND State Medical Eligibles August 2024 Data

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Our Vision

To make North Dakota the healthiest state in the nation

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

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

HHS Guiding Principles

- ✓ **Continuous improvement and innovation:** We embrace continuous improvement and innovation as ways to streamline the delivery of services, drive efficiencies and promote best-in-class customer-centered experiences.
- ✓ **Responsible stewardship:** Our organizational effectiveness and impact is enhanced by our strategic and efficient management of agency funding, assets and resources.
- ✓ **Transparent and open communication:** We prioritize transparent and open communication to facilitate trust, organizational and stakeholder awareness, collaboration and unity.
- ✓ **Engaged collaboration:** We bring a spirit of teamwork and accountability to every interaction, using our combined strengths to drive solutions and success.
- ✓ **Data-centered decisions:** Our decisions are grounded in data; we use facts and metrics to inform and guide our actions and evaluate outcomes.

To achieve strategic goals (**Figure 2:** North Dakota Medicaid Quality Strategy.), ND takes a population health approach to improve health outcomes across the lifespan for:

- Children and adults
- Women and infants
- Individuals with chronic conditions
- Special populations including foster youth and tribal members

ND Medicaid program's design articulates the vision and the data-driven strategy to improve health outcomes for Medicaid members by strengthening quality and performance improvement.

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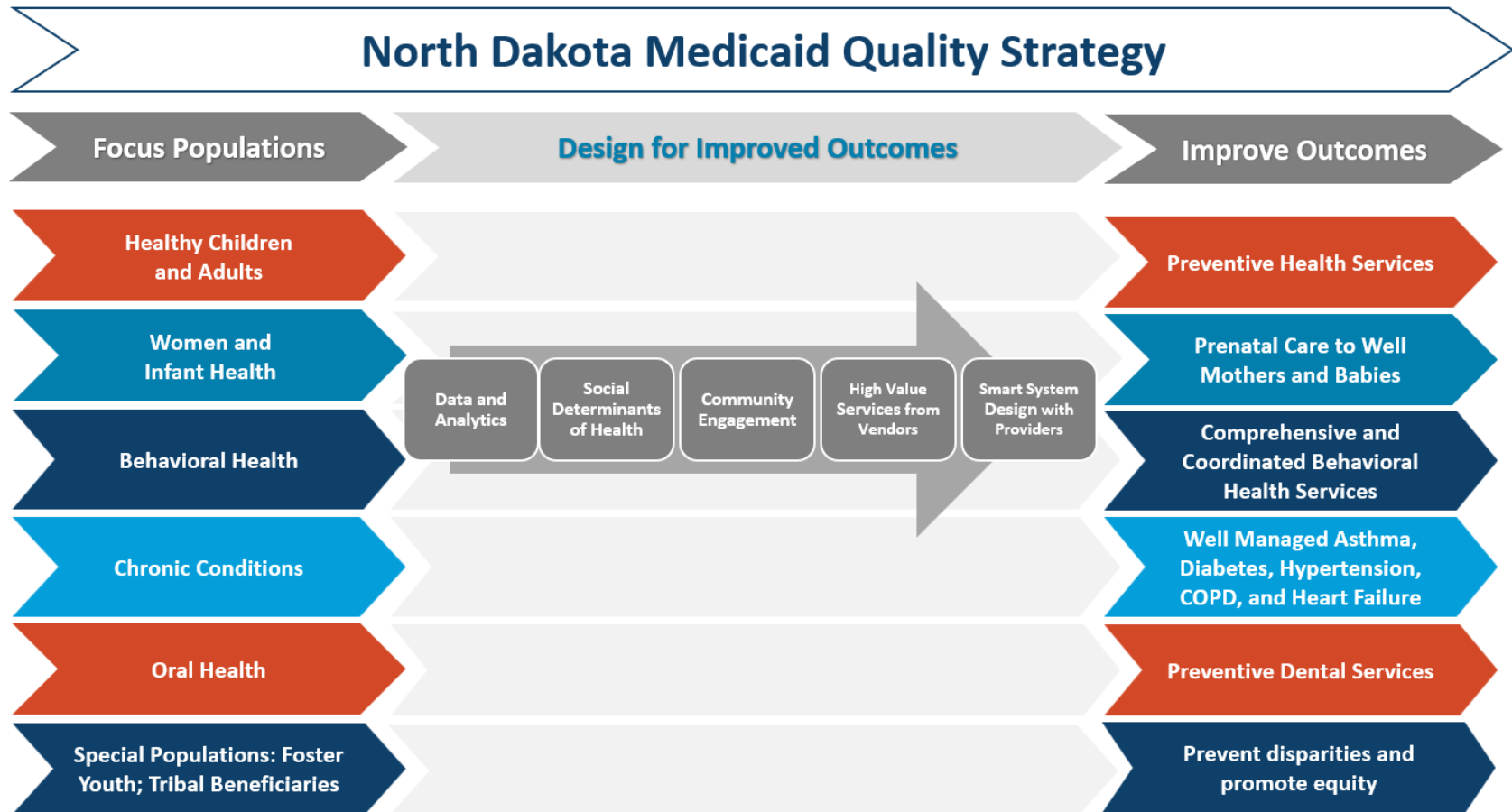


Figure 2: North Dakota Medicaid Quality Strategy.
 COPD: chronic obstructive pulmonary disease.

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Quality Strategy Purpose

The purpose of ND Medicaid's Quality Strategy is to:

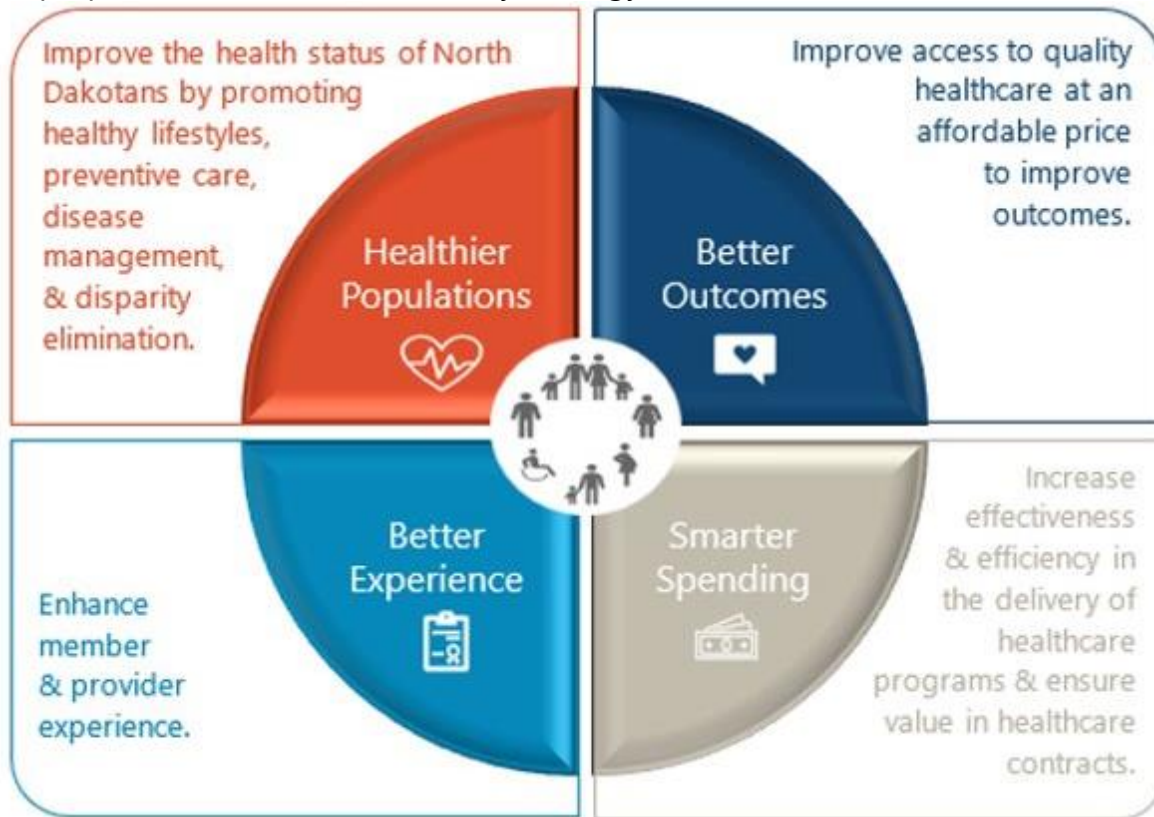


Figure 3: North Dakota's Quadruple Aim

Source: Institute for Healthcare Improvement (IHI)

According to the CMS, the quality strategy is part of a multipronged approach to managed care quality, which is best implemented when aligned and used with other key quality tools and initiatives such as the Medicaid and CHIP Adult and Child Core Set measure reporting; the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) reporting; PIPs, as part of Quality Assessment and Performance Improvement (QAPI) programs, and annual External Quality Review (EQR) with each one informing and reinforcing the others.

Together, these aims create a framework through which ND defines and drives the overall vision for advancing the quality of care provided to the Medicaid program members. These aims, goals, and objectives were designed to align closely with Centers for Medicare & Medicaid Services' (CMS) Quality Strategy, adapted to address ND's

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local priorities, challenges, and opportunities for its Medicaid program. Included within each of the four aims in **Figure 3** is a series of goals and corresponding objectives, intended to highlight key areas of expected progress and quality focus.

Quality Strategy Goals

The Quality Strategy is driven by the goals and objectives presented in **Table 1** to provide a roadmap through which the ND Medicaid program will facilitate improvements in health and healthcare through programmatic innovations, whole-person care, health equity, provider support, and steps to address health-related unmet resource needs. The metrics presented in Table 1 highlight a quality focus on the key objectives to drive progress towards strategic aims.

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Table 1: Quality Strategy Goals and Objectives

Goals and Objectives						
Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
Aim 1: Healthier Populations						
Goal 1.1: Improve Preventive Health						
1.1a	Increase the percentage of women receiving Breast Cancer Screening: Ages 50 to 74	BCS-AD	HEDIS	NCQA	30.4%	52.68
1.1b	Increase the percentage of beneficiaries receiving colorectal cancer screening: Ages 50 to 64	COL-AD	HEDIS	NCQA	14.0%	41.72
Goal 1.2: Improve Postpartum Care						
1.2	Increase the percentage of women delivering a live birth who had a timely postpartum care visit	PPC-AD	HEDIS	NCQA	39.5%	80.23%
Goal 1.3: Improve Behavioral Health Care for Beneficiaries						
1.3	Increase the percentage of follow-up after emergency department visit for mental illness	FUM-AD	HEDIS	NCQA	7-day	
					35.9%	38.62%
					30-day	
					51.5%	53.82%

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Goals and Objectives						
Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
Aim 2: Better Outcomes						
Goal 2.1: Improve Outcomes for Members with Substance Use Disorders						
2.1	Increase the percentage of adults ages 18–64 identified with an Initiation of Alcohol, Opioid, or Other Drug Abuse Treatment within 14 Days of Engagement includes Initiation Treatment with Two Additional Services	IET-AD	HEDIS	NCQA	Total AOD Initiation	
					51.1%	54.68%
					Total AOD Engagement	
					28.0%	>29.94%
Goal 2.2: Improve Health for Members with Chronic Conditions						
2.2a	Decrease the number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries ages 18 and older. <i>(lower rate is better)</i>	PQI08-AD	Adult Core Set	AHRQ	25.94	23.9
2.2b	Decrease the number of inpatient hospital admissions for diabetes	PQI01-AD	Adult Core Set	AHRQ	24.41	17.2

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Goals and Objectives						
Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
	short-term complications per 100,000 beneficiary months for beneficiaries ages 21 and older. <i>(lower rate is better)</i>					
2.2c	Decrease the number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries ages 40 and older <i>(lower rate is better)</i>	PQ105-AD	Adult Core Set	AHRQ	25.41	23.2
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	79.5%	81.12
3.1b	Increase Member Satisfaction by beneficiary rating of health plan	CPA-AD	Survey	CAHPS	71.4%	77.71

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Goals and Objectives						
Objective	Measure Name	Metric	Data Source	Measure Steward	MCO Baseline (FFY 2023)	Performance Target (by FFY 2027)
3.1c	Increase Member Satisfaction with Care rating of all health care	CPA-AD	Survey	CAHPS	82.1%	>82.61
Aim 4: Smarter Spending						
Goal 4.1: Focus on Paying for Value						
4.1	Decrease the ratio of observed all-cause readmissions to expected readmissions (O/E Ratio) among adults ages 18–64 <i>(lower rate is better)</i>	PCR-AD	HEDIS	NCQA	1.0213	0.9853

Baseline rates represent MY 2022. Target rates for HEDIS and CAHPS measures were set as the rate of the 50th MY 2023 Medicaid Quality Compass (QC) percentile. The IET initiation and engagement rates for ND were above the 50th percentile, so were set at the next highest 90th and 95th Quality Compass percentiles. The CAHPS rating of all health care rate for ND was above the 50th percentile, so it was set at the next highest 95th percentile. Target rates for the PQI 08 and PQI 01 measures were set for 2022 national Medicaid median rates, and the target rate for the PQI 05 measure was set for the Medicaid top quartile rate (source: Centers for Medicare & Medicaid Services. Quality of Care for Adults in Medicaid: Findings from the 2022 Adult Core Set. Chart Pack. January 2024). Target rates for the CPA-AD measures were set for the 2022 national median rates (source: Table CPA-AD downloaded from above link).

HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; MCO: managed care organization; NA: not available; AOD: alcohol and other drug; AHRQ: Agency for Healthcare Research and Quality; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

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Section II: ASSESSMENT

Quality and Appropriateness of Care

ND will assess how well the 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 the MCO, and to individuals with special health care needs, as required by *Title 42 Code of Federal Regulations (CFR) Section (§) 438.340*.

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

- State internal monitoring
- Performance Measurement
- Implementation of PIPs
- ND Medicaid Expansion MCO Compliance, Operations, and Quality Reporting (**Table A1**)
- External Quality Review: HHS contracts with an EQRO to conduct independent evaluations of MCO performance, in accordance with federal regulations.

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 health, or emotional conditions and who also require health and related services of a type or amount beyond that required by enrollees, generally. The 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.

Disparities Plan (§ 438.340[b][6])

To comply with the regulatory requirements for State procedures for age, sex, race, ethnicity, disability status, and primary language spoken (*Title 42 CFR § 438.206–438.210*), HHS requires the MCE to participate in North Dakota's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. 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. The MCO shall have a process that allows for the following:

- Identification of an enrollee's race, ethnicity, and primary language
- 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

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- The North Dakota Disability Determination Services (DDS) make medical disability determinations for North Dakotans using Social Security Administration (SSA) guidelines (<https://www.hhs.nd.gov/dds>).

