# Managed Care Program Annual Report (MCPAR) for North Dakota: Medicaid Expansion

| Due date | Last edited | Edited by | Status |
|---|---|---|---|
| 06/29/2023 | 06/20/2023 | Jared Ferguson | In progress |

| | Indicator | Response |
|---|---|---|
| | **Exclusion of CHIP from MCPAR**<br>Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program. | Not Selected |

## Point of Contact

Find in the Excel Workbook
**A_Program_Info**

| Number | Indicator | Response |
|---|---|---|
| **A1** | **State name**<br>Auto-populated from your account profile. | North Dakota |
| **A2a** | **Contact name**<br>First and last name of the contact person. | Jared Ferguson |

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|---|---|---|
| | States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers. | |
| **A2b** | **Contact email address**<br>Enter email address. Department or program-wide email addresses ok. | jadferguson@nd.gov |
| **A3a** | **Submitter name**<br>CMS receives this data upon submission of this MCPAR report. | Not answered |
| **A3b** | **Submitter email address**<br>CMS receives this data upon submission of this MCPAR report. | Not answered |
| **A4** | **Date of report submission**<br>CMS receives this date upon submission of this MCPAR report. | Not answered |

## Reporting Period

Find in the Excel Workbook
**A_Program_Info**

| Number | Indicator | Response |
|---|---|---|
| **A5a** | **Reporting period start date**<br>Auto-populated from report dashboard. | 01/01/2022 |
| **A5b** | **Reporting period end date**<br>Auto-populated from report dashboard. | 12/31/2022 |
| **A6** | **Program name**<br>Auto-populated from report dashboard. | Medicaid Expansion |

## Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Find in the Excel Workbook
**A_Program_Info**

| Indicator | Response |
|---|---|
| **Plan name** | Blue Cross Blue Shield North Dakota |

## Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
**A_Program_Info**

| Indicator | Response |
|---|---|
| **BSS entity name** | State Health Insurance Assistance Program (SHIP) |

## Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
**B_State**

| Number | Indicator | Response |
|---|---|---|

| | | |
|---|---|---|
| **BI.1** | **Statewide Medicaid enrollment**<br>Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled. | 131804 |
| **BI.2** | **Statewide Medicaid managed care enrollment**<br>Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan. | 35948 |

## Topic III. Encounter Data Report

Find in the Excel Workbook
**B_State**

| Number | Indicator | Response |
|---|---|---|
| **BIII.1** | **Data validation entity**<br>Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information. | EQRO |

# Topic X: Program Integrity

Find in the Excel Workbook
**B_State**

| Number | Indicator | Response |
|---|---|---|
| **BX.1** | **Payment risks between the state and plans**<br>Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program.<br>Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. | Quarterly Fraud and Abuse Report filed by MCO; Immediate (within one working day) reporting by MCO of suspected Fraud or Abuse to the State |
| **BX.2** | **Contract standard for overpayments**<br>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one. | State has established a hybrid system |
| **BX.3** | **Location of contract provision stating overpayment standard**<br>Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i). | Section 2.16.1 of North Dakota Medicaid Expansion Contract |
| **BX.4** | **Description of overpayment contract standard**<br>Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2. | A mechanism for a Network Provider to report to MCO when it has received an overpayment, to return the overpayment to MCO within sixty calendars days after the date on which the overpayment was identified. The process, timeframes and documentation required for reporting the recovery of all overpayments. MCO shall not recover from providers via automated review for claims older than one |

| | | |
|---|---|---|
| | | year unless authorized by State. The collected funds from MCO automated reviews are to remain with the MCO. |
| **BX.5** | **State overpayment reporting monitoring**<br>Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?<br>The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting. | Quarterly Fraud and Abuse Report filed by MCO; Immediate (within one working day) reporting by MCO of suspected Fraud or Abuse to the State |
| **BX.6** | **Changes in beneficiary circumstances**<br>Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans). | Regular, recurring transmission of enrollment data from State to MCO. All types of potential Fraud and all types of potential Enrollee Waste or Abuse related to the Medicaid program shall be reported to STATE within one (1) business day of discovery. |
| **BX.7a** | **Changes in provider circumstances: Monitoring plans**<br>Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one. | Yes |
| **BX.7b** | **Changes in provider circumstances: Metrics**<br>Does the state use a metric or indicator to assess plan reporting performance? Select one. | Yes |
| **BX.7c** | **Changes in provider circumstances: Describe metric**<br>Describe the metric or indicator that the state uses. | All types of potential Fraud and all types of potential Enrollee Waste or Abuse related to the Medicaid program shall be reported to STATE within one (1) business day of discovery. |

