MCNA Dental Plans

2016 Compliance Audit

Review Period: September 2015 – August 2016

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Prepared on Behalf of
The State of Louisiana
Louisiana Department of Health

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TABLE OF CONTENTS

Report Content

This report includes the following sections:

Section 1: Background and Introduction

Section 2: Summary report that details each element and corresponding domain for which the plan received a review determination less than fully compliant.

Section 3: Nine detailed final audit tool reports that correspond to each domain that was audited. These reports include IPRO's review determination for each element that was audited.

Section 1: Introduction and Audit Overview

INTRODUCTION

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid Managed Care Organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS). MCNA Dental Plans (MCNA) operates as a Prepaid Ambulatory Health Plan (PAHP) and IPRO followed the CMS EQRO protocol to assess MCNA's compliance with state and federal regulations.

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct Annual Compliance Audits every three years, followed by partial audits in the intervening years. The 2016 Annual Compliance Audit was a full audit of compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

This report presents IPRO's findings of the 2016 Annual Compliance Audit for MCNA.

AUDIT OVERVIEW

The purpose of the audit was to assess MCNA's compliance with federal and state regulations regarding access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management.

The audit included a comprehensive evaluation of MCNA's policies, procedures, files and other materials corresponding to the following nine (9) domains:

1. Core Benefits and Services
2. Provider Network
3. Utilization Management
4. Eligibility, Enrollment and Disenrollment
5. Marketing/Member Education
6. Member Grievances and Appeals
7. Quality Management
8. Reporting
9. Fraud, Waste and Abuse

The file review component assessed the PAHP's implementation of policies and its operational compliance with regulations related to complaints and grievances, care management, utilization management, provider credentialing, and communication between the PAHP and member and provider communities.

Specifically, file review consisted of the following seven (7) areas:

1. Appeals
2. Behavioral Health Care Management
3. Case Management
4. Informal Reconsiderations
5. Member Grievances
6. Provider Credentialing/Recredentialing
7. Utilization Management Denials

Sample sizes for each file review type are presented in **Table 1**.

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10
Behavioral Health Care management	10
Case Management	10
Informal Reconsiderations	5
Member Grievances	10
Provider Credentialing	5
Provider Recredentialing	5
Utilization Management Denials	10

The period of review was September 1, 2015 through August 31, 2016. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," and "compliance not met" were used for each element under review. The definition of each of the review determinations is presented in **Table 2**.

Table 2: Review Determination Definitions

Review Determination	Definition
Full	The PAHP has met or exceeded the standard.
Substantial	The PAHP has met most of the requirements of the standard but has minor deficiencies.
Minimal	The PAHP has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The PAHP has not met the standard.

The 2016 Annual Compliance Audit consisted of three phases: 1) pre-onsite documentation review, 2) onsite visit and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the PAHP's policies and procedures, IPRO prepared nine (9) review tools to reflect the areas for audit. These nine tools were submitted to the LDH for approval at the outset of the audit process in October 2016. The tools included the review elements drawn from the state and federal regulations. Upon reviewing the tools, LDH recommended elements to be added to the review tools to ensure completeness. Based upon the LDH's suggestions, the tools were revised, incorporating the elements added by LDH, and issued as final. These final tools were submitted to the PAHP in October 2016 in advance of the onsite audit.

Once LDH approved the methodology, IPRO sent MCNA a packet that included the review tools along with a request for documentation and a guide to help PAHP staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure FTP site.

To facilitate the audit process, IPRO provided the PAHP with examples of documents that the PAHP could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

Prior to the onsite visit, the PAHP submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. The PAHP was given a period of approximately four weeks to submit documentation to IPRO. To further assist PAHP staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs and the PAHP undergoing the audit, with LDH staff in attendance, approximately one week after the request packet was sent to the MCOs and the PAHP. During the conference call, IPRO detailed the steps in the audit process, the audit timeline and answered any questions posed by MCO/PAHP staff.

After the PAHP submitted the required documentation, a team of three (3) experienced IPRO auditors was convened to review the PAHP's policies, procedures and materials and assess their concordance with the state's contract

requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the onsite review discussion.

Onsite Visit

The onsite component of the audit was comprised of a two (2) day onsite visit, which included a review of elements in each of the nine (9) review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited MCNA on December 5–6, 2016 to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and for the PAHP to provide additional documentation, if available. File review, as indicated, was conducted to assess the PAHP's implementation of policy was conducted in accordance to state standards.

Post-onsite Report Preparation

Following the onsite audit, draft reports were prepared. These draft reports included an initial review determination for each element reviewed, and either evidence that the standard was met or a rationale for why the standard was not met and what evidence was lacking. For each element not fully compliant, IPRO provided a recommendation for the PAHP to consider in order to attain full compliance.

Each draft report underwent a second level of review by IPRO staff not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval the draft reports were sent to the PAHP with a request to furnish any additional documentation for all elements that were determined to be less than fully compliant. The PAHP was given approximately two weeks to respond to the issues noted on the draft reports.

After receiving the PAHP's response and any additional documentation, IPRO re-reviewed each element for which the PAHP provided a response and missing documentation. As a result, several elements' review scores were either raised or converted to "Full Compliance" based on the additional documentation submitted and the reports were issued as final.

Section 2: PAHP Summary of Findings

SUMMARY OF FINDINGS

Table 3 below provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	N/A	% Full
Provider Network	98	97	1	0	0	0	99%
Provider Relations	36	36	0	0	0	0	100%
Utilization Management	79	70	4	0	0	5	95%
Eligibility, Enrollment and Disenrollment	17	17	0	0	0	0	100%
Member Education	77	77	0	0	0	0	100%
Member Grievances and Appeals	64	54	10	0	0	0	84%
Quality Management	75	62	1	0	0	12	98%
Reporting	7	7	0	0	0	0	100%
Fraud Waste and Abuse	95	94	1	0	0	0	99%
TOTAL	**548**	**514**	**17**	**0**	**0**	**17**	**97%**

As displayed in the above, 548 elements were reviewed; 17 were determined to be "substantially met," none were "minimally met" or "not met," and 17 were not applicable. The remaining 514 were "fully met." The overall compliance score was 97%.

It is IPRO's and the LDH's expectation that MCNA submit a corrective action plan for each of the 17 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that MCNA has implemented a corrective action for several of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period.

IPRO extracted from each of the nine detailed reports each element that the PAHP was found to be less than fully compliant into a summary report to facilitate corrective action. This summary report includes each element reviewed, the final review determination, the PAHP's initial response and suggestions to achieve full compliance.

Table 4: Deficient Audit Elements for MCNA

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
Provider Network				
The DBPM shall provide GEO mapping and coding of all network providers for each provider type to geographically demonstrate network capacity. The DBPM shall provide updated GEO coding to LDH quarterly, or upon material change or upon request.	10.300LA Provider Network Development and Management, "Reporting and Program Evaluation," Page 16	Substantial	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Reporting and Program Evaluation," Page 16 GEO Mapping: Partially low for General Dentists in rural areas Low for Pedodontists Low for Orthodontists Low for Oral Surgeons Low for Endodontists Low for Prosthodontists Low for Periodontists Recommendation: The plan should continue to outreach dentists, especially in rural areas. Specifically The plan has difficulty with Regions 4 and 5. In response to the draft report, MCNA provided a log to document its outreach efforts. However, the volume of dentists for some specialties and some regions of the state remains low. Part of the issue may be due to the small universe of dentists available in some regions of the state. MCNA is encouraged to continue and perhaps expand its outreach to bolster its network and perhaps consider incentives to encourage dentists to join. The review determination is unchanged.	MCNA's Response: MCNA's Network Management team conducts ongoing provider outreach and recruitment activities. As part of this response, we are submitting our recruitment log as evidence of our efforts.
Utilization Management				
The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall	3.203LA Lack of Information, Page 1 Paragraph 1 & 2; Page 3-4, Procedure # 1-8	Substantial	The plan has a detailed policy, 3.203LA Lack of Information, regarding the information required from a member and a process to obtain the information it needs. The policy does not state that the information "shall be given verbally to the covered person or health care provider when requested." This requirement should be added to the policy and should be added to the member handbook.	MCNA's response: The same policy was fully met during the 2015 review. Policy 3.203LA, Lack of Information pg. 3 #5, states that providers are notified via telephone, fax, email or provider portal indicating the documentation that is needed. MCNA believes we meet the intent of

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.			In response to the draft report, MCNA provided documentation that the provider is contacted by telephone but the documentation states that the member is contacted in writing and does not indicate any verbal contact. The requirement specifically states that determinations should be "given verbally" to the covered member. It remains unclear from the documentation submitted whether members are also contacted verbally. Policy 3.203 should be revised to include the required language in the element The review determination remains unchanged.	this requirement.
Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	3.201LA Authorizations, Page 1 Paragraph 2 3.500LA Referral Process, Page 1 Paragraph 1	Substantial	Service authorization requests can be made on the web or in writing and the plan accepts member requests for service authorizations via the Member Services Department. The Member Handbook states that MCNA will accept requests for care through the Member Hotline or in writing, (p10) The plan should explicitly state in the Grievance section of the Member Handbook that service authorization requests are included (p17). In response to the draft report, MCNA indicated that the Member Handbook was updated in 2015. While MCNA does accept service authorization requests, the Handbook should be further updated to include MCNA's service authorization request process. The review determination remains unchanged.	MCNA's response: Recommendations from the 2015 audit did not address MCNA adding language in the Grievance section of the member handbook. Based on the findings from 2015, the member handbook was updated with the requirement as recommended by IPRO.
The DBPM shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval	3.201LA Authorizations, Page 3 Paragraph 1	Substantial	Policy 3.201LA Authorizations, (P 3) states that the plan will not reverse its authorization after services have been provided unless one of the conditions specified in the regulation occurred. Reduction of payment for an item or service furnished as stated in the regulation is not specified in the Policy and should be included.	MCNA response: Policy 3.201LA has been revised to include the recommended language regarding reduction in payment.

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
was based upon a material omission or misrepresentation about the member's health condition made by the provider.			In its response to the draft report, MCNA stated that they revised their policy to include the required language. Since the revision was made after the review period, the review determination remains unchanged.	
As part of the DBPM appeal procedures, the DBPM should include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	3.204LA Informal Reconsiderations, Page 1 Paragraph 1	Substantial	The plan has an Informal Reconsideration process and policy that documents its procedures (3.204LA Informal Reconsiderations. However, the denial notification to members does not include reference to a member's right to file an informal reconsideration. Onsite, MCNA staff indicated that the right for members to file Informal Reconsiderations would be added to the denial letter. In its response to the draft report, MCNA stated that the Member Handbook includes a description of the Informal Reconsideration process. However, the denial letter should also reference the right to file an Informal Reconsideration. Given that the information is contained in the member Handbook, the review determination has been revised to "Substantial."	MCNA's response: Members are notified of the informal reconsideration process. It is included in the Member Handbook on page 28. Our current adverse determination letters comply with the Wells Requirement and this was not part of the requirement. MCNA believes we meet the intent of this element.
Member Grievances and Appeals				
The DBPM shall refer all DBPM members who are dissatisfied with the DBPM or its subcontractor in any respect to the DBPM's designee authorized to review and respond to grievances and appeals and require corrective action.	4.104LA Complaints Pg.1 (paragraph 3)	Substantial	This requirement is addressed in Policy 4.104LA Complaints page 1, and references referrals to the Grievance and Appeals Department. However, complaints (which, as per policy, are grievances resolved within 24 hours) are handled by Member Services. The plan differentiates complaints (resolved 24 hours) from formal grievances in Policy 4.104LA Complaints. Complaints are described as "an informal component of the grievance system" in "Policy 4.104LA Complaints," which indicates that complaints are referred to the	MCNA's response: Policy 4.104LA was revised to clarify the process of referring Quality of Care (QOC) complaints to the Quality Improvement department for review. As noted in the policy, all complaints are documented in the DentalTrac™ system. If a complaint is not resolved within 24 hours of receipt it becomes a grievance and is escalated to the Grievances

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			Grievances and Appeals department if they are not resolved to the member's satisfaction within 24 hours. Categories of complaints include quality of care and treatment plan complaints. There is no evidence that potentially clinical complaints are systematically referred by member services to appropriate clinical staff for review. MCNA provided Grievance, Appeal and Fair Hearing log reports for review, which reveal that complaints are reported to the State in an Excel file on the Grievances tab. They are not differentiated from formal grievances in this document. During file review, there was documentation for at least one complaint that an incident report was submitted to quality, but investigation and resolution are not clear. MCNA provided a training PowerPoint for member services staff that is consistent with the policy, and also indicates that supervisors review complaints for completeness. This training also indicates that Member Services is authorized to review and resolve complaints, but there was no guidance for Member Services regarding referring clinical or quality concerns to appropriate staff for review in submitted documentation. It appears from the documents that complaints are referred if the member is not satisfied with Member Services resolution or the issue cannot be resolved in 24 hours. MCNA submitted a third quarter 2016 QIC committee presentation on QI and Risk Management Analysis for review while onsite. This presentation reveals that there were 15 member complaints audited for quality of care in third quarter 2016. Two of the fifteen complaints were not forwarded to QI as per this presentation. <u>Recommendation</u> The plan should ensure that there are clear procedures	and Appeals department for further investigation and resolution. The LDH report does not require for MCNA to differentiate complaints and grievances.

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
			for referring grievances (including complaints) involving quality of care issues to appropriate clinical staff, and that there is tracking and oversight of the handling of all grievances (including complaints). In its response to the draft report, MCNA clarified the process for addressing complaints not resolved within 24 hours of receipt. Such complaints become grievances and are escalated to the Grievances and Appeals department for further investigation and resolution. Since the change occurred after the review period, the review determination remains as substantial" and will be re-reviewed during the next compliance audit.	
Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance or appeal regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	13.105LA Formal Grievance Procedure Pg. 3 (Procedure # 6, Bullet 1) 13.200LA Member Appeals Pg.5 (Procedure # 6, Aii & v.) 13.203LA Expedited Appeal Pg.3 (procedure # 6. b&e)	Substantial	This requirement is addressed in Policy 13.105LA Formal Grievance Procedure page 3, Policy 13.200LA Member Appeals pages 5-6, and Policy 13.203LA Expedited Appeal page 4. It does not appear in Policy 4.104LA Complaints that these complaints are reviewed by a clinical reviewer but rather only by Member Services, although noted categories of complaints include incorrect treatment, careless service and disagreement with treatment plan, which should be reviewed by a clinician. 10/10 appeals were conducted by a reviewer who was not involved in the original determination. 2/10 appeals were administratively upheld, and in one case it was not clear whether the case could have benefited from clinical review. 2/2 clinical formal grievances were appropriately reviewed. 1/9 complaints may have involved a clinical issue but was treated as an untimely appeal, and it was not reviewed by a clinician. One of the verbal complaints was referred to Quality for review. Common complaint types reported in Quality Improvement Committee Minutes submitted by the plan include member dissatisfaction with treatment plan, provider, or treatment.	MCNA's response: Policy 4.104LA was revised to clarify the process of referring Quality of Care (QOC) complaints to the Quality Improvement department for review and investigation as needed.

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			Procedures for determining which complaints Member Services should refer to clinical staff for review are not evident in policy or training. <u>Recommendation</u> MCNA should establish policy and procedures, with accompanying training, for Member Services to facilitate identification of clinical complaints that should be referred for clinical review. In response to the draft report, MCNA's policy has been revised to clarify that quality of care complaints will be referred to the Quality Improvement Department. Since the change occurred after the review period, the review determination remains as substantial" and will be re-reviewed during the next compliance audit.	
Right to State Fair Hearing - The DBPM shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the DBPM's decision in response to an appeal and the process for doing so.	13.200LA Member Appeals Pg. 6 (Procedure # 8, Last Bullet) 13.203LA Expedited Appeal Pg.5 (Procedure #13, Bullet 7)	Substantial	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview page 3, Policy 13.200LA Member Appeals pages 6-7 and Policy 13.203 LA Expedited Appeals p5. Required State Fair Hearing information is included in MCNA Dental Member Handbook Louisiana Medicaid: Adult Denture Program page 19-22, and Member Handbook Louisiana: EPSDT Dental Program page 28-31. <u>File review</u> 9/10 files included notification of the right to a State Fair Hearing. 1/10 files, which was administratively denied for exceeding the 30 day timeframe for submission, did not include the right to a State Fair Hearing in the resolution notice. This file involved a delay in member submission of consent until approximately 2 weeks post the provider's appeal on behalf of the member for a service felt to be medically necessary. Onsite staff indicated that since the MCNA appeal process was not exhausted, since appeal was submitted late and therefore not considered, member was not entitled to a State Fair Hearing.	MCNA's response: The previously approved LDH Member Appeal Letter of Exhaustion has been revised; the letter now informs members of their right to request a State Fair Hearing.

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
			The case summary for this file indicates that "all appeal rights are exhausted due to timeliness of filing. The member's resolution letter indicates that "You have no more appeal rights with MCNA for these services." Therefore, it appears that the member should have been informed of a State Fair Hearing per policy. <u>Recommendation</u> MCNA should ensure that all members who submit appeals that are denied should be informed of right to State Fair Hearing. In response to the draft report, MCNA's Member Appeal letter has been revised. Since the change occurred after the review period and there was one file review case that did not contain notice of a State Fair Hearing, the review determination remains as substantial."	
The member's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #4)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. <u>File review</u> The member's right to a State Fair Hearing is not included in notice of action but is included in appeal resolution letters. 9/10 appeal files included resolution letters in which State Fair Hearing access was addressed. In 1/10 files, the appeal was not reviewed due to untimely filing, and this resolution letter did not include State Fair Hearing language. <u>Recommendation</u> MCNA should ensure that all members who submit appeals that are denied are informed of the right to State Fair Hearing in resolution letters. In response to the draft report, MCNA's Member Appeal	MCNA's response: The previously approved LDH Member Appeal Letter of Untimely Filing has been revised; the letter now informs members of their right to request a State Fair Hearing.

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
			letter has been revised. Since the change occurred after the review period and there was one file review case that did not contain notice of a State Fair Hearing, the review determination remains as substantial."	
For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: the member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or the DBPM justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.	3.202 LA Adverse Determinations Pg.1 (bullet #2) 3.203 LA Lack of Information Pg.1 (paragraph 1)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determination page1, but does not include "expeditiously as member's health condition requires" Extensions are addressed on page 5 for expedited reviews and on page 2 for standard authorization. The extension requirements are also addressed in Policy 3.203LA Lack of Information page 1 and page 4. <u>Recommendation</u> MCNA should include language that indicates that the Notice of Action is mailed expeditiously as the member's health condition requires in its policy. In response to the draft report, MCNA's Policy has been revised. Since the change occurred after the review period, the review determination remains as substantial."	MCNA's response: See pg. 2 of policy 3.202LA. The language has been added.
On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.	3.202 LA Adverse Determinations Pg.2 (paragraph 3)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determinations for untimely services authorization. Notice on the date when the timeframe for the service authorization expires does not appear in policy. <u>Recommendation</u> MCNA should include the requirement for Notice of Action on the date the service authorization expires in policy. In response to the draft report, MCNA's Policy has been revised. Since the change occurred after the review period, the review determination remains as substantial."	MCNA's response: See pg. 2 of policy 3.202LA. The language has been added.

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
For expedited service authorization decisions where a provider indicates, or the DBPM determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	3.202 LA Adverse Determinations Pg. 5 (Requests for Expedited Review section, paragraph 1)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determinations page 5. The provision of a notice should be given as expeditiously as a member's health condition requires is not included in policy. File review There were no expedited service authorization requests among reviewed files. Recommendation MCNA should include language that indicates that notice is provided as expeditiously as the member's health condition requires in policy. In response to the draft report, MCNA's Policy has been revised. Since the change occurred after the review period, the review determination remains as substantial."	MCNA's response: See pg. 2 of policy 3.202LA. The language has been added.
Format of Notice of Disposition - Grievances - The DBPM will provide written notice to the member of the disposition of a grievance. Appeals - For all appeals, the DBPM must provide written notice of disposition. For notice of an expedited resolution, the DBPM must also make reasonable efforts to provide oral notice.	13.105LA Formal Grievance Policy Pg.1 (paragraph 1) 13.200LA Member Appeals Pg. 1(paragraph 4) 13.203LA Expedited Appeals Pg.1 (paragraph 2)	Substantial	This requirement is addressed in Policy 13.105LA Formal Grievance Procedure page 3-4, Policy 13.200LA Member Appeals pages 5-6, and Policy 13.203LA Expedited Appeal page 1. File review 6/6 formal grievances received written notices but none of the nine verbal complaints received written notices. 10/10 appeals files included written resolution notices. 3/3 requests for expedited appeal that were denied included evidence of verbal communication of denial of expedited review within 72 hours. Recommendation The plan should ensure that all members who file grievances, including those filing verbal complaints, receive written notice of disposition. In response to the draft report, MCNA described its policy of documenting complaints and escalating when appropriate. Nevertheless, MCNA should establish a	MCNA's response: Complaints Policy 4.104LA states that all complaints are documented in the DentalTrac™ system. If a complaint is not resolved within 24 hours of receipt it becomes a grievance and is escalated to the Grievances and Appeals department for further investigation and resolution. Notices of acknowledgement and disposition are provided for grievances in accordance with policy 13.105LA.

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
			policy for notifying member's who lodge verbal complaints. The review determination remains as substantial."	
Content of Notice of Appeal Resolution - The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the DBPM's action.	13.200LA Member Appeals Pg. 6 (#8, bullets 2 & 8)	Substantial	This requirement is addressed in Policy 13.200LA Member Appeals pages 5-6. <u>File review</u> 9/10 files included all required elements in the resolution notice. One administratively denied appeal did not include notification regarding State Fair Hearing. The appeal was not considered due to untimely submission, and the plan determined that therefore MCNA's appeal process was not exhausted. The case summary indicates that the appeal process was exhausted and the resolution letter indicated that the member had no further appeal rights with MCNA. <u>Recommendation</u> The plan should ensure that all members whose submitted appeals are denied receive written notice of right to State Fair Hearing. In response to the draft report, MCNA's Member Appeal Letter has been revised. Since the change occurred after the review period, the review determination remains as substantial."	MCNA's response: The previously approved LDH Member Appeal Letter of Untimely Filing has been revised; the letter now informs members of their right to request a State Fair Hearing.
Action Following Denial of a Request for Expedited Resolution - If the DBPM denies a request for expedited resolution of an appeal, it must: transfer the appeal to the timeframe for standard resolution in accordance with the prescribed timeframes; make reasonable efforts to give the member prompt oral notice of the denial, and follow up	13.203LA Expedited Appeals Pg.4 (#8) & Pg. 1 (paragraph 3)	Substantial	This requirement is addressed in Policy 13.203 Expedited Appeals page 1 and page 4. <u>File review</u> There were 3 of 10 files that were requests for expedited appeal resolution; all three were denied, transferred to standard and verbally informed. One file did not include a written follow up letter that addressed denial of expedited appeal. MCNA followed up on this case with the reviewer. <u>Recommendation</u> MCNA should continue to monitor to ensure that	MCNA response: MCNA agrees with this finding.

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within two (2) calendar days with a written notice. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.			members whose request for expedited appeal is denied receive written notice. In response to the draft report, MCNA stated that they agree with the recommendation. The review determination remains as "substantial."	
Quality Management				
The DBPM is encouraged to include a member advocate representative on the QAPI Committee.	2.103LA QAPI Pg.8 (paragraph 2)	Substantial	While Policy 2.103 includes this requirement, it was indicated onsite that MCNA does not have a member advocate who serves on the committee. Recommendation: MCNA should attempt to recruit a member or member advocate familiar with Medicaid Managed Care to serve on the QAPI Committee. In its response to the draft report, MCNA indicated correctly that it is not required to include a member advocate in its QAPI committee and indicated it would revise its policy to that effect. As such, the review determination is revised to "Substantial" since during the review period, MCNA's current policy was in effect and that policy required a member advocate. However, it is recommended that MCNA reconsider its decision to remove the requirement from policy and recruit a member to participate in its QAPI committee since the member's perspective can be highly informative and may help MCNA improve quality of care.	MCNA's response: MCNA is not required by contract to include member representation in its QAPI. As such, MCNA will edit policy 2.103 to remove member representation from the list of committee participants.
Fraud, Waste and Abuse				
Annually, the DBPM must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key personnel. LDH will compare this information against federal databases to confirm that those individuals have not been	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 4	Substantial	This requirement is partially met through the document: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 4 In response to the draft report, MCNA revised the policy to include the required language. The MCO should add "date of birth" to the policy.	MCNA's response: Policy 16.202 pg. 4 has been revised to add "date of birth"

State Contract Requirement Language	PAHP Documentation	Review Determination	IPRO Comments	PAHP Response and Plan of Action
banned or debarred from participating in federal programs [42 CFR §455.104].			Since the change was made after the review period, the review determination remains as "substantial."	

Section 3: PAHP Final Audit Tools

Nine detailed final audit tool reports that correspond to each domain that was audited. These reports include IPRO's review determination for each element that was audited.

