MCNA Dental

2019 Compliance Audit

Review Period: April 01, 2018 – March 31, 2019

Final Report Issued December 2019

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

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Introduction and Audit Overview

Introduction

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care organizations (PAHPs) 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 PAHP. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted PAHPs. Further, 42 CFR 438.350 requires states to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted PAHP. 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).

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. The 2019 annual compliance audit was a full audit of the PAHP's compliance with contractual requirements during the period of April 1, 2018 through March 31, 2019.

This report presents IPRO's findings of the 2019 annual compliance audit for MCNA Dental (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 contractual domains:

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

The file review component assessed the PAHP's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and recredentialing.

Specifically, file review consisted of the following four areas:

1. Appeals
2. Credentialing/recredentialing
3. Member Grievances
4. UM Denials

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	15
Credentialing/recredentialing	5
Member Grievances	10
UM Denials	10

The period of review was April 1, 2018 through March 31, 2019. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance," and "Not Applicable" 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 is compliant with the standard.
Substantial	The PAHP is compliant with most of the requirements of the standard but has minor deficiencies.
Minimal	The PAHP is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The PAHP is not in compliance with the standard.
Not Applicable	The requirement was not applicable to the PAHP.

The 2019 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 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 April 2019. The tools included the review elements drawn from the state and federal regulations. Based upon the LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to the PAHP in April 2019 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 File Transfer Protocol (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 PAHPs undergoing the audit, with LDH staff in attendance, approximately two weeks after the request packet was sent to the PAHPs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline, and answered any questions posed by PAHP staff.

After the PAHP submitted the required documentation, a team of three experienced IPRO auditors was convened to review the PAHP's policies, procedures, and materials, and to assess the PAHP's 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-day onsite visit, which included a review of elements in each of the nine 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 July 15 and 16, 2019, 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 to allow the PAHP to provide additional documentation, if available. File review, as indicated, was conducted to assess the PAHP's implementation of policy in accordance to state standards. PAHP staff was given two days from the close of the onsite review to provide any further documentation.

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 PAHP is compliant with the standard or a rationale for why the PAHP was not compliant and what evidence was lacking. For each element that was deemed not fully compliant, IPRO provided a recommendation for the PAHP to consider in order for them to attain full compliance.

Each draft report underwent a second level of review by IPRO staff members who were 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 provide responses for all elements that were determined to be less than fully compliant. The PAHP was given one week to respond to the issues noted on the draft reports.

After receiving the PAHP's response, IPRO re-reviewed each element for which the PAHP provided a response. As necessary, review scores were updated based on the response of the PAHP.

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	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment & Disenrollment	17	17	0	0	0	0	100%
Fraud, Waste, and Abuse	96	96	0	0	0	0	100%
Member Education	78	78	0	0	0	0	100%
Member Grievances and Appeals	65	65	0	0	0	0	100%
Provider Network	103	101	2	0	0	0	98%
Provider Relations	45	45	0	0	0	0	100%
Quality Management	50	49	1	0	0	0	98%
Reporting	1	1	0	0	0	0	100%
Utilization Management	79	73	0	0	0	6	100%
TOTAL	**534**	**525**	**3**	**0**	**0**	**6**	**99%**

[1] N/As are not included in the calculation.

As presented in **Table 3**, 534 elements were reviewed for compliance. Of the 534, 525 were determined to fully meet the regulations, while 3 substantially met the regulations, and none were determined to be non-compliant. Six elements were "not applicable." The overall compliance score for MCNA was 99% elements in full compliance.

IPRO extracted from each of the nine detailed reports those elements for which the PAHP was found to be less than fully compliant. This information was compiled into a summary report to facilitate corrective action. **Table 4** presents this summary report and includes details about each element reviewed, the final review determination, the PAHP's initial response, and, when possible, recommendations to achieve full compliance.

It is the expectation of both IPRO and the LDH that MCNA submit a corrective action plan (CAP) for each of the three elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Note that MCNA may have implemented corrective actions for some of the areas identified for improvement while the audit was in progress, but these corrective actions will still require a written response since they were made after the period of review. Two of the three issues noted in the review related to network adequacy and one issue was in the Quality Management domain.

Each of the nine review tools and review determinations for each of the elements follow **Table 4**. Note that the yellow highlighting in the element descriptions reflects new language in the state regulations that was added since the 2016 compliance review period.

Table 4: Deficient 2019 Audit Elements

State Contract Requirements [Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230]	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
Provider Network				
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.	P/P for Access and Availability GeoAccess reports P/P Access standards	Substantial	GeoAccess Report for Q1 2019 showed MCNA compliant in all but Plaquemines Parish, where they state they have contracted with 100% of available PCDs. Also reached out to other providers who declined to join network. **Recommendation** MCNA should continue to enroll providers to expand provider coverage to meet the time and distance requirements.	MCNA will continue to reach out to non-participating providers on a quarterly basis by contacting these providers via email, phone, and in person. In addition, MCNA will monitor its current network for potential recruitment opportunities. Provider rosters will be audited for new providers at contracted facilities and those providers will be presented with the opportunity to contract with MCNA.
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.	P/P for Access and Availability GeoAccess reports P/P Access standards	Substantial	GeoAccess Report for Q1 2019 showed MCNA fully compliant for Oral Surgery and Orthodontists. There were gaps in prosthodontists (18.75%), endodontists (29.69%), and periodontists (54.68%). MCNA states that for all but Vermillion Parish endodontists, they have contracted with all available providers. In some rural parishes, there is no availability of providers. Where non-Medicaid participating specialists are available, MCNA reaches out quarterly to engage providers in the network. MCNA also reaches out to neighboring states. **Recommendation** MCNA should continue to enroll providers to expand provider coverage to meet the time and distance requirements.	Currently there are no non-contracted endodontist available in this parish for recruitment. However, MCNA will continuously research this parish on a quarterly basis to identify new endodontist in the area for recruitment. MCNA will also continue to reach out to prosthodontists, and periodontists in the area for recruitment on a quarterly basis. Providers will be contacted via email, phone, and in person for recruitment purposes. In addition, MCNA will monitor it current network of group facilities to identify new endodontic providers at these contracted facilities. Also, prosthodontists, endodontists, and periodontists in neighboring States will be

State Contract Requirements [Federal Regulation: 438.102, 438.114, 438.206, 438.207, 438.208, 438.210, 438.214, 438.224, 438.230]	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				identified and contacted on a quarterly basis for recruitment opportunities.
Quality Management				
The DBPM is encouraged to include a member advocate representative on the QAPI Committee.		Substantial	The QAPI Work Plan does mention the member advocate in passing. The requirement is "encouraged" rather than "must." MCNA has outreach specialists on the QI Committee. Dental Advisory Committee – has member and LSU Dental School. Meets quarterly. **Recommendation** MCNA should include in its policy that it has a member advocate on its QI Committee.	Policy 2.103LA QI Program Description has been updated. See pages 8 & 17.