| | | |
|---|---|---|
| **BX.8a** | **Federal database checks: Excluded person or entities**<br>During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. | No |
| **BX.9a** | **Website posting of 5 percent or more ownership control**<br>Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3). | No |
| **BX.10** | **Periodic audits**<br>If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e). | N/A - awaiting validation and verification from EQRO due to CY2022 being the first year of a new MCO provider. State has one MCO. |

## Topic I: Program Characteristics

Find in the Excel Workbook
**C1_Program_Set**

| Number | Indicator | Response |
|---|---|---|

| | | |
|---|---|---|
| **C1I.1** | **Program contract**<br>Enter the title and date of the contract between the state and plans participating in the managed care program. | North Dakota Medicaid Expansion Managed Care Organization (MCO) Contract |
| **N/A** | N/A | 01/01/2022 |
| **C1I.2** | **Contract URL**<br>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program. | https://www.hhs.nd.gov/healthcare/medicaid-expansion#collapse-accordion-5150-3 |
| **C1I.3** | **Program type**<br>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one. | Managed Care Organization (MCO) |
| **C1I.4a** | **Special program benefits**<br>Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more.<br>Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here. | Behavioral health<br><br>Transportation |
| **C1I.4b** | **Variation in special benefits**<br>What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable. | Covers up to thirty consecutive days in a twelve month period of Skilled Nursing Facility services |
| **C1I.5** | **Program enrollment**<br>Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year. | 35948 |
| **C1I.6** | **Changes to enrollment or benefits** | Effective 1/1/2022, nineteen (19) and twenty (20) year old Expansion enrollees are covered |

| | | |
|---|---|---|
| | Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. | by Fee For Service |

## Topic III: Encounter Data Report

Find in the Excel Workbook
**C1_Program_Set**

| Number | Indicator | Response |
|---|---|---|
| **C1III.1** | **Uses of encounter data**<br>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.<br>Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)). | Rate setting<br>Quality/performance measurement<br>Monitoring and reporting<br>Contract oversight<br>Program integrity<br>Policy making and decision support |
| **C1III.2** | **Criteria/measures to evaluate MCP performance**<br>What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more.<br>Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d). | Timeliness of initial data submissions<br>Timeliness of data corrections<br>Timeliness of data certifications<br>Use of correct file formats<br>Provider ID field complete<br>Overall data accuracy (as determined through data validation) |
| **C1III.3** | **Encounter data performance criteria contract language**<br>Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction | 2.15 |

| | | |
|---|---|---|
| | will be measured. Use contract section references, not page numbers. | |
| **C1III.4** | **Financial penalties contract language**<br>Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers. | 5.9.5(C) |
| **C1III.5** | **Incentives for encounter data quality**<br>Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality. | N/A |
| **C1III.6** | **Barriers to collecting/validating encounter data**<br>Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period. | One instance, 02/22/2022, where MCO did not submit encounter data to the state by the contractual deadline. Liquidated damages assessed on MCO on 02/22/2022. Instance was remedied by the MCO on 02/26/2022. Corrective Action Plan implemented. No recurrences of the instance. |