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
General Provider Network Requirements				
The DBPM must maintain a network of qualified dental providers in sufficient numbers and locations to provide required access to covered services. The DBPM is expected to design a network that provides a geographically convenient flow *of* patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM shall design its dental provider network to maximize the availability of primary dental services and specialty dental services.	10.300LA Provider Network Development and Management, "Objective," Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Objective," Page 3	
The DBPM must provide a comprehensive network to ensure its membership has access at least equal to, or better, than community norms. Services shall be accessible to DBPM members in terms of timeliness, amount, duration and scope equal to services provided by fee for service (FFS) Medicaid at the time the DBPM is implemented [42 CFR §438.210(a)(2)]. If the network is unable to provide necessary services required under contract, the DBPM shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The DBPM shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206(b)(4) and (5)].	10.300LA Provider Network Development and Management, "Objective," Page 3 & "Out-of-Network and Emergency Services," Page 12.	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Objective," Page 3 and "Out-of-Network and Emergency Services," Page 12-13	
All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	10.300LA Provider Network Development and Management, "Cultural Competency," Page 14.	Full	This requirement is met through the document: Network Development and Management, "Cultural Competency," Page 14.	
Requests from Medicaid Providers, including significant traditional providers (STP) to participate in DBPM services are received; the DBPM should make a good faith effort to enter into a contract with such providers. The DBPM shall document efforts made and maintain records for all successful and non-successful agreements.	10.102LA Recruiting Significant Traditional Providers, Paragraph 1, Page 1 10.300LA Provider Network Development and Management, Paragraph 1, Page 7	Full	This requirement is met through the documents: 10.102LA Recruiting Significant Traditional Providers, Paragraph 1, Page 1 10.300LA Provider Network Development and Management, Paragraph 1, Page 7	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
The DBPM shall not discriminate with respect to participation in the Dental Benefit program, reimbursement or indemnification against any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the provider's type of licensure or certification [42 CFR §§438.12(a)(1) and (2)]. In addition, the DBPM must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR §438.214(c)].	10.203LA Non-Discrimination Against Dental Providers, Paragraph 1 & 2, Page 1	Full	This requirement is met through the document: 10.203LA Non-Discrimination Against Dental Providers, Paragraph 1 & 2, Page 1	
The provisions above do not prohibit the DBPM from limiting provider participation to the extent necessary to meet the needs of the DBPM's members. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using reimbursement amounts that are greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR §438.12(b)(1)].	10.300LA Provider Network Development and Management, "Complete Network participation Agreements," Page 10, Bullet 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Complete Network participation Agreements," Page 10, Bullet 3	
The DBPM may decline requests from providers to participate in the DBPM network. Pursuant to [42 CFR §438.12(a)(1)], the DBPM shall give the Provider written notice of the reason for its decision within fourteen (14) calendar days of its decision.	10.106LA Provider Selection and Retention, Bullet c. ii, Page 3	Full	This requirement is met through the document: 10.106LA Provider Selection and Retention, Bullet c. ii, Page 3	
The DBPM may terminate a provider's contract for cause. The DBPM shall provide written notice of termination to the provider. The DBPM shall notify LDH of the termination as soon as the written notification of cancelation is sent to the provider, but no later than seven (7) calendar days.	6.203 Provider Termination & Suspension Process, "For Cause Terminations and Suspensions," 3.i., Page 5	Full	This requirement is met through the document: 6.203 Provider Termination & Suspension Process, "For Cause Terminations and Suspensions," 3.i., Page 5	
The DBPM shall notify the DBPM members that their primary dental care provider's contract has been terminated. Notice shall be sent, within fifteen (15) calendar days after receipt of issuance of the termination notice, as specified in 42 CFR §438.10(f)(5). This notice shall include a list of recommended network providers available to the member in their surrounding area.	11.104LA Member Notification of Terminated Provider, Paragraph 1, Page 1 & Procedure 3.c., Page 2.	Full	This requirement is met through the document: 11.104LA Member Notification of Terminated Provider, Page 1 Paragraph 1, & Procedure 3.c., Page 2.	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
The DBPM shall meet the following requirements:				
Ensure the provision of all core dental benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in the RFP. These minimum requirements do not release the DBPM from ensuring that all necessary covered dental benefits and services required by its members, are provided pursuant to the RFP.	5.105LA Availability & Accessibility of Services, Paragraph 1, Page 1 10.300LA Provider Network Development and Management, "Provider Availability," Page 11	Full	This requirement is met through the document: 5.105LA Availability & Accessibility of Services, Paragraph 1, Page 1 10.300LA Provider Network Development and Management, "Provider Availability," Page 11	
Provide core dental services directly or enter into written agreements with providers or organizations that shall provide core dental services to the members in exchange for payment by the DBPM for services rendered.	10.502LA Provider Contract Requirements, Paragraph 2, Page 1 10.300LA Provider Network Development and Management, "Provider Written Agreements," Page 13	Full	This requirement is met through the document: 10.502LA Provider Contract Requirements, Paragraph 2, Page 1 And 10.300LA Provider Network Development and Management, "Provider Written Agreements," Page 13	
Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/search.aspx and the Systems for Award Management at https://www.sam.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.	10.502LA Provider Contract Requirements, Paragraph 1, Page 1 10.300LA Provider Network Development and Management, Bullet 1, Page 8	Full	This requirement is met through the documents: 10.502LA Provider Contract Requirements, Page 1,Paragraph 1 10.300LA Provider Network Development and Management, , Page 8,Bullet 1	
Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient for the following: member's health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered; information the member needs in order to decide among all relevant treatment options; the risk, benefits, and consequences	Provider Agreement: LA Product Attachment – approved by DHH on 5/8/14, Section 3.8, Page 6 10.300LA Provider Network Development and Management,	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullets 1-4, Page 9 Could not locate first document	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
of treatment and non-treatment; or the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	Paragraph 1, Bullets 1-4, Page 9			
Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The DBPM shall conduct appointment availability surveys annually. The surveys shall be submitted within 30 days after the conclusion of each contract year. The survey results must be kept on file and be readily available for review by LDH upon request. The DBPM may be subject to sanctions for noncompliance of providers with applicable appointment and wait time requirements set forth in this RFP.	5.105LA Availability & Accessibility of Services, Paragraph 1, Page 2 10.300LA Provider Network Development and Management, "Provider Accessibility," Paragraph 3, Page 11	Full	This requirement is met through the documents: 5.105LA Availability & Accessibility of Services, Paragraph 1, Page 2 And 10.300LA Provider Network Development and Management, "Provider Accessibility," Paragraph 3, Page 11	
If a member requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM who accepts new patients, it shall not be considered a violation of the access requirements for the DBPM to grant the member's request.	10.104LA Network Adequacy, Paragraph 1, Page 2 10.300LA Provider Network Development and Management, "Out of Network and Emergency Services," Page 12.	Full	This requirement is met through the documents: 10.104LA Network Adequacy, Paragraph 1, Page 2 and 10.300LA Provider Network Development and Management, "Out of Network and Emergency Services," Page 12	
The DBPM shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206.	10.105LA Availability & Accessibility of Services, "Cultural Competency," Page 2.	Full	This requirement is met through the document : 5.105LA Availability & Accessibility of Services, "Cultural Competency," Page 2.	
The DBPM shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so may result in monetary penalties up to $5,000 per day against the DBPM; whether the data is clean, current or accurate shall be at the discretion of LDH.	10.302LA Validating Accuracy of the Provider Directories, Paragraph 1, Page 1	Full	This requirement is met through the document: 10.302LA Validating Accuracy of the Provider Directories, Paragraph 1, Page 1	
Access Standards and Guidelines				
The DBPM shall ensure access to dental services (distance traveled, waiting time, length of time to				

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
obtain an appointment, after-hours care) in accordance with the provision of services under the RFP. LDH will monitor the DBPM's service accessibility and may require that the DBPM obtain services from out-of-network providers as necessary for the provision of core dental benefits and services. The DBPM shall provide available, accessible and adequate numbers of service locations, service sites, and dental professionals for the provision of core dental benefits and services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:				
Distance: The DBPM shall comply with the following maximum distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps, ArcGIS). Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.	10.104LA Network Adequacy, Paragraph 1, Page 1, "Geo Access Reports"	Full	This requirement is met through the document: 10.104LA Network Adequacy, Paragraph 1, Page 1, "Geo Access Reports"	
Distance to Primary Dental Services - travel distance from member's place of residence shall not exceed forty (40) miles for rural areas and twenty (20) miles for urban areas.	10.104LA Network Adequacy, Grid, Page 1 10.300LA Provider Network Development and Management, Grid, Page 12	Full	This requirement is met through the documents: 10.104LA Network Adequacy, Grid, Page 1 And 10.300LA Provider Network Development and Management, Grid, Page 12	
Distance to Specialty Dental Services - travel distance shall not exceed sixty (60) miles from the member's place of residence for at least 75% of members and shall not exceed ninety (90) miles from the member's place of residence for all members.	10.104LA Network Adequacy, Grid, Page 1 10.300LA Provider Network Development and Management, Grid, Page 12	Full	This requirement is met through the documents: 10.104LA Network Adequacy, Grid, Page 1 And 10.300LA Provider Network Development and Management, Grid, Page 12	
Scheduling/Appointment Waiting Times				
The DBPM shall ensure that its network providers have an appointment system for core dental benefits and services and/or expanded services which are in accordance with prevailing dental community standards as specified below.	5.105LA Availability & Accessibility of Services, Paragraph 1, Page 1	Full	This requirement is met through the document: 5.105LA Availability & Accessibility of Services, Paragraph 1, Page 1	
Formal policies and procedures establishing	5.105LA Availability &	Full	This requirement is met through the	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
appointment standards must be submitted for initial review and approval during the readiness review process. Revised versions of these policies and procedures should be submitted to LDH for record keeping purposes as they become relevant. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, LDH staff must be notified in writing 30 days prior to implementation. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The DBPM shall disseminate these appointment standard policies and procedures to its in-network providers and to its members. The DBPM shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.	Accessibility of Services, Paragraph 1, Page 1 and "Compliance with Regulations," Page 2		document: 5.105LA Availability & Accessibility of Services, "Compliance with Regulations," Page 2 The MCO should add to the policy that "the DBPM shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.	
Timely Access				
Urgent Care must be provided within twenty-four (24) hours [42 CFR §438.206(c)(1)(i)]; Urgent care may be provided directly by the primary care dentist or directed by the DBPM through other arrangements.	5.105LA Availability & Accessibility of Services, Grid, Page 1 10.300LA Provider Network Development and Management, Grid, Page 11	Full	This requirement is met through the documents: 5.105LA Availability & Accessibility of Services, Grid, Page 1, and 10.300LA Provider Network Development and Management, Grid, Page 11	
Routine or preventative dental services must be provided within six (6) weeks.	5.105LA Availability & Accessibility of Services, Grid, Page 1 10.300LA Provider Network Development and Management, Grid, Page 11	Full	This requirement is met through the documents: 5.105LA Availability & Accessibility of Services, Grid, Page 1 10.300LA Provider Network Development and Management, Grid, Page 11	
The DBPM shall establish processes to monitor and reduce the appointment "no-show" rate for primary care dentists. As best practices are identified, LDH may require implementation by the DBPM.	10.600LA Monitoring Member No Show Rates, Procedure section Pages 1&2	Full	This requirement is met through the document: 10.600LA Monitoring Member No Show Rates, Procedure section Pages 1&2	
The DBPM shall have written policies and procedures about educating its provider network about	5.110LA Provider Training Programs, "New Provider	Full	This requirement is met through the documents:	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
appointment time requirements. The DBPM must develop a corrective action plan when appointment standards are not met. If appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR §438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The DBPM is encouraged to include the standards in the provider subcontracts.	Orientation," Procedure #9, Bullet #9. 5.105LA, Availability and Accessibility of Services, Paragraph 1, Page 1, Paragraph 1, Page 2, and #3, Page 3		5.110LA Provider Training Programs, "New Provider Orientation," Procedure #9, Bullet #9. 5.105LA, Availability and Accessibility of Services, Paragraph 1, Page 1, Paragraph 1, Page 2, and #3, Page 3	
Assurance of Adequate Primary Care Dentist Access and Capacity				
The primary care dentist may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)) or outpatient clinic. The DBPM shall provide at least one (1) full time equivalent (FTE) primary care dentist per three thousand (3,000) DBPM members. LDH defines a full time primary care dentist as a provider that provides dental care services for a minimum of thirty-two (32) hours per week of practice time. The DBPM shall require that each individual primary care dentist shall not exceed a total of three thousand (3,000) Medicaid linkages in all DBPMs in which the primary care dentist may be a network provider.	10.300LA Provider Network Development and Management. "Full Time Primary Care Dentist," Page 12	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management. "Full Time Primary Care Dentist," Page 12 The MCO should add the language of how LDH defines a primary care dentist and that each primary care dentist shall not exceed a total of 3,000 Medicaid linkages in all DBPMs.	
The DBPM shall provide access to dentists that offer extended office hours (minimum of 2 hours) at least one day per week (before 8:00 am and after 4:30 pm) and on Saturdays within sixty (60) miles of a member's residence for urgent care.	5.105LA Availability & Accessibility of Services, Paragraph 3, Page 1	Full	This requirement is met through the document: 5.105LA Availability & Accessibility of Services, Paragraph 3, Page 1	
Network providers must offer office hours at least equal to those offered by fee-for-service (FFS) Medicaid at the time the DBP is implemented.	10.105LA Availability & Accessibility of Services, Paragraph 3, Page 1 10.300LA Provider Network Development and Management, Paragraph 3, Page 11	Full	This requirement is met through the documents: 10.105LA Availability & Accessibility of Services, Paragraph 3, Page 1 And 10.300LA Provider Network Development and Management, Paragraph 3, Page 11	
Monthly, the DBPM shall provide on or before the first of each month, the primary care dentist with a report (electronic or hard copy) of all members linked to their	10.300LA Provider Network Development and Management, "Full	Full	This requirement is met through the document: 10.300LA Provider Network Development and	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
practice.	Time Primary Care Dentist," Paragraph 2, Page 12.		Management, "Full Time Primary Care Dentist," Paragraph 2, Page 12.	
Access to Specialty Providers				
The DBPM shall assure the availability of access to specialty providers for all Group A (Medicaid recipients who are under 21 years of age) members. The DBPM shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.	10.104LA Network Adequacy, Paragraph 1, Page 1	Full	This requirement is met through the document: 10.104LA Network Adequacy, Paragraph 1, Page 1	
The DBPM shall establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members under the age of 21 without excessive travel requirements. This means that, at a minimum: the DBPM has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and the DBPM is in compliance with access and availability requirements.	10.300LA Provider Network Development and Management, "Network Management and Development," Page 6	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Network Management and Development," Page 6	
The DBPM shall assure, at a minimum, the availability of the following providers, as appropriate for members under the age of 21: endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs prosthodontists.	10.300LA Provider Network Development and Management, "Network Management and Development," Page 6, #3.	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Network Management and Development," Page 6, #3.	
The DBPM must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the needs for a general dentist.	10.300LA Provider Network Development and Management, "Network Management and Development," Paragraph 1, Page 6.	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Network Management and Development," Paragraph 1, Page 6.	
The DBPM shall meet standards for timely access to all specialists. In accordance with 42 CFR §438.208(c)(4) for members determined to need a course of treatment or regular care monitoring, the DBPM must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's	3.804LA Members with Special Needs, Paragraph 3, Page 1	Full	This requirement is met through the document: 3.804LA Members with Special Needs, Paragraph 3, Page 1	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
condition and identified needs.				
FQHC/RHC Clinic Services				
The DBPM must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) and include them in its provider network.	10.300LA Provider Network Development and Management, Paragraph 1, Page 7 10.101LA Contracting with Public Health Providers, Paragraph 1, Page 1	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Page 7 And 10.101LA Contracting with Public Health Providers, Paragraph 1, Page 1 The MCO should also add to both the language they will "include them in its provider network"	
If the DBPM does not enter into a contract with the FQHCs and/or RHCs within the geographic services area and within the time and distance travel standards of the primary dental care provider, the DBPM is not required to reimburse for out-of-network services. Exception is given when it is determined that the services provided were considered emergency services and in compliance with 42 CFR §438.114 emergency.	10.300LA Provider Network Development and Management, Paragraph 1, Page 7 10.101LA Contracting with Public Health Providers , Paragraph 2, Page 1	Full	This requirement is met through the documents: 10.300LA Provider Network Development and Management, Paragraph 1, Page 7 And 10.101LA Contracting with Public Health Providers , Paragraph 2, Page 1	
The DBPM shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from LDH.	10.300LA Provider Network Development and Management, Paragraph 1, Page 7 10.101LA Contracting with Public Health Providers, Paragraph 3, Page 1	Full	This requirement is met through the documents: 10.300LA Provider Network Development and Management, Paragraph 1, Page 7 And 10.101LA Contracting with Public Health Providers, Paragraph 3, Page 1	
Significant Traditional Providers. The DBPM shall make a good faith effort to include in its network, primary care dentists and specialists who are significant traditional providers (STPs) provided that the STP: agrees to participate as an in-network provider and abide by the provisions of the provider contract; and meets the credentialing requirements. The list of STPs will be available on the LDH web site.	10.102LA Recruiting Significant Traditional Providers, Paragraph 1, Page 1	Full	This requirement is met through the document: 10.102LA Recruiting Significant Traditional Providers, Paragraph 1, Page 1	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Provider Network Development Management Plan				
The DBPM shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur [42 CFR §438.207(b)]. The Network Development and Management Plan shall be submitted to LDH within thirty (30) days from the date the DBPM signs to contract with LDH for evaluation and approval, as well as when significant changes occur and annually thereafter within thirty (30) days of the start of each contract year. The Network Development and Management Plan shall include the DBPM's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the DBPM shall consider the following (42 CFR §438.206):	10.300LA Provider Network Development and Management, Paragraph 1, Page 1	Full	This requirement is partially met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Page 1 Also on page 12, paragraph 2, and Page 3, paragraph 1	
Anticipated maximum number of Medicaid members;	10.300LA Provider Network Development and Management, "Provider Selection Criteria," #6, Page 7	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Provider Selection Criteria," #6, Page 7	
Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the DBPM;	10.300LA Provider Network Development and Management, "Provider Selection Criteria," #10, Page 8	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Provider Selection Criteria," #10, Page 8	
The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services;	10.300LA Provider Network Development and Management, "Provider Selection Criteria," #11, Page 8	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Provider Selection Criteria," #11, Page 8	
The numbers of DBPM providers who are not accepting new DBPM members; and	10.300LA Provider Network Development and Management, "Provider Selection Criteria," #13, Page 8	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Provider Selection Criteria," #13, Page 8	
The geographic location of providers and members,	10.300LA Provider	Full	This requirement is met through the	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Network Development and Management, "Provider Selection Criteria," #8, Page 7		document: 10.300LA Provider Network Development and Management, "Provider Selection Criteria," #8, Page 7	
The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:				
Assurance of Adequate Capacity and Services	10.300LA Provider Network Development and Management, Paragraph 1, Bullet #1, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullet #1, Page 3	
Access to Primary Care Dentists	10.300LA Provider Network Development and Management, Paragraph 1, Bullet #2, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullet #2, Page 3	
Access to Specialists	10.300LA Provider Network Development and Management, Paragraph 1, Bullet #3, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullet #3, Page 3	
Timely Access	10.300LA Provider Network Development and Management, Paragraph 1, Bullet #4, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullet #4, Page 3	
Service Area	10.300LA Provider Network Development and Management. , Paragraph 1, Bullet #5, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management. , Paragraph 1, Bullet #5, Page 3	
Second Opinion	10.300LA Provider Network Development and Management, Paragraph 1, Bullet #6, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullet #6, Page 3	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Out-of-Network Providers	10.300LA Provider Network Development and Management, Paragraph 1, Bullet #7, Page 3	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, Paragraph 1, Bullet #7, Page 3	
The Network Provider Development and Management Plan shall identify gaps in the DBPM's provider network and describe the process by which the DBPM shall assure all covered services are delivered to DBPM members. Planned interventions to be taken to resolve such gaps shall also be included.	10.104LA Network Adequacy, Paragraph 2, Page 1	Full	This requirement is met through the document: 10.104LA Network Adequacy, Paragraph 2, Page 1	
The DBPM shall provide GEO mapping and coding of all network providers for each provider type to geographically demonstrate network capacity. The DBPM shall provide updated GEO coding to LDH quarterly, or upon material change or upon request.	10.300LA Provider Network Development and Management, "Reporting and Program Evaluation," Page 16	Substantial	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Reporting and Program Evaluation," Page 16 GEO Mapping: Partially low for General Dentists in rural areas Low for Pedodontists Low for Orthodontists Low for Oral Surgeons Low for Endodontists Low for Prosthodontists Low for Periodontists Recommendation: The plan should continue to outreach dentists, especially in rural areas. Specifically The plan has difficulty with Regions 4 and 5. In response to the draft report, MCNA provided a log to document its outreach efforts. However, the volume of dentists for some specialties and some regions of the state remains low. Part of the issue may be due to the small universe of dentists available in some regions of the state. MCNA is encouraged to continue and perhaps expand its outreach to bolster its network and	MCNA's Response: MCNA's Network Management team conducts ongoing provider outreach and recruitment activities. As part of this response, we are submitting our recruitment log as evidence of our efforts.

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
			perhaps consider incentives to encourage dentists to join. The review determination is unchanged.	
The DBPM shall develop and implement Network Development and Management policies and procedures that comply with 42 CFR §438.214(a) and (b).				
Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	10.300LA Provider Network Development and Management, "Network Retention," #1, Page 10	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Network Retention," #1, Page 10	
Monitor network compliance with policies and rules of LDH and the DBPM, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	10.300LA Provider Network Development and Management, "Monitoring Activities," #4, Page 7	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Monitoring Activities," #4, Page 7	
Evaluate the quality of services delivered by the network;	10.300LA Provider Network Development and Management, "Monitoring Activities," #2, Page 7	Full	This requirement is met through the document: 10.300LA Provider Network Development and Management, "Monitoring Activities," #2, Page 7	
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	10.104LA Network Adequacy, Paragraph 4, Page 1 10.300LA Provider Network Development and Management, "Out of Network and Emergency Services," Paragraph 1, Page 12.	Full	This requirement is met through the document: 10.104LA Network Adequacy, Paragraph 4, Page 1 And 10.300LA Provider Network Development and Management, "Out of Network and Emergency Services," Paragraph 1, Page 12.	
Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;	10.104LA Network Adequacy, "Cultural Competency," Paragraph 1, Page 2.	Full	This requirement is met through the document: 10.104LA Network Adequacy, "Cultural Competency," Paragraph 1, Page 2.	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Process expedited and temporary credentials. During the transition period, LDH has allowed a sixty (60) days grace period from the date the contract has been signed to have all providers credentialed. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	6.301a Express Credentialing Process	Full	This requirement is met through the document: 6.301a Express Credentialing Process	
Provide training for its providers and maintain records of such training;	5.110LA Provider Training Programs, Paragraph 1, Page 1	Full	This requirement is met through the document: 5.110LA Provider Training Programs, Paragraph 1, Page 1	
Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	10.300LA Provider Network Development and Management, "Monitoring Activities," #3, Page 7. 5.116LA Provider Complaints, "System Capabilities, Identifying Opportunities for improvement and Reporting," Page 2, #2.B., Page 4	Full	This requirement is met through the documents: 10.300LA Provider Network Development and Management, "Monitoring Activities," #3, Page 7. And 5.116LA Provider Complaints, "System Capabilities, Identifying Opportunities for improvement and Reporting," Page 2, #2.B., Page 4	
Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 calendar days of receipt (this does not include inquiries from LDH). If not resolved in 30 days the DBPM must document why the issue goes unresolved; however, the issue must be resolved within 90 calendar days.	5.116LA Provider Complaints, Paragraph 2, Page 1 & Procedures 1-8, Page 2 & 3	Full	This requirement is met through the document: 5.116LA Provider Complaints, Paragraph 2, Page 1 & Procedures 1-8, Page 2 & 3	
Inquiries from LDH must be acknowledged by the next business day and the resolution, or process for resolution, communicated to LDH within twenty-four (24) hours.	5.401LA Resolving Provider Complaints received from DHH, Paragraph 1, Page 1	Full	This requirement is met through the document: 5.401LA Resolving Provider Complaints received from DHH, Paragraph 1, Page 1	
Material Change to Provider Network				
The DBPM shall provide written notice to LDH, no later than seven (7) business days of any network provider				

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
contract termination that materially impacts the DBPM's provider network, whether terminated by the DBPM or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the DBPM's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:				
Any change that would cause more than five percent (5%) of members to change the location where services are received or rendered.	10.107LA Material Changes, Bullet 1, Page 2	Full	This requirement is met through the document: 10.107LA Material Changes, Bullet 1, Page 2	
A decrease in the total of individual primary care dentists by more than five percent (5%);	10.107LA Material Changes, "Material Change," Bullet #2, Page 2	Full	This requirement is met through the document: 10.107LA Material Changes, "Material Change," Bullet #2, Page 2	
A loss of any participating specialist which may impair or deny the members' adequate access to providers;	10.107LA Material Changes, Bullet 3, Page 2	Full	This requirement is met through the document: 10.107LA Material Changes, Bullet 3, Page 2	
Other adverse changes to the composition of the DBPM which impair or deny the members' adequate access to providers.	10.107LA Material Changes, Bullet 4, Page 2	Full	This requirement is met through the document: 10.107LA Material Changes, Bullet 4, Page 2	
The DBPM shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.	10.107LA Material Changes, Paragraph 2 Bullet 4, Page 1 10.300LA Provider Network Development and Management, Paragraph 2, Bullet 4, Page 16	Full	This requirement is met through the document: 10.107LA Material Changes, Paragraph 2 Bullet 4, Page 1 And 10.300LA Provider Network Development and Management, Paragraph 2, Bullet 4, Page 16	
When the DBPM has advance knowledge that a material change will occur, the DBPM must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	10.107LA Material Changes, "Anticipated Material Changes," Page 2	Full	This requirement is met through the document: 10.107LA Material Changes, "Anticipated Material Changes," Page 2	
The request must include a description of any short-term gaps indentified as a result of the change and the	10.107LA Material Changes, "Anticipated	Full	This requirement is met through the document:	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
alternatives that will be used to fill them.	Material Changes," Procedure 1.iii., Page 2		10.107LA Material Changes, "Anticipated Material Changes," Procedure 1.iii., Page 3	
LDH will respond within thirty (30) calendar days to the material change request and the notice received by DBPM. If LDH fails to respond within such time, the request and notice will be considered approved. Changes and alternative measures must be within the contractually agreed requirements. The DBPM shall within thirty (30) calendar days give advance written notice of provider network material changes to affected members. The DBPM shall notify LDH of emergency situation and submit request to approve material changes. LDH will act to expedite the approval process.	10.107LA Material Changes, "Anticipated Material Changes" Procedure 2 & 4, Page 3, "Non-Anticipated Material Changes," Procedure 1, Page 3	Full	This requirement is met through the document: 10.107LA Material Changes, "Anticipated Material Changes" Procedure 2 & 4, Page 3, "Non-Anticipated Material Changes," Procedure 1, Page 3	
The DBPM shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)]. The notification shall include:	10.107LA Material Changes, Paragraph 3, Page 1, "Non-Anticipated Material Changes," Procedure 2, Page 3 10.300LA Provider Network Development and Management, Paragraph 2, Page 16	Full	This requirement is met through the document: 10.107LA Material Changes, Paragraph 3, Page 1, "Non-Anticipated Material Changes," Procedure 2, Page 3 And 10.300LA Provider Network Development and Management, Paragraph 2, Page 16	
Information about how the provider network change will affect the delivery of covered services, and	10.107LA Material Changes, "Non-Anticipated Material Changes," Procedure 2.a., Page 3	Full	This requirement is met through the document: 10.107LA Material Changes, "Non-Anticipated Material Changes," Procedure 2.a., Page 3	
The DBPM's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	10.107LA Material Changes, "Non-Anticipated Material Changes," Procedure 2.b., Page 3	Full	This requirement is met through the document: 10.107LA Material Changes, "Non-Anticipated Material Changes," Procedure 2.a., Page 3	
Coordination with Other Service Providers				
The DBPM shall encourage network providers and subcontractors to cooperate and communicate with	10.300LA Provider Network Development	Full	This requirement is met through the document:	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
other service providers who serve Medicaid members in the coordination and delivery of health care services. Such other service providers may include: Head Start programs; Bayou Health Prepaid and Shared Savings Plans; Magellan; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; FQHCs and RHCs; dental schools; dental hygiene programs; and parish school systems. Such cooperation may involve sharing of information (with the consent of the member).	and Management, "Care Coordination," Page 14.		10.300LA Provider Network Development and Management, "Care Coordination," Page 14.	
Subcontract Requirements				
The DBPM shall provide or assure the provision of all core dental benefits and services. The DBPM may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the DBPM for services rendered. Provider contracts are required with all providers of services unless otherwise approved by LDH. Any plan to delegate responsibilities of the DBPM to a major subcontractor shall be submitted to LDH for approval.	10.502LA Provider Contract Requirements, Paragraph 2, Page 1 1.200LA Contracting and Ongoing Monitoring, Paragraph 1, Page 1	Full	This requirement is met through the document: 10.502LA Provider Contract Requirements, Paragraph 2, Page 1 1.200LA Contracting and Ongoing Monitoring, Paragraph 1, Page 1	
The DBPM shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.	10.106LA Provider Selection and Retention, Paragraph 1, Page 1, "I. Provider Selection," Page 1, & "II. Provider Retention," Page 3	Full	This requirement is met through the document: 10.106LA Provider Selection and Retention, Paragraph 1, Page 1, "I. Provider Selection," Page 1, & "II. Provider Retention," Page 3	
The subcontractor shall follow the state's credentialing and re-credentialing policy.	6.100 MCNA Credentialing Department Overview, Page 1, Paragrapgh1 Bullet 2	Full	This requirement is met through the document: 6.100 MCNA Credentialing Department Overview, Page 1, Paragrapgh1 Bullet 2	
The DBPM provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	10.203LA Non-Discrimination Against Dental Providers, Paragraph 1, Page 1	Full	This requirement is met through the document: 10.203LA Non-Discrimination Against Dental Providers, Paragraph 1, Page 1	
As required by 42 CFR §438.230, the DBPM shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor,				