The MCO shall utilize the top 15 languages spoken by individuals with limited English proficiency in ND that indicate the availability of language assistance in accordance with guidance issued under *the Patient Protection and Affordable Care Act Section 1557* and by CMS, HHS, and the Office for Civil Rights. The 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 the MCO and any contractors have oral interpretive services for those who speak any foreign language.

HHS provides demographic information for age, sex, race/ethnicity, and primary language spoken to the MCE as part of the member eligibility file, and the MCE is expected to use the data to analyze potential disparities in their membership through quality improvement efforts. Through performance measure data collection, the MCO shall examine data by race/ethnicity to identify health disparities and improve outcomes.

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, ND regularly reviews the MCO's routine reports and deliverables as required by Appendix D of the contract (**Table A1**). As described, ND also contracts with its EQRO to conduct comprehensive Interlaboratory Quality Assurance Program (IQAP) compliance reviews. The implementation and compliance standards of the Quality Strategy will be measured, monitored, and evaluated by ND and the EQRO.

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

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- Program integrity
- Provider network management, including provider directory standards
- Adoption and dissemination of practice guidelines that are based on valid and reliable clinical evidence of a consensus of providers in the particular field and consider the needs of the enrollees.
- 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 will follow the contract’s Appendix D: MCO Compliance, Operations, and Quarterly Reporting (**Table A1**). 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 the MCO, the state shall provide written documentation to the MCO attesting to such matters, and grant allowances, as appropriate, for the MCO to meet deadlines as required in contractual reporting requirements.

Reports should be submitted electronically in a format approved by the state. If a report requires revisions or format changes, the state shall provide written notice of such request to the MCO. The MCO shall maintain a data gathering and storage system sufficient to meet the requirements of the contract.

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

In accordance with § 438.356 and § 438.358, ND contracts with an EQRO to conduct both the mandatory *and* optional EQR activities.

Mandatory EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, ND’s EQRO conducts mandatory external quality review (EQR) activities for the ND Medicaid Expansion program. The state has contracted with its EQRO to perform the activities shown in **Figure 4**.



Figure 4: External Quality Review Activities.

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Review of Compliance with Medicaid and CHIP Managed Care Regulations

ND's EQRO conducts comprehensive, 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 *Title 42 CFR Part 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. **Table 2** lists relevant *Title 42 CFR Part 438* regulations and MCO compliance standards

Table 2: Title 42 CFR Part 438 and MCO Compliance 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

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MCO Compliance Standards
§ 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)

MCO: managed care organization.

Validation of Performance Measures

In accordance with § 438.340(b)(3)(i), ND requires the MCO to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with § 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 § 438.340(b)(3)(ii), ND requires the MCO to conduct PIPs in accordance with § 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 member satisfaction.

In accordance with § 438.358(b)(1)(i), the state’s EQRO validates PIPs required by the state to comply with the requirements of § 438.330(d). The state’s EQRO validation

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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 member satisfaction. The state requires the MCO to report the status and results of each project conducted from this section to the state in a semi-annual report, but not less than once per year as described in § 438.330(d)(3).

Network Adequacy Validation

In accordance with § 438.358(b)(1)(iv), ND's EQRO performs validation of the MCO network adequacy to comply with the requirements set forth in *Title 42 CFR § 438.68* and § 438.14(b)(1). The validation process includes determining whether the network standards, as defined by HHS, were met in accordance with the state's established provider-to-member ratios, maximum travel time or distance to providers, and timely appointment standards through a validation of the data and methods used by the MCE to assess network adequacy, validating the results and generating a validation rating, and reporting the validation to HHS and the MCEs.

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. The North Dakota EQRO 2022 Compliance Review included an assessment of provider-to-recipient ratios, e.g., PCP to Enrollee Ratio Report. Also see Availability of Services (§ 438.206), below.
- Geographic network distribution: time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider as defined by MCO contract. The North Dakota EQRO 2022 Compliance Review included an assessment of geographical access time and distance tables in the format specified by the State of adult PCP, outpatient behavioral health, and Specialists, e.g., PCP Providers Accepting New Patients Geographic Access Report.
- Appointment availability: average length of time (number of days) to see a provider as defined by MCO contract. The North Dakota 2022 Compliance Review included an assessment of time/distance standards, e.g., emergency services available 24 hours a day, 7 days a week; Primary Care Providers (including OB/GYN and women's health specialists) within 6 weeks of member request for routine, non-urgent or preventative care appointments; within 24 hours for urgent, symptomatic, but not life-threatening care; non-urgent sick care within 72 hours, or sooner if condition deteriorate into urgent or emergency condition; and maintain ratio for 1 full-time equivalent PCP for every 2,500 members. The FY 2023 PCP Access Telephone Survey Report evaluated the following standards for appointment availability: Appointments were considered timely when the visit was within 6 weeks of the call for routine well-check visits and within 3 calendar

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days for sick visits.

Optional EQR Activities

CMS optional EQR activities that ND has elected to have the EQRO perform include:

- **Validation of Encounter Data**

In accordance with *Title 42 CFR § 438.358(c)(1)*, HHS's EQRO conducts an encounter data validation (EDV) study. The EDV study is conducted based on three evaluation activities designed to evaluate the validity, accuracy and completeness of the MCE encounter data and uphold to the 95% state standards per contract requirement. In part, the encounter data validation is 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**

In accordance with *Title 42 CFR § 438.358(c)(2)*, the MCEs are responsible for obtaining a CAHPS vendor to administer the CAHPS survey on their behalf. The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. HHS's EQRO presents and analyzes the results of the MCEs' member experience surveys as part of the annual EQR.

- **Other Available EQR Activities**

- Calculation of additional performance measures in addition to those reported by the MCO and validated by the EQRO.
- Conduct additional PIPs in addition to those conducted by the MCO and validated by an EQRO
- Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time. These focus studies incorporate disparity analyses by stratifying data by such factors as age, sex, and disability or foster care status, as well as by race/ethnicity, and quantifying risk/protective factors for the study outcome(s).
- 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.

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EQR Technical Reporting

The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule-requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCEs. DHCFP's EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed over the previous 12 months preceding the finalization of the annual report. (*Title 42 CFR § 438.358[a][3], § 438.358[b][1], and § 457.1250[a]*). In addition, the annual EQR technical report must include outcomes data and results from quantitative assessments in addition to validation information (*Title 42 CFR § 438.364[a][2][iii] and § 457.1250[a]*).

In accordance with *Title 42 CFR § 438.364*, the report includes the following information for each mandatory and optional activity conducted:

- Assessment of quality, timeliness, and access to the care furnished by each MCE.
- Activity objectives.
- Technical methods of data collection and analysis.
- Description of data obtained.
- Conclusions drawn from the data.
- Assessment of MCE strengths and weaknesses.
- Recommendations for improving the quality of healthcare services furnished by the MCE, including how HHS can target goals and objectives in the Quality Strategy to support program improvement.
- Methodologically appropriate comparative information of the MCE in the program.
- An assessment of the degree to which the MCE has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

HHS uses the information obtained from each of the EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the Quality Strategy. The EQR technical report also includes the EQRO's evaluation of HHS's Quality Strategy,

The executive summary and full annual technical report will be made available on the ND Department of Health and Human Services Medicaid website. The most recent and historical EQR technical reports may be accessed at: [Medicaid Expansion | Health and Human Services North Dakota](#)

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

The EQRO will meet these obligations by utilizing the most recently published EQR protocols developed by CMS to perform the mandatory activities required of EQROs, as mentioned in § 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 § 438.350. This information will be obtained through methods consistent with established protocols and will include the elements described in the EQR results section. The results will be made available, as specified in the regulation.