## Topic IV. Appeals, State Fair Hearings & Grievances

Find in the Excel Workbook
**C1_Program_Set**

| Number | Indicator | Response |
|---|---|---|
| **C1IV.1** | **State's definition of "critical incident," as used for reporting purposes in its MLTSS program**<br>If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? | N/A |

| | | |
|---|---|---|
| | Respond with "N/A" if the managed care program does not cover LTSS. | |
| **C1IV.2** | **State definition of "timely" resolution for standard appeals**<br>Provide the state's definition of timely resolution for standard appeals in the managed care program.<br>Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal. | MCO must provide the Enrollee, Provider, or their authorized representative the opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records and any other documents and records considered, relied upon, or generated by MCO in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge, and sufficiently in advance of the thirty (30) calendar days of MCO's receipt of the Appeal for standard Appeals or sufficiently in advance of the three days of MCO's receipt of the Appeal for expedited Appeals to provide enough time for review. |
| **C1IV.3** | **State definition of "timely" resolution for expedited appeals**<br>Provide the state's definition of timely resolution for expedited appeals in the managed care program.<br>Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. | MCO shall resolve each expedited Appeal and provide notice of resolution to affected parties as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the when MCO receives the Appeal |
| **C1IV.4** | **State definition of "timely" resolution for grievances**<br>Provide the state's definition of timely resolution for grievances in the managed care program.<br>Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance. | MCO shall review the Grievance and provide written notice to the Enrollee of the disposition of a Grievance as expeditiously as the Enrollee's health condition requires and no later than ninety (90) calendar days from the date the MCO receives the Grievance. |

# Topic V. Availability, Accessibility and Network Adequacy

## Network Adequacy

> Find in the Excel Workbook

**C1_Program_Set**

| Number | Indicator | Response |
|---|---|---|
| **C1V.1** | **Gaps/challenges in network adequacy**<br>What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards. | Recruiting for Specialty Providers due to rural nature of the state is a challenge. Patient access standards are being met for all providers. |
| **C1V.2** | **State response to gaps in network adequacy**<br>How does the state work with MCPs to address gaps in network adequacy? | Quarterly scatter-point maps and enrollment information identify any potential gaps in network adequacy |

## Topic V. Availability, Accessibility and Network Adequacy

### Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
**C2_Program_State**

**Access measure total count: 3**

Complete

## C2.V.1 General category: General quantitative availability and accessibility standard

1 / 3

**C2.V.2 Measure standard**

"Except in rural areas of the state, MCO shall ensure that every Enrollee has a choice of PCPs whose office is located within thirty (30) minutes or thirty (30) miles driving distance from the Enrollee's North Dakota residence, as indicated on the enrollment file provided to MCO by STATE. In the case of Enrollees residing in rural areas of the state, MCO must ensure a choice of PCPs whose office is located within fifty (50) minutes or fifty (50) miles driving distance from the Enrollee's North Dakota residence."

**C2.V.3 Standard type**

Maximum distance to travel

| C2.V.4 Provider | C2.V.5 Region | C2.V.6 Population |
|---|---|---|
| Primary care | Statewide | Adult |

**C2.V.7 Monitoring Methods**

Geomapping

**C2.V.8 Frequency of oversight methods**

Quarterly

Complete

## C2.V.1 General category: General quantitative availability and accessibility standard

2 / 3

**C2.V.2 Measure standard**

MCO must maintain a ratio for each high volume Behavioral/Mental Health and substance use disorder Practitioner type of one full time equivalent Practitioner per three thousand (3,000) Enrollees.

**C2.V.3 Standard type**

Provider to enrollee ratios

| C2.V.4 Provider | C2.V.5 Region | C2.V.6 Population |
|---|---|---|
| Behavioral health | Statewide | Adult |

**C2.V.7 Monitoring Methods**

Plan provider roster review, Geomapping

**C2.V.8 Frequency of oversight methods**

Quarterly

Complete

**C2.V.1 General category: General quantitative availability and accessibility standard** 3 / 3

**C2.V.2 Measure standard**

"General: Emergency Services – available twenty-four (24) hours a day, seven days a week. Urgent Care – within twenty-four (24) hours. Non-Urgent Sick Care – within seventy-two (72) hours, or sooner, if condition deteriorates into urgent or emergency condition. Routine, Non-Urgent or Preventative Care Visits – within six weeks of Enrollee request. Behavioral/Mental Health and/or Substance Use Disorder: Emergency Services, Life Threatening – Immediate. Emergency Services, Non- Life Threatening – Within 6 hours. Urgent Care – within twenty-four (24) hours. Initial Visits, Routine Care –within ten (10) working days. Follow-Up Visits, Routine Care –within thirty (30) days."