PAHP Final Audit Tools

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

Eligibility and Enrollment & Disenrollment

Eligibility, Enrollment & Disenrollment					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response 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:			Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2.	
Does not make a primary care dentist selection; or	Policy for Primary Care Dentist Assignment PC Dentist Assignment List		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 3.	
Selects a primary care dentist within the DBPM that has restrictions/limitations (e.g. pediatric only practice).	Policy for Primary Care Dentist Assignment PC Dentist Assignment List		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on 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.	Policy for Primary Care Dentist Assignment PC Dentist Assignment List Member handbook		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2.	
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	Policy for Primary Care Dentist Assignment PC Dentist Assignment List		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2.	

Eligibility, Enrollment & Disenrollment					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
sex of the member and geographic proximity.	Member handbook Dentist Assignment Algorithm				
The final primary care dentist automatic assignment methodology must be provided thirty (30) days from 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.	Policy for Primary Care Dentist Assignment PC Dentist Assignment List Dentist Assignment Algorithm Evidence of Timely Submission to LDH Provider Handbook		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2 and in the Provider Manual on pages 20 and 21. During onsite discussion, MCNA explained the methodology used in automatic assignment and indicated that it was approved by LDH upon contract initiation.	
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.	Policy for Primary Care Dentist Assignment PC Dentist Assignment List Evidence of communication with LDH Quarterly reports to LDH		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2 and in the provider manual on page 3.	
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.	Policy for Primary Care Dentist Assignment PC Dentist Assignment List Member Handbook		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2 and in the provider manual on page 1.	
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.	Policy for Primary Care Dentist Assignment Member Handbook		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on page 2 and in the provider manual on page 1.	
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	Policy for Primary Care Dentist Assignment Member handbook Policy for Primary Care Dentist Selection Notification to Members		Full	This requirement is addressed in the Member Notification of Terminated Providers Policy on page 1.	

Eligibility, Enrollment & Disenrollment					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 options for selecting a new primary care dentist.					
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.	Policy for Member Disenrollment Member Notification Letter Member Handbook		Full	This requirement is addressed in the Disenrollment Policy on page 1.	
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;	Policy for Member Disenrollment Member Notification Letter Member Handbook		Full	This requirement is addressed in the Disenrollment Policy on page 1 and in the Member Handbook on page 8.	
Death of a member;	Policy for Member Disenrollment Member Notification Letter Member Handbook		Full	This requirement is addressed in the Disenrollment Policy on page 1 and in the member handbook on page 8.	
Member's intentional submission of fraudulent information;	Policy for Member Disenrollment Member Notification Letter Member Handbook		Full	This requirement is addressed in the Disenrollment Policy on page 1 and in the member handbook on page 8.	
Member becomes an inmate in a public institution;	Policy for Member Disenrollment Member Notification Letter Member Handbook		Full	This requirement is addressed in the Disenrollment Policy on page 1.	
Member moves out-of-state;	Policy for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy on page 1 and in the	

Eligibility, Enrollment & Disenrollment					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Member Notification Letter Member Handbook			member handbook on page 8.	
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.	Policy for Member Disenrollment Member Notification Letter Member Handbook		Full	This requirement is addressed in the Disenrollment Policy on page 1 and in the member handbook on page 8.	

Fraud, Waste, and Abuse

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response 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.	Policy for the FWA Program Meeting Minutes from the meeting with the Attorney General		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 25 and in the Attorney General Meeting Agendas.	
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 ten 10 years from the completion of an audit or the contract expiration, whichever is later 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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 25 and 26.	
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 unrestricted access and the right to examine and make copies, excerpts or transcripts from all	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 25 and 26.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and 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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 22.	
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.	Policy for Grievances and Appeals Policy for Enrollment and Termination Practices		Full	This requirement is addressed in the Grievances and Appeals Department Overview policy on page 4.	
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.	Policy for the FWA Program Example of FWA Reports		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26 and by the quarterly compliance reports.	
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	Policy for the FWA Program Evidence of Timely Report		Full	This requirement is addressed in the 2018-2019 Compliance Program policy on page 16.	