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

MCO accreditation by a private independent nationally recognized accrediting entity is required per contract section 2.13.3. MCO shall be accredited by NCQA or URAC for its Medicaid product. When accreditation is obtained by the MCO for the ND Medicaid Expansion population, the information from the review standards, which are comparable to the EQR mandatory activities as described in *Title 42 CFR § 438.358(b)(1)(i-iii)* and § 457.1250, may be utilized to avoid duplication.

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Section III: STATE STANDARDS

North Dakota State Standards

The Quality Strategy is organized to reflect the standards outlined in *Title 42 CFR Part 438 Subparts D and E of the Medicaid Managed Care Rules and Regulations*. The standards of ND are at least as stringent as those specified in *Title 42 CFR Part 438* and divided into three standards: Access, Structure and Operations, and Measurement and Improvement. Each standard has multiple components as indicated in **Table 3** and the summaries that follow.

Table 3: Quality Strategy Standards

Standard and 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 and § 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 Standards

Network Adequacy

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

- Anticipated Medicaid enrollment
- Expected utilization of services

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- 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
- Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions

In accordance with CMS proposed a new federal regulation (*§ 438.68[f]* and *§ 438.10[d][2]*) the state has contracted with its EQRO to conduct annual secret shopper surveys of managed care plans' compliance with appointment wait time standards proposed and the accuracy of certain data in all managed care plans' electronic provider directories). To comply with *§ 438.10(h)(3)(iii)* the secret shopper survey makes oral interpretation available in all languages.

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. The MCO must ensure that coverage is available to enrollees on a 24-hours-a-day, 7-days-a-week basis. The MCO must ensure that network providers offer hours of operation that are no less than those offered to commercial enrollees (or comparable to ND Medicaid fee-for-service if a provider serves only Medicaid enrollees; consistent with *§ 438.206[c][1][ii]*).

The MCO must maintain a provider network sufficient to provide all enrollees with access to the full range of covered services required under the contract. The 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.

The 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

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guidelines and consistent with generally accepted practice parameters.

- The MCO must 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, the 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. The 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.
- There must be a ratio for each High-Volume and High-Impact Specialist of one full-time equivalent physician per 3,000 enrollees.
- There must be a ratio for each High-Volume Mental Health and Substance Use Disorder Practitioner type of one full-time equivalent practitioner per 3,000 enrollees.
- The MCO must incorporate access standards developed jointly by the MCO and ND.

The 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.

The 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 § 438.206(b)(3).

To assess the MCEs' compliance with the state-defined network adequacy standards,

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HHS contracts with its EQRO to perform annual network adequacy validation activities. HHS also monitors network adequacy through quarterly MCE GeoAccess reports and monthly/quarterly MCE grievance reports.

The MCO must establish mechanisms to ensure that network providers comply with the state standards of timely access requirements. The 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 **Table 4**.

Table 4: Access and Timeliness Standards for Appointments

Appointment Standards		
General	Mental Health and/or Substance Use Disorder	High-Volume and High-Impact Specialty
<ul style="list-style-type: none"> • <u>Emergency Services</u> – available 24 hours a day, 7 days a week • <u>Urgent Care</u> – within 24 hours • <u>Non-Urgent Sick Care</u> – within 72 hours, or sooner if condition deteriorates into urgent or emergency condition • <u>Routine, Non-Urgent or Preventative Care Visits</u> – within 6 weeks of enrollee request 	<ul style="list-style-type: none"> • <u>Emergency Services, Life Threatening</u> – immediate • <u>Emergency Services, Non-Life Threatening</u> – within 6 hours • <u>Urgent Care</u> – within 48 hours • <u>Initial Visits, Routine Care</u> – within 10 working days • <u>Follow-Up Visits, Routine Care</u> within 30 days 	<ul style="list-style-type: none"> • Consultation within one month of referral or as clinically indicated

The 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. The MCO must monitor this regularly to determine compliance and take corrective action if there is a failure to comply.

To assess compliance with timely appointment standards, the state’s EQRO is required to conduct an annual secret shopper survey across the MCO’s provider network to identify

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appointment standards and access to services for providers consistent with the appointment standards identified in the State's contract with the MCE.

Assurances of Adequate Capacity and Services (§ 438.207)

The MCO shall provide an appropriate range of covered services adequate for the anticipated number of enrollees for the service and that the 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.

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

Coordination and Continuity of Care (§ 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 the MCO implement procedures to deliver primary care to and coordinate health care services for all enrollees.

The MCO must assist all ND Medicaid Expansion enrollees in selecting a PCP. The MCO must provide a clinically appropriate PCP with the skills and experience to meet the needs of enrollees with special health care needs. The 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 mental health & substance use disorder health services. The MCO should also furnish a care coordinator to an enrollee when the MCO determines one is required through an assessment of the enrollee's health and support needs.

The 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 ND. 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]). The 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]).

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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, the 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 the 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 care shall be clearly described by the MCO and explained to each enrollee upon enrollment.

If the contracted network is unable to provide the necessary medical services covered under the contract to a particular enrollee, the MCO must adequately and in a timely manner 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 the MCO with respect to payment and to ensure that the 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)

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

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

The 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 members whose health conditions have 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, the 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 the MCO received a capitation payment for the enrollee.

If covered services are not available within the MCO's network, the 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 §

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438.206(b)(4). The MCO will not be obligated to provide an enrollee with access to out-of-network services if such services become available from a network provider.

Another aspect to consider regarding continuity of care pertains to ensuring continued access to services during transitions of care between ND Traditional FFS Medicaid and the MCO for ND Medicaid Expansion. In accordance with § 438.62, if the absence of continued services would result in serious detriment to an enrollee's health or risk hospitalization, ND and the MCO maintain and comply with a transition of care policy that 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 permission 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
- Provide copies of enrollee's medical records, upon request, as consistent with federal and state law

Coverage & Authorization of Services (§ 438.210)

The MCO must provide 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]). The MCO must provide a comprehensive health care services benefit package. The covered services will include all services that ND requires to 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
- Prescription drugs (to be provided through ND DHHS's FFS system, effective 01/01/2020)
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management

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The 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
- Complies with the *Mental Health Parity and Addiction Equity Act*
- Addresses the extent to which the 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
 - 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 ND Medicaid fee-for-service. The 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

The 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 § 438.210(b), which includes, at a minimum:

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

The MCO is not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees. (*Title 42 CFR 438.12[b][3]*)

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The 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, the MCO must comply with the requirements of § 438.236(c), § 456.111 (Hospitals), § 438.910(d) (*Mental Health and Substance Use Parity*), and § 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.

The MCO must provide written notification to the requesting provider and give the enrollee written notice of any decision by the 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 (§ 438.210[c])

The 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 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 ND
- Failure of the MCO to act within the timeframes provided in § 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 § 438.52(b)(2)(ii), to obtain services outside the network for a resident of a Rural/Frontier or an area with only one MCO
- Denial of enrollee's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities

Each contract must provide for the MCO to notify the requesting provider and give the enrollee written notice of any decision by the 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.