**C2.V.3 Standard type**

Ease of getting a timely appointment

| C2.V.4 Provider | C2.V.5 Region | C2.V.6 Population |
|---|---|---|
| Primary care | Statewide | Adult |

**C2.V.7 Monitoring Methods**

Secret shopper calls, Plan provider roster review, Geomapping

**C2.V.8 Frequency of oversight methods**

Annually

## Topic IX: Beneficiary Support System (BSS)

Find in the Excel Workbook
**C1_Program_Set**

| Number | Indicator | Response |
|---|---|---|
| **C1IX.1** | **BSS website**<br>List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas. | https://ndcpd.org/ndnavigator/ |

| | | |
|---|---|---|
| **C1IX.2** | **BSS auxiliary aids and services**<br>How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))?<br>CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested. | Accessible in multiple ways including phone, internet, in-person, and text. Auxiliary aides and services available upon request. |
| **C1IX.3** | **BSS LTSS program data**<br>How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4). | N/A |
| **C1IX.4** | **State evaluation of BSS entity performance**<br>What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance? | Review of metrics reported to State for activity pertaining to initial contact resolution and satisfaction report |

## Topic X: Program Integrity

Find in the Excel Workbook
**C1_Program_Set**

| Number | Indicator | Response |
|---|---|---|
| **C1X.3** | **Prohibited affiliation disclosure**<br>Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d). | No |

## Topic I. Program Characteristics & Enrollment

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1I.1** | **Plan enrollment**<br>What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year? | **Blue Cross Blue Shield North Dakota**<br>35,948 |
| **D1I.2** | **Plan share of Medicaid**<br>What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment?<br>• Numerator: Plan enrollment (D1.I.1)<br>• Denominator: Statewide Medicaid enrollment (B.I.1) | **Blue Cross Blue Shield North Dakota**<br>27.3% |
| **D1I.3** | **Plan share of any Medicaid managed care**<br>What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?<br>• Numerator: Plan enrollment (D1.I.1)<br>• Denominator: Statewide Medicaid managed care enrollment (B.I.2) | **Blue Cross Blue Shield North Dakota**<br>100% |

## Topic II. Financial Performance

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1II.1a** | **Medical Loss Ratio (MLR)**<br>What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the | **Blue Cross Blue Shield North Dakota**<br>80.6% |

| | | |
|---|---|---|
| | Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience.<br>If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. | |
| **D1II.1b** | **Level of aggregation**<br>What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one.<br>As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations. | **Blue Cross Blue Shield North Dakota**<br>Program-specific statewide |
| **D1II.2** | **Population specific MLR description**<br>Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable.<br>See glossary for the regulatory definition of MLR. | **Blue Cross Blue Shield North Dakota**<br>N/A |
| **D1II.3** | **MLR reporting period discrepancies**<br>Does the data reported in item D1.II.1a cover a different time period than the MCPAR report? | **Blue Cross Blue Shield North Dakota**<br>Yes |
| **N/A** | Enter the start date. | **Blue Cross Blue Shield North Dakota**<br>01/01/2021 |
| **N/A** | Enter the end date. | **Blue Cross Blue Shield North Dakota**<br>12/31/2021 |

# Topic III. Encounter Data

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1III.1** | **Definition of timely encounter data submissions**<br>Describe the state's standard for timely encounter data submissions used in this program.<br>If reporting frequencies and standards differ by type of encounter within this program, please explain. | **Blue Cross Blue Shield North Dakota**<br>"MCO shall submit all Encounter Claims no later than twenty-five (25) calendar days after the date MCO adjudicates the Claim. Encounter submissions are due no later than the fifteenth (15th) of the month following the month of payments that is included in the Enrollee Encounter Data file. If the fifteenth (15th) falls on the weekend or a holiday, the submission is due on the next business day. If MCO is unable to make a submission during a certain month, MCO shall notify STATE of the reason for the delay and the estimated date when STATE can expect the submission. For all Enrollee Encounter Claims, when STATE returns or rejects a file of Claims, MCO shall have twenty (20) calendar days from the date MCO receives the file to resubmit the file with all of the required data elements in the correct file format." |
| **D1III.2** | **Share of encounter data submissions that met state's timely submission requirements**<br>What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission?<br>If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received | **Blue Cross Blue Shield North Dakota**<br>92% |