Fraud, Waste, and Abuse					
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approved method.					
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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 5.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the Ownership and Management Disclosure policy on page 1.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the Review of Office of Inspector General and Systems for Award Management policy and procedure on page 1.	
The DBPM is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to	Policy for the FWA Program Policy for Improper paid		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	funds			policy on page 21.	
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.	Policy for the FWA Program Policy for Improper paid funds		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 21.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 22.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 22.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 22.	
The DBPM shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns	Policy for the FWA Program Policy for Identification and		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Investigation of Fraud Evidence of Timely Notification			policy on page 22.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 22.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23.	
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	Policy for the FWA Program Policy for Identification and Investigation of Fraud		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 14.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
whom the incident was reported, or to another agency designated by the agency that received the report, after reporting 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.	Evidence of Notification to LDH Policy for Fraud Reporting				
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting Investigation Reports		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 14.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26.	
The State shall not transfer its law enforcement functions to the DPBM.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 6.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26 and in the Provider Contract Requirements policy on page 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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the Initial Credentialing Application policy on page 9.	
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.	Policy for the FWA Program Policy for Identification and Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting		Full	This requirement is addressed in the Medicare/Medicaid Sanctions policy on page 1.	
In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the DBPM shall report	Policy for the FWA Program Policy for Identification and		Full	This requirement is addressed in the Recoupment of Overpayment policy and	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
overpayments made by LDH to the DBPM as well as overpayments made by the DBPM to a provider and/or subcontractor.	Investigation of Fraud Evidence of Notification to LDH Policy for Fraud Reporting			procedure on page 2.	
Fraud and Abuse Compliance Plan					
In accordance with 42 CFR §438.608(a), the DBPM shall have a compliance program that includes 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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 3 and in the 2018-2019 Compliance Program policy on page 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.	Policy for the FWA Program List of Compliance Committee Members including Roles and Responsibilities		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 5 and in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 6 and 9.	
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:	Policy for the FWA Program Evidence of Timely Submission		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 4 and 25.	
Written policies, procedures, and standards of conduct that articulate DBPM's commitment to comply with all applicable	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Compliance Program policy on page 7.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
federal and state standards;					
Effective lines of communication between the compliance officer and the DBPM's employees, providers and contractors enforced through well-publicized disciplinary guidelines;	Policy for the FWA Program Policy for the Compliance Program Evidence of disciplinary guidelines		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 25 and 26.	
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;	Policy for the FWA Program Policy for the Compliance Program Policy of monitoring/auditing of claims processing, continuous quality improvement activities and provider activities		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 7.	
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;	Policy for the FWA Program Policy for the Compliance Program		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 9.	
Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR Part 438.608(b)(4-6);	Policy for the FWA Program Policy for the Compliance Program		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 7.	
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;	Policy for the FWA Program Policy for the Compliance Program		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 15.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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);	Policy for the Compliance Program		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 10.	
Well-publicized disciplinary procedures that shall apply to employees who violate the DBPM's compliance program;	Policy for the Compliance Program		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 8 and 9.	
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;	Policy for the Compliance Program Compliance Training Materials		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 8, in the Compliance and Fraud, Waste and Abuse Program – Employee Education and Training policy on page 1, and in the Compliance Training & Fraud, Waste, and Abuse Training material.	
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;	Evidence of annual FWA training		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23 and 24, in the Compliance and Fraud, Waste and Abuse Program – Employee Education and Training policy on page 1, and in the Compliance Training & Fraud, Waste, and Abuse Training material.	
Procedures for timely consistent exchange of information and collaboration with the LDH Program Integrity Unit;	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 25 and 26.	
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	Policy for the Compliance Program		Full	This requirement is address in the 2018-2019 Compliance Program policy on page 4.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response 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.	Policy for the Compliance Program Training Materials List of Employees Trained		Full	This requirement is addressed in the Compliance and Fraud, Waste and Abuse Program – Employee Education and Training policy on page 1, in the Employee Privacy Awareness Training and Education policy on page 1, and in the Compliance Training & Fraud, Waste, and Abuse Training material.	
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.	Policy for the FWA Program Policy for Prohibited Affiliations		Full	This requirement is addressed in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 1, and in the 2018-2019 Compliance Program policy on page 16.	
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 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:	Policy for the Compliance Program Policy for Prohibited Affiliations Screen Shot of Exclusion Sites		Full	This requirement is addressed in the 2018-2019 Compliance Program policy on page 16, in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 2 and 3, and in the Employee OIG_SAM Results spreadsheet.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
• 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.					
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).	Policy for the Compliance Program Policy for Prohibited Affiliations		Full	This requirement is addressed in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 1 and in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26.	
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.	Policy for the Compliance Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26 and in the 2018-2019 Compliance Program policy on page 16 and 17.	
The DBPM shall notify LDH within three (3) business days of the	Policy for the Compliance		Full	This requirement is addressed in the 2018-	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Program			2019 Compliance Program policy on page 17.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26.	
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.	Policy for the FWA Program Policy for Fraud Reporting Fraud Reports		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 15.	
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, but are not limited to:	Policy for the FWA Program Policy for Fraud Reporting Fraud Reports		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Number of complaints of fraud, abuse, waste, neglect and overpayments made to the DBPM that warrant preliminary investigation (defined at 42 CFR §455.14);	Policy for the FWA Program Policy for Fraud Reporting Fraud Reports		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23.	
Number of complaints reported to the Compliance Officer; and	Policy for the FWA Program Policy for the FWA Program Policy for Fraud Reporting Fraud Reports		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 23.	
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.	Policy for the FWA Program Policy for the Compliance Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26.	
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:	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 1.	
Accurate and legible;	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 1.	
Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 1.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
treated, and is accessible for review and audit; and					
Readily available for review and provides dental and other clinical data required for Quality and Utilization Management review.	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 1.	
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);	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
Primary language spoken by the member and any translation needs of the member;	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
Services provided through the DBPM, date of service, service site, and name of service provider;	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
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;	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
Referrals including follow-up and outcome of referrals;	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
Documentation of emergency and/or after-hours encounters and follow-up;	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
Signed and dated consent forms (as applicable);	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
Documentation of advance directives, as appropriate; and	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7.	
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-	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 7 and 8.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
The DBPM must provide one (1) free copy per calendar year of any part of member's record upon member's request.	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 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.	Policy for Maintaining Dental Records		Full	This requirement is addressed in the Dental Record Review policy on page 2 and in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 22.	
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.	Policy for the FWA Program		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 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 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.	Policy for Recoupment of Overpayments		Full	This requirement is addressed in the Complex Claims review policy on page 1 and 2.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
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.	Policy for Recoupment of Overpayments		Full	This requirement is addressed in the Complex Claims review policy on page 1.	
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.	Policy for Recoupment of Overpayments Policy for Complex Review		Full	This requirement is addressed in the Complex Claims review policy on page 1.	
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.	Policy for Recoupment of Overpayments		Full	This requirement is addressed in the Complex Claims review policy on page 1.	
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.	Policy for Recoupment of Overpayments		Full	This requirement is addressed in the Complex Claims review policy on page 1 and 2.	
LDH must notify the DBPM of an identified mispayment from a "complex" or "automated" review prior to 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.	Policy for Recoupment of Overpayments		Full	This requirement is addressed in the Complex Claims review policy on page 1.	
The DBPM shall not correct the claims nor initiate an audit on the	Policy for Recoupment of		Full	This requirement is addressed in the	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
claims upon notification by the Department or its agent.	Overpayments			Complex Claims review policy on page 1.	
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	Policy for Payment Withholds		Full	This requirement is addressed in the Complex Claims review policy on page 1.	
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	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 26.	
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 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.	Policy for Criminal Background Check		Full	This requirement is addressed in the Background Checks policy on page 1.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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].	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website Policy for Criminal Background Check		Full	This requirement is addressed in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 4 and 5 and in the Employee OIG_SAM Results spreadsheet.	
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.	Policy for Excluded Providers Screen Shot of Provider Exclusion website		Full	This requirement is address in the Provider Contract Requirements policy on page 1 and in the Provider Network Development and Management Program policy on page 8.	
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 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.	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website Policy for Criminal Background Check Policy for Excluded Providers		Full	This requirement is address in the Medicare/Medicaid Sanctions policy on page 1.	
Utilization Requirements					

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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).	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website Policy for Criminal Background Check Policy for Excluded Providers		Full	This requirement is addressed in the Timely Processing of Clean Claims policy on page 2.	
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).	Policy for Identification and Investigation of Fraud		Full	This requirement is addressed in the Monitoring for Over and Under Utilization of Dental Services policy on page 3.	
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.	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website Policy for Criminal Background Check Policy for Excluded Providers		Full	This requirement is addressed in the Claims Adjudication Overview policy on page 1, 2, and 5.	
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.	Policy for Explanation of Benefits Requirements sampling process.		Full	This requirement is addressed in the 2018-2019 Fraud, Waste, and Abuse Program policy on page 21 and 22.	
Reporting Requirements					

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 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.	Policy for Ownership Disclosure Ownership Disclosure Form Evidence of Timely Submission to LDH		Full	This requirement is addressed in the Ownership and Management Disclosure policy on page 1.	
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.	Policy for Business Transactions Evidence of Timely Submission to LDH		Full	This requirement is addressed in the Business Transactions policy on page 1 and 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.	Policy for Business Transactions Policy for Parties in Interest		Full	This requirement is addressed in the Business Transactions policy on page 1.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 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.	Policy for Persons Convicted of Crimes		Full	This requirement is addressed in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 4.	
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	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website Policy for Criminal		Full	This requirement is addressed in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 2 and 3.	