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
including, but not limited to:				
All provider subcontracts must fulfill the requirements of 42 CFR Part §438 that are appropriate to the service or activity delegated under the subcontract.	1.200LA Contracting and Ongoing Monitoring, Paragraph 2, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 2, Page 1	
LDH shall have the right to review and approve or disapprove any and all major subcontracts entered into for the provision of any services under the RFP.	1.200LA Contracting and Ongoing Monitoring, Paragraph 1, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 1, Page 1	
The DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 1, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 1, Page 1	
The DBPM must have a written agreement between the DBPM and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	1.200LA Contracting and Ongoing Monitoring, Paragraph 2, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 2, Page 1	
The DBPM shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.	1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 2, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 2, Page 1	
The DBPM shall identify deficiencies or areas for improvement, and take corrective action.	1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 3, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 3, Page 1	
The DBPM shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under the RFP to LDH for prior review and approval. LDH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under the RFP.	1.200LA Contracting and Ongoing Monitoring, Paragraph 1, Page 1	Full	This requirement is met through the document: 1.200LA Contracting and Ongoing Monitoring, Paragraph 4, Bullet 3, Page 1	
The DBPM shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 (42 U.S.C. 1320a-7) (2001, as amended) or §1156	6.309LA Medicare-Medicaid Sanctions, Paragraph 1, Page 1	Full	This requirement is met through the document: 6.309LA Medicare-Medicaid Sanctions, Paragraph 1, Page 1	

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
(42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The DBPM shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.				
The DBPM shall provide written notification to LDH of its intent to terminate any provider subcontract that may materially impact the DBPM's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the DBPM shall provide immediate written notice to the provider.	10.107LA Material Changes, Paragraph 3, Page 1, Paragraph 1, Page 2.	Full	This requirement is met through the document: 10.107LA Material Changes, Paragraph 3, Page 1, Paragraph 1, Page 2.	
If termination is related to network access, the DBPM shall include in the notification to LDH their plans to notify DBPM members of such change and strategy to ensure timely access to DBPM members through out-of-network providers. If termination is related to the DBPM's operations, the notification shall include the DBPM's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.	10.107LA Material Changes, "Provider "For Cause" Terminations and Suspensions," Page 3	Full	This requirement is met through the document: 10.107LA Material Changes, "Provider "For Cause" Terminations and Suspensions," Page 3	
The DBPM shall give written notice of termination of a subcontract provider, within fifteen (15) calendar days after receipt of issuance of the termination notice, to each DBPM member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).	10.107LA Material Changes, Paragraph 1, Page 2	Full	This requirement is met through the document: 10.107LA Material Changes, Paragraph 1, Page 2	
All subcontracts executed by the DBPM pursuant to this section shall, at a minimum, include the terms and conditions listed in Section III.F ("Subcontracts"). No other terms or conditions agreed to by the DBPM and its subcontractor shall negate or supersede the requirements in Section III.F.	Subcontract agreement between MCNA and MIC	Full	This requirement is met through the documents: Louisiana DASA and the First Amendment to the LA DASA	
Provider-Member Communication Anti-Gag Clause				

Provider Network				
State Contract Requirements (Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
In accordance with 42 CFR §438.102, the DBPM shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:				
The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Provider Agreement: LA Product Attachment – Page 25, Section 3.8 "Non-interference by MCNA,"	Full	This requirement is met through the document: LA Contract, page 25, Section 3.8	
Any information the member needs in order to decide among relevant treatment options;	Provider Agreement: LA Product Attachment – Page 25, Section 3.8 "Non-interference by MCNA,"	Full	This requirement is met through the document: LA Contract, page 25, Section 3.8	
The risks, benefits and consequences of treatment or non-treatment; and	Provider Agreement: LA Product Attachment – Page 25 Section 3.8 "Non-interference by MCNA,"	Full	This requirement is met through the document: LA Contract, page 25, Section 3.8	
The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Provider Agreement: LA Product Attachment – Page 25 Section 3.8 "Non-interference by MCNA,"	Full	This requirement is met through the document: LA Contract, page 25, Section 3.8	
Any DBPM that violates the anti-gag provisions set forth in 42 CFR §438.102 shall be subject to intermediate sanctions.	10.502LA Provider Contract Requirements, Page 2 , Last paragraph	Full	This requirement is met through the document: 10.502LA Provider Contract Requirements, Page 2 , Last paragraph	
The DBPM shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to Provider Incentive Plans.	10.502LA Provider Contract Requirements, Page 2 , Last paragraph	Full	This requirement is met through the document: 10.502LA Provider Contract Requirements, Page 2 , Last paragraph	

Provider Relations				
State Contract Requirements (Federal Regulation: 438.10, 438.100)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Provider Handbook				
The DBPM shall develop and issue a provider handbook within thirty (30) days of the date the DBPM signs the Contract with DHH. The DBPM may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all providers that explains how to obtain the provider handbook from the DBPM's website. This notification shall also detail how the provider can request a hard copy from the DBPM at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding DBPM covered services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all DBPM requirements are met. At a minimum, the provider handbook shall include the following information:	5.514LA Provider Manual, Paragraph 2, Page 1 5.514LA Provider Manual, Paragraph 2 – 3, Page 1	Full	Addressed in Provider Manual, pg. 1. Assumption was made that "The DBPM shall develop and issue a provider handbook within thirty (30) days of the date the DBPM signs the Contract with DHH."	
Description of the DBPM;	MCNA's Provider Manual, Welcome, Page 8	Full	Addressed in MCNA's Manual, p.8.	
Core dental benefits and services the DBPM must provide;	MCNA's Provider Manual, Section 10 Covered Services, Page 35 Section 19 EPSDT Covered Services and Fee Schedules, Page 67	Full	Addressed in MCNA's Provider Manual, pg. 35. Addressed in MCNA's Provider Manual, pg. 67.	
Emergency dental service responsibilities;	MCNA's Provider Manual, Section 9.1 Emergency Treatment Authorization, Page 33	Full	Addressed in MCNA's Provider Manual, pg. 33.	
Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the DBPM to file a provider complaint and which individual(s) has the authority to review a provider complaint;	MCNA's Provider Manual, Section 12 Provider Complaint Process, Page 47	Full	Addressed in MCNA's Provider Manual, pg. 47.	
Information about the DBPM's Grievance System, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the	MCNA's Provider Manual, Section 18 Member Grievances and Appeal	Full	Addressed in MCNA's Provider Manual, pg. 62.	

Provider Relations				
State Contract Requirements (Federal Regulation: 438.10, 438.100)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;	Process, Page 62			
Medical necessity standards as defined by DHH and practice guidelines;	MCNA's Provider Manual, Section 13.3 Clinical Practice Guidelines, Page 49, Section 13.4 Clinical Decisions, Page 49, Section 13.5 Medical-Necessity Denials, Page 49	Full	Addressed in MCNA's Provider Manual, pg. 49.	
Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	MCNA's Provider Manual, Section 13.3 Clinical Practice Guidelines, Page 49 Section 26 Dental Guidelines, Page 138	Full	Addressed in MCNA's Provider Manual, pg. 49. Note that Section 26, p 138 does not make note of guidelines pertaining to the treatment of chronic and complex conditions	
Primary care dentist responsibilities;	MCNA's Provider Manual, Section 6.2 Primary Care Dentist Role and Responsibilities, Page 19	Full	Addressed in MCNA's Provider Manual, pg. 19.	
Other provider responsibilities under the subcontract with the DBPM;	MCNA's Provider Manual, Section 6 Provider Roles and Responsibilities, Pages 19-29	Full	Addressed in MCNA's Provider Manual, pgs. 19-29.	
Prior authorization and referral procedures;	MCNA's Provider Manual, Section 9 Pre-Authorization of Care, Page 33	Full	Addressed in MCNA's Provider Manual, pg.33. Note that the referral process is stated in other sections of the Provider Manual but does not appear ion pg 33 Pre-Authorization of Care.	
Dental records standards;	MCNA's Provider Manual, Section 6.8 Dental Records Standards, Page 24	Full	Addressed in MCNA's Provider Manual, pg. 24.	
Claims submission protocols and standards, including	MCNA's Provider Manual,	Full	Addressed in MCNA's Provider Manual, pg.	

Provider Relations				
State Contract Requirements (Federal Regulation: 438.10, 438.100)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;	Section 11 Claims Administration, Page 37		37. Elements of what constitutes a clean claim are noted.	
DBPM prompt pay requirements;	MCNA's Provider Manual, Section 11.4 Claims Payment, Page 37	Full	Addressed in MCNA's Provider Manual, pg. 37.	
Notice that provider complaints regarding claims payment shall be sent to the DBPM;	MCNA's Provider Manual, Section 12 Provider Complaint Process, Page 47	Full	Addressed in MCNA's Provider Manual, pg. 47.	
Quality performance requirements; and	MCNA's Provider Manual, Section 14 Quality Improvement, Page 50	Full	Addressed in MCNA's Provider Manual, pg. 50.	
Provider rights and responsibilities.	MCNA's Provider Manual, Section 6 Provider Roles and Responsibilities, Pages 19-29	Full	Addressed in MCNA's Provider Manual, pgs. 19-29.	
The DBPM shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	5.514LA Provider Manual, Paragraph 3, Page 1	Full	Addressed in Provider Manual, pg. 1.	
Provider Complaint System				
The DBPM shall establish a Provider Complaint System for in-network and out-of-network providers to dispute the DBPM's policies, procedures, or any aspect of the DBPMs administrative functions. As part of the Provider Complaint system, the DBPM shall:	MCNA's Provider Manual, Section 6 Provider Roles and Responsibilities, Pages 19-29	Full	Addressed in Provider Complaints, pg. 1. Language does not state "Provider Compliant System" but "complaint process" in paragraph 1. Complaint Process/system is discussed.	
Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	MCNA's Provider Manual, Section 9 Pre-Authorization of Care, Page 33	Full	Addressed in Provider Complaints, pg. 1.	
Identify a staff person specifically designated to receive and process provider complaints;	MCNA's Provider Manual, Section 6.8 Dental Records Standards, Page 24	Full	Addressed in Provider Complaints, pg.1, as Provider Relations Representative in paragraph 2.	
Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the DBPM's written policies and procedures; and	MCNA's Provider Manual, Section 11 Claims Administration, Page 37	Full	Addressed in 5.116LA Procedure 3 Pg. 3.	

Provider Relations				
State Contract Requirements (Federal Regulation: 438.10, 438.100)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Ensure that DBPM executives with the authority to require corrective action are involved in the provider complaint process as necessary.	MCNA's Provider Manual, Section 11.4 Claims Payment, Page 37	Full	Addressed in Provider Complaints, pg. 2, as Quality Improvement Committee (comprised of Executive Management and Directors).	
The DBPM shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The DBPM shall submit its Provider Complaint System policies and procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed. The policies and procedures shall include, at a minimum:	MCNA's Provider Manual, Section 12 Provider Complaint Process, Page 47	Full	Addressed in Provider Complaints, pg. 1.	
Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the DBPM and the resolution time;	5.116LA Provider Complaints, Paragraph 1, Page 1	Full	Addressed in Provider Complaints, pg. 1, as "verbal or written provider complaints" in paragraph 1.	
A description of how and under what circumstances providers are advised that they may file a complaint with the DBPM for issues that are DBPM Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the DBPM;	5.116LA Provider Complaints, "Consolidated Complaints of Multiple Claims," Page 4	Full	Addressed in 5.1116LA Provider Complaints, pg.4 where a description of the provider complaint process appears. Also the process for submitting a complaint is outlined in the Provider manual. Also through the Provider Manual (Page 47 Provider Complaint Process) has been revised to include the right to complain directly to DHH/MMIS.	
A description of how provider relations staff are trained to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf with the member's written consent;	5.116LA Provider Complaints, Section 1e, Page 3	Full	Addressed in Provider Complaints, pg. 3.	
A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;	5.116LA Provider Complaints, Paragraph 1, Page 1 Consolidated Complaints of multiple Claims Response: Provider Manual (Page 47 Provider Complaint Process) has been revised to include language about consolidating claims.	Full	Addressed in Provider Complaints, pg. 1. Language regarding consolidated complaints is included in this policy. The policy states that the provider is made aware of the right to submit consolidated claims in the Provider Manual. Additionally in the Provider Manual (Page 47 Provider Complaint Process) has been revised to include language about consolidating claims.	

Provider Relations				
State Contract Requirements (Federal Regulation: 438.10, 438.100)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.	5.116LA Provider Complaints, Procedure 3, Page 3	Full	Addressed in Provider Complaints, pg. 3.	
A description of the methods used to ensure that DBPM executive staff with the authority to require corrective action are involved in the complaint process, as necessary;	5.100LA Provider Relations, Procedure 9, Page 2	Full	Policy 100LA Provider Relations, pg. 2. States that the Provider Relations Dept. oversees the corrective action process. Missing is the inclusion of an MCNA executive staff person with this authority. In Policy 5.116LA, it is stated that the Quality Improvement Committee is comprised of Executive Management and Directors. 5.100LA has been revised to include the recommended language. Page 3, procedure 9.	
A process for giving providers (or their representatives) the opportunity to present their cases in person;	5.116LA Provider Complaints, Paragraph 2, Page 1	Full	Addressed in Provider Complaints, pg. 1. The step is outlined in procedure 1.c. If the provider or representative files a complaint, verbally, in writing or in person, the same process is followed. The Provider Manual has been updated, pg. 47, Provider Complaint Process, paragraph 3	
Identification of specific individuals who have authority to administer the provider complaint process;	5.116LA Provider Complaints, Paragraph 1, Page 1	Full	Addressed in Provider Complaints, pg. 1, as "Provider Relations Department staff" in paragraph 1.	
A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and	5.116LA Provider Complaints, "System Capabilities, Identifying Opportunities for Improvement and Reporting," Page 2	Full	Addressed in Provider Complaints, pg. 2.	
A provision requiring the DBPM to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.	5.116LA Provider Complaints, "System Capabilities, Identifying Opportunities for Improvement and Reporting," Page 5	Full	Addressed in Provider Complaints, pg. 5.	
The DBPM shall include a description of the Provider	5.514LA Provider Manual,	Full	Addressed in Provider Manual, pg. 47, which	

Provider Relations				
State Contract Requirements (Federal Regulation: 438.10, 438.100)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Complaint System in the Provider Handbook and include specific instructions regarding how to contact the DBPMs Provider Relations staff; and contact information for the person from the DBPM who receives and processes provider complaints.	Paragraph 2, Page 1		includes the contact information for MCNA's Provider Relations Department where the complaint should be filed	
The DBPM shall distribute the DBPM's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice. The DBPM may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the DBPM's website. This summary shall also detail how the in-network provider can request a hard copy from the DBPM at no charge to the provider.	5.116LA Provider Complaints, Paragraph 1, Page 1	Full	Addressed in Provider Complaints, pg. 1.	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
General Requirements				
The DBPM shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization, which include, at a minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to LDH for written approval within thirty (30) days from the date the Contract is signed by the DBPM, annually thereafter, and prior to any revisions.	3.101LA 2016 Utilization Management Program Description, Section III. Paragraph 1 page 3.	Full	The plan's 2016 Utilization Management Program Description, details the policies, procedures and structure of the program and is tailored to the regulations in effect in Louisiana.	
The UM Program policies and procedures shall meet all URAC or equivalent standards and include medical management criteria and practice guidelines that: are adopted in consultation with contracting dental care professionals; are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field; are considering the needs of the members; and are reviewed annually and updated periodically as appropriate.	3.101LA 2016 Utilization Management Program Description Section II. Paragraph 1 page 2. 3.207LA UM Criteria & Updates, Page 1 #1-5	Full	The plan's 2016 Utilization Management Program Description indicates that the UM program meets current URAC standards. MCNA adopts other practice guidelines as needed.	
The policies and procedures shall include, but not be limited to:				
The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;	3.201LA Authorizations, Page 4 #2-4; Page 5 #1-2	Full	Policy 3.201LA Authorizations describes the process to evaluate medical necessity (p4)	
The data sources and clinical review criteria used in decision making;	3.207LA UM Criteria & Updates, Page 1-2 Paragraph 3	Full	Policy 3.207LA UM Criteria & Updates describes the criteria used for UM decision making	
The appropriateness of clinical review shall be fully documented;	3.207LA UM Criteria & Updates, Page 1 Paragraph 1	Full	Policy 3.207LA UM Criteria & Updates requires that clinical reviews be fully documented.	
The process for conducting informal reconsiderations for adverse determinations;	3.204LA Informal Reconsideration Process, Entire policy	Full	The plan has a Policy for conducting informal reconsiderations: 3.204LA Informal Reconsideration Process	
Mechanisms to ensure consistent application of review criteria and compatible decisions;	3.702LA Inter-Rater Reliability Audits, Page 1 Paragraph 1	Full	The plan conducts Inter-rater reliability studies to ensure consistency of the reviews - 3.702LA Inter-Rater Reliability Audits.	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Data collection processes and analytical methods used in assessing utilization of dental care services; and	3.602LA Monitoring for Over and Under Utilization of Dental Services, Page 1, Paragraph 2 & 3.	Full	The plan has a comprehensive process for reviewing utilization data to identify trends and develop interventions to improve utilization of dental services as described in their 602LA Monitoring for Over and Under Utilization of Dental Services policy	
Provisions for assuring confidentiality of clinical and proprietary information.	3.116 Confidentiality for Patient Specific Information, Entire Policy	Full	The plan ensures that all aspects of patient-specific and provider-specific information remain confidential as described in: 3.116 Confidentiality for Patient Specific Information policy.	
The DBPM shall disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM shall take steps to encourage adoption of the guidelines.	2.105LA Clinical Practice Guidelines, Page 1 Paragraph 1	Full	Practice guidelines are regularly disseminated to providers via the website, the manual and newsletters and are provided to members upon request as stated in the plan's policy: 2.105LA Clinical Practice Guidelines.	
The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:				
The vendor must be identified if the criteria was purchased;	Not applicable	N/A	Vendors are not used	
The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;	3.207LA Utilization Management (UM) Criteria and Updates, Page 1-2 Paragraph 3	Full	Dental review criteria, for the review of service authorization requests, are developed by the standards of the American Academy of Pediatric Dentistry (AAPD) and, the American Dental Association (ADA) as documented in 3.207LA Utilization Management (UM) Criteria and Updates.	
The guideline source must be identified if the criteria are based on national best practice guidelines; and	3.207LA Utilization Management (UM) Criteria and Updates, Page 1-2 Paragraph 3	Full	Guidelines and the source of the guidelines are documented in 3.207LA Utilization Management (UM) Criteria and Updates.	
The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM Dental Director or other qualified and trained professionals.	Not applicable	Full	Policy 3.208 (p2) "Requests for UM Criteria" states that the clinical reviewer should be consulted. During the onsite review of UM files, it was determined that all of the UM files were	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			reviewed by the Dental Director	
UM Program dental management criteria and practice guidelines shall be disseminated to all affected providers, and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	2.105LA Clinical Practice Guidelines, Page 1, paragraph 1, Page 1, paragraph 2	Full	Criteria and practice guidelines are regularly disseminated to providers and members upon request. The clinical practice guidelines are based on the enrolled membership as stated in: 2.105LA Clinical Practice Guidelines Policy.	
The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.	3.203LA Lack of Information, Page 1 Paragraph 1 & 2; Page 3-4, Procedure # 1-8	Substantial	The plan has a detailed policy, 3.203LA Lack of Information, regarding the information required from a member and a process to obtain the information it needs. The policy does not state that the information "shall be given verbally to the covered person or health care provider when requested". This requirement should be added to the policy and should be added to the member handbook. In response to the draft report, MCNA provided documentation that the provider is contacted by telephone but the documentation states that the member is contacted in writing and does not indicate any verbal contact. The requirement specifically states that determinations should be "given verbally" to the covered member. It remains unclear from the documentation submitted whether members are also contacted verbally. Policy 3.203 should be revised to include the required language in the element The review determination remains unchanged.	MCNA's response: The same policy was fully met during the 2015 review. Policy 3.203LA, Lack of Information pg. 3 #5, states that providers are notified via telephone, fax, email or provider portal indicating the documentation that is needed. MCNA believes we meet the intent of this requirement.
The DBPM shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the DBPM may deny authorization of the requested service(s).	3.203LA Lack of Information, Page 1 Paragraph 3; Page 4 Procedure #7	Full	The plan's policy: 3.203LA Lack of Information specifies the process followed in the event that a member or provider fails to provide necessary information and the possibility authorization may be denied in such cases.	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.	3.102a UM Staff Responsibilities for UM Decision Making, Page 1 Paragraph 1	Full	The plan's policy: 3.102a UM Staff Responsibilities for UM Decision Making, describes the role of MCNA's staff and the need for clinical expertise	
The DBPM shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with the State's definition.	3.101LA Utilization Management (UM) Program Description, Page 10 Section X, Paragraph 3	Full	The plan uses LDH's medical necessity definition as defined in LAC 50:I.1101 as documented in the Utilization Management (UM) Program Description (p10)	
The DBPM shall submit written policies and processes for LDH approval, within (30) calendar days, but no later than prior to the Readiness Review of the contract signed by the DBPM, on how the core dental benefits and services the DBPM provides ensure: the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to attain, maintain, or regain functional capacity.	3.101LA Utilization Management (UM) Program Description, Page 3, Section III, Paragraph 1; Page 9 Section IX Paragraph 1	Full	The Utilization Management (UM) Program Description cites the standard. The policy was approved by LDH at the time of contracting	
The DBPM must identify the qualification of staff who will determine medical necessity.	3.102a UM Staff Responsibilities for UM Decision Making, Page 2 Clinical Reviews and Determinations Section	Full	Policy 3.102a UM Staff Responsibilities for UM Decision Making describes the qualifications of the staff determining medical necessity.	
Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	3.102a UM Staff Responsibilities for UM Decision Making, Page 2 Clinical Reviews and Determinations Section	Full	Policy 3.102a UM Staff Responsibilities for UM Decision Making specifies that qualified staff are required for determinations of medical necessity	
The DBPM shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	3.201LA Authorizations, Page 1 Paragraph 2	Full	Policy 3.201LA Authorizations requires that only licensed clinical professionals determine service authorization requests.	
The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to	3.202LA Adverse Determinations, Page 3 Paragraph 1	Full	This requirement is addressed i3.202LA Adverse Determinations, (P 3)	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
the clinical peer reviewer's physical, mental, or professional or moral character.				
The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.	3.202LA Adverse Determinations, Page 3 Paragraph 1 3.104LA Clinical Reviewer Attestation, Page 1 Paragraph 1	Full	This requirement is addressed i3.202LA Adverse Determinations, (P 3)	
The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of health care services.	3.101LA Utilization Management (UM) Program Description, Page 21 – 22, Section XXXI Bullet 3	Full	The responsibilities of the UM Committee includes Reducing duplicative , inappropriate and/or unnecessary dental services without adversely affecting the outcome, as stated in Policy 3.101LA Utilization Management (UM) Program Description, (p 21 – 22);	
Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligible's under the Medicaid State Plan.	3.101LA Utilization Management (UM) Program Description, Page 9 Section IX Paragraph 1	Full	The scope of the services requirement is specified in The UM Program Description (p9)	
The DBPM shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member.	3.101LA Utilization Management (UM) Program Description, Page 9 Section IX Paragraph 1	Full	This requirement is addressed in The UM Program Description (p10)	
The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.	3.101LA Utilization Management (UM) Program Description, Page 9 Section IX Paragraph 1	Full	The appropriate limits requirement is addressed in The UM Program Description (p9)	
The DBPM shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210.	3.101LA Utilization Management (UM) Program Description, Page 3 Bullet 1	Full	The compensation requirement is specified in The UM Program Description (p3)	
The DBPM shall report fraud and abuse information	3.101LA Utilization	Full	The mechanism for detecting fraud and abuse	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
identified through the UM program to LDH's Program Integrity Unit in accordance with 42 CFR 455.1(a)(1).	Management (UM) Program Description, Page 26 *Fraud and Abuse Mechanism*		is specified in The UM Program Description (p26)	
The DBPM Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:				
Identification of the enrollee;	3.101LA Utilization Management (UM) Program Description, Page 25 Section XXXV	Full	This requirement is addressed in the plan's UM Program Description (p25)	
The name of the enrollee's dentist;	3.101LA Utilization Management (UM) Program Description, Page 25 Section XXXV	Full	This requirement is addressed in the plan's UM Program Description (p25)	
Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	3.101LA Utilization Management (UM) Program Description, Page 25 Section XXXV	Full	This requirement is addressed in the plan's UM Program Description (p25	
The plan of care;	Not applicable, applies to medical	N/A	MCNA includes a plan of care for individual members but a plan of care post hospitalization does not apply to MCNA	
Date of operating room reservation, if applicable; and	Not applicable	N/A	Not applicable for dental care	
Justification of emergency admission, if applicable.	Not applicable	N/A	Not applicable for dental care	
Utilization Management Committee				
The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the DBPM as appropriate and supports the QAPI Program (refer to the Quality Management subsection for details regarding the QAPI Program).	3.101LA Utilization Management (UM) Program Description, Page 8 Section VII Paragraph 1	Full	The UM committee is described in the UM Program Description (p8) Minutes were provided and meetings occur quarterly	
The UM Committee shall provide utilization review and monitoring of UM activities of both the DBPM and its providers and is directed by the DBPM Dental Director. The UM Committee shall convene no less than quarterly and shall submit a summary of the meeting				

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
minutes to LDH with other quarterly reports. UM Committee responsibilities include:				
Monitoring providers' requests for rendering healthcare services to its members;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #4	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #2	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #5	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #6	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Monitoring consistent application of "medical necessity" criteria;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #7	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Application of clinical practice guidelines;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #7	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Monitoring over- and under-utilization;	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #9	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Review of outliers, and	3.109LA UM Committee, Page 2 Roles and Responsibilities Bullet #10	Full	This requirement is addressed in the Roles and Responsibilities section of the 3.109 UM Committee Policy	
Dental Record Reviews – Dental Record Reviews shall be conducted to ensure that primary care dentists provide high quality health care that is documented according to established standards. The DBPM shall establish and distribute to providers standards for Record Reviews that include all dental record documentation requirements addressed in the Contract.	2.108LA Dental Record Review, Page 1 Paragraph 1 and 2	Full	The plan has procedures in place to conduct dental record reviews (2.108LA Dental Record Review)	
Dental Record Review Strategy				
The DBPM shall maintain a written strategy for	2.108LA Dental Record	Full	The plan has a comprehensive process for	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
conducting dental record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed by the DBPM and annually thereafter. The strategy shall include, at a minimum, the following: designated staff to perform this duty; the method of case selection; the anticipated number of reviews by practice site; the tool the DBPM shall use to review each site; and how the DBPM shall link the information compiled during the review to other DBPM functions (e.g. QI, credentialing, peer review, etc.).	Review, Page 2 Reporting Paragraph 1		medical record review and is detailed in 2.108LA Dental Record Review	
The DBPM shall conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The DBPM shall review each site at least one (1) time during each five (5) year period.	2.108LA Dental Record Review, Page 1 Paragraph 1	Full	The quantity of medical record reviews as required in the contract is specified in policy 2.108LA Dental Record Review.	
The DBPM shall review a reasonable number of records, in a random process, at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary in specific instances.	2.108LA Dental Record Review, Page 2 Paragraph 1	Full	The quantity of medical record reviews as required in the contract is specified in policy 2.108LA Dental Record Review An MR report was submitted and reviewed onsite	
The DBPM shall report the results of all record reviews to LDH quarterly with an annual summary.	2.108LA Dental Record Review, Page 4 Procedure # 20	Full	The reporting timeframe is specified in policy 2.108LA Dental Record Review, (P 4) Onsite it was confirmed that the report of record reviews is submitted to LDH quarterly with an annual summary.	
Utilization Management Reports				
The DBPM shall submit reports as specified by LDH. LDH reserves the right to request additional reports as deemed by LDH. LDH will notify the DBPM of additional required reports no less than 30 calendar days prior to due date of those reports. However, there may be occasions the DBPM will report in a shorter time frame.	3.700LA UM Reporting Requirements, Page 1 Paragraph 1	Full	Reporting to LDH is specified in policy 3.700LA UM Reporting Requirements In a discussion onsite, it was determined that occasionally LDH will ask MCNA for an ad hoc report. An example was a report on the number of referrals that resulted in a visit to a specialist. MCNA staff indicated that there were no issues in meeting these requests.	
Service Authorization				

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Service authorization includes, but is not limited to, prior authorization.				
The DBPM UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR 438.210 and state laws and regulations and the court-ordered requirements of Chisholm v. Kliebert and Wells v. Kliebert for initial and continuing authorization of services that include, but are not limited to, the following:				
Written policies and procedures for processing requests for initial and continuing authorizations of services, where a member requests a service authorization because provider refuses a service or does not request a service in a timely manner;	N/A	Full	Policy "Authorizations," a3.201, p1 contains the required language in the regulation.	
Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	3.702LA Inter-Rater Reliability Audits, Page 1 Paragraph 1	Full	The plan has an inter-rater reliability studies to ensure consistent reviews. The process is described in 3.702LA Inter-Rater Reliability Audits. An IRR report tool was provided for review.	
Requirement that 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 made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	3.202LA Adverse Determinations, Page 1 Paragraph 1	Full	Denial of Service authorization policy is described in policy 3.202LA Adverse Determinations	
Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	3.201LA Authorizations, Page 1 Paragraph 2 3.500LA Referral Process, Page 1 Paragraph 1	Substantial	Service authorization requests can be made on the web or in writing and the plan accepts member requests for service authorizations via the Member Services Department. The Member Handbook states that MCNA will accept requests for care through the Member Hotline or in writing, (p10) The plan should explicitly state in the Grievance section of the Member Handbook that service authorization requests are included (p17). In response to the draft report, MCNA	MCNA's response: Recommendations from the 2015 audit did not address MCNA adding language in the Grievance section of the member handbook. Based on the findings from 2015, the member handbook was updated with the requirement as recommended by IPRO.