| | | |
|---|---|---|
| | from the managed care plan for the reporting period. | |
| **D1III.3** | **Share of encounter data submissions that were HIPAA compliant**<br>What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance?<br>If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period. | **Blue Cross Blue Shield North Dakota**<br>100% |

# Topic IV. Appeals, State Fair Hearings & Grievances

## Appeals Overview

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1IV.1** | **Appeals resolved (at the plan level)**<br>Enter the total number of appeals resolved as of the first day of the last month of the reporting year.<br>An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review. | **Blue Cross Blue Shield North Dakota**<br>1167 |
| **D1IV.2** | **Active appeals**<br>Enter the total number of appeals still pending or in process (not yet resolved) as of | **Blue Cross Blue Shield North Dakota**<br>58 |

| | | |
|---|---|---|
| | the first day of the last month of the reporting year. | |
| **D1IV.3** | **Appeals filed on behalf of LTSS users**<br>Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable.<br>An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed). | **Blue Cross Blue Shield North Dakota**<br>N/A |
| **D1IV.4** | **Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal**<br>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”.<br>Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”.<br>The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.<br>To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were | **Blue Cross Blue Shield North Dakota**<br>N/A |

| | | |
|---|---|---|
| | filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident. | |
| **D1IV.5a** | **Standard appeals for which timely resolution was provided**<br>Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period.<br>See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals. | **Blue Cross Blue Shield North Dakota**<br>1138 |
| **D1IV.5b** | **Expedited appeals for which timely resolution was provided**<br>Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period.<br>See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals. | **Blue Cross Blue Shield North Dakota**<br>29 |
| **D1IV.6a** | **Resolved appeals related to denial of authorization or limited authorization of a service**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service.<br>(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c). | **Blue Cross Blue Shield North Dakota**<br>246 |
| **D1IV.6b** | **Resolved appeals related to reduction, suspension, or termination of a previously authorized service**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | termination of a previously authorized service. | |
| **D1IV.6c** | **Resolved appeals related to payment denial**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered. | **Blue Cross Blue Shield North Dakota**<br>917 |
| **D1IV.6d** | **Resolved appeals related to service timeliness**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state). | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.6e** | **Resolved appeals related to lack of timely plan response to an appeal or grievance**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.6f** | **Resolved appeals related to plan denial of an enrollee's right to request out-of-network care**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO). | **Blue Cross Blue Shield North Dakota**<br>52 |
| **D1IV.6g** | **Resolved appeals related to denial of an enrollee's request to dispute financial liability** | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability. | |

## Topic IV. Appeals, State Fair Hearings & Grievances

### Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1IV.7a** | **Resolved appeals related to general inpatient services**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services.<br>Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>294 |
| **D1IV.7b** | **Resolved appeals related to general outpatient services**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not | **Blue Cross Blue Shield North Dakota**<br>802 |

| | | |
|---|---|---|
| | cover general outpatient services, enter "N/A". | |
| **D1IV.7c** | **Resolved appeals related to inpatient behavioral health services**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>9 |
| **D1IV.7d** | **Resolved appeals related to outpatient behavioral health services**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>6 |
| **D1IV.7e** | **Resolved appeals related to covered outpatient prescription drugs**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>N/A |
| **D1IV.7f** | **Resolved appeals related to skilled nursing facility (SNF) services**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>7 |
| **D1IV.7g** | **Resolved appeals related to long-term services and supports (LTSS)** | **Blue Cross Blue Shield North Dakota**<br>N/A |

| | | |
|---|---|---|
| | Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A". | |
| **D1IV.7h** | **Resolved appeals related to dental services**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>N/A |
| **D1IV.7i** | **Resolved appeals related to non-emergency medical transportation (NEMT)**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.7j** | **Resolved appeals related to other service types**<br>Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>20 |