Fraud, Waste, and Abuse					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Background Check Policy for Excluded Providers				
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 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).	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Screen shot of the HHS-OIG website Policy for Criminal Background Check Policy for Excluded Providers		Full	This requirement is addressed in the Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) policy on page 1 and 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.	Policy for Staffing Requirements Policy for Screening Employees and sub-contractors Policy for Prohibited Payment		Full	This requirement is addressed in the LDH Contract Terms and Conditions policy on page 6.	

Member Education

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response 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.	Policy for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the Member Education and Marketing Materials – Approval Process Policy on page 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.	Policy for Member Orientation Member Handbook Policy for Member Education Example of member education material		Full	This requirement is addressed in the Member Education Materials Policy on page 4.	
The DBPM shall identify and educate members who access the system inappropriately and provide continuing education as needed.	Member Handbook Policy for Member Education Evidence of Continuing Education Example of member education Material		Full	This requirement is substantially addressed in the Member Education Materials Policy on page 4. MCNA provided training materials for members and discussed their training efforts while onsite.	
The DBPM may propose, for approval by LDH, alternative methods for orienting new members and must be prepared to demonstrate their efficacy.	Policy for Alternative Methods for Orienting new Members. Evidence of efficacy Evidence of approval from and communication with LDH		Full	This requirement is addressed in the Member Education Materials Policy on page 7.	
The DBPM shall have written policies and procedures notifying for newly identified members within ten (10) business days after receiving the Member File from the FI. This notification must be	Policy for Member Notification Example of Member		Full	This requirement is addressed in the Member Education Materials Policy on page 3.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Notification Example of timely member notification				
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.	Policy for Contacting a New Member Policy for Member Education Evidence of approval from LDH Evidence of timely submission		Full	This requirement is addressed in the Member Education Materials Policy on page 2.	
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.	Policy for Members Primary Care Dentist Selection Member Handbook		Full	This requirement is addressed in the Member Assignment to a Primary Care Dentist Policy on pages 1 and 2.	
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.	Policy for Newly Eligible Members. Policy for Assigning New Members Example of the Welcome packet		Full	This requirement is addressed in the Member Education Materials Policy on page 3.	
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.	Policy for New Members Example of Welcome Packet Evidence of Timely Mailing		Full	This requirement is addressed in the Member Education Materials Policy on page 3.	
The DBPM must mail a welcome packet to each new member.	Policy for New Members		Full	This requirement is addressed in the	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Example of Welcome Packet Evidence of Timely Mailing			Member Education Materials Policy on page 3.	
All contents of the welcome packet are considered member education materials and, as such, shall be 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:	Policy for New Members Example of Welcome Packet Evidence of Timely Mailing Policy for Member Education Evidence that the Member Handbook has been tested against the reading level standard Evidence that the member education materials were approved by LDH		Full	This requirement is addressed in the Member Education Materials Policy on page 3.	
A welcome letter highlighting major program features and contact information for the DBPM; and	Policy for New Members Example of Welcome Packet Policy for Member Education Copy of Welcome Letter		Full	This requirement is addressed in the Member Education Materials Policy on page 3.	
A Provider Directory when specifically requested by the member (also must be available in searchable format on-line).	Member Handbook Provider Directory Evidence of availability online		Full	This requirement is addressed in the Member Education Materials Policy on pages 3 through 5.	
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).	Policy for the Provider Directory Dental Benefit Program Companion Guide?		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
Member Identification (ID) Card					
DBPM members shall use their LDH issued Medicaid ID card to	Member Handbook		Full	This requirement is addressed in the	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
access benefits and services covered as part of the Dental Benefit Program. The DBPM will not provide members with a separate ID card.	Policy for Dental Benefits Program			Member Education Materials Policy on page 3.	
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.	Policy for the Electronic Eligibility verification system		Full	This requirement is addressed in the Member Education Materials policy on page 3.	
Provider Directory for Members					
The DBPM shall develop and maintain a Provider Directory in two (2) formats:					
Web-based, in a searchable machine readable file, online directory for members and the public; and	Policy for Provider Directory Provider Directory (website link) Member Handbook		Full	This requirement is addressed in the Website Development and Maintenance Policy on page 1. MCNA provided screenshots of WAVE Readability Reports for Member and Provider websites.	
A hard copy directory for members upon request only.	Policy for Provider Directory Provider Directory (hard copy) Member Handbook		Full	This requirement is addressed in the Member Education Materials Policy on page 4.	
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	Policy for Provider Directory Provider Directory (hard copy)		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
time, however no less than weekly.	Member Handbook Policy for Member Rights and Responsibilities				
In accordance with 42 CFR §438.10(f) (6), the provider directory shall include, but not be limited to:					
Names, as well as any group affiliations, locations, telephone numbers of, website URLs, as appropriate and non-English languages spoken by current contracted providers or skilled interpreter at the provider's office in the Medicaid enrollee's service area, and whether the provider has completed cultural competence training, including identification of providers, primary care dentists, specialists, and providers that are not accepting new patients at a minimum;	Policy for Provider Directory Provider Directory (hard copy) Member Handbook Policy for Member Rights and Responsibilities		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
Whether network providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment;			Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
Identification of primary care dentists, specialists, and dental groups in the service area;	Policy for Provider Directory Provider Directory (hard copy) Member Handbook Policy for Member Rights and Responsibilities		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Policy for Provider Directory Provider Directory (hard copy) Member Handbook Policy for Member Rights and Responsibilities		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m.	Policy for Provider Directory		Full	This requirement is addressed in the Member Education Materials Policy on page	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
or any weekend hours).	Provider Directory (hard copy) Member Handbook Policy for Member Rights and Responsibilities			5.	
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:	Policy for Member Services Call Center		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
DBPM policies and procedures;	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
Prior authorizations;	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
Access information;	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
Information on primary care dentists or specialists;	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
Referrals to participating specialists;	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
Resolution of service and/or dental delivery problems; and	Policy for Member Services		Full	This requirement is addressed in the	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Call Center Call Center Staff List Call Center Staff Training			Member Services Department Overview Policy on page 1.	
Member grievances.	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1.	
The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday.	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	
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 return all calls by close of business the following business day.	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training Evidence of timely response calls		Full	This requirement is addressed in the Member Services Department Overview Policy on pages 2 and 3.	
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.	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training		Full	This requirement is addressed in the Member Services Department Overview Policy on pages 2 and 6.	
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	Policy for Member Services Call Center Call Center Staff List Call Center Staff Training Policy for Hiring Call Center		Full	This requirement is addressed in the Member Services Department Overview Policy on page 6.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Staff Policy for Call Center Access Standards				