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Timeframe for Decisions (§ 438.210[d][1], [2] and [e])

The 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 an extension
 - The 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, the 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.
 - The MCO may extend the 72-hour time period by up to 14 calendar days if the enrollee requests an extension or if the MCO justifies, to the state upon request, a need for additional information and how the extension is in the enrollee's interest. Concurrent review is not required for inpatient hospital services under the Diagnosis Related Group (DRG) payment methodology.
- Compensation for UM activities: Each contract must provide that, consistent with § 438.3(i), and § 422.208, 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

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

The 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, the MCO must respond fully, and completely, to each appeal and establish a tracking mechanism to document the status and final disposition of each appeal.

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The 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 ND, in treating the enrollees' condition or disease.

The 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 ND's state fair hearing system, and a network provider appeal process. The MCO shall maintain records of any grievance and appeal. The grievance and appeal process must be approved by the state.

Enrollee Grievance Process

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

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

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

Enrollee Appeal Process

For an adverse benefit determination, the MCO shall provide an enrollee or provider with 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, the enrollee is deemed to have exhausted the MCO's appeal process, and an enrollee may initiate a state fair hearing. The 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

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teletypewriter/telecommunications for the deaf (TTY/TDD) and interpreter capability.

The MCO must ensure that the decision-maker on an appeal was not involved in previous levels of review or decision-making and is a health care professional 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
- Any appeal involving clinical issues

The MCO shall define an 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.

The 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, the 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
- Consider the enrollee, representative, or legal representative of a deceased enrollee as parties to the appeal

The 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. The MCO may extend the timeframe once, by up to 14 calendar days, if the enrollee requests the extension or the 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.

The MCO shall provide a 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

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- If the action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits

The MCO shall continue the enrollee's benefits if:

- The appeal is filed in a timely manner, 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
- The enrollee requests an extension of benefits

If the 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
- The authorization expires or authorization service limits are met

The 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 the MCO's favor. When services are not furnished, the 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.

The MCO shall establish and maintain an expedited review process for appeals when the MCO determines or the network provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life, 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. The MCO shall inform the enrollee of the limited time available for the enrollee to present evidence and

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allegations of fact or law, in person and in writing, in the case of expedited resolution.

- The MCO shall resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, not exceeding 3 business days after the MCO receives the appeal. An extension of up to 14 calendar days may be extended if the enrollee requests the extension or the MCO shows that there is a need for additional information including how the delay is in the enrollee's interest.
- In addition to written notice, the MCO shall also make reasonable efforts to provide oral notice.
- The MCO shall ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

Grievance Systems (§ 438.228)

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

Access to State Fair Hearing

When the enrollee or provider has exhausted the MCO's appeal process, the MCO shall include in enrollee and provider information: ND's fair hearing description and how to obtain it. If the MCO takes action and the enrollee requests a state fair hearing, the state will grant one. The 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

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

Structure and Operations Standards

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.

The MCO must establish documented processes to credential and re-credential providers with whom it has signed contracts or participation agreements. ND 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 NCQA and relevant state regulations, including regulations issued by the Board of Registration of

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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* or *Title 42 U.S. Code § 1320a-7*. In addition, the MCO may not authorize any providers terminated or suspended from the MCO to treat enrollees and must deny payment to such providers. This does not preclude the MCO from terminating or suspending providers for cause prior to action by the state. The MCO is responsible for providing timely notification to enrollees when a provider has been terminated or suspended.

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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.

The MCO must provide all enrollee notices, information materials, and instructional materials in a manner and format that may be easily understood, in accordance with § 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, the MCO must provide enrollees with notice of their right to request and obtain information on the various items required in § 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. The 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 the MCO and ND 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 *Title 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 § 438.56, the 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 the MCO's health plan seriously impairs the MCO's ability to furnish services to the enrollee or other enrollees).

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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, the 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
- The MCO has received information indicating that an enrollee may not be eligible for coverage under the health plan
- The 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 of Fraud and Abuse

The MCO must investigate and, if appropriate, report to the appropriate agency all suspected provider and enrollee fraud and abuse cases. The MCO must report all suspected provider and enrollee fraud and abuse to ND within 5 business days.

The 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 the MCO
- 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
 - Any legal or administrative actions taken

Subcontractual Relationships and Delegation (§ 438.230)

The health plan entity must oversee and remain accountable for any functions and responsibilities that are delegated to subcontractors. This entails ongoing monitoring

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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]).

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Section IV. MEASUREMENT AND IMPROVEMENT STANDARDS

Practice Guidelines (§ 438.236)

The application of evidence-based clinical practice guidelines has been proven to reduce variation in treatment, resulting in improved quality. The 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
- 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.

The MCO will use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers, or fails to deliver, for the targeted clinical conditions. The MCO will utilize evidence-based clinical guidelines and identify the source of the guidelines. The following are examples of clinical practice guidelines used by the MCO BCBS ND: The COPD or Asthma in Older Adults Admission Rate PIP provides a link to the Asthma Management Guidelines: Focused Updates 2020 (National Heart, Lung, and Blood Institute, 2021). The Diabetes Care PIP provides a link to the

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document Clinical Guidance for Diabetes (CDC, 2024). These clinical care standards and/or practice guidelines will be adopted by the MCO's Physician Quality Committee and/or the Pharmacy and Therapeutics Committee and reviewed by the MCO Quality Assurance/Quality Improvement (QA/QI) Committee. All clinical practice guidelines will be available on the MCO's website to providers, and enrollees and potential enrollees upon request. The MCO clinical practice guidelines will be used to inform their coverage decisions, utilization management, and enrollee educational activities.

The 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 the 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, the 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.

Examples of practice guidelines are, but are not limited to:

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

Performance Measure Reporting (§ 438.330)

Performance measurement is key to monitoring and improving quality. HHS uses HEDIS and the Adult Core Set and Child Core Set performance measures to assess performance against national performance to identify additional opportunities for improvement in the ND Medicaid FFS population and in the ND Medicaid managed care program population. To the extent possible, HHS relies on national performance measures that support comparisons and benchmark performance against other national and state entities. National measures with defined technical specifications ensure consistency in reporting and allow North Dakota to benchmark performance against other Medicaid and the CHIP programs.

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ND requires the MCO to collect and report on performance measures, as defined by HEDIS® and the CMS Adult Core Set, by reporting performance measure results to the state annually and adhere to all CMS Mandatory reporting guidance each year. The CMS Adult and Child core set measures can be found at : [Medicaid Adult and Child Core Set Measures](#)

HHS supports CMS’s collection of consistent performance measure data from states through its collection and reporting of CMS’s Adult Core Set and Child Core Set healthcare quality measures.

The state’s EQRO conducts CMS Core Measure Sets validation audits of the MCO annually and reports the results to the state. 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 quarterly state trending reports to monitor the 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, the state/EQRO will conduct performance monitoring and review to assess for the implementation and effectiveness of the action plan.

Public Posting of Quality Measures and Performance Outcomes

In accordance with *Title 42 CFR § 438.340(b)(3)(i)* and *§ 457.1240(e)*, HHS reports and publicly posts performance measures at the MCE level as well as at the state level through the annual EQR technical report. The performance measures included in the technical report include all measures in Table 1: Quality Strategy Goals and Objectives, as well as additional measures that align to the goals and objectives in this Quality Strategy. The ND Medicaid managed care member annual EQR technical report is published on [HHS’s website](#) under reports.