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			indicated that the Member Handbook was updated in 2015. While MCNA does accept service authorization requests, the Handbook should be further updated to include MCNA's service authorization request process. The review determination remains unchanged.	
The DBPM's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	3.201LA Authorizations, Page 2 Paragraph 2	Full	Policy 3.201LA Authorizations specifies the inclusion of the authorization number and effective dates for authorization	
The DBPM's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	3.201LA Authorizations, Page 1-2 Paragraph 4	Full	3.201LA Authorizations, Page addresses the system and contains all of the required information as specified in the regulation	
The DBPM shall not deny continuation of higher level of services for failure to meet medical necessity unless the DBPM can provide the service through an in-network or out-of-network provider for a lower level of care.	3.202LA Adverse Determinations, Page 1 b.	Full	The regulation is addressed in 3.202LA Adverse Determinations,(P1)	
Timing of Service Authorization Decisions				
Standard Service Authorization				
The DBPM shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. The DBPM shall maintain documentation system to report to LDH on a monthly basis all service authorizations provided in the format specified by LDH.	3.201LA Authorizations, Page 2 Timeliness of Decision Making Table	Full	The timeliness and threshold standards are specified in policy 3.201LA Authorizations,(P 2 table)	
An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if	3.203LA Lack of Information, Page 1 Paragraph 1	Full	The 14 day extension is noted in policy 3.203LA Lack of Information, Page 1	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
the DBPM justifies to LDH a need for additional information and the extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than twenty-five (25) calendar days from receipt of the request.				
Expedited Service Authorization				
In the event a provider indicates, or the DBPM determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	3.202LA Adverse Determinations, Page 5 *Request for Expedited Reviews* Paragraph 1	Full	The expedited authorization process is detailed in policy 3.202LA Adverse Determinations, (p5)	
The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to LDH a need for additional information and how the extension is in the member's best interest.	3.201LA Authorizations, Page 2 Timeliness of Decision Making Table	Full	The extension is noted in 3.201LA Authorizations, (P 2 table)	
Post Authorization				
The DBPM shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	N/A	N/A	Determine onsite whether retrospective reviews are required	
The DBPM shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	3.201LA Authorizations, Page 3 Paragraph 1	Substantial	Policy 3.201LA Authorizations, (P 3) states that the plan will not reverse its authorization after services have been provided unless one of the conditions specified in the regulation occurred. Reduction of payment for an item or service furnished as stated in the regulation is not specified in the Policy and should be included. In its response to the draft report, MCNA stated that they revised their policy to include	MCNA response: Policy 3.201LA has been revised to include the recommended language regarding reduction in payment.

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			the required language. Since the revision was made after the review period, the review determination remains unchanged.	
Timing of Notice				
Notice of Action				
Approval [Notice of Action]				
Approval - For service authorization approval for a non-emergency admission, procedure or service, the DBPM shall notify the provider as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	3.201LA Authorizations, Page 2 Timeliness of Decision Making Table	Full	Routine and non-emergency timeliness standards are specified in 3.201LA Authorizations (p 2 table)	
Approval - For service authorization approval for extended stay or additional services, the DBPM shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.	3.201LA Authorizations, Page 7 #6	Full	Service authorization approval notification within one day is noted in policy 3.201LA Authorizations (p7)	
Adverse [Notice of Action]				
Adverse - The DBPM shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other adverse action as defined in this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.10(c) and (d), 42 CFR §438.404(c), and 42 CFR §438.210(b)(c)(d) and in this RFP for member written materials.	3.202LA Adverse Determination, Decisions and Notices of Action Page 1 Paragraph 1	Full	Member notification regulation is addressed in the document: Determination, Decisions and Notices of Action (p1). The member will be notified in writing using language that is easily understood. Recommendation: Though the notice includes the reasons for denial, the list contains clinical reasons which may not be relevant to the member's particular case. For example, the wording is such that the case is denied because one or more of a listing of criteria are met (but the letter does not explicitly state which one(s)). Onsite it was explained that the precise reason is contained within a text box in the system and cannot be readily extracted without a major system modification.	MCNA response: MCNA's denial notices are audited on a monthly basis by LDH in accordance with the Wells requirements. The current notification contents are in keeping with the requirements and template provided by the LDH and we believe no additional changes are required.

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			It is recommended that MCNA work to autopopulate this information, since members are not currently able to easily understand the reasons why the case was denied clinically. Perhaps the criteria can be reformatted to a listing on a drop down menu and the medical necessity denial criterion can be checked when appropriate. This information can then be extracted electronically. In its response to the draft report, MCNA indicated that it follows the template provided by LDH. Based on this fact, the review determination has been revised to "full". However, the recommendation remains that a specific reason for the denial be incorporated into the Notice of Action to facilitate understanding by the member.	
Adverse - The DBPM shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	3.202LA Adverse Determination, Decisions and Notices of Action Page 1 Paragraph 1	Full	Notification to the provider of a decision to deny an authorization request is noted in 3.202LA Adverse Determination, Decisions and Notices of Action. The policy does not include the following and should be revised accordingly: "The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification." Recommendation: Onsite, Policy 3.201 was reviewed which includes a table that presents	MCNA's response: Policies 3.202LA and 3.201LA includes the notification timeframes. The same policy was reviewed during the 2015 audit and MCNA fully met the requirement.

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			the timelines for prior authorization reviews. The notification timeframes can be included in another table in this policy. In re-reviewing the policy, the timeframes are included in the table entitled "timeliness of Decision Making". The review determination has been revised to "full".	
Informal Reconsideration				
As part of the DBPM appeal procedures, the DBPM should include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	3.204LA Informal Reconsiderations, Page 1 Paragraph 1	Substantial	The plan has an Informal Reconsideration process and policy that documents its procedures (3.204LA Informal Reconsiderations. However, the denial notification to members does not include reference to a member's right to file an informal reconsideration. Onsite, MCNA staff indicated that the right for members to file Informal Reconsiderations would be added to the denial letter. In its response to the draft report, MCNA stated that the Member Handbook includes a description of the Informal Reconsideration process. However, the denial letter should also reference the right to file an Informal Reconsideration. Given that the information is contained in the member Handbook, the review determination has been revised to "Substantial".	MCNA's response: Members are notified of the informal reconsideration process. It is included in the Member Handbook on page 28. Our current adverse determination letters comply with the Wells Requirement and this was not part of the requirement. MCNA believes we meet the intent of this element.
In a case involving an initial determination, the DBPM should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination.	3.204LA Informal Reconsiderations, Page 1 Paragraph 1	Full	3.204LA Informal Reconsiderations details the informal reconsideration request procedure The process is also detailed in the member handbook (p17)	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the DBPM's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day.	3.204LA Informal Reconsiderations, Page 1 Paragraph 2	Full	The timeliness standard for Informal Reconsiderations is detailed in policy 3.204LA Informal Reconsiderations and is included in the member handbook (p17)	
The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.	3.204LA Informal Reconsiderations, Page 1 Paragraph 2	Full	The 30 day period is detailed in policy 3.204LA Informal Reconsiderations and is included in the member handbook (p17)	
Exceptions to Requirements				
The DBPM shall not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out-of-network provider.	3.201LA Authorizations, Page 1 Paragraph 2	Full	The plan does not require service authorizations for emergency services as specified in 3.201LA Authorizations (p1)	
The DBPM shall not require service authorization or referral for EPSDT dental screening services.	3.201LA Authorizations, Page 1 Paragraph 2	Full	The plan does not require service authorization or referral for EPSDT dental screening services as specified in policy 3.201LA Authorizations, (p 1)	
The DBPM shall not require service authorization for the continuation of covered services of a new member transitioning into the DBPM, regardless of whether such services are provided by an in-network or out-of-network provider, however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.	3.305LA Continuity of Care for New Members, Page 1 Paragraph 1	Full	The plan does not require service authorization for continuation of covered services of a new member as specified in policy 3.305LA Continuity of Care for New Members	
Primary Care Dentist Utilization and Quality Profiling				
The DBPM shall profile its primary care dentists and analyze utilization data to identify primary care dentist utilization and/or quality of care issues.	2.203LA Provider Profiling, Page 1 Paragraph 1	Full	The plan has a policy which details its profiling analyses and studies (2.203LA Provider Profiling) Provider profiling reports were discussed onsite and sample reports reviewed.	
The DBPM shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	2.203LA Provider Profiling, Page 1 Paragraph 1	Full	Policy 2.203LA Provider Profiling details the use of provider profiling reports to improve quality of care. A letter about Sealant Use sent to providers	

Utilization Management				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			was submitted onsite.	
LDH reserves the right to request additional reports as deemed necessary. LDH will make every effort to notify the DBPM of additional required reports no less than sixty (60) days prior to due date of those reports. However, there may be occasions the DBPM will be required to produce reports in a shorter timeframe.	2.203LA Provider Profiling, Page 1 Paragraph 1	Full	In its Provider Profiling policy, the plan states that it will comply with the timeframes for submitting additional required reports as requested by LDH	

Eligibility, Enrollment and Disenrollment				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.226)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Primary Care Dentist Auto-Assignments				
The DBPM is responsible for developing a primary care dentist automatic assignment methodology in collaboration with LDH to assign a member for whom the DBPM is the primary payer to a primary care dentist when the member:	11.304LA Member Assignment to a Primary Care Dentist pg. 1-2 "PCD Member Assignment Methodology"	Full	This Requirement is met through the document: 11.304LA which describes the procedure for auto assignment of a PCD when none has been chosen by the member. See pages 1–2.	
Does not make a primary care dentist selection; or	11.304LA Member Assignment to a Primary Care Dentist Page 3, Procedure 2.a.	Full	This requirement is met through the document: Policy 11.304LA, states that members who have not selected a PCD will be auto assigned and that consideration will be given to zip code, previous PCDs and assignment of the same PCD to family members.	
Selects a primary care dentist within the DBPM that has restrictions/limitations (e.g. pediatric only practice).	11.304LA Member Assignment to a Primary Care Dentist Page 3, Procedure 2.b.	Full	This requirement is met through the document: Policy 11.304LA addresses auto assignment when the member has selected a PCD that has limitations or restrictions, Page 3	
Assignment shall be made to a primary care dentist with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical primary care dentist relationship, the member may be auto-assigned to a provider who is the assigned primary care dentist for an immediate family member enrolled in the DBPM. If other immediate family members do not have an assigned primary care dentist, auto-assignment shall be made to a provider with whom a family member has a historical provider relationship.	11.304LA Member Assignment to a Primary Care Dentist Page 2, Paragraph 3 Bullets 1-3	Full	This requirement is met through the document: Policy 11.304LA explicitly addresses use of fee for service claims or prior linkage in assigning PCDs. IT also addresses existing linkages with family members with a PCD on page 2 of the document.	
If there is no member or immediate family historical usage, members shall be auto-assigned to a primary care dentist using an algorithm developed by the proposer, based on the age and sex of the member and geographic proximity.	11.304LA Member Assignment to a Primary Care Dentist Page 2, Paragraph 4	Full	This requirement is met through the document: Policy 11.304LA addresses selection of PCDs based on the member's zip code, age and sex. This is addressed on page 2 of the policy.	
The final primary care dentist automatic assignment methodology must be provided thirty (30) days from	11.304LA Member Assignment to a Primary	Full	This requirement is met through the document:	

Eligibility, Enrollment and Disenrollment				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.226)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
the date the DBPM signs the contract with LDH. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the DBPM's website and Provider Handbook.	Care Dentist Page 2, Paragraph 5		Policy 11.304LA states that approval of the methodology will occur within 30 days of the date the contractor signs a contract with LDH, Page 2	
The DBPM shall be responsible for providing to LDH, information on the number of Medicaid member linkages and remaining capacity of each individual primary care dentist of additional Medicaid member linkages on a quarterly basis.	11.304LA Member Assignment to a Primary Care Dentist Page 3, Procedure 6	Full	This requirement is met through the document: 11.304LA .Procedure 6 on page 3 PCD linkages report shows all of the network providers and access points and how many are assigned to each. -No restriction on capacity	
If the member does not select a primary care dentist and is auto assigned to a primary care dentist by the DBPM, the DBPM shall allow the member to change primary care dentist.	11.304LA Member Assignment to a Primary Care Dentist Page 1, Paragraph 3	Full	This requirement is met through the document: Policy 11.304LA makes provision for member changes to PCD. Page 1 of the policy states that members who are auto assigned will be assisted in changing PCDs upon request; page 2 of the policy further states that members can change PCD at any time.	
If a member requests to change his or her primary care dentist at any time, the DBPM may agree to grant this request for good cause.	11.304LA Member Assignment to a Primary Care Dentist Page 1, Paragraph 2	Full	This requirement is met through the document: 11.304LA states that members may change PCD at any time, page 2.	
The DBPM shall have written policies and procedures for allowing members to select a new primary care dentist, including auto-assignment, and provide information on options for selecting a new primary care dentist when it has been determined that a primary care dentist is non-compliant with provider standards (i.e. quality of care) and is terminated from the DBPM, or when a primary care dentist change is ordered as part of the resolution to a grievance proceeding. The DBPM shall allow members to select another primary care dentist within ten (10) business days of the postmark date of the termination of primary care dentist notice to members and provide information on	11.104LA Member Notification of Terminated Providers Page 1, Paragraph 2 and Paragraph 5	Full	This requirement is met through the document: 11.304LA. In addition to the procedures noted in which allow members to change PCDs at any time, the plan submitted documentation under policy 11.104LA relating to terminated providers which addresses notification to members when provider terminate voluntarily or when the plan terminates a provider for failure to meet standards. This policy addresses notification to members of terminated providers and	

Eligibility, Enrollment and Disenrollment				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.226)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
options for selecting a new primary care dentist.			assistance to be offered in selecting a new PCD.	
Disenrollment				
Disenrollment is any action taken by LDH or its designee to remove a DBPM member from the DBPM following the receipt and approval of a written request for disenrollment or a determination made by LDH or its designee that the member is no longer eligible for Medicaid or the DBP.	11.403LA Disenrollment Page 1, Paragraph 1	Full	This requirement is met through the document: Policy 11.403LA addresses procedures to be followed upon disenrollment of a member from DBPM or LDH determination that the member is no longer eligible.	
LDH will notify the DBPM of the member's disenrollment due to the following reasons:				
Loss of Medicaid eligibility or loss of DBPM enrollment eligibility;	11.403LA Disenrollment Page 1, Bullet 1 Page 1, # 5	Full	This requirement is met through the document: Policy 11.403LA addresses reporting to LDH via the monthly reconciliation process of all disenrollments and a quarterly report listing all disenrollments for that period.	
Death of a member;	11.403LA Disenrollment Page 1, Bullet 2	Full	This requirement is met through the document: Policy 11.403LA explicitly addresses this scenario	
Member's intentional submission of fraudulent information;	11.403LA Disenrollment Page 1, Bullet 3	Full	This requirement is met through the document: Policy 11.403LA explicitly addresses this scenario	
Member becomes an inmate in a public institution;	11.403LA Disenrollment Page 1, Bullet 4	Full	This requirement is met through the document: Policy 11.403LA explicitly addresses this scenario	
Member moves out-of-state;	11.403LA Disenrollment Page 1, Bullet 5	Full	This requirement is met through the document: Policy 11.403LA explicitly addresses this scenario	