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.	Policy for Hiring Call Center Staff Policy for Call Center Access Standards Policy for Telephone Help Line Policy for Telephone Help Line Performance Standards Evidence of LDH approval of Help Line Policy Sample Call Reports		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1, and in the Monitoring Phone Calls Policy on page 1.	
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 quality criteria and protocols to LDH for review and approval annually.	Policy for Hiring Call Center Staff Policy for Call Center Access Standards Policy for Telephone Help Line Policy for Telephone Help Line Performance Standards		Full	This requirement is addressed in the Member Services Department Overview Policy on page 1, and in the Monitoring Phone Calls Policy on page 1.	
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;	Policy for Call Center Access Standards Policy for Telephone Help Line		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Policy for Telephone Help Line Performance Standards				
Transfer calls to other telephone lines;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	
Provide an option to speak to a live person (during call center hours of operation);	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	
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;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Call Center Phone Tracking and Reporting Mechanism Policy on page 1.	
Provide a message that notifies callers that the call may be monitored for quality control purposes;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Call Line Script		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	
Measure the number of calls in the queue at peak times;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Call Center Phone Tracking and Reporting Mechanism Policy on page 1.	
Measure the length of time callers are on hold;	Policy for Call Center Access		Full	This requirement is addressed in the Call	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Standards Detailed Call Reports			Center Phone Tracking and Reporting Mechanism Policy on page 1.	
Measure the total number of calls and average calls handled per day/week/month;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Call Center Phone Tracking and Reporting Mechanism Policy on page 1.	
Measure the average hours of use per day;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Call Center Phone Tracking and Reporting Mechanism Policy on page 1.	
Assess the busiest times and days by number of calls;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Call Center Phone Tracking and Reporting Mechanism Policy on page 1.	
Record calls to assess whether answered accurately;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Records		Full	This requirement is addressed in the Call Center Phone Tracking and Reporting Mechanism Policy on page 1.	
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;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	
Inform the member to dial 911 if there is an emergency.	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script		Full	This requirement is addressed in the Member Services Department Overview Policy on page 2.	
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;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script Evidence of Timely live pick up or timely automatic pick up		Full	This requirement is addressed in the Monitoring Member Hotline Performance Policy on page 1.	
No more than one percent (1%) of incoming calls receive a busy signal;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script Evidence of Timely live pick up or timely automatic pick		Full	This requirement is addressed in the Monitoring Member Hotline Performance Policy on page 1.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	up				
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;	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script Evidence of Timely hold time		Full	This requirement is addressed in the Monitoring Member Hotline Performance Policy on page 1.	
Maintain abandoned rate of calls of not more than five (5) percent.	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script		Full	This requirement is addressed in the Monitoring Member Hotline Performance Policy on page 1.	
The DBPM must conduct ongoing quality assurance to ensure these standards are met.	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script Quality Reports		Full	This requirement is addressed in the Monitoring Member Hotline Performance Policy on page 1.	
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.	Policy for Call Center Access Standards Policy for Telephone Help Line Performance Standards Detailed Call Reports Call Line Script Evidence of Call Line		Full	This requirement is addressed in the Monitoring Member Hotline Performance Policy on page 2.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Monitoring				
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.	Policy for Members Rights and Responsibilities Provider/ Employee Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 1.	
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.	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 1.	
The DBPM members' responsibilities shall include but are not limited to:					
Presenting their LDH issued Medicaid ID card when using health care services;	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	
Being familiar with the DBPM procedures to the best of the member's abilities;	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	
Calling or contacting the DBPM to obtain information and have	Policy for Member		Full	This requirement is addressed in the	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
questions answered;	Education Policy for Member Enrollment Member Handbook Member Education			Ensuring Member Rights and Responsibilities Policy on page 2.	
Providing participating network providers with accurate and complete dental information;	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	
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;	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	
Living healthy lifestyles and avoiding behaviors know to be detrimental to their health;	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	
Following the grievance process established by the DBPM if they have a disagreement with a provider; and	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	
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.	Policy for Member Education Policy for Member Enrollment		Full	This requirement is addressed in the Ensuring Member Rights and Responsibilities Policy on page 2.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Member Handbook Member Education				
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.	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education Policy for Member Termination Member Notification Evidence of timely Member Notification		Full	This requirement is addressed in the Member Notification of Terminated Providers Policy on page 1.	
The DBPM shall provide notice to a member, who has 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.	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education Policy for Member Termination Member Notification Evidence of timely Member Notification		Full	This requirement is addressed in the Member Notification of Terminated Providers Policy on page 1.	
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	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education Policy for Member Termination		Full	This requirement is addressed in the Member Notification of Terminated Providers Policy on pages 1 and 2.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
of notification of termination.	Member Notification Evidence of timely Member Notification				
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.	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education Example of bulletins/newsletter		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
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.	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education Example of bulletins/newsletter		Full	This requirement is addressed in the Member Education Materials Policy on page 5.	
All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	Policy for Member Education Policy for Member Enrollment Member Handbook Member Education Example of bulletins/newsletter Member Materials Evidence of approval by LDH for member Materials		Full	This requirement is addressed in the Member Education Materials Policy on page 5. MCNA provided evidence of LDH approval of member education materials.	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
The DBPM must make oral interpretation services including oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language (ASL), available free of charge to each potential member and member. Oral interpretation services shall be available in all non-English languages not just those that Louisiana specifically 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.	Policy for oral and written interpretation services Policy for notification of member of interpretation services and how to access the services Member Handbook Policy for Member Rights and Responsibilities		Full	This requirement is addressed in the Member Education Materials Policy on page 2.	
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).	Policy for oral and written interpretation services Policy for notification of member of interpretation services and how to access the services Member Handbook Policy for Member Rights and Responsibilities		Full	This requirement is addressed in the Member Education Materials Policy on page 2.	
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.	Policy for Written Member Materials Guidelines Sample written member materials Member Handbook Evidence that the Member Handbook has been tested against the reading level standard		Full	This requirement is addressed in the Member Education Materials Policy on page 2.	
The DBPM shall include in all member materials the following: the date of issue; the date of revision; and/or if prior versions are	Policy for Written Member Materials Guidelines		Full	This requirement is addressed in the Member Education Materials Policy on page	