## Topic IV. Appeals, State Fair Hearings & Grievances

### State Fair Hearings

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| D1IV.8a | **State Fair Hearing requests**<br>Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination. | **Blue Cross Blue Shield North Dakota**<br>9 |
| D1IV.8b | **State Fair Hearings resulting in a favorable decision for the enrollee**<br>Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee. | **Blue Cross Blue Shield North Dakota**<br>2 |
| D1IV.8c | **State Fair Hearings resulting in an adverse decision for the enrollee**<br>Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee. | **Blue Cross Blue Shield North Dakota**<br>2 |
| D1IV.8d | **State Fair Hearings retracted prior to reaching a decision**<br>Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision. | **Blue Cross Blue Shield North Dakota**<br>0 |
| D1IV.9a | **External Medical Reviews resulting in a favorable decision for the enrollee**<br>If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B). | **Blue Cross Blue Shield North Dakota**<br>0 |

| Number | Indicator | Response |
|---|---|---|
| D1IV.9b | **External Medical Reviews resulting in an adverse decision for the enrollee**<br>If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".<br>External medical review is defined and described at 42 CFR §438.402(c)(i)(B). | **Blue Cross Blue Shield North Dakota**<br>0 |

## Topic IV. Appeals, State Fair Hearings & Grievances

### Grievances Overview

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| D1IV.10 | **Grievances resolved**<br>Enter the total number of grievances resolved by the plan during the reporting year.<br>A grievance is "resolved" when it has reached completion and been closed by the plan. | **Blue Cross Blue Shield North Dakota**<br>0 |
| D1IV.11 | **Active grievances**<br>Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year. | **Blue Cross Blue Shield North Dakota**<br>0 |
| D1IV.12 | **Grievances filed on behalf of LTSS users**<br>Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. | **Blue Cross Blue Shield North Dakota**<br>N/A |

| | | |
|---|---|---|
| | An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A. | |
| **D1IV.13** | **Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance**<br>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.<br>If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. | **Blue Cross Blue Shield North Dakota**<br>N/A |

| | | |
|---|---|---|
| | To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident. | |
| **D1IV.14** | **Number of grievances for which timely resolution was provided**<br>Enter the number of grievances for which timely resolution was provided by plan during the reporting period.<br>See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances. | **Blue Cross Blue Shield North Dakota**<br>0 |

## Topic IV. Appeals, State Fair Hearings & Grievances

### Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1IV.15a** | **Resolved grievances related to general inpatient services**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | cover this type of service, enter "N/A". | |
| **D1IV.15b** | **Resolved grievances related to general outpatient services**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.15c** | **Resolved grievances related to inpatient behavioral health services**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.15d** | **Resolved grievances related to outpatient behavioral health services**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.15e** | **Resolved grievances related to coverage of outpatient prescription drugs**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | cover this type of service, enter "N/A". | |
| **D1IV.15f** | **Resolved grievances related to skilled nursing facility (SNF) services**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.15g** | **Resolved grievances related to long-term services and supports (LTSS)**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>N/A |
| **D1IV.15h** | **Resolved grievances related to dental services**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>N/A |
| **D1IV.15i** | **Resolved grievances related to non-emergency medical transportation (NEMT)**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A". | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.15j** | **Resolved grievances related to other service types**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A". | |

## Topic IV. Appeals, State Fair Hearings & Grievances

### Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1IV.16a** | **Resolved grievances related to plan or provider customer service**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16b** | **Resolved grievances related to plan or provider care management/case management**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.<br>Care management/case management grievances | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process. | |
| **D1IV.16c** | **Resolved grievances related to access to care/services from plan or provider**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16d** | **Resolved grievances related to quality of care**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16e** | **Resolved grievances related to plan communications**<br>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.<br>Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications. | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| **D1IV.16f** | **Resolved grievances related to payment or billing issues**<br>Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16g** | **Resolved grievances related to suspected fraud**<br>Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16h** | **Resolved grievances related to abuse, neglect or exploitation**<br>Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16i** | **Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)**<br>Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request | **Blue Cross Blue Shield North Dakota**<br>0 |

| | | |
|---|---|---|
| | (including requests to expedite or extend appeals). | |
| **D1IV.16j** | **Resolved grievances related to plan denial of expedited appeal**<br>Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.<br>Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance. | **Blue Cross Blue Shield North Dakota**<br>0 |
| **D1IV.16k** | **Resolved grievances filed for other reasons**<br>Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above. | **Blue Cross Blue Shield North Dakota**<br>0 |

## Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook
**D2_Plan_Measures**

**Quality & performance measure total count: 29**

Complete

## D2.VII.1 Measure Name: Cervical Cancer Screening

1 / 29

**D2.VII.2 Measure Domain**

Primary care access and preventative care

**D2.VII.3 National Quality Forum (NQF) number**

0032

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Chlamydia Screening in Women ages 21 to 24

2 / 29

**D2.VII.2 Measure Domain**

Primary care access and preventative care

**D2.VII.3 National Quality Forum (NQF) number**

0033

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Colorectal Cancer Screening

3 / 29

**D2.VII.2 Measure Domain**

Primary care access and preventative care

**D2.VII.3 National Quality Forum (NQF) number**

0034

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Flu Vaccinations for Adults Ages 21 to 24

4 / 29

**D2.VII.2 Measure Domain**

Primary care access and preventative care

**D2.VII.3 National Quality Forum (NQF) number**

0039

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Breast Cancer Screening

5 / 29

**D2.VII.2 Measure Domain**

Primary care access and preventative care

**D2.VII.3 National Quality Forum (NQF) number**

2372

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Controlling High Blood Pressure

6 / 29

**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0018

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Avoidance of Antibiotic Treatment for Acute Bronchitis / Bronchiolitis: Age 21 and Older



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0058

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients with Diabetes



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0059

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Diabetes Short Term Complications Admission Rate



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0272

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: COPD or Asthma in Older Adults Admission Rate



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0275

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Heart Failure Admission Rate



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0277

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Asthma in Younger Adults Admission Rate



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0283

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Plan All Cause Readmission

13 / 29

**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

1768

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Asthma in Younger Adults Admission Rate

14 / 29

**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

0283

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: HIV Viral Load Suppression



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

2082

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Use of Opioids at High Dosage in Persons Without Cancer



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

2940

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Concurrent Use of Opioids and Benzodiazepines



**D2.VII.2 Measure Domain**

Care of acute and chronic conditions

**D2.VII.3 National Quality Forum (NQF) number**

3389

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

0004

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Medical Assistance with Smoking and Tobacco Use Cessation



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

0027

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Antidepressant Medication Management



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

0105

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Screening for Depression and Follow-Up Plan: Age 21 and Older



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

0418

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: Age 21 and Older



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

0576

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

1932

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

2607

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Use of Pharmacotherapy for Opioid Use Disorder



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

3400

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence



**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

3488

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Follow-Up after Emergency Department Visit for Mental Illness

27 / 29

**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

3489

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

## D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

28 / 29

**D2.VII.2 Measure Domain**

Behavioral health care

**D2.VII.3 National Quality Forum (NQF) number**

N/A

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

Complete

**D2.VII.1 Measure Name: Consumer Assessment of Healthcarw Providers and Systems (CAHPS) Health Plan Survey 5.1H, Adult Version (Medicaid)** 29 / 29

**D2.VII.2 Measure Domain**

Health plan enrollee experience of care

**D2.VII.3 National Quality Forum (NQF) number**

0006

**D2.VII.4 Measure Reporting and D2.VII.5 Programs**

Program-specific rate

**D2.VII.6 Measure Set**

Medicaid Adult Core Set

**D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range**

Yes

**D2.VII.8 Measure Description**

N/A

**Measure results**

**Blue Cross Blue Shield North Dakota**

N/A - awaiting validation and verification from EQRO

## Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Find in the Excel Workbook
**D3_Plan_Sanctions**