Eligibility, Enrollment and Disenrollment				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.226)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
To implement the decision of a hearing officer in an appeal proceeding by the member against the DBPM or as ordered by a court of law.	11.403LA Disenrollment Page 1, Bullet 6	Full	This requirement is met through the document: Policy 11.403LA explicitly addresses this scenario (page 1).	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Member Education – Required Materials and Services				
The DBPM shall ensure all materials and services do not discriminate against DBPM members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the DBPM.	11.302LA Member Education and Marketing Materials – Approval Process, pg. 1; paragraph 4	Full	This requirement is met through the document: Policy 11.302LA, P 1	
New Member Orientation				
The DBPM shall have written policies and procedures for the following, but not limited to: orienting new members of its benefits and services; role of the primary care dentist; what to do during the transition period; how to utilize services; what to do in a dental emergency or urgent dental situation; and how to a file a grievance and appeal.	11.301LA Member Education Materials, pg. 4; Member Handbook and Provider Directory, paragraph 1 bullets 8, 10, 12, 13, and 18	Full	This requirement is met through the document: Policy 11.301LA addresses the required elements with regard to member notification of services, changes in network and how to file grievances and appeals. It addresses both new member and ongoing member communication. The member handbook addresses all required elements.	
The DBPM shall identify and educate members who access the system inappropriately and provide continuing education as needed.	11.301LA Member Education Materials, pg. 3; last sentence	Full	This requirement is met through the document: Page 3 of policy 11.301LA addresses this contractual language. Also through the Member handbook. Pg.5	
The DBPM may propose, for approval by LDH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.	11.301LA Member Education Materials, pg. 7; last sentence	Full	This requirement is met through the document: 11.301LA references this language. Discuss onsite whether the plan has proposed any such alternate methods of orienting members and if so, request evidence of evaluation of efficacy. A tracking report was provided onsite.	
The DBPM shall have written policies and procedures for notifying newly identified members within ten (10) business days after receiving the Member File from the FI. This notification must be in writing and include a listing of primary care dentist names (and include locations, and office telephone numbers) that the member may choose as their primary dental care provider.	11.301LA Member Education Materials, pg. 3; paragraph 1	Full	This requirement is met through the document: Policy 11.301LA addresses this requirement. Request evidence of mailing within 10 business days of receipt of member file. Request information on how the plan monitors compliance with this requirement. The sample introductory letter indicates that members are provided with a list of PCDs at	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
			the time of enrollment. Letter was provided onsite	
The DBPM shall submit a copy of the procedures to be used to contact DBPM members for initial member education to LDH for approval within thirty (30) days following the date the Contract is signed by the DBPM.	11.302LA Member Education and Marketing Materials – Approval, pg. 1; Marketing and Member Education Plan Approal	Full	This requirement is met through the document: Policy 11.301LA	
New Medicaid eligibles who have not proactively selected a primary care dentist or whose choice of primary care dentist is not available will have the opportunity to select a primary care dentist within the DBPM that: 1) has entered into a subcontract with the DBPM; and 2) is within a reasonable commuting distance from their residence.	11.304LA Member Assignment to Primary Care Dentist, pg. 1; paragraph 3-4	Full	This requirement is met through the document: Policy 11.304LA addresses this requirement. The sample letter sent to members informs them that they may choose another PCD and provides a list of PCDs in their area.	
Communication with New Members				
LDH's FI shall send the DBPM a daily file in the format specified in the DBPM Systems Companion Guide. The file shall contain the names, addresses and phone numbers of all newly eligible members, as determined by the DBPM. The DBPM shall use the Member File to assign primary care dentists and to identify and initiate communication with new members via welcome packet mailings as prescribed in this RFP.	11.301LA Member Education Materials, pg. 3; paragraph 1	Full	This requirement is met through the document: Policy 11.301LA A sample introductory letter was provided. Also through the Enrollment disenrollment policy, page 1 and 2. #11.304.	
Welcome Packets				
The DBPM shall send a welcome packet to new members within ten (10) business days from the date of receipt of the Member File from the FI. During the transition of the DBPM Program from the FFS Program, the DBPM may have up to twenty-one (21) days to provide welcome packets.	11.301LA Member Education Materials, pg. 3; paragraph 1	Full	This requirement is met through the document: Policy 11.301LA addresses this requirement. A tracking report was provided onsite.	
The DBPM must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the DBPM is only required to send one welcome packet.	11.301LA Member Education Materials, pg. 3; paragraph 2	Full	This requirement is met through the document: Policy 11.301LA	
All contents of the welcome packet are considered member education materials and, as such, shall be	11.301LA Member Education Materials, pg.	Full	This requirement is met through the document:	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
reviewed and approved in writing by LDH prior to distribution according to the provisions described in this RFP. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:	2; paragraph 3		Policy 11.301LA	
A welcome letter highlighting major program features and contact information for the DBPM; and	11.301LA Member Education Materials, pg. 3 bullet 1	Full	This requirement is met through the document: The plan provided a sample letter and member handbook.	
A Provider Directory when specifically requested by the member (also must be available in searchable format on-line).	11.301LA Member Education Materials; pg. 4; paragraph 3 and pg. 5; paragraph 1	Full	This requirement is met through the document: The sample letter indicates that a list of PCDs in enclosed.	
The DBPM shall adhere to the requirements for the Provider Directory as specified in this RFP, the Dental Benefit Program Companion Guide, its attachments, and in accordance with 42 CFR §438.10 (f)(6).	11.301LA Member Education Materials; pg. 5; paragraph 1 bullets 1-4	Full	This requirement is met through the document: Policy 11.301LA	
Member Identification (ID) Card				
DBPM members shall use their LDH issued Medicaid ID card to access benefits and services covered as part of the Dental Benefit Program. The DBPM will not provide members with a separate ID card.	11.301LA Member Education Materials; pg. 3; ID Cards and Verification of Eligibility	Full	This requirement is met through the document: Policy 11.301LA. Additionally, page 6 of the member handbook instructs members to use their Medicaid ID card when accessing dental services.	
A LDH issued Medicaid ID card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by DBPM providers. These systems will contain the most current information available to LDH, including specific information regarding DBPM enrollment.	11.301LA Member Education Materials; pg. 3; ID Cards and Verification of Eligibility	Full	This requirement is met through the document: Policy 11.301LA.	
Provider Directory for Members				
The DBPM shall develop and maintain a Provider Directory in two (2) formats:				
Web-based, searchable, online directory for members and the public; and	11.301LA Member Education Materials; pg. 4; Member Handbook and Provider Directory	Full	This requirement is met through the document: Member handbooks and introductory letters provide members with information on	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	12.800 Website Development and Maintenance, Page 1, Bullet 5		accessing the website. Policy 12.800 Website Development and Maintenance describes the contractual requirements of the website.	
A hard copy directory for members upon request only.	11.301LA Member Education Materials; pg. 4; paragraph 3	Full	This requirement is met through the document: Policy 11.301LA. Additionally, the member handbook instructs members on how to request a printed directory.	
LDH or its designee shall provide the file layout for the electronic directory to the DBPM after approval of the Contract. The DBPM shall submit templates of its provider directory to LDH within thirty (30) days from the date the Contract is signed, but no later than prior to Readiness Review. .				
The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill only requests. The web-based online version shall be updated in real time, however no less than weekly.	11.301LA Member Education Materials; pg. 5; paragraph 1	Full	This requirement is met through the document: Policies 11.301LA and 12.800.	
In accordance with 42 CFR §438.10(f) (6), the provider directory shall include, but not be limited to:				
Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, primary care dentists, specialists, and providers that are not accepting new patients at a minimum;	11.301LA Member Education Materials; pg. 5; bullet 1	Full	This requirement is met through the document: Policies 11.301LA and 12.800. The required elements can be found in the Provider Manual (p.17)	
Identification of primary care dentists, specialists, and dental groups in the service area;	11.301LA Member Education Materials; pg. 5; bullet 2	Full	This requirement is met through the document: Policies 11.301LA and 12.800. Primary care and specialty care is described in the Provider Manual (p19-20)	
Identification of any restrictions on the enrollee's freedom of choice among network providers; and	11.301LA Member Education Materials; pg. 5; bullet 3	Full	This requirement is met through the document: Policies 11.301LA and 12.800. Information on	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
			restrictions to freedom of choice can be found in the provider Manual (p59). Age restrictions are noted (p 20).	
Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	11.301LA Member Education Materials; pg. 5; bullet 4	Full	This requirement is met through the document: Policies 11.301LA and 12.800. Hours of operation including after hour requirements are included in the Provider Manual. (p16 and p23)	
Member Call Center				
The DBPM shall maintain a toll-free member service call center, physically located in the United States. The member services line shall be adequately staffed and individuals trained to accurately respond to questions regarding:	4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policy 4.107A. Members are notified of call center numbers in the Member Handbook.	
DBPM policies and procedures;	4.106LA Management of Member Calls for Inquiries, , Page 1 Bullet 2 4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite.	
Prior authorizations;	4.106LA Management of Member Calls for Inquiries, , Page 1, Bullet 3 4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite.	
Access information;	4.106LA Management of Member Calls for Inquiries, Page 1, Bullet 4 4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite.	
Information on primary care dentists or specialists;	4.106LA Management of	Full	This requirement is met through the	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	Member Calls for Inquiries, Page 1, Bullet 5 4.107LA Member Services Department Overview, pg. 1		document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite.	
Referrals to participating specialists;	4.106LA Management of Member Calls for Inquiries, Page 1, Bullet 6 4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite.	
Resolution of service and/or dental delivery problems; and	4.106LA Management of Member Calls for Inquiries, Bullet 7, Page 1 4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite.	
Member grievances.	4.106LA Management of Member Calls for Inquiries, Bullet 8, Page 1 4.107LA Member Services Department Overview, pg. 1	Full	This requirement is met through the document: Policies 4.106LA and 4.107LA address the requirement. Additionally Policy 4.120 which was provided onsite	
The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday.	4.107LA Member Services Department Overview, pg. 2	Full	This requirement is met through the document: Policy 4.107A addresses this requirement.	
The toll-free line shall have an automated system, available 24-hours a day and seven days a week, including all federal and state holidays. This automated system must include the capability of providing callers with operating instructions on what to do in case of a dental emergency and the option to leave a message, including instructions on how to leave a message and when that message will be returned. The DBPM must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff	4.107LA Member Services Department Overview, pg. 2; Member Help Line paragraphs 1 and 3	Full	This requirement is met through the document: Policy 4.107A addresses this requirement. The reports submitted for review show evidence of timely response to calls.	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
return all calls by close of business the following business day.				
The DBPM shall have sufficient telephone lines to answer incoming calls. The DBPM shall ensure sufficient staffing to meet performance standards listed in the RFP. LDH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by LDH.	4.107LA Member Services Department Overview, pg. 2; Member Help Line paragraph 1 4.107LA Member Services Department Overview, pg. 4; Staffing Responsibilities	Full	This requirement is met through the document: Policy 4.107A addresses this requirement. The reports submitted for review show evidence of timely response to calls.	
The DBPM must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for DBPM performance. The DBPM must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.	4.107LA Member Services Department Overview, pg. 4; Staffing Responsibilities	Full	This requirement is met through the document: Policy 4.107A addresses this requirement.	
The DBPM must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The DBPM shall submit these telephone help line policies and procedures, including performance standards, to LDH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The DBPM call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.	4.107LA Member Services Department Overview; pg. 4 Staffing Responsibilities; pg. 2 paragraph 1; 4.114LA Monitoring Phone Calls, Paragraph 1, Page 1 4.115LA Call Standard for Productivity, pg. 1 paragraph 1	Full	This requirement is met through the document: Policies 4.107LA, 4.114LA and 4.115LA address the requirements. Additionally a call synopsis report which was provided onsite.	
The DBPM shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The DBPM shall submit call center	4.112LA Call Center Quality Monitoring, Paragraph 2, Page 1	Full	This requirement is met through the document: Policy 4.112A addresses this requirement. The policy states that calls are monitored to	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
quality criteria and protocols to LDH for review and approval annually.			ensure quality and that aggregated results are submitted for review quarterly to committee. A Quality Monitoring report was provided onsite.	
ACD System				
The DBPM shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:				
Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;	4.107LA Call Center Operations Department Overview - Member Services, Member Helpline , Page 2, Paragraph 1	Full	This requirement is met through the document: Policy 4.107LA addresses this requirement.	
Transfer calls to other telephone lines;	4.107LA Call Center Operations Department Overview - Member Services, Member Helpline , Page 2, Paragraph 1	Full	This requirement is met through the document: Policy 4.107LA addresses this requirement.	
Provide an option to speak to a live person (during call center hours of operation);	4.107LA Call Center Operations Department Overview - Member Services, Member Helpline , Page 2, Paragraph 1	Full	This requirement is met through the document: Policy 4.107LA addresses this requirement.	
Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 # 8-15	Full	This requirement is met through the document: Policy 4.116LA. Additionally, the plan provided call center reports for the review period. Bullet 8 references reporting by type of call. The reports provided show calls broken out by those choosing to speak to a representative. Request information on other ways in which type of call are tracked – e.g. request for information relating to benefits, assistance in selecting a dentist etc. A call Log was provided onsite and different categories	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
			and process explained.	
Provide a message that notifies callers that the call may be monitored for quality control purposes;	4.107LA Call Center Operations Department Overview - Member Services, Member Helpline , Page 2, Paragraph 1	Full	This requirement is met through the document: Policy 4.107LA.	
Measure the number of calls in the queue at peak times;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 #2	Full	This requirement is met through the document: Policy 4.116LA.	
Measure the length of time callers are on hold;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 #3	Full	This requirement is met through the document: Policy 4.116LA. Call center reports include hold times.	
Measure the total number of calls and average calls handled per day/week/month;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 #4	Full	This requirement is met through the document: Policy 4.116LA. Call center reports provide these statistics.	
Measure the average hours of use per day;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 #5	Full	This requirement is met through the document: Policy 4.116LA. A call status report was provided onsite	
Assess the busiest times and days by number of calls;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 #6	Full	This requirement is met through the document: Policy 4.116LA. A call status report was provided onsite and process explained.	
Record calls to assess whether answered accurately;	4.116LA Call Center Phone Tracking and Reporting Mechanism, Page 1 #7	Full	This requirement is met through the document: Policy 4.116LA. Quality report and scorecard was provided and discussed onsite.	
Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines is not disrupted;	4.107LA Call Center Operations Department Overview - Member Services, Page 1 Paragraph 4	Full	This requirement is met through the document: Policy 4.107LA.	
Provide interactive voice response (IVR) options that	4.107LA Call Center	Full	This requirement is met through the	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
are user-friendly to members and include a decision tree illustrating IVR system; and	Operations Department Overview - Member Services, Member Helpline, Page 2 Paragraph 2		document: Policy 4.107LA.	
Inform the member to dial 911 if there is an emergency.	4.107LA Call Center Operations Department Overview - Member Services, Member Helpline, Page 2 Paragraph 3	Full	This requirement is met through the document: Policy 4.107LA.	
Member Call Center Performance Standards				
Answer ninety- (90%) percent of calls within thirty (30) seconds by a live person or direct the call to an automatic call pickup system with IVR options;	4.115LA Call Standard for Productivity, Page 1 , #1	Full	This requirement is met through the document: Policy 4.115LA. Call center reports show calls answered within the timeframe. However, hold times for callers wishing to speak to a representative exceed 30 seconds. Discussed onsite, answering time was In the 90th percent	
No more than one percent (1%) of incoming calls receive a busy signal;	4.115LA Call Standard for Productivity, Page 1, #2	Full	This requirement is met through the document: Policy 4.115LA. Call center reports meet the requirement.	
Maintain an average hold time (the time a caller spends waiting to speak to a live person, once requested) of three (3) minutes or less;	4.115LA Call Standard for Productivity Page 1 , #3	Full	This requirement is met through the document: Policy 4.115LA. Call center reports meet the requirement.	
Maintain abandoned rate of calls of not more than five (5) percent.	4.115LA Call Standard for Productivity, Page 1, #4	Full	This requirement is met through the document: Policy 4.115LA. Call center reports meet the requirement.	
The DBPM must conduct ongoing quality assurance to ensure these standards are met.	4.115LA Call Standard for Productivity, Page 1 Paragraph 1	Full	This requirement is met through the document: Policy 4.115LA. The plan monitors performance daily and produces monthly roll-ups.	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
If LDH determines that it is necessary to conduct onsite monitoring of the DBPM's member call center functions, the DBPM is responsible for all reasonable costs incurred by LDH or its authorized agent(s) relating to such monitoring.	4.115LA Call Standard for Productivity, Page 1 Paragraph 2	Full	This requirement is met through the document: Policy 4.115LA.	
The DBPM shall have written policies regarding member rights and responsibilities. The DBPM shall comply with all applicable state and federal laws pertaining to member rights and privacy. The DBPM shall further ensure that the DBPM's employees, contractors and DBPM providers consider and respect those rights when providing services to members.	4.100LA Ensuring Member Rights and Responsibilities, Page 1, Paragraph 1	Full	This requirement is met through the document: Policy 4.100LA. Member rights and responsibilities are communicated to the members in the Member Handbook.	
Member Responsibilities				
The DBPM shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate dental, medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	4.100LA Ensuring Member Rights and Responsibilities, Page 1, Bullet 1	Full	This requirement is met through the document: Policy 4.100LA. Member rights and responsibilities are communicated to the members in the Member Handbook.	
The DBPM members' responsibilities shall include but are not limited to:				
Presenting their LDH issued Medicaid ID card when using health care services;	4.100LA Ensuring Member Rights and Responsibilities, Page 2, Bullet 1	Full	This requirement is met through the document: Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Being familiar with the DBPM procedures to the best of the member's abilities;	4.100LA Ensuring Member Rights and Responsibilities, Page 2, Bullet 2	Full	This requirement is met through the document: Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Calling or contacting the DBPM to obtain information and have questions answered;	4.100LA Ensuring Member Rights and	Full	This requirement is met through the document:	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	Responsibilities, Page 2, Bullet 3		Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Providing participating network providers with accurate and complete dental information;	4.100LA Ensuring Member Rights and Responsibilities, Page 2, Bullet 4	Full	This requirement is met through the document: Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;	4.100LA Ensuring Member Rights and Responsibilities, Page 2, Bullet 5	Full	This requirement is met through the document: Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Living healthy lifestyles and avoiding behaviors know to be detrimental to their health;	4.100LA Ensuring Member Rights and Responsibilities, Page 2 , Bullet 6	Full	This requirement is met through the document: Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Following the grievance process established by the DBPM if they have a disagreement with a provider; and	4.100LA Ensuring Member Rights and Responsibilities, Page 2 , Bullet 7	Full	This requirement is met through the document: Policy 4.100LA. The complaints and grievance process is described in the Member Handbook	
Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.	4.100LA Ensuring Member Rights and Responsibilities, Page 2 , Bullet 8	Full	This requirement is met through the document: Policy 4.100LA. Member responsibilities are communicated to the members in the Member Handbook.	
Notice to Members of Provider Termination				
The DBPM shall give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	11.104LA Member Notification of Terminated Providers, Page 1, Paragraph 1	Full	This requirement is met through the document: Policy 11.104LA contains language regarding notification of termination of a provider. Sample letters are provided in the Policy Onsite: sample letters to members reviewed.	
The DBPM shall provide notice to a member, who has	11.104LA Member	Full	This requirement is met through the	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the DBPM becomes aware of such, if it is prior to the change occurring.	Notification of Terminated Providers, Page 1, Paragraph 3		document: Policy 11.104LA contains the required language regarding the notice for prior authorization. Onsite: Sample notices reviewed.	
Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the DBPM becoming aware of the circumstances. The DBPM shall document the date and method of notification of termination.	11.104LA Member Notification of Terminated Providers, , Page 2; #5	Full	This requirement is met through the document: Policy 11.104LA Page 1, paragraph 3. A sample notification was also provided and reviewed onsite.	
Additional Member Educational Materials and Programs				
The DBPM shall prepare and distribute educational materials, not less than two (2) times a year, that provide information on preventive care, health promotion, access to care or other targeted dental related issues.	11.301LA Member Materials, Page 5, Paragraph 3	Full	This requirement is met through the document: Policy 11.301LA. Member newsletters were provided for the review.	
This should include notification to its members of their right to request and obtain the welcome packet at least once a year; and any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date.	11.301LA Member Materials, Page 5, Paragraph 2	Full	This requirement is met through the document: Policy 11.301LA and it is noted in the Member Handbook.	
All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	11.301LA Member Materials, Page 1, Paragraph 2	Full	This requirement is met through the document: Policy 11.301LA meets the requirement and member newsletters were provided for the review. Also discussed onsite.	
Oral and Written Interpretation Services				
The DBPM must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages not just those that Louisiana specifically	4.113LA Toll-Free TTY Procedures and Language Line Service, Page 1, Paragraph 2	Full	This requirement is met through the document: Policy 4.113LA. It is also addressed in the Member Handbook on page 11.	

Member Education				
State Contract Requirements (Federal Regulation: 438.10, 438.100, 438.102, 438.218)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
requires (Spanish and Vietnamese). The member is not to be charged for interpretation services. The DBPM must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.				
The DBPM shall ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language by more than five percent (5%) of the population statewide. Within 90 calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the DBPM and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	11.301LA Member Materials, Page 2, Paragraph 2	Full	This requirement is met through the document: Policy 11.301LA addresses this requirement. Member Handbooks were submitted for review in both English and Spanish. However, no reports showing languages spoken were submitted for review. Request copies of reports used to determine prevalence of spoken languages statewide. An example was provided and discussed onsite. Spanish and Vietnamese, English required. There is a sentence at the bottom of the welcome letters that meets compliance.	
Member Materials				
The DBPM is responsible for providing all written materials in alternative formats and in a manner that considers the special needs of those who, for example, are visually limited or have limited reading proficiency.	11.301LA Member Materials, Page 2, Paragraph 1	Full	This requirement is met through the document: Policy 11.301LA addresses this requirement.	
The DBPM shall include in all member materials the following: the date of issue; the date of revision; and/or if prior versions are obsolete.	11.301LA Member Materials, Page 2, First sentence	Full	This requirement is met through the document: Policy 11.301LA addresses this requirement. Letters were revised and updated. Put a statement at the top that says revised as required by LDH.	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Member Grievance and Appeals Procedures				
Member and State Fair Hearing Procedures - The DBPM must have a grievance system that complies with 42 CFR, Part 438, Subpart F. The DBPM shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws.	13.100LA Grievance and Appeals Department Overview Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview, Policy 13.105LA Formal Grievance Procedure and Policy 13.200LA Utilization Management (UM) Appeals (Member Appeals).	
The DBPM's grievance and appeals procedures and any changes thereto must be approved in writing by LDH prior to their implementation and must include at a minimum the requirements set forth in the RFP.	13.100 LA Grievance and Appeals Department Overview Pg.4 (Reporting to DHH Section, paragraph 1)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 4.	
The DBPM shall refer all DBPM members who are dissatisfied with the DBPM or its subcontractor in any respect to the DBPM's designee authorized to review and respond to grievances and appeals and require corrective action.	4.104LA Complaints Pg.1 (paragraph 3)	Substantial	This requirement is addressed in Policy 4.104LA Complaints page 1, and references referrals to the Grievance and Appeals Department. However, complaints (which, as per policy, are grievances resolved within 24 hours) are handled by Member Services. The plan differentiates complaints (resolved 24 hours) from formal grievances in Policy 4.104LA Complaints. Complaints are described as “an informal component of the grievance system” in “Policy 4.104LA Complaints,” which indicates that complaints are referred to the Grievances and Appeals department if they are not resolved to the member’s satisfaction within 24 hours. Categories of complaints include quality of care and treatment plan complaints. There is no evidence that potentially clinical complaints are systematically referred by member services to appropriate clinical staff for review. MCNA provided Grievance, Appeal and Fair Hearing log reports for review, which reveal	MCNA’s response: Policy 4.104LA was revised to clarify the process of referring Quality of Care (QOC) complaints to the Quality Improvement department for review. As noted in the policy, all complaints are documented in the DentalTrac™ system. If a complaint is not resolved within 24 hours of receipt it becomes a grievance and is escalated to the Grievances and Appeals department for further investigation and resolution. The LDH report does not require for MCNA to differentiate complaints and grievances.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			that complaints are reported to the State in an Excel file on the Grievances tab. They are not differentiated from formal grievances in this document. During file review, there was documentation for at least one complaint that an incident report was submitted to quality, but investigation and resolution are not clear. MCNA provided a training PowerPoint for member services staff that is consistent with the policy, and also indicates that supervisors review complaints for completeness. This training also indicates that Member Services is authorized to review and resolve complaints, but there was no guidance for Member Services regarding referring clinical or quality concerns to appropriate staff for review in submitted documentation. It appears from the documents that complaints are referred if the member is not satisfied with Member Services resolution or the issue cannot be resolved in 24 hours. MCNA submitted a third quarter 2016 QIC committee presentation on QI and Risk Management Analysis for review while onsite. This presentation reveals that there were 15 member complaints audited for quality of care in third quarter 2016. Two of the fifteen complaints were not forwarded to QI as per this presentation. <u>Recommendation</u> The plan should ensure that there are clear procedures for referring grievances (including complaints) involving quality of care issues to appropriate clinical staff, and that there is tracking and oversight of the handling of all grievances (including complaints).	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			In its response to the draft report, MCNA clarified the process for addressing complaints not resolved within 24 hours of receipt. Such complaints become grievances and are escalated to the Grievances and Appeals department for further investigation and resolution. Since the change occurred after the review period, the review determination remains as substantial" and will be re-reviewed during the next compliance audit.	
The member must exhaust the DBPM's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.	13.100LA Grievances and Appeals Department Overview Pg. 2 (State Fair Hearing Section, paragraph 1) 13.301LA State Fair Hearings Pg. 1 (paragraph 2)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 2 and Policy 13.301LA State Fair Hearings page 1. This information is also provided in the MCNA Dental Member Handbook Louisiana Medicaid: Adult Denture Program page 20, and Member Handbook Louisiana: EPSDT Dental Program page 29. This information also appears in the sample Appeal Resolution letter.	
The DBPM shall not create barriers to timely due process. The DBPM shall be subject to sanctions if it is determined by LDH that the DBPM has created barriers to timely due process, and/or, if ten (10) percent or higher of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to: labeling complaints as inquiries and funneled into an informal review; failing to inform members of their due process rights; failing to log and process grievances and appeals; failure to issue a proper notice including vague or illegible notices; failure to inform of continuation of benefits; and failure to inform of right to State Fair Hearing.	13.100LA Grievances and Appeals Department Overview Pg. 4 Liquidated Damages section, (paragraph 1, see bullets 1-6)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 4. This requirement is also addressed in MCNA's Grievance and Appeal Department training PowerPoint Louisiana Medicaid Grievances and Appeals Training. Discussion of the handling of complaints versus grievances was discussed with MCNA staff onsite. Per MCNA, complaints are grievances that are resolved within 24 hours by Member Services. MCNA's policy 13.100 indicates that complaints are an informal part of the grievance process. MCNA Policy 4.104 LA describes the process for complaints, which differs from grievances.	MCNA's response: If the caller's question or concern is resolved on the call or via a call back that same day there is no investigation or follow-up needed. Policy 4.104LA states that all complaints are documented in the DentalTrac™ system. If a complaint is not resolved within 24 hours of receipt it becomes a grievance and is escalated to the Grievances and Appeals department for further investigation and resolution. Complaints are documented, tracked and monitored to ensure they are resolved timely and reported to the LDH on the Fair Hearing Log report and MCNA's