Member Education					
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
obsolete.	Sample written member materials Member Handbook Evidence that the Member Handbook has been tested against the reading level standard			2.	

Member Grievances and Appeals

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Member Grievance and Appeals Procedures					
The DBPM must have a grievance system. 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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
The DBPM's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in the RFP.					
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
The member must exhaust the DBPM's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.	Grievance and Appeals Policy Member Handbook		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview. This is communicated in the MCNA Member Handbook found on their website.	
The DBPM shall not create barriers to timely due process. The DBPM shall be subject to sanctions if it is determined by DHH 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	Grievance and Appeals Policy Grievance system metrics reports		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
to State Fair Hearing.					
The DBPM shall take no punitive action against a provider who either requests an expedited resolution or supports an enrollee's appeal. [42 CFR 438.410(b)]	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy Grievance System flowchart		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy Member Handbook Provider Manual		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy Member Handbook Provider Manual		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy Member Handbook Provider Manual		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview. <u>Note:</u> MCNA policy sets the time limit at 60 calendar days, which is a greater allowance than required by contract. MCNA states this is in response to federal requirements and that they were told LDH will update the policy.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
A 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 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.	Grievance and Appeals Policy Member Handbook Provider Manual		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview. This is communicated in the MCNA Member Handbook found on their website and in the provider handbook.	
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.	Grievance and Appeals Policy Member Handbook Member website Provider Manual		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.103LA - Grievances & Appeals File Maintenance.	
The DBPM shall electronically provide DHH 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.	Grievance and Appeals Policy Grievance and Appeals reports submitted during the review period		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview. MCNA provided monthly reports for the period under review, including attestations by senior management.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
The DBPM will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the DBPM member. DHH may submit recommendations to the DBPM regarding the merits or suggested resolution of any grievance/appeal.					
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;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 13.105LA - Formal Grievance Procedure. **File Review** Grievances Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the requirement.	
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;	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.105LA - Formal Grievance Procedure.	
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 DHH, 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.	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 13.105LA - Formal Grievance Procedure. **File Review** Grievances Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the requirement.	
Special Requirements for Appeals - The process for appeals must:					
Provide that oral inquiries seeking to appeal an action are treated	Grievance and Appeals		Full	This requirement is addressed in policy	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
as appeals (to establish the earliest possible filing date for the appeal), unless the member or the provider requests 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; however if filed orally the requestor must follow up in writing however, if filed orally the requestor must follow up in writing.	Policy			13.206LA - Oral Appeal Requests.	
Once an oral appeal is received:					
MCO will notify the enrollee verbally that a written confirmation is required for the appeal process to continue. MCO should inform the enrollee they will be receiving a notice for written confirmation of the appeal.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests.	
The DBPM will send a notice to the enrollee acknowledging the oral appeal request was received and written confirmation is required. This notice must contain the timeframe for receipt of the written confirmation and future actions.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests.	
The DBPM will provide a form for the enrollee to sign and send back, as well as the options available for receipt of written confirmation (fax, email, regular postal mail).	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests.	
The enrollee has 15 days from the date of the notice to send their written confirmation.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests.	
If written confirmation is not received within the 15 day timeframe:					
The DBPM will close the appeal as incomplete for non-receipt of written confirmation.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests.	
The DBPM will send a notification to the enrollee of the appeal closure. This notice must consist of the reason for the incomplete appeal and inform the enrollee that they may submit a new appeal if they are within the original 60 days of the adverse action. [Note: This closure does not escalate the appeal to a State Fair Hearing since the initial appeal process was not been	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests. **File Review** Grievances Fifteen (15) of 15 files met the requirement.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
completed].				Appeals Ten (10) of 10 files met the requirement.	
Once a request for an oral appeal has been closed for non-receipt of a written confirmation, a new appeal date can be established with an oral or written appeal request if it is within the original 60 days of the adverse action.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.206LA - Oral Appeal Requests.	
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).	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview.	
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.	Grievance and Appeals Policy Training Plan		Full	This requirement is addressed in policy 13.300 - Training and Education – Grievances and Appeals. MCNA provided 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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.200LA - Utilization Management Appeals.	
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 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	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 13.200LA - Utilization Management Appeals. **File Review** Grievances	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
the date upon which a final determination should have been made.				Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the requirement.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.200LA - Utilization Management Appeals. The member handbook includes the required notification.	
Notice of Action					
Language and Format Requirements - The notice must be in writing and must meet the language and format requirements to ensure ease of understanding.	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. Fleisch Kincaid score is 4.5. **File Review** Grievances Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the 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;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Grievances Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the requirement.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
The reasons for the action;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Grievances Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the requirement.	
The member's or the provider's right to file an appeal with the DBPM;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Grievances Fifteen (15) of 15 files met the requirement. Appeals Ten (10) of 10 files met the requirement.	
The member's right to request a State Fair Hearing, after the DBPM's appeal process has been exhausted;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Appeals Three of the files were decided in the member's favor and were not applicable. Seven of seven remaining files met the requirement.	
The procedures for exercising the rights specified in this section;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Grievances Fifteen (15) of 15 files met the requirement.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				Appeals Ten (10) of 10 files met the requirement.	
The circumstances under which expedited resolution is available and how to request it;	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Appeals Ten (10) of 10 files met the requirement.	
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	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Appeals Three of the files were decided in the member's favor and were not applicable. Seven of seven remaining files met the requirement.	
Oral interpretation is available for all languages and how to access it.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 3.202LA = Adverse Determinations.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations.	
For denial of payment, at the time of any action affecting the claim.					
For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition	Grievance and Appeals Policy		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 DHH upon request) a need for additional information and how the extension is in the member's interest.	Includes File Review			**File Review** Appeals Zero files contained a request for an extension.	
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.	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 13.205LA - 14-Day Extension. **File Review** Appeals Zero files contained a request for an extension.	
On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations.	
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.	Grievance and Appeals Policy Includes File Review		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations. **File Review** Appeals Zero files contained a request for an expedited review.	
The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the DBPM justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 3.202LA - Adverse Determinations.	
Resolution and Notification					
The DBPM must dispose of a grievance and resolve each appeal,					

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.105LA - Formal Grievance.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.200LA - Utilization Management.	
Expedited Resolution of Appeals - For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the DBPM receives the appeal.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.200LA - Utilization Management.	
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 DHH, 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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.200LA - Utilization Management.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.200LA - Utilization Management.	
Content of Notice of Appeal Resolution - The written notice of the resolution must include the following: the results of the	Grievance and Appeals Policy	13.200LA Utilization Management Appeals, Pgs.	Full	This requirement is addressed in policy 13.200LA - Utilization Management.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.		6-7			
Requirements for State Fair Hearings - The DBPM shall comply with all requirements as outlined in the RFP.					
Availability - If the member has exhausted the DBPM 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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.301LA - State Fair Hearings.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.301LA - State Fair Hearings.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.203LA - Expedited Appeals.	
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	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.203LA - Expedited Appeals.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
a Notice of Action. The Member may file a grievance in response to this decision.					
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.203LA - Expedited Appeals.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.203LA - Expedited Appeals.	
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.203LA - Expedited Appeals.	
Continuation of Benefits					
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.					
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,	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.209LA - Continuation of Services.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.209LA - Continuation of Services.	
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.	Grievance and Appeals Policy Member Handbook		Full	This requirement is addressed in policy 13.209LA - Continuation of Services.	
Information to Providers and Contractors					
The DBPM must provide the information specified in federal regulations about the grievance system to all providers and contractors at the time they enter into a contract.	Grievance and Appeals Policy Provider Manual		Full	This requirement is addressed in policy 13.100LA - Grievance and Appeals Department Overview. The grievance and appeal process is communicated clearly in the provider manual.	
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,	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.209LA - Continuation of Services.	

Member Grievances & 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
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.	Grievance and Appeals Policy		Full	This requirement is addressed in policy 13.209LA - Continuation of Services.	