HHS also publicly posts annual performance measures at the state level (Fee-for-Service) as well as performance measures at the MCO level through a North Dakota Annual Performance Report for the Child and Adult populations on the [HHS website](#) under reports.

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Quality Assessment and Performance Improvement Program (§ 438.330)

To complement the ND Quality Strategy, and in compliance with *Title 42 CFR § 438.330*, the MCO must develop, maintain, and operate a comprehensive Quality Assessment and Performance Improvement (QAPI) program that objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided to members through quality related activities, and pursue opportunities for improvement on an ongoing as required by § 438.240. The QAPI is subject to approval by the state. In addition to complying with contractual terms related to specific QI activities, processes, and reporting, the MCO shall conform to all applicable federal and state regulations.

The QAPI must have procedures that includes:

- Designated staff members with expertise in quality assessment, utilization management, care coordination, healthcare analytics, and predictive modeling.
- Use quality indicators, including HEDIS® data and CMS's Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) performance measures to continually assess each MCE's achievement of the Quality Strategy goals and objectives.
- Integration of the results from annual PIPs, performance measure rate monitoring, and compliance with federal and State standards.
- A health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data.
- Use of clinical care standards/practice guidelines.
- Implement mechanisms to detect the over- and under-utilization of services.
- Regularly monitor and evaluate compliance with state standards for the 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.
- Include a full description of how clinical program initiatives will be addressed as specified by state for the ND Medicaid Expansion population.
- Include 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 (**Table A1**).

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- Measure and report to the state its expansion program performance using standard performance measures required by the state, including those developed in consultation with the state and other relevant stakeholders (§ 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.
- Report the status and results of each project to the state upon request and annually as requested for the EQR process and produce new information on quality of care every year.
- Process for evaluation of the impact and assessment of the MCE’s own QAPI program.

The MCO will be subject to a quarterly 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 ND Medicaid Expansion population, including but not limited to:

- Performance on the required standard performance measures
- The outcomes and trending results of the 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 (§ 438.330[d])

As described in § 438.330(b)(1), ND requires the MCO to conduct performance improvement projects (PIPs) annually, in accordance with § 438.330(d). The MCO’s QAPI program must also initiate and maintain PIPs, approved by the state, at least one of which must have a mental health or substance use disorder 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 § 438.358(b)(1)(i), the state’s EQRO validates PIPs required by the state and § 438.330(b)(1) on an annual basis.

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

- Measurement of performance using objective quality indicators.
- 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

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Table 5 lists the ND PIPs to be completed annually.

Table 5: Annual Performance Improvement Projects

Performance Improvement Projects	
Comprehensive Diabetes	
PIP Aim:	By establishing a relationship with a health care provider and having at least one ambulatory or preventive visit with that provider each year, there will be a decrease in inpatient admission related to diabetes complications for Medicaid Expansion enrollees during the calendar year.
PIP Interventions:	<ul style="list-style-type: none"> • Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND. • Case Management reached out to enrollees for the start of case management interventions, medical appointment needs including appointments with PCP and/or specialty care, and social/community needs. • Case Management conducted in-home hemoglobin A1c (HbA1c) labs for enrollees with a diabetes diagnosis (type 1 and 2). • Quality Management sent monthly reports on members with multiple admissions to case management for follow for medical interventions, follow up appointment needs with PCP or specialty provider and community support.
COPD or Asthma in Older Adults Admission Rate	
PIP Aim:	By establishing a relationship with a health care provider and having at least one ambulatory or preventive visit with that provider each year, there will be a decrease in patient admissions related to COPD or Asthma for Medicaid Expansion enrollees during the calendar year.
PIP Interventions:	<ul style="list-style-type: none"> • Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports and participated in collaboration calls with BCBSND. • Case Management made outbound engagement calls in order to reach members for start of case management interventions, medical

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Performance Improvement Projects	
	<p>appointment needs including appointments with PCP and/or specialty care, and social/community needs.</p> <ul style="list-style-type: none"> • Utilization management sent daily reports with enrollee discharges from inpatient or observation setting and sends weekly reports on outpatient services approved to case management to engage with members to assess healthcare needs including but not limited to appointments, medications, and services as well as assess and provide community support.
Substance Use	
PIP Aim:	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 principal diagnosis of substance use disorder or any diagnosis of drug overdose.
PIP Interventions:	<ul style="list-style-type: none"> • Participating providers with BlueAlliance Care+ received quality scorecards and gaps-in-care reports, and participated in collaboration calls with BCBSND. • Case Management made outbound engagement calls in order to reach members for start of case management interventions, medical appointment needs including appointments with PCP and/or specialty care, and social/community needs. • Case management receives alerts from BCBSND, local ER and HIN on members that have been treated in the ER or were admitted to acute inpatient. Case management addressed healthcare needs following receiving alerts such as follow up appointments, gaps in care, health education needs, home visits and social supports. • BCBSND provided case management vendor with list of enrollees that fell into the denominator for the FUA and FUI measure, case management will review list to determine additional outreach and case management needs. • BCBSND implemented peer support services. • BCBSND implemented peer support services. • Enrolled members into the coordinated services program, to ensure close monitoring and care from an established PCP

COPD: chronic obstructive pulmonary disease; ED: emergency department.

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Health Information Systems (§ 438.242)

The MCO must maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of § 438.242. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for others than loss of Medicaid eligibility.

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

- Collect data on enrollee and provider characteristics, as specified by ND, and on services furnished to enrollees through an encounter data system or other methods as specified by the state
- 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
 - Making all collected data available to the state and, upon request, to CMS

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Section V: 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 ND and the 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
- Charting progress towards quality goals

The state's EQRO reports will include an assessment of the 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 the 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 (§ 438.340[b][7])

The premise behind the Quality Strategy process is one of continuous quality improvement. ND strongly believes in working with the 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 the MCO plan meet the federal requirements of *Title 42 CFR Part 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 the MCO contract under the conditions specified below.

Whenever the state determines that the MCO is failing to provide one or more core benefits and services, it may authorize enrollees to obtain the covered service from another source. If the Medical Services Division determines that the MCO failed to

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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 the 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, the MCO must implement the initial or revised CAP within the timeframes specified by the state.

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Section VI: PROCESS FOR QUALITY STRATEGY DEVELOPMENT, REVIEW, & REVISIONS

Development and Review of Quality Strategy

North Dakota Department of Health and Human Services contracts with the EQRO for North Dakota, to assist in the development and ongoing review of the Quality Strategy. To ensure compliance with the regulatory requirements in the 2021 CMS Medicaid and CHIP Managed Care Quality Strategy Toolkit, **Appendix B** provides a crosswalk of each required element and the corresponding section of the Managed Care Quality Strategy where the element is located.

Throughout the development of the Quality strategy, the *Title 42 CFR § 438.340* was utilized to ensure compliance with the rules governing Medicaid managed care. Throughout this report, all section references (§) refer to *Title 42 CFR* unless otherwise noted.

Updates & Revision of the Quality Strategy

Updates to the Quality Strategy will be a part of North Dakota’s continuous quality improvement process, as required by *Title 42 CFR § 438.364(a)(4)*, will consider the recommendations provided by the EQRO for improving the quality of healthcare services provided by the MCO and how HHS can target goals and objectives in the Quality Strategy to better support improvement in the quality, timeliness, and access to healthcare services provided to Medicaid members.