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			MCNA submitted Member Services training that differentiates complaints from inquiries. Members are informed of due process rights per policy and training. Notices are not created for complaints. Complaints are logged and reported to the State as grievances. MCNA submitted reports that include State Fair Hearings. These reports did not reveal reversal of ten percent of grievances. Recommendation MCNA should not consider complaints an informal component of the grievance process. Complaints should be documented, investigated as appropriate, tracked and reported regardless of turnaround time of resolution. In its response to the draft report, MCNA indicated that "If a complaint is not resolved within 24 hours of receipt it becomes a grievance and is escalated to the Grievances and Appeals department for further investigation." Since the regulation is centered around the need to not create barriers to due process and it's clear that MCNA is not creating barriers, the review determination is changed to "full."	Quality Improvement Committee.
General Grievance System Requirements				
Grievance System - The DBPM must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the DBPM's appeal process has been exhausted.	13.100LA Grievances and Appeals Department Overview Pg.2 (State Fair Hearing Section paragraph 1)	Full	MCNA's grievance system is outlined in Policy 13.100LA Grievance and Appeals Department Overview, and includes grievance and appeals processes as well as State Fair Hearing access. Grievance and appeal processes are further detailed in Policy 13.105LA Formal Grievance Procedure and Policy 13.200LA Utilization Management (UM) Appeals (Member Appeals).	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			MCNA's policy 13.100 Grievances and Appeals Department Overview includes language: "Members who choose to seek a State Fair Hearing without pursuing MCNA's process must do so within 30 days of receipt of MCNA's notice of action" in addition to the appropriate language. Recommendation MCNA should ensure consistent language and clarity in policy that members have access to State Fair Hearing once the plan's process has been exhausted.	
Filing Requirements				
Authority to File				
A member, or authorized representative acting on the member's behalf, may file a grievance and a DBPM level appeal, and may request a State Fair Hearing, once the DBPM's appeals process has been exhausted.	13.100LA Grievances and Appeals Department Overview Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 1.	
A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	13.100LA Grievances and Appeals Department Overview Pg.1 (paragraph 1)	Full	Policy 13.100LA Grievance and Appeals Department Overview page 1 addresses this requirement.	
Time Limits for Filing - The member must be allowed thirty (30) calendar days from the date on the DBPM's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	13.100LA Grievances and Appeals Department Overview Pg. 1 (bullet #1) 13.105LA Formal Grievance Procedure Pg.1 (paragraph 1) 13.200LA Member Appeals Pg.1 (paragraph 1& 2)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 1, 13.200LA Member Appeals page 1 and 13.105LA Formal Grievance Procedure page 1.	
Procedures for Filing - The member may file a grievance either orally or in writing with the DBPM. The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the	13.105LA Formal Grievance Procedure Pg. 1 (paragraph 1) 13.200LA Member	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 1, 13.200LA Member Appeals page 1 and 13.105LA Formal Grievance	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
member's written consent, may file an appeal either orally or in writing, and unless he or she orally requests an expedited resolution, and follows up with a written, signed appeal request.	Appeals Pg. 1 (paragraph 2)		Procedure page 1. This requirement is also addressed in MCNA Dental Member Handbook Louisiana Medicaid: Adult Denture Program pages 15-22, and Member Handbook Louisiana: EPSDT Dental Program page 29.the Louisiana Member Handbook EPSDT Dental Program 25-31.	
Notice of Grievance and Appeal Procedures				
The DBPM shall ensure that all DBPM members are informed of the State Fair Hearing process and of the DBPM's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the DBPM shall be available through the DBPM, and must be provided upon request of the member. The DBPM shall make all forms easily available on the DBPM's website.	13.100LA Grievances and Appeals Department Overview Pg1 (bullet #4)) 4.104 Complaints Pg.1 Paragraph 1	Full	These requirements are addressed in Policy 13.100LA Grievance and Appeals Department Overview pages 3-4. These requirements are communicated to members in the MCNA Dental Member Handbook Louisiana Medicaid: Adult Denture Program pages 15-22 and Member Handbook Louisiana: EPSDT Dental Program 25-31.	
Grievance/Appeal Records and Reports				
The DBPM must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	13.103LA Grievance & Appeal File Maintenance Pg. 1 (paragraph 3)	Full	This requirement is addressed in Policy 13.103LA Grievance and Appeal File Maintenance page 1. MCNA provided a complaint log for onsite review, and verified that the log is maintained for required timeframes.	
The DBPM shall electronically provide LDH with a monthly report of the grievances/appeals in accordance with the requirements outlined in the RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.	13.100LA Grievances and Appeals Department Overview Pg.4 (Reporting to DHH section, paragraph 2)	Full	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department overview page 4. As per Policy 4.104LA Complaints, complaints are provided to DHH in a complaint log on request if they do not become grievances. However, onsite staff provided the Q3 2016LA-Verbal Complaints Log, which tracks all complaints that are resolved in 24 hours and includes required elements. The plan includes complaints in the grievances and appeals report to LDH, and provided reports for	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			review onsite.	
The DBPM will be responsible for promptly forwarding any adverse decisions to LDH for further review/action upon request by LDH or the DBPM member. LDH may submit recommendations to the DBPM regarding the merits or suggested resolution of any grievance/appeal.	13.100LA Grievances and Appeals Department Overview Pg.4 (Reporting to DHH section, paragraph 3)	Full	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview page 4.	
Handling of Grievances and Appeals				
General Requirements - In handling grievances and appeals, the DBPM must meet the following requirements:				
Acknowledge receipt of each grievance and appeal in writing;	13.105LA Formal Grievance Procedure Pg.3 (# 3) 13.200LA Member Appeals Pg.5 (#4)	Full	This requirement is addressed in Policy 13.105LA Formal Grievance Procedure page 3 and Policy 13.200LA Member Appeals page 5. During file review, it was noted that 9 out of 10 appeals included a written acknowledgment; the tenth case received a resolution notice within 5 days. Five of six formal grievances received written acknowledgement within 5 days. One verbal complaint that became a grievance was resolved and notice sent within one day of receipt. Verbal complaints are resolved in one day and therefore do not receive acknowledgement letters. Two of the formal grievances originated as complaints.	
Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	13.100LA Grievances and Appeals Department Overview Pg. 4 (Paragraph 2 , Bullets # 1 & 2) 13.105LA Formal Grievance Procedure Pg.2 (paragraph 2) 13.200LA Member Appeals pg.2 (paragraph 3)	Full	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview pages 1-4, Policy 13.105LA Formal Grievance Procedure page 2, Policy 13.200LA Member Appeals page 2 and Policy 13.203LA Expedited Appeals page 2.	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
	13.203LA Expedited Appeal Pg.2 (paragraph 1)			
Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance or appeal regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	13.105LA Formal Grievance Procedure Pg. 3 (Procedure # 6, Bullet 1) 13.200LA Member Appeals Pg.5 (Procedure # 6, Aii & v.) 13.203LA Expedited Appeal Pg.3 (procedure # 6. b&e)	Substantial	This requirement is addressed in Policy 13.105LA Formal Grievance Procedure page 3, Policy 13.200LA Member Appeals pages 5-6, and Policy 13.203LA Expedited Appeal page 4. It does not appear in Policy 4.104LA Complaints that these complaints are reviewed by a clinical reviewer but rather only by Member Services, although noted categories of complaints include incorrect treatment, careless service and disagreement with treatment plan, which should be reviewed by a clinician. 10/10 appeals were conducted by a reviewer who was not involved in the original determination. 2/10 appeals were administratively upheld, and in one case it was not clear whether the case could have benefited from clinical review. 2/2 clinical formal grievances were appropriately reviewed. 1/9 complaints may have involved a clinical issue but was treated as an untimely appeal, and it was not reviewed by a clinician. One of the verbal complaints was referred to Quality for review. Common complaint types reported in Quality Improvement Committee Minutes submitted by the plan include member dissatisfaction with treatment plan, provider, or treatment. Procedures for determining which complaints Member Services should refer to clinical staff for review are not evident in policy or training. Recommendation	MCNA's response: Policy 4.104LA was revised to clarify the process of referring Quality of Care (QOC) complaints to the Quality Improvement department for review and investigation as needed.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			MCNA should establish policy and procedures, with accompanying training, for Member Services to facilitate identification of clinical complaints that should be referred for clinical review. In response to the draft report, MCNA's policy has been revised to clarify that quality of care complaints will be referred to the Quality Improvement Department. Since the change occurred after the review period, the review determination remains as substantial" and will be re-reviewed during the next compliance audit	
Special Requirements for Appeals - The process for appeals must:				
Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing unless the member or the provider requests expedited resolution. The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing No additional member follow-up is required.	13.206LA Oral Appeal Requests Pg. 1 (paragraph 2)	Full	This requirement is addressed in Policy 13.206 Oral Appeal Requests page 1, Policy 13.200LA Member Appeals page 5 and Policy 13.203LA Expedited Appeals p. 1	
Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The DBPM must inform the member of the limited time available for this in the case of expedited resolution).	13.100LA Grievances and Appeals Department Overview Pg. 2 (bullet #3) 13.105LA Formal Grievance Procedure Pg.1 (Paragraph 2, bullet 1) 13.200LA Member Appeals Pg. 2 (paragraph 2,Bullet # 1) 13.203LA Expedited Appeal Pg. 2 (bullet # 1)	Full	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview page 2, Policy 13.200LA Member Appeals page 2, and Policy 13.203LA Expedited Appeal page 2. The limited time available for expedited review is included in the Provider Manual and Member Handbooks. Recommendation The plan should consider adding language to denial letters that informs members of the limited time available for submission of evidence for expedited review.	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including dental records, and any other documents and records considered during the appeals process.	13.100LA Grievances and Appeals Department Overview Pg.2 (Bullet #1) 13.200LA Member Appeals Pg.2 (Bullet #2) 13.203LA Expedited Appeal Pg.2 (Bullet #2)	Full	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview page 2, Policy 13.200LA Member Appeals page 2, and Policy 13.203LA Expedited Appeal page 2.	
Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	13.100LA Grievances and Appeals Department Overview Pg.1 (Bullet #2) 13.200LA Member Appeals Pg.2 (paragraph 1) 13.203LA Expedited Appeal Pg.1 (paragraph 4)	Full	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview page 1, Policy 13.200LA Member Appeals page 2, and Policy 13.203LA Expedited Appeals page 1.	
Training of DBPM Staff - The DBPM's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	13.300 Training and Education-Grievance and Appeals Department Pg. 1 (paragraph1)	Full	This requirement is addressed in Policy 13.300 Training and Education-Grievance and Appeals Department, and evidence by MCNA's submission of the Louisiana Medicaid Grievances and Appeals Training PowerPoint and training sign-in sheets.	
Identification of Appropriate Party - The appropriate individual or body within the DBPM having decision making authority as part of the grievance/appeal procedure shall be identified.	13.105LA Formal Grievance Procedure Pg.4 (Procedure # 8, Bullet # 6 13.200LA Member Appeals Pg.6 (Procedure # 8, Bullet # 6) 13.203LA Expedited Appeal Pg. 5 (Procedure #13, Bullet 6)	Full	This requirement is addressed in the Policy 13.105LA Formal Grievance Procedure page 3-4, Policy 13.200LA Member Appeals pages 5-6, and Policy 13.203LA Expedited Appeal page 4.	
Failure to Make a Timely Decision - Appeals shall be resolved no later than stated time frames and all parties shall be informed of the DBPM's decision. If a	13.200LA Member Appeals Pg. 1 (paragraph 5	Full	This requirement is addressed in Policy 13.200LA Member Appeals page 1-2 and Policy 13.203LA Expedited Appeal page 1.	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
determination is not made in accordance with the timeframes specified in the RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	13.203LA Expedited Appeal Pg.1 (paragraph 4)		During file review, 10/10 appeals files were resolved within timeframes and parties notified.	
Right to State Fair Hearing - The DBPM shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the DBPM's decision in response to an appeal and the process for doing so.	13.200LA Member Appeals Pg. 6 (Procedure # 8, Last Bullet) 13.203LA Expedited Appeal Pg.5 (Procedure #13, Bullet 7)	Substantial	This requirement is addressed in Policy 13.100LA Grievances and Appeals Department Overview page 3, Policy 13.200LA Member Appeals pages 6-7 and Policy 13.203 LA Expedited Appeals p5. Required State Fair Hearing information is included in MCNA Dental Member Handbook Louisiana Medicaid: Adult Denture Program page 19-22, and Member Handbook Louisiana: EPSDT Dental Program page 28-31. File review 9/10 files included notification of the right to a State Fair Hearing. 1/10 files, which was administratively denied for exceeding the 30 day timeframe for submission, did not include the right to a State Fair Hearing in the resolution notice. This file involved a delay in member submission of consent until approximately 2 weeks post the provider's appeal on behalf of the member for a service felt to be medically necessary. Onsite staff indicated that since the MCNA appeal process was not exhausted, since appeal was submitted late and therefore not considered, member was not entitled to a State Fair Hearing. The case summary for this file indicates that "all appeal rights are exhausted due to timeliness of filing. The member's resolution letter indicates that "You have no more appeal rights with MCNA for these services." Therefore, it appears that the member should	MCNA's response: The previously approved LDH Member Appeal Letter of Exhaustion has been revised; the letter now informs members of their right to request a State Fair Hearing.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			have been informed of a State Fair Hearing per policy. Recommendation MCNA should ensure that all members who submit appeals that are denied should be informed of right to State Fair Hearing. In response to the draft report, MCNA's Member Appeal letter has been revised. Since the change occurred after the review period and there was one file review case that did not contain notice of a State Fair Hearing, the review determination remains as substantial."	
Notice of Action				
Language and Format Requirements - The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) to ensure ease of understanding.	3.202 LA Adverse Pg. 1 (paragraph 1) & Pg.2 (paragraph 2)	Full	This requirement is addressed in Policy 3.202LA Adverse Determinations page 2. File review 11/11 reviewed UM files met this requirement.	
Content of Notice of Action - The Notice of Action must explain the following:				
The action the DBPM or its contractor has taken or intends to take;	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #1)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files met this requirement.	
The reasons for the action;	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #2)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files met this requirement. 2/11 files included multiple reasons for the action, all of which may not have been applicable to the case. MCNA explained that	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			this information is not easily extractable from the system. Recommendation MCNA should establish procedures to specifically indicate to the member, and provider filing on their behalf as applicable, the relevant reason for the denial.	
The member's or the provider's right to file an appeal with the DBPM;	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #3)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files met this requirement.	
The member's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #4)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review The member's right to a State Fair Hearing is not included in notice of action but is included in appeal resolution letters. 9/10 appeal files included resolution letters in which State Fair Hearing access was addressed. In 1/10 files, the appeal was not reviewed due to untimely filing, and this resolution letter did not include State Fair Hearing language. Recommendation MCNA should ensure that all members who submit appeals that are denied are informed of the right to State Fair Hearing in resolution letters. In response to the draft report, MCNA's Member Appeal letter has been revised. Since the change occurred after the review period and there was one file review case that did not contain notice of a State Fair	MCNA's response: The previously approved LDH Member Appeal Letter of Untimely Filing has been revised; the letter now informs members of their right to request a State Fair Hearing.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			Hearing, the review determination remains as substantial."	
The procedures for exercising the rights specified in this section;	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #5)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files included this information.	
The circumstances under which expedited resolution is available and how to request it;	3.202 LA Adverse Determinations Pg.2 (paragraph 2,#6)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files included this information.	
The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	3.202 LA Adverse Determinations Pg.2 (paragraph 2, #7)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files included this information.	
Oral interpretation is available for all languages and how to access it.	3.202 LA Adverse Determinations Pg.2 (paragraph 2,#8)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2 and the sample UM Denial Notification letter in Attachment A. File review 11/11 reviewed files included this information.	
Timing of Notice of Action - The DBPM must mail the Notice of Action within the following timeframes:				
For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except when the period of advanced notice is shortened to five days if probable member fraud has been verified by the date of the action for the following:	3.202 LA Adverse Determinations Pg.2 (paragraph 1)	Full	This requirement is addressed in Policy 3.202LA Adverse Determination page 2. File review All applicable files met this requirement.	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
☐ In the death of a member, ☐ A signed member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information), ☐ The member's admission to an institution where he is ineligible for further services, ☐ The member's address is unknown and mail directed to him has no forwarding address, ☐ The member has been accepted for Medicaid services by another local jurisdiction, or ☐ The member's dentist prescribes the change in the level of dental care as permitted under 42 C.F.R. §431.213 and §431.214				
For denial of payment, at the time of any action affecting the claim.	9.301LA Adverse Determination Pg.1 (paragraph 3)	Full	Policy 9.301LA Adverse Determination page 6 and Policy 3.201LA Authorizations. File review All applicable files met this requirement.	
For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: the member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or the DBPM justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.	3.202 LA Adverse Determinations Pg.1 (bullet #2) 3.203 LA Lack of Information Pg.1 (paragraph 1)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determination page1, but does not include "expeditiously as member's health condition requires" Extensions are addressed on page 5 for expedited reviews and on page 2 for standard authorization. The extension requirements are also addressed in Policy 3.203LA Lack of Information page 1 and page 4. Recommendation MCNA should include language that indicates that the Notice of Action is mailed expeditiously as the member's health condition requires in its policy. In response to the draft report, MCNA's Policy has been revised. Since the change occurred after the review period, the review determination remains as	MCNA's response: See pg. 2 of policy 3.202LA. The language has been added.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			substantial."	
If the DBPM extends the timeframe in accordance, it must: give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	3.203 LA Lack of information Pg. 1 (paragraph 4)	Full	This requirement is addressed in Policy 3.203LA Lack of Information page 1-2.	
On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.	3.202 LA Adverse Determinations Pg.2 (paragraph 3)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determinations for untimely services authorization. Notice on the date when the timeframe for the service authorization expires does not appear in policy. Recommendation MCNA should include the requirement for Notice of Action on the date the service authorization expires in policy. In response to the draft report, MCNA's Policy has been revised. Since the change occurred after the review period, the review determination remains as substantial."	MCNA's response: See pg. 2 of policy 3.202LA. The language has been added.
For expedited service authorization decisions where a provider indicates, or the DBPM determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	3.202 LA Adverse Determinations Pg. 5 (Requests for Expedited Review section, paragraph 1)	Substantial	This requirement is addressed in Policy 3.202LA Adverse Determinations page 5. The provision of a notice should be given as expeditiously as a member's health condition requires is not included in policy. File review There were no expedited service authorization requests among reviewed files. Recommendation MCNA should include language that indicates that notice is provided as expeditiously as the	MCNA's response: See pg. 2 of policy 3.202LA. The language has been added.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			member's health condition requires in policy. In response to the draft report, MCNA's Policy has been revised. Since the change occurred after the review period, the review determination remains as substantial."	
The DBPM may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the DBPM justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest. LDH shall conduct random reviews to ensure that members are receiving such notices in a timely manner.	3.202 LA Adverse Determinations Pg. 5 (Requests for Expedited Review section, paragraph 1)	Full	This requirement is addressed in Policy 3.202 LA Adverse Determinations page 5. File review There were no extensions among the files submitted for review.	
Resolution and Notification				
The DBPM must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.				
Specific Timeframes				
Standard Disposition of Grievances - For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the DBPM receives the grievance. This timeframe may be extended under the terms of the RFP.	13.105LA Formal Grievance Procedure Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.105LA Formal Grievance Procedure page 1. File Review 15/15 grievances were resolved within 90 days and parties notified. Notifications were provided verbally for complaints and written for grievances.	
Standard Resolution of Appeals - For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the DBPM receives the appeal.	13.200LA Member Appeals Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.200LA Member Appeals page 1. File review 15/15 standard appeals were resolved within 30 days and parties notified.	
Expedited Resolution of Appeals - For expedited resolution of an appeal and notice to affected parties,	13.200LA Member Appeals Pg.1 (paragraph	Full	This requirement is addressed in Policy 13.200LA Member Appeals page 1 and Policy	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
the timeframe is established as seventy-two (72) hours after the DBPM receives the appeal.	4) 13.203LA Expedited Appeal Pg.1 (paragraph 2)		13.203LA Expedited Appeal page 1. File review 3/3 request for expedited appeal were denied and parties were notified within 72 hours.	
Extension of Timeframes - The DBPM may extend the timeframes of this section by up to fourteen (14) calendar days if: the member requests the extension; or the DBPM shows (to the satisfaction of LDH, upon its request) that there is need for additional information and how the delay is in the member's interest. If the DBPM extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	13.205LA 14-Day Extensions Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.200LA Member Appeals page 2 and Policy 13.205LA 14-Day Extensions. File review There were no files submitted that required extensions.	
Format of Notice of Disposition - Grievances - The DBPM will provide written notice to the member of the disposition of a grievance. Appeals - For all appeals, the DBPM must provide written notice of disposition. For notice of an expedited resolution, the DBPM must also make reasonable efforts to provide oral notice.	13.105LA Formal Grievance Policy Pg.1 (paragraph 1) 13.200LA Member Appeals Pg. 1(paragraph 4) 13.203LA Expedited Appeals Pg.1 (paragraph 2)	Substantial	This requirement is addressed in Policy 13.105LA Formal Grievance Procedure page 3-4, Policy 13.200LA Member Appeals pages 5-6, and Policy 13.203LA Expedited Appeal page 1. File review 6/6 formal grievances received written notices but none of the nine verbal complaints received written notices. 10/10 appeals files included written resolution notices. 3/3 requests for expedited appeal that were denied included evidence of verbal communication of denial of expedited review within 72 hours. Recommendation The plan should ensure that all members who file grievances, including those filing verbal complaints, receive written notice of disposition. In response to the draft report, MCNA described its policy of documenting complaints and escalating when appropriate.	MCNA's response: Complaints Policy 4.104LA states that all complaints are documented in the DentalTrac™ system. If a complaint is not resolved within 24 hours of receipt it becomes a grievance and is escalated to the Grievances and Appeals department for further investigation and resolution. Notices of acknowledgement and disposition are provided for grievances in accordance with policy 13.105LA.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			Nevertheless, MCNA should establish a policy for notifying member's who lodge verbal complaints. The review determination remains as substantial."	
Content of Notice of Appeal Resolution - The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the DBPM's action.	13.200LA Member Appeals Pg. 6 (#8, bullets 2 & 8)	Substantial	This requirement is addressed in Policy 13.200LA Member Appeals pages 5-6. File review 9/10 files included all required elements in the resolution notice. One administratively denied appeal did not include notification regarding State Fair Hearing. The appeal was not considered due to untimely submission, and the plan determined that therefore MCNA's appeal process was not exhausted. The case summary indicates that the appeal process was exhausted and the resolution letter indicated that the member had no further appeal rights with MCNA. Recommendation The plan should ensure that all members whose submitted appeals are denied receive written notice of right to State Fair Hearing. In response to the draft report, MCNA's Member Appeal Letter has been revised. Since the change occurred after the review period, the review determination remains as substantial."	MCNA's response: The previously approved LDH Member Appeal Letter of Untimely Filing has been revised; the letter now informs members of their right to request a State Fair Hearing.
Requirements for State Fair Hearings - The DBPM shall comply with all requirements of 42 CFR §431.200(b), §431.220(5) and 42 CFR §438.414 and §438.10(g)(1). The DBPM shall comply with all requirements as outlined in the RFP.				
Availability - If the member has exhausted the DBPM	13.301LA State Fair	Full	This requirement is addressed in Policy	

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the DBPM's notice of resolution.	Hearing Pg.1 (paragraph 2)		13.200LA Member Appeals Attachment C Appeal Resolution Letter and Policy 13.301LA State Fair Hearings page 1.	
Parties - The parties to the State Fair Hearing include the DBPM as well as the member and his or her representative or the representative of a deceased member's estate.	13.301LA State Fair Hearing Pg.1 (paragraph 2)	Full	This requirement is addressed in Policy 13.301LA State Fair Hearings page 1.	
Expedited Resolution of Appeals				
The DBPM must establish and maintain an expedited review process for appeals, when the DBPM determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	13.203LA Expedited Appeals Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.203LA Expedited Appeals page 1 and Policy 13.200LA Member Appeals page 1.	
Prohibition Against Punitive Action - The DBPM must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	13.203LA Expedited Appeals Pg.1 (paragraph 5)	Full	This requirement is addressed in Policy 13.200LA Member Appeals page 2 and Policy 13.203 Expedited Appeals page1.	
Action Following Denial of a Request for Expedited Resolution - If the DBPM denies a request for expedited resolution of an appeal, it must: transfer the appeal to the timeframe for standard resolution in accordance with the prescribed timeframes; make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	13.203LA Expedited Appeals Pg.4 (#8) & Pg. 1 (paragraph 3)	Substantial	This requirement is addressed in Policy 13.203 Expedited Appeals page 1 and page 4. File review There were 3 of 10 files that were requests for expedited appeal resolution; all three were denied, transferred to standard and verbally informed. One file did not include a written follow up letter that addressed denial of expedited appeal. MCNA followed up on this case with the reviewer. Recommendation MCNA should continue to monitor to ensure that members whose request for expedited appeal is denied receive written notice.	MCNA response: MCNA agrees with this finding.

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			In response to the draft report, MCNA stated that they agree with the recommendation. The review determination remains as "substantial."	
Failure to Make a Timely Decision - Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the DBPM's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	13.200LA Member Appeals Pg. 1-2 (last paragraph)	Full	This requirement is addressed in Policy 13.200LA Member Appeals page 2. File review None of the 10 files that were reviewed exceeded resolution timeframes.	
Process - The DBPM is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Appeals filed orally must be followed up in writing. No additional follow-up may be required. The DBPM shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	13.203LA Expedited Appeal Pg. 2 (1st bullet)	Full	This requirement is addressed in Policy 13.203LA Expedited Appeal page 2 and 5. Members or providers acting on their behalf who request expedited appeal are informed verbally of 72 hour timeframe available for resolution. File review This information was not evident in letters of acknowledgement or denial letters for the 3 files that were requests for expedited appeals. Recommendation The plan should inform members of limited time to present evidence in the case of expedited resolution in denial letters and acknowledgment letters if applicable.	
Authority to File - The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	13.203LA Expedited Appeal Pg. 1 (paragraph 2)	Full	This requirement is addressed in Policy 13.203LA Expedited Appeal page1.	
Format of Resolution Notice - In addition to written notice, the DBPM must also make reasonable effort to provide oral notice.	13.203LA Expedited Appeal Pg. 5 (Procedure #12)	Full	This requirement is addressed in Policy 13.203LA Expedited Appeal page1 and 5. File review All 3 reviewed expedited appeal requests received verbal notice.	
Continuation of Benefits				

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the DBPM mailing the notice of action; or the intended effective date of the DBPM's proposed action.	13.209LA Continuation of Services Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.209LA Continuation of Services page 1.	
Continuation of Benefits - The DBPM must continue the member's benefits if: the member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of benefits.	13.209LA Continuation of Services Pg.1 (paragraph 1)	Full	This requirement is addressed in Policy 13.209LA Continuation of Services page 1.	
Duration of Continued or Reinstated Benefits - If, at the member's request, the DBPM continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: the member withdraws the appeal; ten (10) calendar days pass after the DBPM mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; a State Fair Hearing Officer issues a hearing decision adverse to the member; the time period or service limits of a previously authorized service has been met.	13.209LA Continuation of Services Pg.1 (paragraph 2)	Full	This requirement is addressed in Policy 13.209LA Continuation of Services page 1.	
Member Responsibility for Services Furnished While the Appeal is Pending - If the final resolution of the appeal is adverse to the member, that is, upholds the DBPM's action, the DBPM may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 CFR §431.230(b).	13.209LA Continuation of Services Pg.1 (paragraph 3)	Full	This requirement is addressed in Policy 13.209LA Continuation of Services page 1.	
Information to Providers and Contractors				

Member Grievances and Appeals				
State Contract Requirements (Federal Regulation: 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
The DBPM must provide the information at 42 CFR §438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	13.100 Grievance and Appeals Department Overview Pg.3 (paragraph 3)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 4. It is also addressed in the Provider Manual pages 62-66 and MCNA Dental Provider Agreement and Louisiana Medicaid Product Attachment.	
Recordkeeping and Reporting Requirements				
Reports of grievances and resolutions shall be submitted to LDH as specified in the RFP. The DBPM shall not modify the grievance procedure without the prior written approval of LDH.	13.100LA Grievance and Appeals Department Overview Pg.4 (paragraph 1)	Full	This requirement is addressed in Policy 13.100LA Grievance and Appeals Department Overview page 4 and evidenced by MCNA's submitted Grievance and Appeals monthly reports for August 2015-September 2016.	
Effectuation of Reversed Appeal Resolutions				
Services not Furnished While the Appeal is Pending - If the DBPM or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBPM must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	13.209LA Continuation of Services Pg.2 (paragraph 1)	Full	This requirement is addressed in Policy 13.209LA Continuation of Services page 2.	
Services Furnished While the Appeal is Pending - If the DBPM or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the DBPM must pay for those services, in accordance with this Contract.	13.209LA Continuation of Services Pg.2 (paragraph 2)	Full	This requirement is addressed in Policy 13.209LA Continuation of Services page 2.	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Quality Assessment and Performance Improvement Program (QAPI)				
The DBPM shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program to:				
Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	2.103LA QAPI Pg. 2 (paragraph 3)	Full	MCNA has a comprehensive QAPI program in place to evaluate and improve quality of care for its members	
Incorporate improvement strategies that include, but are not limited to: performance improvement projects; dental record audits; performance measures; and surveys;	2.103LA QAPI Pg. 2 (paragraph 3)	Full	MCNA conducts performance improvement projects, member surveys, provider surveys, performance measures and record audits to help identify areas for improvement and has provided evidence of each activity QIC record audit tools were reviewed onsite.	
Detect underutilization and overutilization of services;	2.103LA QAPI Pg. 6 (Section IV. Bullet # 16)	Full	MCNA has a policy stating that it conducts analyses to detect over and under utilization of services (2.103, p 6). Provider profiling reports were provided as documentation.	
Assess the quality and appropriateness of care furnished to enrollees with special health care needs.	2.103LA QAPI Pg. 9 (Bullet #9)	Full	MCNA has a policy stating that it assesses the quality and appropriateness of care furnished to enrollees with special health care needs (2.103, p 9). Onsite, it was explained and the Performance Improvement project results are broken out by subgroups, including by race, ethnicity and language. IPRO, as the state's EQRO, reviews the reports. Results are presented to the Quality Improvement Committee to address any disparity of care issues.	
The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	2.103LA QAPI Pg. 2 (Paragraph 3)	Full	MCNA has a comprehensive policy describing its Quality Improvement program (Policy 2.103 LA QAPI)	
The QAPI Program shall define and implement	2.103LA QAPI Pg.2	Full	Policy 2.103 makes provision for processes to	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	(paragraph 3)		enhance clinical efficiency. To support this effort, MCNA's program includes PIPs that are designed to enhance clinical and non-clinical efficiency and high-risk and high-volume areas of patient care receive priority in the selection of quality assessment and performance improvement activities.	
The DBPM shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed.	2.103LA QAPI Pg.2 (paragraph 2)	Full	MCNA's policy dictates that it will submit its QAPI program to DHH within 30 days of the date of the contract, which was prior to the review period.	
The DBPM's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the DBPM's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the DBPM.	2.103LA QAPI Pg.4 (paragraph 2)	Full	The implementation, maintenance, and support of MCNA's QI Program falls under the authority of MCNA's Board of Directors. The CDO, as a member of the Board of Directors, maintains accountability for the overall function of the QI Program and serves as the chairperson of the QIC. (Policy 2.103, p4)	
QAPI Committee				
The DBPM shall form a QAPI Committee that shall, at a minimum include:	2.103LA QAPI Pg.8 (paragraph 2)	Full	MCNA's Quality Improvement Committee has the authority to promote organizational accountability in identifying, assessing, and correcting quality of care issues, as well as in improving dental care services. Provider and organizational participation is essential in accomplishing these tasks. The committee meets quarterly. Agendas and minutes were provided for the review period.	
The DBPM Dental Director must serve as either the chairman or co-chairman;	2.103LA QAPI Pg.8 (QIC Membership, Bullets 7-17)	Full	The QAPI committee is Chaired by the CDO as stated in Policy 2.1903, p.7. Meeting minutes confirm this requirement	
Appropriate DBPM staff representing the various departments of the organization will have membership on the committee; and	2.103LA QAPI Pg.8 (QIC Membership, Bullets 7-18)	Full	The QAPI committee is represented by diverse staff as stated in Policy 2.1903, p.7. Meeting minutes confirm this requirement	
The DBPM is encouraged to include a member advocate representative on the QAPI Committee.	2.103LA QAPI Pg.8 (paragraph 2)	Substantial	While Policy 2.103 includes this requirement, it was indicated onsite that MCNA does not have a member advocate who serves on the committee.	MCNA's response: MCNA is not required by contract to include member representation in its QAPI. As such, MCNA will edit policy 2.103 to remove member representation