Provider Network

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
General Provider Network Requirements					
The DBPM must maintain a network of qualified dental providers in sufficient number, mix and geographic distribution to provide adequate access to all services covered services under the contract for all enrollees in the service area, including those with limited English proficiency or physical or mental disabilities.. 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.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program.	
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)].	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program.	
All providers shall be in compliance with 42 CFR 438.206(c)(3) and American with Disabilities Act (ADA) requirements and provide physical access reasonable accommodations and accessible equipment for Medicaid members with disabilities.	Provider manual/handbook Provider contracts		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program.	
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	Provider manual/handbook Provider contracts Evidence of successful and		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
a contract with such providers. The DBPM shall document efforts made and maintain records for all successful and non-successful agreements.	attempted agreements			MCNA states they accept all providers once assessed through credentialing. MCNA reaches out six months prior to re-credentialing date to offer assistance in completing the process. Any exclusions are limited to state, federal, and URAC requirements.	
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)].	Provider manual/handbook Provider contracts P/P for Provider Selection and Retention		Full	This requirement is addressed in policy 10.203LA - Non-discrimination Against Dental Providers.	
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)].	Provider manual/handbook Provider contracts P/P for Provider Selection and Retention		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program.	
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.	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention Evidence of timely notice of		Full	This requirement is addressed in policy 10.106LA - Provider Selection and Retention.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	denied provider requests for participation Sample notice to providers				
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.	Provider contracts P/P for Provider Selection and Retention P/P for Provider Termination Evidence of timely notice of provider termination to LDH		Full	This requirement is addressed in policy 6.203 - Provider Termination & Suspension Process.	
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.	P/P for Provider Termination Sample notice to members		Full	This requirement is addressed in policy 11.104LA - Member Notification of Terminated Provider. MCNA provided examples of actual letters sent to members whose dentists were no longer with the network.	
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.	GeoAccess reports P/P for Access and Availability		Full	This requirement is addressed in policy 5.105LA - Availability & Accessibility of Services.	
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.	Evidence of signed contracts with listed specialty provider types		Full	This requirement is addressed in policy 5.105LA - Availability & Accessibility of Services.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	P/P for Provider Selection and Retention P/P provider contracting		Full	This requirement is addressed in policy 6.309 - Medicare-Medicaid Sanctions.	
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 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.	P/P care coordination Provider manual/handbook P/P for Monitoring Provider Compliance with Access Standards		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program.	
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.	P/P for Monitoring Provider Compliance with Access Standards Sample of appointment availability survey		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management Program. MCNA uploaded their annual Access & Availability Survey Report.	
If a member requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the	P/P for Provider Network P/P for Access and		Full	This requirement is addressed in policy 10.300LA - Provider Network Development	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Availability			and Management Program. MCNA also recruits out-of-network providers or enters into single case agreement as needed.	
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.	Member Handbook Provider manual/handbook P/P for Informing Members/Potential Members of Interpretation Services P/P for Interpreter Services P/P for Cultural Competency		Full	This requirement is addressed in policy 5.105LA - Availability & Accessibility of Services.	
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.	P/P for Quarterly reporting Evidence of quarterly demographic data reports		Full	This requirement is addressed in policy 5.302MIC - Validating Accuracy of the Provider Directories. MCNA provide their most recent quarterly provider validation.	
General Provider Network Requirements					
The DBPM shall ensure access to dental services (distance traveled, waiting time, length of time to 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:					

Provider Network					
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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.	P/P for Access and Availability GeoAccess reports Requests for exceptions P/P Access standards		Full	This requirement is addressed in policy 10.104LA - Network Adequacy.	
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.	P/P for Access and Availability GeoAccess reports P/P Access standards		Substantial	GeoAccess Report for Q1 2019 showed MCNA compliant in all but Plaquemines Parish, where they state they have contracted with 100% of available PCDs. Also reached out to other providers who declined to join network. **Recommendation:** MCNA should continue to enroll providers to expand provider coverage to meet the time and distance requirements.	MCNA will continue to reach out to non-participating providers on a quarterly basis by contacting these providers via email, phone, and in person. In addition, MCNA will monitor its current network for potential recruitment opportunities. Provider rosters will be audited for new providers at contracted facilities and those providers will be presented with the opportunity to contract with MCNA.
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.	P/P for Access and Availability GeoAccess reports P/P Access standards		Substantial	GeoAccess Report for Q1 2019 showed MCNA fully compliant for Oral Surgery and Orthodontists. There were gaps in prosthodontists (18.75%), endodontists (29.69%), and periodontists (54.68%). MCNA states that for all but Vermillion Parish endodontists, they have contracted with all available providers. In some rural parishes, there is no availability of providers. Where non-Medicaid participating specialists are available, MCNA	Currently there are no non-contracted endodontist available in this parish for recruitment. However, MCNA will continuously research this parish on a quarterly basis to identify new endodontist in the area for recruitment. MCNA will also continue to reach out to prosthodontists, 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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				reaches out quarterly to engage providers in the network. MCNA also reaches out to neighboring states. **<u>Recommendation:</u>** MCNA should continue to enroll providers to expand provider coverage to meet the time and distance requirements.	periodontists in the area for recruitment on a quarterly basis. Providers will be contacted via email, phone, and in person for recruitment purposes. In addition, MCNA will monitor it current network of group facilities to identify new endodontic providers at these contracted facilities. Also, prosthodontists, endodontists, and periodontists in neighboring States will be identified and contacted on a quarterly basis for recruitment opportunities.
Waiting Times and Timely Access					
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.	P/P for Provider Network P/P for Scheduling Dental Service Evidence of appointment system		Full	This requirement is addressed in policy 5.105LA - Availability of Services. MCNA provide their most recent quarterly provider validation.	
Formal policies and procedures establishing 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	P/P Appointment Scheduling and Standards Evidence of P/P submission to LDH Provider/member training materials		Full	This requirement is addressed in policy 5.105LA - Availability of Services. Appointment standards are contained in the provider manual.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
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.	P/P for Urgent Care		Full	This requirement is addressed in policy 5.105LA - Availability of Services.	
Routine or preventative dental services must be provided within six (6) weeks.	P/P for Routine or preventive dental services		Full	This requirement is addressed in policy 5.105LA - Availability of Services.	
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.	P/P for "No Show" appointments Plan of correction for "no show" appointments		Full	This requirement is addressed in policy 5.715LA - Monitoring Member No-Show Rates. MCNA provided a copy of their monthly reports of outreach to members who did not show up for a scheduled appointment. MCNA is undertaking a new process to work with the dentist office to understand their own process in an effort to reduce no-shows.	
The DBPM shall have written policies and procedures about educating its provider network about 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.	P/P for Provider Appointment Standards P/P for Provider Network Evidence of corrective action plan templates Provider manual/handbook		Full	This requirement is addressed in policy 5.105LA - Availability of Services.	
Assurance of Adequate Primary Care Dentist Access and Capacity					