**Sanction total count: 2**

Complete

**D3.VIII.1 Intervention type: Liquidated damages** 1 / 2

**D3.VIII.2 Intervention topic**

Reporting

**D3.VIII.3 Plan name**

Blue Cross Blue Shield North Dakota

**D3.VIII.4 Reason for intervention**

Initial enrollment information not provided to new enrollees in timely manner as required by contract

**Sanction details**

**D3.VIII.5 Instances of non-compliance**

1

**D3.VIII.6 Sanction amount**

$ 1000

**D3.VIII.7 Date assessed**

02/22/2022

**D3.VIII.8 Remediation date non-compliance was corrected**

Yes 02/22/2022

**D3.VIII.9 Corrective action plan**

Yes

Complete

### D3.VIII.1 Intervention type: Liquidated damages

2 / 2

**D3.VIII.2 Intervention topic**

Reporting

**D3.VIII.3 Plan name**

Blue Cross Blue Shield North Dakota

**D3.VIII.4 Reason for intervention**

Failure to submit encounter data to the state by the 15th of the month following the month of payments.

**Sanction details**

**D3.VIII.5 Instances of non-compliance**

1

**D3.VIII.6 Sanction amount**

$ 25000

**D3.VIII.7 Date assessed**

02/22/2022

**D3.VIII.8 Remediation date non-compliance was corrected**

Yes 02/26/2022

**D3.VIII.9 Corrective action plan**

Yes

## Topic X. Program Integrity

Find in the Excel Workbook
**D1_Plan_Set**

| Number | Indicator | Response |
|---|---|---|
| **D1X.1** | **Dedicated program integrity staff**<br>Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii). | **Blue Cross Blue Shield North Dakota**<br>1.25 |
| **D1X.2** | **Count of opened program integrity investigations**<br>How many program integrity investigations have been opened by the plan in the past year? | **Blue Cross Blue Shield North Dakota**<br>38 |
| **D1X.3** | **Ratio of opened program integrity investigations to enrollees**<br>What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year? | **Blue Cross Blue Shield North Dakota**<br>1.06:1,000 |
| **D1X.4** | **Count of resolved program integrity investigations**<br>How many program integrity investigations have been resolved by the plan in the past year? | **Blue Cross Blue Shield North Dakota**<br>15 |
| **D1X.5** | **Ratio of resolved program integrity investigations to enrollees**<br>What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year? | **Blue Cross Blue Shield North Dakota**<br>0.48:1,000 |
| **D1X.6** | **Referral path for program integrity referrals to the state**<br>What is the referral path that the plan uses to make program integrity referrals to the state? Select one. | **Blue Cross Blue Shield North Dakota**<br>Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently |

| | | |
|---|---|---|
| **D1X.7** | **Count of program integrity referrals to the state**<br>Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals | **Blue Cross Blue Shield North Dakota**<br>38 |
| **D1X.8** | **Ratio of program integrity referral to the state**<br>What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator. | **Blue Cross Blue Shield North Dakota**<br>1.06 |
| **D1X.9** | **Plan overpayment reporting to the state**<br>Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3).<br>Include, for example, the following information:<br>• The date of the report (rating period or calendar year).<br>• The dollar amount of overpayments recovered.<br>• The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2). | **Blue Cross Blue Shield North Dakota**<br>CY2022 MLR not finalized, unable to provide data at this time |
| **D1X.10** | **Changes in beneficiary circumstances**<br>Select the frequency the plan reports changes in beneficiary circumstances to the state. | **Blue Cross Blue Shield North Dakota**<br>Daily |

## Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information

on how BSS entities support program-level functions is on the Program-Level BSS page.

Find in the Excel Workbook
**E_BSS_Entities**

| Number | Indicator | Response |
|---|---|---|
| **EIX.1** | **BSS entity type**<br>What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b). | **State Health Insurance Assistance Program (SHIP)**<br>State Health Insurance Assistance Program (SHIP) |
| **EIX.2** | **BSS entity role**<br>What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b). | **State Health Insurance Assistance Program (SHIP)**<br>Enrollment Broker/Choice Counseling |