Review and updates to the Quality Strategy will take place at least once every three years, and as needed whenever significant changes occur. Prior to finalizing a revised or renewed Quality Strategy, North Dakota will submit a copy of the revised Quality Strategy to CMS at a minimum of every three years and when significant changes are made. Each revision of the Quality strategy is made publicly available on the HHS website at: <https://www.hhs.nd.gov/healthcare-coverage/medical-services/publications>. **Table 6** shows the Quality Strategy evaluation dates and corresponding measurement periods.

Table 6: Quality Strategy Evaluation Dates and Measurement Periods

Evaluation Date	Measurement Period
2024	CY 2023
2025	CY 2024
2026	CY 2025
2027	CY 2026

CY: calendar year.

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Public Comment and Tribal Consultation

In accordance with § 438.340(c), HHS invites public comment, Medicaid Medical Care Advisory Committee (MMAC) input, and tribal consultation by way of tribal consultation meetings, by forwarding the MMAC the Draft Quality strategy, and by publishing on ND HHS website at (<https://www.hhs.nd.gov/events>). Public comments received are also added to the state's website.

Once the public comment period ends and consensus is reached by all stakeholders, including the MAC, members, and Tribal Nations, the Quality Strategy is finalized, shared with all pertinent stakeholders, sent to CMS, and posted on HHS's website for public view at: at <https://www.hhs.nd.gov/healthcare-coverage/medical-services/publications>.

Updates for Significant Changes

At a minimum, HHS and EQRO reviews progress on the Quality Strategy goals and objectives at least annually and updates the Quality Strategy at least triennially to incorporate new goals and objectives for the following years or more frequently when there is significant change. For purposes of reviewing and updating the Quality Strategy, "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.
- Any change that triggers public comment, tribal consultation, and input from North Dakota's Medicaid Member Advisory Committee (MMAC).
- Any change to the Quality Strategy's defined goals, including adding or removing goals and objectives.

If revisions to the Quality Strategy are due to significant changes, it will be placed on ND's website at <https://www.hhs.nd.gov/events> for public comment and the final version will be placed on ND's website at <https://www.hhs.nd.gov/healthcare/medicaid-expansion>.

Annual Evaluation of the Quality Strategy

HHS and its EQRO review and evaluate the implementation and effectiveness of the Quality Strategy and publish the results of the evaluation through each annual EQR technical report. HHS works closely with its EQRO throughout the year to support, oversee, and monitor quality activities and evaluate the North Dakota Medicaid managed care program's progress in achieving the goals and objectives included as part of the Quality Strategy. The EQRO provides ongoing technical support to HHS in the development of monitoring strategies. The EQRO also works with HHS to ensure that the MCEs stay informed about new State and federal requirements and evolving

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technologies for quality measurement and reporting. Additionally, HHS and its EQRO conduct a formal, annual evaluation of the Quality Strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to members, providers, and other stakeholders was accomplished.

The annual Quality Strategy evaluation includes an assessment of:

- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvements in care and services) and trending of performance measure data.
- The appropriateness of the program structure, processes, and objectives.
- The identification of program limitations and barriers to performance improvement.
- The evaluation of findings from internal activities, including quality improvement committees and workgroups; member complaints, grievances, and appeals; and provider complaints and issues, when trends and/or focus areas are identified by HHS and/or other stakeholders through these activities.
- EQRO recommendations resulting from the previous year's EQR activities and subsequent actions implemented by the MCO and HHS as a result of those recommendations.
- Feedback obtained from HHS administration, the MCO, the provider community, advocacy groups, Medicaid members, and other internal and external stakeholders.
- Current goals and objectives within the Quality Strategy to determine whether these goals and objectives will continue to support program improvement.

HHS uses several tools to evaluate the effectiveness and achievement of goals, including:

- The annual EQR technical report findings.
- Validated PIP results.
- Validated performance measure results.
- Validated network adequacy results.
- EDV results.
- MCE compliance review results.
- Ongoing review of contractually required MCE deliverables.
- Member grievance and appeal information.
- MCE cultural competency and QAPI programs.
- Stakeholder feedback.

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The success of the Quality Strategy requires effective implementation and coordination between ND and the 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, to continually track the progress toward achieving the goals outlined in the Quality Strategy, take a population perspective on the ND Medicaid Expansion program, and, to the greatest degree possible, harmonize quality initiatives across the ND Medicaid, MCO and ND Medicaid Expansion programs.

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

The state and 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.

Further, in an effort to promote and meet the Quality Strategy goals and objectives, HHS encourages the MCE managed care program to align with the Quality Strategy goals and objectives through its QAPI program. Annually, HHS and its EQRO assesses the MCE's QAPI program evaluation to ensure the MCE continually monitors and evaluates its own achievement of goals and objectives to improve the accessibility, timeliness, and quality of services provided to the ND Medicaid expansion members.

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CONCLUSION

The Quality strategy allows ND 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 Services Division programs on quality activities. The plan to institute formal quality strategies on a regular basis will strengthen these collaborations and ensure 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.

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Appendix A: MCO COMPLIANCE, OPERATIONS, AND QUALITY REPORTING

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

Table A1: MCO Compliance, Operations, and Quality Reporting

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 by 31 December and upon request from STATE, a copy of the current organizational chart with reporting structures, names, and positions
Key Personnel Changes	As relevant, changes to MCO personnel in key positions
Enrollment	
Enrollment Discrepancy Report	Monthly 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 one business day 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)

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Report Title	Description
Enrollee Inquiries	Semiannual report identifying the number and type of the top ten (10) inquiries received, due 31 March and 30 September
Covered Services	
Mental Health and Substance Use Parity	Annual report documenting compliance with the Mental Health Parity and Addiction Equity Act of 2008 due 1 June
Value-Added Benefits	As relevant, any changes to value-added benefits offered
Value-Added Benefits	Annually, a report on the impact of its value-added benefits due 1 June
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 providers suspended or terminated by MCO independently due 15 January
Report of Suspended/Terminated Providers	Weekly report of compliance with MCO Provider suspensions and terminations requirements and report
Provider Handbook	Annual Provider Handbook which includes specific information about MCO Covered Services, non MCO Covered Services, and other requirements relevant to Provider responsibilities due 31 December
Provider Complaints Report	Annual report that includes all Provider complaints

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Report Title	Description
	received, and MCO actions to address them due 1 June
Claims Summary Report	Monthly report on paid and denied claims by claim type
Claims Payment Accuracy Report	Monthly report on claims payment accuracy based on an audit conducted by MCO
Network Development and Management Plan	Annual plan describing MCO's Network development and Network management activities and results, including findings of Provider non-compliance and any corrective action plan and/or measures taken by MCO to bring Provider into compliance, and Enrollee access to Provider types where STATE has granted MCO an exception to a time or distance or appointment accessibility standard due 15 February
Network Adequacy	
PCP Geographic-Access Report	Semi-annual report of percentage of Enrollees by County with access to open PCPs within the network accessibility standards in Appendix C of the contract due 31 March and 30 September
PCP to Enrollee Ratio Report	Semi-annual report of open PCPs per number of Enrollees by geographic region as defined by STATE (includes data collection methodologies) due 31 March and 30 September
Top 5 High Volume Specialists Geographic Access Report	Semi-annual report of Enrollee's geographic access to top five (5) high volume specialty types by geographic region as defined by STATE due 31 March and 30 September
Significant Changes in Provider Network Report	Immediate notice and Semi-Annual Summary report due 31 March and 30 September of significant changes in Provider Network that will affect the adequacy and capacity of services
Summary Access and Availability Analysis Report	Annual report of key findings from all access reports and data sources (e.g., Grievance system, telephone contacts with access/availability associated reason codes, Provider site visits, use of Out-of-Network alternatives due to access/availability, use of limited Provider agreements, care management staff