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			Recommendation: MCNA should attempt to recruit a member or member advocate familiar with Medicaid Managed Care to serve on the QAPI Committee. In its response to the draft report, MCNA indicated correctly that it is not required to include a member advocate in its QAPI committee and indicated it would revise its policy to that effect. As such, the review determination is revised to "Substantial" since during the review period, MCNA's current policy was in effect and that policy required a member advocate. However, it is recommended that MCNA reconsider its decision to remove the requirement from policy and recruit a member to participate in its QAPI committee since the member's perspective can be highly informative and may help MCNA improve quality of care	from the list of committee participants.
QAPI Committee Responsibilities				
The committee shall:				
Meet on a quarterly basis;	2.103LA QAPI Pg. 8 (Quality Improvement Committee, paragraph 1)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Direct and review quality improvement (QI) activities;	2.103LA QAPI Pg. 9 (QIC Main Functions, bullet #6)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Assure than QAPI activities are implemented throughout the DBPM;	2.103LA QAPI Pg. 9 (QIC Main Functions, bullet #5)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Review and suggest new and or improved QI activities;	2.103LA QAPI Pg. 9 (QIC Main Functions, bullet #6)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	2.103LA QAPI Pg. 8 (QIC Main Functions, bullet #1)	Full	Requirement is stated in Policy 2.103. Onsite, it was explained that special task forces are not convened but MCNA uses its Dental Advisory Committee, which meets quarterly, to review provider availability and	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			over/under utilization issues. An example was provided onsite that related to the underutilization of Dental Sealants, which resulted in an initiative to improve the use of Dental Sealants in the Medicaid population. This use of the Advisory Committee meets this requirement.	
Designate evaluation and study design procedures;	2.103LA QAPI Pg.9 (bullet #18)	Full	The progress of PIPs are discussed during the committee meetings	
Conduct individual primary care dentist and primary care dentist practice quality performance measure profiling;	2.103LA QAPI Pg.9 (bullet #26)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Report findings to appropriate executive authority, staff, and departments within the DBPM;	2.103LA QAPI Pg.9 (bullet #27)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Direct and analyze periodic reviews of members' service utilization patterns;	2.103LA QAPI Pg.9 (bullet #10)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103	
Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH with other quarterly reports;	2.103LA QAPI Pg.9 (paragraph 1)	Full	Confirmed by QAPI meeting minutes and stated in Policy 2.103. Meeting minutes are prepared. Onsite, it was confirmed that minutes are shared with LDH	
Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management activities; and	2.103LA QAPI Pg.15 (Section XIII. Bullet #1	Full	Requirement is stated in Policy 2.103 but review evidence onsite Onsite, it was determined that the report was submitted to LDH on March 30, 2016	
Ensure that a QAPI committee designee attends DHH Quality Committee meetings.	2.103LA QAPI Pg.8 (Quality Improvement Committee, paragraph 1)	N/A	Requirement is stated in Policy 2.103 but MCNA was unaware of that there attendance was required. Recommendation: MCNA should coordinate with LDH to determine if the plan can benefit from attending either by phone or in person the state's quality meetings. The meetings' agenda may help determine whether a representative from MCNA should attend. There may be opportunity for MCNA to	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			collaborate with the mainstream plans on a performance improvement project where improving dental coverage is an objective, e.g., enhancing preventive care for pregnant members	
QAPI Work Plan				
The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the DBPM and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:	2.103LA QAPI Pg.2 (paragraph 2) 2.700LA QI Reporting Requirements Pg. 3 (*Attachment A, Other Reports,* Procedure #1)	Full	Requirement is stated in Policy 2.103. Onsite, it was confirmed that the QAPI was submitted to the state at the time of contracting and annually thereafter.	
Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	2.700LA Quality Improvement Reporting Requirements Pg. 3 (*Attachment A, Other Reports,* Procedure #1.a.)	Full	As stated in Policy 2.700 Quality Improvement Reporting requirements (p3)	
Include processes to evaluate the impact and effectiveness of the QAPI Program;	2.700LA Quality Improvement Reporting Requirements Pg. 4 (*Attachment A, Other Reports,* Procedure #1.b.)	Full	As stated in Policy 2.700 Quality Improvement Reporting requirements (p4). Performance measures are reported.	
Include a description of the DBPM staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and	2.700LA Quality Improvement Reporting Requirements Pg. 4 (*Attachment A, Other Reports,* Procedure #1.c.)	Full	Policy 2.700 includes a description of the staff assigned to the QAPI program	
Describe the role of its providers in giving input to the QAPI Program.	2.700LA Quality Improvement Reporting Requirements Pg.4 (*Attachment A, Other Reports,* Procedure #1.d.)	Full	Policy 2.700 Quality Improvement Reporting requirements (p4) describes the role of providers	
QAPI Reporting Requirements				
The DBPM shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Evaluation of the impact and effectiveness of the QAPI program. DHH	2.700LA Quality Improvement Reporting Requirements Pg.3 (*Attachment A, Annually,* Procedure #4, Bullet #1-	Full	Stated in policy 2.700. Onsite, it was confirmed that the QAPI reports are sent to LDH annually, as required.	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
reserves the right to request additional reports as deemed necessary. DHH will notify the DBPM of additional required reports no less than sixty (60) days prior to due date of those reports.	3): pg.1 (paragraph 1)			
Performance Measures				
The DBPM shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by DHH.	2.701LA Performance Measures Pg.1 (paragraph 2)	Full	PM measures are collected and reported. Reports were submitted to document PM collection.	
The DBPM shall report on PMs listed in Appendix N which include, but are not limited to, Agency for Healthcare Research and Quality Review (AHRQ) measures, Dental Quality Alliance (DQA) measures, and/or other measures as determined by DHH. Appendix N PMs: - Percentage of EPSDT members (enrolled for at least 90 consecutive days) receiving one annual dental preventive service - Percentage of EPSDT members (enrolled for at least 90 consecutive days), age 6-9 years, receiving one or more sealants on permanent molar teeth.	2.701LA Performance Measures Pg.2 (procedure #1); Pg.6 Attachment C	Full	PM measures are collected and reported. Reports were submitted to document PM collection and a report was provided onsite indicating that the two required EPSDT measures were submitted to LDH in January, 2016 for reporting year 2015.	
The DBPM shall have processes in place to monitor and report all performance measures.	2.701LA Performance Measures Pg.2 (procedure #12)	Full	Policy 2.701 describes the procedures to collect PMs	
Clinical PM outcomes shall be submitted to DHH at least annually and upon DHH request. Detailed data shall be made available to support any summary report of Clinical outcomes QIPIs.	2.701LA Performance Measures Pg.1 (paragraph 2)	Full	PM measures are reported annually and reports were reviewed.	
Administrative PMs shall be submitted to DHH at least quarterly and upon DHH request. Detailed data shall be made available to support any summary report of Administrative QIPIs.	2.701LA Performance Measures Pg.1 (paragraph 2)	Full	PM measures are reported quarterly and reports were reviewed.	
The reports and data shall demonstrate adherence to clinical practice guidelines and shall demonstrate changes in patient outcomes.	2.701LA Performance Measures Pg.1 (paragraph 1)	Full	Clinical PMs are reported annually and reports were submitted for reviewed	
Performance measures may be used to create PIPs which are the DBPM's activities to design, implement and sustain systematic improvements based on their own data.	2.701LA Performance Measures Pg.1 (paragraph 1)	Full	Performance measures are included in MCNA's PIPs to track progress over time.	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
Performance Measures Reporting				
All Administrative PMs are reporting measures. • Administrative measure reporting is required at least quarterly and upon DHH request. • Clinical Performance measures shall be reported at least annually and upon DHH request, 12 months after services begin.	2.701LA Performance Measures Pg. 1 (paragraph 2) 2.701LA Performance Measures Pg.2 (procedure #1)	Full	Administrative PMs are reported quarterly and clinical PMs are reported annually and reports were submitted for review.	
DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.				
Performance Measure Goals				
The Department shall establish benchmarks for Performance Measures utilizing statewide data of the Medicaid Fee for Service Population from 2013 with the expectation that performance improves by a certain percentage toward the benchmarks.				
The Performance Measure Goals are contained in Appendix N. Appendix N PM Goals: - Percentage of EPSDT members (enrolled for at least 90 consecutive days) receiving one annual dental preventive service Baseline - 47.60% Contract Year 1 - 52.6% Contract Year 2 – 54.6% Contract Year 3 – 55% - Percentage of EPSDT members (enrolled for at least 90 consecutive days), age 6-9 years, receiving one or more sealants on permanent molar teeth. Baseline – 14.31% Contract Year 1 – 16.31% Contract Year 2 – 18.31% Contract Year 3 – 20.31%				
At the department's discretion after the initial contract year, a maximum of 2.5% (0.5% for each of 5 specific performance measures) of the total monthly capitation payment may be deducted from the total capitation payment to be made in the month of October following	N/A Contract Provision	N/A	Deduction is at the discretion of LDH	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.				
Performance Indicator Reporting Systems				
The DBPM shall utilize DHH-approved systems, operations, and performance monitoring tools and/or automated methods for monitoring. Access to such systems and tools shall be granted to DHH as needed for oversight.	2.701LA Performance Measures Pg.1 (paragraph 1)	Full	The use of LDH-approved systems is stated in 2.701LA Performance Measures (p1)	
The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	2.701LA Performance Measures Pg.1 (paragraph 1)	Full	Requirement is stated in 2.701LA Performance Measures (p1)	
The DBPM shall have processes in place to monitor and self-report performance measures including but not limited to measures listed in Appendix F. Appendix F: Administrative PM Set - Percent of practices that provide daily, 24 hour verified phone access with ability to speak to a dental care provider (minimal performance standard ≥95%) - Percent of standard service authorizations processed within 2 business days (minimal performance standard ≥80%) - Percent of standard service authorizations processed within 14 calendar days or as extended within allowable timeframes (minimal performance standard 100%) - Percent of expedited service authorizations processed within 72 hours (minimal performance standard 100%) - Rejected claims returned to provider with reason code within 15 days of receipt of claims submission (minimal performance standard ≥99%) - Percent of call center calls answered by a live person within 30 seconds of selection, or zero out (minimal performance standard ≥90%)	2.701LA Performance Measures Pg.2 (procedure #4 & Attachment A)	Full	Cited PMs are reported and reports were submitted for review	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
- Call center call average hold time for live person (minimal performance standard 3 minutes) - Call center call abandonment rate (minimal performance standard ≤5% - Percent of grievances and request for appeals received by the DBP including grievances received via telephone and resolved within the timeframe of the contract (minimal performance standard ≥95%) - Percent of clean claims paid for each provider type within 15 business days (minimal performance standard ≥90%) - Percent of clean claims paid for each provider type within 30 calendar days (minimal performance standard ≥99%)				
The DBPM shall provide individual primary care dentist clinical quality profile reports.	2.203LA Provider Profiling Pg.1 (paragraph 1)	Full	Individual reports are collected and samples were provided for review	
Performance Measure Monitoring				
DHH will monitor the DBPM's performance using Benchmark Performance and Improvement Performance data.				
During the course of the Contract, DHH or its designee shall communicate with the DBPM regarding the data and reports received as well as meet with representatives of the DBPM to review the results of performance measures.	2.701LA Performance Measures Pg.1 (paragraph 3)	Full	Requirement is stated in Policy 2.701 LA Performance Measures (p1)	
The DBPM shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual dental audits to ensure that it provides quality and accessible health care to DBPM members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual dental records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the	2.213LA Collaboration with EQRO Pg.1 (paragraph2)	Full	MCNA has collaborated with the EQRO in conducting PIPs and in the compliance review process.	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
reasons for member disenrollment.				
The standards by which the DBPM shall be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the DBPM must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the DBPM's progress in correcting the deficiencies.	2.213LA Collaboration with EQRO Pg.1 (paragraph 2)	Full	MCNA has complied with past compliance audits conducted by the EQRO, including addressing any findings from prior compliance audits that required correction.	
Performance Measure Corrective Action Plan				
A corrective action plan (CAP) shall be required for performance measures that do not reach the Department's performance benchmark.	2.701LA Performance Measures Pg.3 (procedure #5)	N/A	Requirement is stated in Policy 2.701. Onsite it was confirmed that MCNA was not subject to any CAPS during the review period.	
The DBPM shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.	2.701LA Performance Measures Pg.3 (procedure #5)	N/A	Requirement is stated in Policy 2.701. Onsite it was confirmed that MCNA was not subject to any CAPS during the review period.	
Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the DBPM shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.	2.701LA Performance Measures Pg.3 (procedure #6)	N/A	Requirement is stated in Policy 2.701. Onsite it was confirmed that MCNA was not subject to any CAPS during the review period.	
Upon approval of the CAP, whether the initial CAP or the revised CAP, the DBPM shall implement the CAP within the time frames specified by DHH.	2.701LA Performance Measures Pg.3 (procedure #7)	N/A	Requirement is stated in Policy 2.701. Onsite it was confirmed that MCNA was not subject to any CAPS during the review period.	
DHH may impose monetary penalties, and sanctions pending attainment of acceptable quality of care.				
Annual Member Satisfaction Surveys				
The DBPM shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year.	N/A	Full	MCNA has a policy in place to conduct CAHPs (4.102). Onsite, it was explained that since CAHPS is not relevant to MCNA, which is a dental plan, LDH required MCNA to conduct its own developed member survey in place of CAHPS. ..	
Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	N/A	N/A	The member survey report (Excel document) does not include a description of the survey process. Recommendation: In addition to providing	MCNA's response: MCNA reports in accordance with LDH requirements using Report LA 132. Policy 4.102 outlines the survey process. Additionally, member satisfaction

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			LDH with the survey's quantitative results, MCNA should prepare a brief report indicating the sampling process, the mode of administration and number of mailings, response rates and a summary of findings, perhaps trending results from year to year. Ideally, any area where performance is lacking should be identified and strategies to improve should be developed and reported. In its response to the draft report, MCNA indicated that it uses Report LA 132 to document its survey proves, in line with current LDJH requirements. As such, the review determination has been revised to N/A. Recommendation: It's unclear from the slide that was provided if there is a narrative report that is prepared for internal use. It might be helpful for MCNA to prepare a survey report that includes methodology used, sampling process, response rate and breaks out the survey results by region or parish. Such a report can be used to identify trends (e.g., a fall off in response rates) and help direct improvement efforts to those areas of the state where satisfaction may be lower than other areas.	survey results are trended over time and reported to the QIC. Please see attached slide from the most recent report. This information is shared with LDH on quarterly basis.
The survey shall be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey.	N/A	N/A	It's unclear from the documentation how the sample was selected. In its response to the draft report, MCNA indicated that it uses Report LA 132 to document its survey proves, in line with current LDJH requirements. As such, the review determination has been revised to N/A.	MCNA's response: MCNA reports in accordance with LDH requirements using LA 132. Please see policy 4.102
The surveys shall provide valid and reliable data for results statewide and by parish.	N/A	N/A	Survey results were presented in the aggregate but not by parish. In its response to the draft report, MCNA	MCNA response: Since the inception of the contract, MCNA has been reporting our Member Satisfaction Survey statewide results and

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
			indicated that it uses Report LA 132 to document its survey proves, in line with current LDJH requirements. As such, the review determination has been revised to N/A.	analysis using template LA 132. MCNA has not received any feedback from LDH in regards to reporting by parish.
Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	N/A	Full	While state or national benchmarks may not exist, MCNA should trend survey internal results from year to year. In its response to the draft report, MCNA indicated and documented that it rends results quarterly. State or national benchmarks do not exist since the survey has been developed internally. The review determination has been revised to full.	MCNA's response: There are no state or national benchmarks available. MCNA does trend its survey results quarterly year over year as noted in the slide attached from the most recent QIC. Additionally, our analysis is reported to LDH annually. The report and analysis is being submitted with this response.
The most current CAHPS DBPM Survey (currently 4.0) for Medicaid Enrollees shall be used and include:	N/A	N/A	MCNA has a policy in place to conduct CAHPs (4.102) but is not required to report CAHPs.	
Getting Needed Care	N/A	Full	Getting Care Needed in a Timely Manner is a survey question.	
Getting Care Quickly	N/A	Full	Getting an appointment in a timely manner is a survey question.	
How Well Doctors Communicate	N/A	Full	Whether the dentist staff spoke the member's language is a survey question.	
DBPM Customer Service	N/A	Full	Satisfaction with MCNA's member services staff is a survey question.	
Global Ratings	N/A	Full	Overall level of satisfaction is a survey question.	
Member Satisfaction Survey Reports are due 120 days after the end of the contract year.	N/A	Full	MCNA submits survey results to LDH annually.	
Provider Satisfaction Surveys				
The DBPM shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes.	5.111LA Provider Satisfaction Survey Pg.1 (paragraph 1)	Full	A provider survey was administered during the review period and a report was provided.	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	5.111LA Provider Satisfaction Survey Pg.1 (paragraph1)	Full	Onsite it was confirmed that an email exchange between MCNA and LDH was used to solicit the approval of LDH.	
The DBPM shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.	5.111LA Provider Satisfaction Survey Pg.1 (paragraph 2)	Full	A provider survey was administered during the review period and a report was provided. The report provided the results by item and onsite it was explained that the results are submitted to the QIC Provider Relations subcommittee to drive improvement	
DHH Oversight of Quality				
DHH shall evaluate the DBPM's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract.				
If DHH determines that the DBPM's quality performance is not acceptable, the DBPM must submit a corrective action plan (CAP) for each unacceptable performance measure. If the DBPM fails to provide a CAP within the time specified, DHH will sanction the DBPM in accordance with the provisions of sanctions set forth in the Contract.	2.103LA QAPI Pg.15 (Section XIII. bullet #1)	N/A	MCNA was not subject to any CAPs during the review period.	
Upon any indication that the DBPM's quality performance is not acceptable, DHH may impose sanctions or terminate the contract.	2.103LA QAPI Pg.15 (Section XIII. bullet #1)	N/A	There was no indication that MCNA's performance was unacceptable during the review period.	
The DBPM shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.	2.103LA QAPI Pg.15 (Section IX. paragraph 1)	Full	MCNA has fully cooperated regarding the current compliance audit conducted by the EQRO.	
Credentialing and Re-credentialing of Providers and Clinical Staff				
The DBPM must have a written credentialing and re-credentialing process for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. (An independent relationship exists when the DBPM selects and directs it members to see a specific provider or group of providers.)	6.100 MCNA Credentialing Department Program Description & Supporting Credentialing Policies and Procedures Pg.1 (paragraph 4)	Full	MCNA has a policy, 6.100 Credentialing Department Program Description & Supporting Credentialing Policies and Procedures that describes its credentialing procedures.	

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.	6.100 MCNA Credentialing Department Program Description Pg.1 (paragraph 4)	Full	The procedures are updated, as appropriate, annually.	
The process for periodic re-credentialing shall be implemented at least once every thirty-six (36) months. The process for credentialing shall be completed within Sixty (60) days."	6.100 MCNA Credentialing Department Program Description Pg.7 (paragraph 1) 8&9) 6.401 Re-credentialing Pg.1 (paragraph 1)	Full	The required timeframes are reflected in Policy 6.100 (p7) and Policy 6.401 (p1)	
If the DBPM has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The DBPM must require that the subcontractor provide assurance that all licensed dental professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the delegated entity.	6.512 Delegation of Initial and Re-Credentialing Activities Pg.1 (paragraph 1, paragraph 2 bullet #5).	Full	As stated in Policy 6.512, The delegate is required to provide assurance that all licensed dental professional are credentialed in accordance with the state agency's credentialing requirements.	
The DBPM shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	6.100 MCNA Credentialing Department Program Description Pg.5-6(last paragraph bullet #4) 6.201 Credentialing Committee Pg.2 (Procedures 5,6 &11) 6.203 Provider Termination & Suspension Process Pg.1 (paragraph 1&2)	Full	MCNA has policies in place for approval of new providers and termination or suspension of providers. However, there is no provision for encouraging providers to seek Board Certification. Recommendation: MCNA should encourage providers, when appropriate, to seek Board Certification during the contracting process or at follow-up site visits conducted by the Dental Medical Director. The benefits of Board Certification should be included in the Provider Manual or in a Provider bulletin. In its response to the draft report, Policy 6.100 was referred to and, upon review, a statement is made that "MCNA encourages its dental care professionals to obtain board certification." The statement also appears in the Provider Manual. (p16). The review determination is revised to "Full."	MCNA's response: Refer to policy 6.100 Provider Credentialing Program Description, Section 3 Organizational Structure and Credential Committee on page 3 as evidence of encouraging providers, when appropriate, to seek Board Certification. Additionally, Section 5.3 of the Provider Manual statement regarding encouraging providers to become Board Certified. This statement meets the requirement.

Quality Management				
State Contract Requirements (Federal Regulation: 438.214, 438.240)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Response and Plan of Action**
The DBPM shall develop and implement a mechanism, with DHH's approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	6.702 Adverse Action Report Pg.1 (paragraph 2)	Full	MCNA reports quality deficiencies in its Adverse Action Report; Policy 6.702 was submitted for review.	
The DBPM shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the DBPM against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	6.203 Provider Termination & Suspension Pg.1 (paragraph 1) 6.204 Level I Provider Appeals Pg.1 (paragraph 1) 6.205 Level II Provider Appeals Pg.1 (paragraph 1) 2.209LA Peer Review Program Pg.1 (paragraph 1)	Full	MCNA has provider dispute and appeal process policies in place (6.204 Level I Provider Appeals and 6.205 Level II Provider Appeals)	

Reporting				
State Contract Requirements (Federal Regulation: 438.242)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Reporting				
The DBPM shall comply with all the reporting requirements established by the Contract. As per 42 CFR 438.242(a)(b)(1)(2) and (3), the DBPM shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals. The DBPM shall collect data on member and provider characteristics and on services furnished to members.	12.600LA Reporting Requirements, page 1 paragraph 1	Full	This requirement is met through the document 12.600LA Reporting Requirements page 1, paragraph 1.	
The DBPM shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by LDH and at no cost to LDH. Any changes to the formats must be approved by LDH prior to implementation.	12.600LA Reporting Requirements, page 1 paragraph 2	Full	This requirement is met through the document 12.600LA Reporting Requirements page 1, paragraph 2.	
The DBPM shall provide LDH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed, but no later than prior to the Readiness Review.	12.600LA Reporting Requirements, page 1 paragraph 2	Full	This requirement is met through the document 12.600LA Reporting Requirements page 1, paragraph 2.	
In the event that there are no instances to report, the DBPM shall submit a report so stating.	12.600LA Reporting Requirements, page 3 procedure 4	Full	This requirement is met through the document 12.600LA Reporting Requirements on page3, procedure 4.	
As required by 42 CFR 438.604(a) and (b), and 42 CFR 438.606, the DBPM shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, financial reports, encounter data, and other information as specified within the Contract and the RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The DBPM must submit the certification concurrently with the certified data and documents. LDH will identify specific data that requires certification.	12.600LA Reporting Requirements, page 1, Certification of Reports, Para 1	Full	This requirement is met through the document 12.600LA Reporting Requirements page 1, paragraph 3.	
The data shall be certified by one of the following: •DBPM's Chief Executive Officer (CEO); or •An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.	12.600LA Reporting Requirements, page 1, Certification of Reports, paragraph 1	Full	This requirement is met through the document 12.600LA Reporting Requirements page 1, paragraph 3.	