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Report Title	Description
	experiences with scheduling appointments) due 1 July
Care Management	
Care Management	Annual report on care management program due 1 August
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 due 1 July
Potentially Avoidable ED visits and Inpatient Readmissions	Quarterly report on potentially avoidable hospital ED visits and inpatient readmissions.
Provider Preventable Conditions	Annual report on Provider Preventable Conditions due 1 July
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 Final Audit Report	Annual report, prepared by an external contractor of Performance Measurement due 15 July
CAHPS AHRQ Dataset Submission	Annual file submission of CAHPS survey results to AHRQ database due 30 June
CAHPS Survey	Annual report of CAHPS survey results due 31 July

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Report Title	Description
Quality Assessment and Program Improvement goal report	Quarterly reports of progress toward QAPI goals including status and outcomes of performance improvement projects
Health Plan Accreditation Report	As relevant, copy of final accreditation report for each accrediting cycle
Performance Evaluation and External Quality Review	
Report of mandatory EQR activities Program	External Quality Review Organization report of validation of performance improvement projects, Validation of Performance Measures, and Compliance with strategy standards. Due 1 July
Data Management and Information Systems	
Encounter data	Monthly by the fifteenth (15 th) 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 this Contract.
Managed Care Reporting Template	Semi-annual due on 1 May and 1 August
Cash Flow Statement	Annually and upon request, cash flow statements to demonstrate compliance with the requirement to maintain sufficient cash flow and liquidity to meet obligations
Audited Financial Statements	Annual copies of NDID financial reports due 31 December
Third Party Liability	Monthly report indicating the claims where the MCO has billed or made a recovery of a claim subject to TPL

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Report Title	Description
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. Due on 30 June

MCO: managed care organization; NDMA: North Dakota Medical Association; ND: North Dakota; PCP: primary care provider; HEDIS: Healthcare Effectiveness Data and Information Set; CAHPS: Consumer Assessment of Healthcare Providers and Systems; QAPI: quality assessment and performance improvement; MLR: Medical Loss Ratio; NDID: North Dakota Insurance Department; TPL: Third Party Liability; APM: Alternative Payment Methodology; PCMH: Patient Centered Medical Home; ACO: Accountable Care Organization.

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Appendix B: NORTH DAKOTA QUALITY STRATEGY CROSSWALK TO CMS TOOLKIT

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

Table B1: Crosswalk to CMS Toolkit

Regulatory Reference <i>Title 42 CFR</i>	Required State Element	Description	Page or Link Reference
§ 438.340(b)(1)	Network Adequacy and Clinical Practice Guidelines	The State’s quality strategy includes the State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by § 438.68 and § 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with § 438.236 .	Page 19 (network adequacy) and 40 (clinical practice guidelines)
§ 438.340(b)(2)	Goals and Objectives	The State’s quality strategy includes goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served	Page 9

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Regulatory Reference Title 42 CFR	Required State Element	Description	Page or Link Reference
		by the MCO, PIHP, and PAHP, and PCCM entity described in § 438.310(c)(2) .	
§ 438.340(b)(3)(i)	Quality Metrics and Performance Targets	The State’s quality strategy includes a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with § 438.330(c) . The State must identify which quality measures and performance outcomes the State will publish at least annually on the website required under § 438.10(c)(3) .	Page 9
§ 438.340(b)(3)(ii)	Performance Improvement Projects	The State’s quality strategy includes a description of the performance improvement projects to be implemented in accordance with § 438.330(d) , including a description of any interventions the State proposes to improve access, quality, or	Page 44

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Regulatory Reference Title 42 CFR	Required State Element	Description	Page or Link Reference
		timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.	
§ 438.340(b)(4)	Annual External Independent Review	Arrangements for annual, external independent reviews, in accordance with § 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in § 438.310[c][2]) contract.	Page 16
§ 438.340(b)(5)	Transition of Care Policy	A description of the State's transition of care policy required under § 438.62(b)(3). Continued services to enrollees: The State must make its transition of care policy publicly available and provide instructions to enrollees and potential enrollees on how to access continued services upon transition.	Page 28
§ 438.340(b)(6)	Identifying, Evaluating, and Reducing Health Disparities	The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. For purposes of this paragraph (b)(6), "disability status" means, at a minimum, whether the	Page 14, https://www.hhs.nd.gov/dds

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Regulatory Reference Title 42 CFR	Required State Element	Description	Page or Link Reference
		individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status.	
§ 438.340(b)(7)	Sanctions	For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	Page 48
§ 438.340(b)(8)	Identification of Persons Needing Long-term Services and Supports and Persons with Special Needs	The mechanisms implemented by the State to comply with § 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	Page 14
§ 438.340(b)(9)	Non-duplication	The information required under § 438.360(c) (relating to non-duplication of EQR activities).The State must identify in its	Page 22

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Regulatory Reference Title 42 CFR	Required State Element	Description	Page or Link Reference
	of EQR Activities	quality strategy under § 438.340 the EQR activities for which it has exercised the option described in this section, and explain the rationale for the State's determination that the Medicare review or private accreditation activity is comparable to such EQR activities.	
§ 438.340(b)(10)	Definition of Significant Change	The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section. A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	Page 51
§ 438.340(c)(1)(i)(ii)	Public Comment	Make the strategy available for public comment before submitting the strategy to the CMS for review, including: i. Obtaining input from the Medical Services Fund Advisory Council (established by § 431.12 of this chapter), beneficiaries, and other stakeholders.	Page 51, https://www.hhs.nd.gov/events

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Regulatory Reference Title 42 CFR	Required State Element	Description	Page or Link Reference
		ii.If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.340(c)(2) , consulting with Tribes in accordance with the State's Tribal consultation policy.	
§ 438.340(c)(2)(i)(ii)(iii)	Updating Quality Strategy	In drafting or revising its quality strategy, the State must review and update the quality strategy as needed, but no less than once every 3 years. This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years. The State must make the results of the review available on the Web site required under § 438.10(c)(3) . Updates to the quality strategy must take into consideration the recommendations provided pursuant to § 438.364(a)(4) .	Page 50, https://www.hhs.nd.gov/healthcare-coverage/medical-services/publications
§ 438.340(c)(3)(i)(ii)	Submitting Revised Quality Strategies to CMS	The State must submit to CMS the following: i.A copy of the initial strategy for CMS comment and feedback prior to adopting it in final.	Page 50

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Regulatory Reference Title 42 CFR	Required State Element	Description	Page or Link Reference
		ii.A copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	
§ 438.340(d)	Availability of the Final Quality Strategy on the Website	The State must make the final quality strategy available on the Web site required under § 438.10(c)(3). The State must operate a website that provides the content, either directly or by linking to individual MCO, PIHP, PAHP, or PCCM entity websites, specified in paragraphs (g), (h), and (i) of this section.	Page 50, https://www.hhs.nd.gov/healthcare/medicaid-expansion

CFR: the Code of Federal Regulations.

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