Reporting				
State Contract Requirements (Federal Regulation: 438.242)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
The MCO shall comply with all court-ordered reporting requirements currently including but not limited to the Wells v. Kliebert and Chisholm v. Kliebert cases in the manner determined by LDH.	7.901 Page 1, Para 1	Full	This requirement is met through the document 7.901 Reporting Requirements page 1, paragraph 1.	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
General Requirements				
The DBPM and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR §438.1-438.812 and La. R.S. 46:437.1-437.14; and LAC 50.I.4101-4235.				
The DBPM shall meet with LDH and the Attorney General's Medicaid Fraud Control Unit (MFCU), periodically, at LDH's request, to discuss fraud, abuse, neglect and overpayment issues. For purposes of this Section, the DBPM's compliance officer shall be the point of contact for the DBPM.	2016-2017 Fraud, Waste, and Abuse Program, pg. 23 Component #13; paragraph 1	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 23 Component #13; paragraph 1	
The DBPM shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, the United States Department of Health and Human Services HHS, the United States and/or Louisiana's Legislative Auditor's Office, the United States and/or Louisiana's Office of the Attorney General, the United States, General Accountability Office (GAO), Comptroller General of the United States, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.	2016-2017 Fraud, Waste, and Abuse Program, pg. 23-24 Component #13; paragraphs 1, 2, and 3	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 23-24 Component #13; paragraphs 1, 2, and 3	
The DBPM and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. Each federal and state agency shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and	2016-2017 Fraud, Waste, and Abuse Program, pg. 23-24 Component #13; paragraphs 1, 2, and 3	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 23-24 Component #13; paragraphs 1, 2, and 3	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
transcriptions, contact and conduct private interviews with DBPM clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The DBPM shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.				
DBPM's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	2016-2017 Fraud, Waste, and Abuse Program, pg. 20	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 20	
The DBPM and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals filed by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of the DBPM's grievance procedures, in compliance with 42 CFR §§ 438.226-438.228.	13.100LA Grievance and Appeals Department Overview, pg. 4 "Reporting to LDH," paragraph 3	Full	This requirement is met through the document: 13.100LA Grievance and Appeals Department Overview, pg. 4 "Reporting to LDH," paragraph 3	
The DBPM shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The DBPM shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and LDH policy.	2016-2017 Fraud, Waste, and Abuse Program, pg. 24 Component #13; paragraph 1	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program	
The DBPM shall report to LDH, within three (3) business days, when it is discovered that any DBPM employees, network provider, contractor, or contractor's employees have been excluded, suspended, or debarred from any state or federal healthcare benefit program through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219 or LDH prior approved method.	2016-2017 Fraud, Waste, and Abuse Program, pg. 24 Component #14; paragraph 2 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 2 "Ongoing Monitoring" paragraph 1	Full	This requirement is met through the documents: 2016-2017 Fraud, Waste, and Abuse Program, pg. 24 Component #14; paragraph 2 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 2 "Ongoing Monitoring" paragraph 1 2016-2017 Compliance Program, pg. 16 "Disclosure Requirements"	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	2016-2017 Compliance Program, pg. 16 "Disclosure Requirements"			
The DBPM shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The DBPM shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	2016-2017 Fraud, Waste, and Abuse Program, pg. 5 "Company's Commitment"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 5 "Company's Commitment"	
The DBPM, as well as its subcontractors and providers, whether contract or non-contact, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified I 42 CFR Part 455, Subpart B and Louisiana Medicaid Policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	6.100 Provider Credentialing Program Description, pg. 2-3; paragraphs 23 1.105LA Ownership and Management Disclosure, pg. 1; paragraphs 1 and 2	Full	This requirement is met through the documents: 6.100 Provider Credentialing Program Description, pg. 2-3; paragraphs 23 And 1.105LA Ownership and Management Disclosure, pg. 1; paragraphs 1 and 2	
The DBPM, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the DBPM dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg.1 paragraphs 1 and 2 6.309 Medicare/ Medicaid Sanctions, pg. 1; paragraph 2	Full	This requirement is met through the document: 6.309 Medicare/ Medicaid Sanctions, pg. 1; paragraph 2 And 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg.1 paragraphs 1 and 2	
The DBPM is prohibited from taking any actions to recoup or withhold improperly paid funds already paid	2016-2017 Fraud, Waste, and Abuse Program,	Full	This requirement is met through the document:	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria: 1. The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or 2. The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or 3. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	pg. 24 Component #3		2016-2017 Fraud, Waste, and Abuse Program, pg. 19 Component #3	
This prohibition described above in Section III.D.1.L of the contract shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the DBPM obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the DBPM will return the funds to LDH.	2016-2017 Fraud, Waste, and Abuse Program, pg. 24 Component #3	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 19 Component #3	
The DBPM shall comply with all federal and state requirements regarding fraud waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.	2016-2017 Fraud, Waste, and Abuse Program, pg. 20			
Reporting and Investigating Suspected Fraud and Abuse				
The DBPM shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.	2016-2017 Fraud, Waste, and Abuse Program, Pg. 20 "Reporting and Investigating Suspected Fraud and Abuse"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Pg. 20 "Reporting and Investigating Suspected Fraud and Abuse"	
The DBPM shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
The DBPM shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the DBPM shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.	2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	
The DBPM shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows: **a)** All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to LDH and MFCU; **b)** Suspected fraud and abuse in the administration of the program shall be reported to LDH and MFCU; **c)** All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH and MFCU; and **d)** All confirmed or suspected enrollee fraud and abuse shall be reported immediately to LDH and local law enforcement.	2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	
The DBPM shall utilize a Fraud Reporting Form deem satisfactory by the agency to whom the report is to be made under the terms of this Contract.	2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	
The DBPM shall be subject to a civil penalty, to be imposed by LDH, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to LDH MFCU, as appropriate.	2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Pg. 21 "Reporting and Investigating Suspected Fraud and Abuse"	
The DBPM shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting	2016-2017 Fraud, Waste, and Abuse Program, "Preliminary and Full Investigations" pg. 13	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, "Preliminary and Full Investigations" pg. 13	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the DBPM shall not take any of the following actions as they specifically relate to Medicaid claims: a) Contact the subject of investigation about any matters related to the investigation b) Enter into or attempt to negotiate any settlement or agreement regarding the incident, or c) Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.				
The DBPM shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that receives the report.	2016-2017 Fraud, Waste, and Abuse Program, "Preliminary and Full Investigations" pg. 13	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, "Preliminary and Full Investigations" pg. 13	
The DBPM shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview DBPM employees and consultants, including but not limited to those with expertise in the administration of the program and/or dental questions or in any matter related to an investigation.	2016-2017 Fraud, Waste, and Abuse Program, pg. 24; paragraph 3	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 24; paragraph 3	
The State shall not transfer its law enforcement functions to the DPBM.	2016-2017 Fraud, Waste, and Abuse Program, pg. 6 Special Investigations Unit	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 6 Special Investigations Unit	
The DBPM, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and dental records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under	2016-2017 Fraud, Waste, and Abuse Program, Component #13, pg. 24; paragraph 3	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #13, pg. 24; paragraph 4	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.				
The DBPM and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section III.D of the DBPM Contract.	2016-2017 Fraud, Waste, and Abuse Program, Component #13, pg. 24 10.502LA Provider Contract Agreements, pg. 2	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #13, pg. 24 And 10.502LA Provider Contract Agreements, pg. 2	
The DBPM shall notify LDH when the DBPM denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	6.301 Initial Credentialing Application, pg. 5; Procedure 12.c.	Full	This requirement is met through the document: 6.301 Initial Credentialing Application, pg. 5; Procedure 12.c.	
Except as described in Section III.D of the DBPM Contract, nothing herein shall require the DBPM to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.	6.309 Medicare/ Medicaid Sanctions, pg. 1; paragraph 2	Full	This requirement is met through the document: 6.309 Medicare/ Medicaid Sanctions, pg. 1; paragraph 2	
In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the DBPM shall report overpayments made by LDH to the DBPM as well as overpayments made by the DBPM to a provider and/or subcontractor.	9.109 Recoupment of Overpayments, pg. 2	Full	This requirement is partially met through the document: 9.109 Recoupment of Overpayments, pg. 2 The MCO should add the required language to the policy. This policy provided is for the state of FL, not Louisiana. In response to the draft report, MCNA provided the policy document with reference to Louisiana highlighted. Review determination has been revised to "full."	MCNA's response: Policy 9.109 pg. 2 contains the contract language. The policy is a corporate policy which means it applies to multiple lines of business. Please see the header of the policy where we indicate that the policy applies to Louisiana.
Fraud and Abuse Compliance Plan				
In accordance with 42 CFR §438.608(a), the DBPM shall have a compliance program that includes	2016-2017 Fraud, Waste, and Abuse Program, pg. 3	Full	This requirement is met through the document:	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.			2016-2017 Fraud, Waste, and Abuse Program, pg. 3 Also pg. 14 under payment documents Pg.16 under Resolution Pg. 19 #5	
In accordance with 42 CFR §438.608(b)(2), the DBPM shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the DBPM's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The DBPM shall have an adequately staffed Medicaid compliance office with oversight by the compliance officer.	2016-2017 Compliance Program, pg. 5	Full	This requirement is met through the document: 2016-2017 Compliance Program, pg. 5	
The DBPM shall submit the Fraud and Abuse Compliance Plan within thirty (30) calendar days from the date the Contract is signed with the DBPM, but no later than thirty (30) calendar days prior to the Readiness Review. The DBPM shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of making them effective. LDH, at its sole discretion, may require that the DBPM modify its compliance plan. The DBPM compliance program shall incorporate the policy and procedures specified in Appendix U – Coordination of DBP Fraud and Abuse Complaints and Referrals and shall incorporate the following:	2016-2017 Fraud, Waste, and Abuse Program, pg. 4 2016-2017 Fraud, Waste, and Abuse Program, Component #12, pg. 23	Full	This requirement is met through the documents: 2016-2017 Fraud, Waste, and Abuse Program, pg. 4 2016-2017 Fraud, Waste, and Abuse Program, Component #12, pg. 23	
Written policies, procedures, and standards of conduct that articulate DBPM's commitment to comply with all applicable federal and state standards;	2016-2017 Compliance Program, Component #2; pg. 7	Full	This requirement is met through the document: 2016-2017 Compliance Program, Component #2; pg. 7	
Effective lines of communication between the compliance officer and the DBPM's employees, providers and contractors enforced through well-publicized disciplinary guidelines;	2016-2017 Compliance Program, Component #5 and 6; pg. 8-9 2016-2017 Fraud, Waste, and Abuse Program,	Full	This requirement is met through the documents: 2016-2017 Compliance Program, Component #5 and 6; pg. 8-9 2016-2017 Fraud, Waste, and Abuse Program,	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	Component #15; pg. 25		Component #15; pg. 25	
Procedures for ongoing monitoring and auditing of DBPM systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;	2016-2017 Compliance Program, Component #3; pg. 7 2016-2017 Fraud, Waste, and Abuse Program, pg. 5	Full	This requirement is met through the document: 2016-2017 Compliance Program, Component #3; pg. 7 And 2016-2017 Fraud, Waste, and Abuse Program, pg. 5	
Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;	2016-2017 Compliance Program, Compliance Hotline; paragraph 1 2016-2017 Fraud, Waste, and Abuse Program, pg. 10	Full	This requirement is met through the documents: 2016-2017 Compliance Program, Compliance Hotline; paragraph 1 2016-2017 Fraud, Waste, and Abuse Program, pg. 10	
Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR Part 438.608(b)(4-6);	2016-2017 Fraud, Waste, and Abuse Program, pg. 5	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, pg. 5	
Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the DBPM. The DBPM shall ensure that the identity of individuals reporting violations of the compliance plan shall be held in confidence to the utmost extent possible. Anyone who believes that he or she has been retaliated against may report this violation to the Louisiana Medicaid Office of Program Integrity and/or the U.S. Office of Inspector General;	2016-2017 Fraud, Waste, and Abuse Program, Component#11; pg. 23 2016-2017 Compliance Program, pg. 15	Full	This requirement is met through the documents: 2016-2017 Fraud, Waste, and Abuse Program, Component#11; pg. 23 And 2016-2017 Compliance Program, pg. 15	
Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR Part 438.608(b)(7);	2016-2017 Compliance Program, pg. 10	Full	This requirement is met through the document: 2016-2017 Compliance Program, pg. 10	
Well-publicized disciplinary procedures that shall apply to employees who violate the DBPM's compliance program;	2016-2017 Compliance Program, Component #5; pg. 8 2016-2017 Fraud, Waste, and Abuse Program,	Full	This requirement is met through the documents: 2016-2017 Compliance Program, Component #5; pg. 8 And 2016-2017 Fraud, Waste, and Abuse	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	Component#10; pg. 23		Program, Component#10; pg. 23	
Effective training and education for the compliance officer, managers, employees, providers and members to ensure that they know and understand the provisions of DBPM's compliance plan;	2016-2017 Fraud, Waste, and Abuse Program, Component#8; pg. 21-22 2016-2017 Compliance Program, Component #4; pg. 8 7.101a Compliance and Fraud, Waste and Abuse Program – Employee Education and Training, pg. 1; paragraphs 1 and 2	Full	This requirement is met through the documents: 2016-2017 Compliance Program, Component #4; pg. 8 7.101a Compliance and Fraud, Waste and Abuse Program – Employee Education and Training, pg. 1; paragraphs 1 and 2 And 2016-2017 Fraud, Waste, and Abuse Program, Component#8; pg. 21-22	
Fraud, waste and abuse training shall include, but not be limited to: **a.** Annual training of all employees; and **b.** New hire training within thirty (30) days of beginning date of employment;	2016-2017 Compliance Program, Component #4; pg. 8 2016-2017 Fraud, Waste, and Abuse Program, Component#8; pg. 22 7.101a Compliance and Fraud, Waste and Abuse Program – Employee Education and Training, pg. 1; paragraphs 1 and 2	Full	This requirement is met through the document: 2016-2017 Compliance Program, Component #4; pg. 8 2016-2017 Fraud, Waste, and Abuse Program, Component#8; pg. 22 And 7.101a Compliance and Fraud, Waste and Abuse Program – Employee Education and Training, pg. 1; paragraphs 1 and 2	
Procedures for timely consistent exchange of information and collaboration with the LDH Program Integrity Unit;	2016-2017 Fraud, Waste, and Abuse Program, Component#13; pg. 23	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component#13; pg. 23	
Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments; and	2016-2017 Compliance Program, Obligation to Comply with Applicable Laws; pg. 4	Full	This requirement is met through the document: 2016-2017 Compliance Program, Obligation to Comply with Applicable Laws; pg. 4	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: a. MCO Code of Conduct Training; b. Privacy and Security – Health Insurance Portability and Accountability Act; c. Fraud, waste and abuse; d. Procedures for timely consistent exchange of information and collaboration with LDH; and e. Provisions that comply with 42 CFR §438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.	7.101a Compliance and Fraud, Waste and Abuse Program – Employee Education and Training, New Employee Education #1; pg. 2 2016-2017 Compliance Program, Code of Ethical Conduct; pg. 10 7.101b Employee Privacy Awareness Training and Education - HIPAA Requirements; pg. 1 2016-2017 Fraud, Waste, and Abuse Program, Component#8; pg. 22 2016-2017 Compliance Program, Obligation to Comply with Applicable Laws; pg. 4	Full	This requirement is met through the documents: 7.101a Compliance and Fraud, Waste and Abuse Program – Employee Education and Training, New Employee Education #1; pg. 2, pg.19 2016-2017 Compliance Program, Code of Ethical Conduct; pg. 10 7.101b Employee Privacy Awareness Training and Education - HIPAA Requirements; pg. 1 2016-2017 Fraud, Waste, and Abuse Program, Component#8; pg. 22 And 2016-2017 Compliance Program, Obligation to Comply with Applicable Laws; pg. 4	
Prohibited Affiliations				
In accordance with 42CFR §438.610, the DBPM is prohibited from knowingly having a relationship with: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM); pg1; paragraph 1 2016-2017 Compliance Program, Code 14; pg. 16 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	Full	This requirement is met through the documents: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM); pg1; paragraph 1 2016-2017 Compliance Program, Code 14; pg. 16 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	
The DBPM shall comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. The DBPM shall screen all employees and contractors to determine whether they have been excluded from participation in	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM); Prospective Employee, pg.	Full	This requirement is met through the document: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM); Prospective Employee, pg. 2	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the DBPM shall search the following websites to comply with requirements set forth at 42 CFR §455.436: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) • Healthcare Integrity and Protection Data Bank •Louisiana Exclusion Database (LED); •The System of Award Management (SAM); and •Other applicable sites as may be determined by LDH.	2			
The DBPM shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to LDH within three (3) business days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 1; paragraph 2 2016-2017 Compliance Program, Code 15; pg. 17 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	Full	This requirement is met through the documents: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 1; paragraph 2 2016-2017 Compliance Program, Code 15; pg. 17 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	
An individual who is an affiliate of a person described above and include: • A director, officer, or partner of the DBPM; • A person with beneficial ownership of 5 percent or more of the DBPM's equity; or • A person with an employment, consulting or other arrangement with the DBPM for the provision of items and services which are significant and material to the DBPM's obligations.	2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24-25 2016-2017 Compliance Program, Code 14; pg. 16	Full	This requirement is met through the documents: 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24-25 And 2016-2017 Compliance Program, Code 14; pg. 16	
The DBPM shall notify LDH within three (3) business	16.202 Review of Office of	Full	This requirement is met through the	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
days of the time it receives notice that action is being taken against the DBPM or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	Inspector General (OIG) and Systems for Award Management (SAM), pg. 1; paragraph 2 2016-2017 Compliance Program, Code 15; pg. 17 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24		documents: 2016-2017 Compliance Program, Code 15; pg. 17 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24 And 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 1; paragraph 2	
Excluded Providers				
Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency dental services. The DBPM is responsible for the return of any money paid for services provided by an excluded provider.	2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	
Reporting				
In accordance with 42 CFR § 455.1(a)(1) and §455.17, the DBPM shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the State Office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s). Additionally, the DBPM shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the DBPM or DBPM employee, network providers contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the DBPM or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 1; paragraph 2 2016-2017 Fraud, Waste, and Abuse Program, Component#14; pg. 24	Full	This requirement is met through the 2016-2017 Fraud, Waste, and Abuse Program, page 19	
The DBPM, through its compliance officer, shall report all activities on a quarterly basis to LDH. If fraud, abuse, waste, neglect and overpayment issues are suspected, the DBPM compliance officer shall report it to LDH immediately upon discovery. Reporting shall include,	2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
but are not limited to:				
Number of complaints of fraud, abuse, waste, neglect and overpayments made to the DBPM that warrant preliminary investigation (defined at 42 CFR §455.14);	2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	
Number of complaints reported to the Compliance Officer; and	2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	
For each complaint that warrants investigation (defined at 42 CFR §455.15 and §455.16), the DBPM shall provide LDH, at a minimum, the following: • Name and ID number of provider and member involved if available; • Source of complaint; • Type of provider; • Nature of complaint; • Approximate dollars involved if applicable; and • Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.	2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #6; pg. 21	
The DBPM, through its compliance officer, shall attest monthly to LDH that a search of the websites referenced in Section III.D.4 of the DBPM contract has been completed to capture all exclusions.	2016-2017 Fraud, Waste, and Abuse Program, Component #14; pg. 24	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #14; pg. 24	
Dental Records				
The DBPM shall have a method to verify that services for which reimbursement was made, was provided to members. The DBPM shall have policies and procedures to maintain, or require DBPM providers and contractors to maintain, an individual dental record for each member. The DBPM shall ensure the dental record is:	2.108LA Dental Record Review, pg.1; paragraph 1	Full	This requirement is met through the document: 2.108LA Dental Record Review, pg.1; paragraph 1	
Accurate and legible;	2.108LA Dental Record Review, pg.1; paragraph 2	Full	This requirement is met through the document: 2.108LA Dental Record Review, pg.1; paragraph 2	
Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all	2.108LA Dental Record Review, pg.1; paragraph 2	Full	This requirement is met through the document:	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
members evaluated or treated, and is accessible for review and audit; and			2.108LA Dental Record Review, pg.1; paragraph 2	
Readily available for review and provides dental and other clinical data required for Quality and Utilization Management review.	2.108LA Dental Record Review, pg.1; paragraph 2	Full	This requirement is met through the document: 2.108LA Dental Record Review, pg.1; paragraph 2	
The DBPM shall ensure the dental record includes, minimally, the following:				
Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	2.108LA Dental Record Review, Attachment B; #1	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #1	
Primary language spoken by the member and any translation needs of the member;	2.108LA Dental Record Review, Attachment B; #2	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #2	
Services provided through the DBPM, date of service, service site, and name of service provider;	2.108LA Dental Record Review, Attachment B; #3	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #3	
Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the DBPM;	2.108 LA Dental Record Review, Attachment B; #4	Full	This requirement is met through the document: 2.108 LA Dental Record Review, Attachment B; #4	
Referrals including follow-up and outcome of referrals;	2.108LA Dental Record Review, Attachment B; #5	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #5	
Documentation of emergency and/or after-hours encounters and follow-up;	2.108LA Dental Record Review, Attachment B; #6	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #6	
Signed and dated consent forms (as applicable);	2.108LA Dental Record Review, Attachment B; #7	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #7	
Documentation of advance directives, as appropriate; and	2.108LA Dental Record Review, Attachment B; #	Full	This requirement is met through the document:	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
	8		2.108LA Dental Record Review, Attachment B; # 8	
Documentation of each visit, which must include: • Date and begin and end times of service; • Chief complaint or purpose of the visit; • Diagnoses or dental impression; • Objective findings; • Patient assessment findings; • Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); • Medications prescribed; • Health education provided; • Name and credentials of the provider rendering services (e.g. DDS) and the signature or initials of the provider; and • Initials of providers must be identified with correlating signatures.	2.108LA Dental Record Review, Attachment B; #9-17	Full	This requirement is met through the document: 2.108LA Dental Record Review, Attachment B; #9-17	
The DBPM must provide one (1) free copy per calendar year of any part of member's record upon member's request.	2.108LA Dental Record Review; Reporting, pg. 2	Full	This requirement is met through the document: 2.108LA Dental Record Review; Reporting, pg. 2	
All documentation and/or records maintained by the DBPM or any and all of its network providers shall be maintained for at least six (6) years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	2.108LA Dental Record Review; Record Retention, pg. 2	Full	This requirement is met through the document: 2.108LA Dental Record Review; Record Retention, pg. 2	
Rights of Review and Recovery by DBPM and LDH				
The DBPM is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the DBPM subcontracts to outside entities.	2016-2017 Fraud, Waste, and Abuse Program, Component #1; pg. 10	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #1; pg. 10	
The DBPM has the exclusive right of review and recovery for twelve (12) months from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment, by delivering notice to the	9.200LA Complex Claims Review, pg. 1 paragraph 1 9.200LA Complex Claims Review, pg.2	Full	This requirement is met through the document: 9.200LA Complex Claims Review, pg. 1 paragraph 1	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
provider in writing of initiation of such a review. No such notice shall be required in instances resulting from suspected fraud, which the DBPM has identified and referred to the Department, the Medicaid Fraud Control Unit, or other appropriate law enforcement agency. A "complex" review is one for which a review of medical, financial and/or other records is necessary to determine the existence of a mispayment.			And 9.200LA Complex Claims Review, pg.2	
The DBPM shall complete its review and notify the provider of the results of such review within sixty (60) days of the date of receipt of documentation from the provider, not to exceed one hundred and twenty (120) days of the date of the notice to the provider. The DBPM shall notify the Department, on at least a quarterly basis, the results of reviews as well as instances of suspected fraud.	9.200LA Complex Claims Review, Procedure #6; pg. 2 9.200LA Complex Claims Review, pg.1; paragraph 2	Full	This requirement is met through the document: 9.200LA Complex Claims Review, Procedure #6; pg. 2 And 9.200LA Complex Claims Review, pg.1; paragraph 2	
The DBPM shall not retain the exclusive right of review and/or recovery beyond twelve (12) months from the original date of service of a claim for a "complex" review, but the DBPM may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Such audits must be communicated to the Department at least quarterly.	9.200LA Complex Claims Review, pg.1; paragraph 2	Full	This requirement is met through the document: 9.200LA Complex Claims Review, pg.1; paragraph 2	
If the DBPM does not initiate action with respect to a "complex" claim review within the twelve (12) month-period from the date of service of the claim, the Department or its agent may recover from the provider any overpayment which they identify and said recovered funds will be returned to the State.	9.200LA Complex Claims Review, pg.1; paragraph 3	Full	This requirement is met through the document: 9.200LA Complex Claims Review, pg.1; paragraph 3	
The DBPM shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies mispayments as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine the existence of a mispayment. No additional documentation is required to be submitted from the provider to determine the existence of an overpayment.	9.200LA Complex Claims Review, pg.2 9.200LA Complex Claims Review, pg. 1; paragraph 2	Full	This requirement is met through the document: 9.200LA Complex Claims Review, pg.2 9.200LA Complex Claims Review, pg. 1; paragraph 2	
LDH must notify the DBPM of an identified mispayment from a "complex" or "automated" review prior to	9.200LA Complex Claims Review, pg.1; paragraph 3	Full	This requirement is met through the document:	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
notifying any providers. The DBPM shall have thirty (30) calendar days from the date of notification of potential mispayments to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.			9.200LA Complex Claims Review, pg.1; paragraph 3	
The DBPM shall not correct the claims nor initiate an audit on the claims upon notification by the Department or its agent.	9.200LA Complex Claims Review, pg.1; paragraph 3	Full	This requirement is met through the document: 9.200LA Complex Claims Review, pg.1; paragraph 3	
In the event the provider does not refund overpayments identified by the Department or its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment, the Department or its agent will notify the DBPM and the DBPM shall initiate a payment withhold on the provider in the amount due to the Department. The MCO shall collect and refund the overpayment to the Department	9.200LA Complex Claims Review, pg.1; paragraph 4	Full	This requirement is met through the document: 9.200LA Complex Claims Review, pg.1; paragraph 4	
Staffing Requirements/Qualifications				
For the purposes of this RFP, the DBPM shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The DBPM must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal healthcare programs. The HHS-OIG website, which can be searched by the names of any individual, can be accessed at the following URL: http://www.oig.hhs.gov/fraud/exclusions.asp	2016-2017 Fraud, Waste, and Abuse Program, Component #14; pg. 24	Full	This requirement is met through the document: 2016-2017 Fraud, Waste, and Abuse Program, Component #14; pg. 24	
The DBPM shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and	16.207 Background Checks, pg. 1	Full	This requirement is met through the document: 16.207 Background Checks, pg. 1	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
recipients. It shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.				
Annually, the DBPM must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key personnel. LDH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 4	Substantial	This requirement is partially met through the document: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 4 In response to the draft report, MCNA revised the policy to include the required language. The MCO should add "date of birth" to the policy. Since the change was made after the review period, the review determination remains as "substantial."	MCNA's response: Policy 16.202 pg. 4 has been revised to add "date of birth"
Provider Network Requirements				
Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal healthcare programs under either section 1128 or section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded healthcare programs. The list of providers excluded from federally funded healthcare programs can be found at http://exclusions.oig.hhs.gov/search.aspx and the Systems for Award Management at https://www.sam.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.	10.502LA Provider Contract Requirements, pg. 1; paragraph 1 10.300LA Provider Network Development Program Description, pg. 8	Full	This requirement is met through the document: 10.502LA Provider Contract Requirements, pg. 1; paragraph 1 10.300LA Provider Network Development Program Description, pg. 8 P&P 10.300LA is found in the Provider Network folder.	
The DBPM shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from	6.309 Medicare/ Medicaid Sanctions; pg. 1	Full	This requirement is met through the document: 6.309 Medicare/ Medicaid Sanctions; pg. 1	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
participation in the Medicaid and/or Medicare program. The DBPM shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.				
Utilization Requirements				
The DBPM shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The DBPM shall not pay any claim submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).	9.103LA Timely Processing of Clean Claims, pg. 2	Full	This requirement is met through the document: 9.103LA Timely Processing of Clean Claims, pg. 2 And through the 2016-2017 Fraud Waste and Abuse Program	
The DBPM shall report fraud and abuse information identified through the UM program to LDH's Program Integrity Unit in accordance with 42 CFR 455.1(a)(1).	3.602LA Monitoring Over and Under Utilization, pg. 1; paragraph 1	Full	This requirement is met through the document: 3.602LA Monitoring Over and Under Utilization, pg. 1; paragraph 1	
Claims Management				
Provider Validation – Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted.	9.100 Claims Adjudication Overview, pg.4; paragraph 1	Full	This requirement is met through the document: 9.100 Claims Adjudication Overview, pg.4; paragraph 1	
Within three (3) business days, results indicating that paid services may not have been received, shall be referred to the DBPM's fraud and abuse department for review and to LDH through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219.	2016-2017 Fraud, Waste, and Abuse Program; Component #5, pg. 19-20	Full	This requirement is met through the document: 2016-2017 Fraud, Waste and Abuse Program, page 24.	
Reporting Requirements				
Ownership Disclosure - Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR 455.100-455.106). The Medicaid Ownership and Disclosure Form is to be submitted to LDH with the proposal; then resubmitted prior to implementation for each Contract period or when any change in the	1.105LA Ownership and Management Disclosure; pg.1; paragraph 1	Full	This requirement is met through the document: 1.105LA Ownership and Management Disclosure; pg.1; paragraph 1	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
DBPM's management, ownership or control occurs. The DBPM shall report any changes in ownership and disclosure information to LDH within thirty (30) calendar days prior to the effective date of the change.				
Information Related to Business Transactions - 1. The DBPM shall furnish to LDH or to the HHS, information related to significant business transactions as set forth in 42 CFR 455.105. Failure to comply with this requirement may result in termination of this Contract. 2. The DBPM shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about: a) The ownership of any subcontractor with whom the DBPM has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and b) Any significant business transactions between the DBPM and any wholly owned supplier or between the DBPM and any subcontractor, during the five (5) year period ending on the date of this request. 3. For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (five percent) percent of the DBPM's total operating expenses whichever is greater.	14.105LA Business Transactions; pg.1; paragraph 1 and pg. 2	Full	This requirement is met through the document: 14.105LA Business Transactions; pg.1; and pg. 2	
Report of Transactions with Parties in Interest - The DBPM shall report to LDH all "transactions" with a "party of interest" as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B), as required by Section 1903(m)(4)(A) of the Social Security Act. Federally qualified plans are exempt from this requirement. LDH may require that the information on business transactions be accompanied by a consolidated financial statement for the DBPM and the party in interest. If the DBPM has operated previously in the commercial	14.105LA Business Transactions; pg.1, paragraph 2 14.105LA Business Transactions; pg.1, paragraph 3 14.105LA Business Transactions; pg.1, paragraph 4 14.105LA Business Transactions; pg.1, paragraph 5	Full	This requirement is met through the document: 14.105LA Business Transactions; pg.1, paragraph 2 14.105LA Business Transactions; pg.1, paragraph 3 14.105LA Business Transactions; pg.1, paragraph 4 14.105LA Business Transactions; pg.1, paragraph 5	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the DBPM's business transactions must be reported. If the contract is renewed or extended, the DBPM must disclose information on business transactions which occurred during the prior contract period.				
Information on Persons Convicted of Crimes - The DBPM shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR 455.106. Failure to comply with this requirement may lead to termination of this Contract.	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), Reporting Persons Convicted of a Criminal Offense pg. 3	Full	This requirement is met through the document: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), Reporting Persons Convicted of a Criminal Offense pg. 3	
Additional Terms and Conditions				
The DBPM agrees to comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the DBPM must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal healthcare programs. To help make this determination, the DBPM may search the following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE http://exclusions.oig.hhs.gov/search.aspx; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp and/or the Excluded Parties List Serve (EPLS) www.EPLS.gov.	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 2 6.309 Medicare- Medicaid Sanctions, pg. 1; paragraph 3	Full	This requirement is partially met through the documents: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM), pg. 2 6.309 Medicare- Medicaid Sanctions, pg. 1; paragraph 3	
The DBPM shall conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be reported to LDH within three (3) business days. Any individual or entity that employs or subcontracts with an excluded provider	16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM); pg. 1 and 2	Full	This requirement is met through the documents: 16.202 Review of Office of Inspector General (OIG) and Systems for Award Management (SAM); pg. 1 and 2	

Fraud, Waste and Abuse				
State Contract Requirements (Federal Regulation: 438.210, 438.236, 438.404)	**PAHP Documentation**	**Review Determination**	**IPRO Comments**	**PAHP Report and Plan of Action**
cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).	6.309 Medicare- Medicaid Sanctions, pg. 2		6.309 Medicare- Medicaid Sanctions, pg. 2	
Prohibited Payments - Payment for the following shall not be made: • Non-emergency dental services provided by or under the direction of an excluded individual; • Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; and • Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan.	1.110LA LDH Contract Terms and Conditions; pg. 6	Full	This requirement is met through the document: 1.110LA LDH Contract Terms and Conditions; pg. 6	