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 five thousand (5,000) 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 five thousand (5,000) Medicaid linkages in all DBPMs in which the primary care dentist may be a network provider.	Provider manual/handbook Provider contracts Contracts with FQHC/RHCs Evidence of meeting provider to member ratios P/P for PCD Responsibilities		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management. The policy provided does not specifically define the maximum linkage ratio of 5,000:1. MCNA states that LDH removed this requirement. MCNA provided an email from LDH dated 1/28/19 stating that although the DBPM contract has not been amended, "LDH is looking to remove limitations and excedance is not being enforced." MCNA provided PCD linkage reports for each quarter. The Q1 2019 report listed 2,422 providers with an average linkage of 85 members and a maximum of 1,163.	
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.	P/P for Access and Availability Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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.	P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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 practice.	Provider Report (electronic and hard copy) P/P for Provider Network		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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	P/P for Access to Specialty Providers		Full	This requirement is addressed in policy 10.104LA - Network Adequacy.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
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.	P/P for Access to Specialty Providers Evidence of signed contracts with listed specialty provider types		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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.	P/P for Access to Specialty Providers Evidence of signed contracts with listed specialty provider types P/P for Coordination with Other Service Providers		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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.	P/P for Access to Specialty Providers Evidence of signed contracts with listed specialty provider types P/P for Coordination with Other Service Providers		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management. The MCNA Provider Manual also addresses this requirement.	
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 condition and identified needs.	P/P for Access to Specialty Providers Evidence of signed contracts with listed specialty provider types P/P for Coordination with		Full	This requirement is addressed in policy 3.804 - Members with Special Needs.	

Provider Network					
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	Other Service Providers				
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.	P/P for Provider Network Contracts with FQHC/RHCs		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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.	P/P for use of out-of-network services P/P for Emergency Services Requests for exceptions		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The DBPM shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from LDH.	Network Provider Development and Management Plan Evidence of approval from LDH		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Significant Traditional Providers					
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.	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Credentialing		Full	This requirement is addressed in policy 10.102LA - Recruiting Significant Traditional Providers.	
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	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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):	Evidence of Provider Network Development and Management Plan submission to LDH P/P for Provider Network				
Anticipated maximum number of Medicaid members;	Network reports		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the DBPM;	Needs assessment findings		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services;	Provider Training materials Training meeting minutes and attendance sheet		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The numbers of DBPM providers who are not accepting new DBPM members; and	List of DMB providers not accepting new members		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	P/P for Access and Availability GeoAccess reports		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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	Network Provider		Full	This requirement is addressed in policy	

Provider Network					
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	Development and Management Plan P/P for Provider Network P/P for Access and Availability			10.300LA - Provider Network Development and Management.	
Access to Primary Care Dentists	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Access to Specialists	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Timely Access	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Service Area	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Second Opinion	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	P/P for Access and Availability				
Out-of-Network Providers	Network Provider Development and Management Plan P/P for use of out-of-network providers		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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.	Network Provider Development and Management Plan P/P for Access and Availability		Full	This requirement is addressed in policy 10.104LA - Network Adequacy.	
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.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports P/P for Provider Network		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management. MCNA provided quarterly GeoAccess Reports and attestations for the period.	
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;	Network Contracts		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
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;	P/P for Network Development and Management		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Evaluate the quality of services delivered by the network;	P/P for Network Services Evidence of quality services		Full	This requirement is addressed in policy 10.300LA - Provider Network Development	

Provider Network					
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	evaluation			and Management.	
Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	P/P Network Services		Full	This requirement is addressed in policy 10.104LA - Network Adequacy.	
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 or with physical or mental disabilities.;	P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.104LA - Network Adequacy.	
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;	P/P for Provider Network Provider contracts P/P for Provider Credentialing and Re-credentialing Request to review credentialing and re-credentialing policies. Also request to see the credentialing and re-credentialing timeline of providers that were credentialed and re-credentialed to determine if the documented policies were followed. Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in policy 6.301aLA - Express Credentialing Process. **Credentialing File Review Results** Five of five files reviewed met all requirements. **Credentialing File Review Results** Five of five files reviewed met all requirements.	
Provide training for its providers and maintain records of such training;	Provider manual/handbook Provider training materials Evidence of training attendance sheets		Full	This requirement is addressed in policy 5.110LA - Provider Training Programs. MCNA provided a sample signed new provided training.	

Provider Network					
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Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Evidence of Provider Reports Tracking Report		Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process. MCNA supplied monthly provider call center reports.	
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.	P/P for Provider Complaints Evidence of timely process submission		Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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.	Evidence of communication with LDH		Full	This requirement is addressed in policy 5.401LA - Resolving Provider Inquiries Received from the Louisiana Department of Health.	
Material Change to Provider Network					
The DBPM shall provide written notice to LDH, no later than seven (7) business days of any network provider 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.	P/P for Provider Termination Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
A decrease in the total of individual primary care dentists by more than five percent (5%);	P/P for Provider Termination Evidence of communication		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network	

Provider Network					
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	with LDH				
A loss of any participating specialist which may impair or deny the members' adequate access to providers;	P/P for Provider Termination P/P for Access and Availability Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
Other adverse changes to the composition of the DBPM which impair or deny the members' adequate access to providers.	P/P for Access and Availability Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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.	Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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.	P/P for Provider Network P/P for Change requests Notification to Member Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
The request must include a description of any short-term gaps indentified as a result of the change and the alternatives that will be used to fill them.	P/P for Change requests Notification to Member		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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	P/P for Change requests Notification to Member Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
to approve material changes. LDH will act to expedite the approval process.					
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:	Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
Information about how the provider network change will affect the delivery of covered services, and	P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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.	P/P for Provider Network P/P for Access and Availability Evidence of communication with LDH		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
Coordination with Other Service Providers					
The DBPM shall implement procedures for network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members to ensure that each enrollee has an ongoing source of care appropriate to their needs.. 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). The DBPM shall formally designate a person or entity as primarily responsible for coordinating services accessed by the members. The DBPM shall provide the member	P/P for Coordination with Other Service Providers		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management. The designated contact is the supervisor of case management. Communication is based on protocol of the other MCOs. All plans have been given contact info for supervisor, her boss, and their generic case management email address.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
information on how to contact their designated person or entity.					
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.	Network Provider Development and Management Plan P/P Provider Contracting		Full	This requirement is addressed in policy 10.502LA - Provider Contract Requirements.	
The DBPM shall have written policies and procedures for selection and retention of providers in accordance with 42 CFR §438.214.	P/P for Provider Selection and Retention		Full	This requirement is addressed in policy 10.106LA - Provider Selection and Retention.	
The subcontractor shall follow the state's credentialing and re-credentialing policy.	P/P for credentialing & re-credentialing		Full	This requirement is addressed in policy 6.100 - Provider Credentialing Program Description.	
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.	P/P for Provider Selection and Retention P/P for Access to Specialty Providers		Full	This requirement is addressed in policy 10.203LA - Non-discrimination Against Dental Providers.	
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, 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.	P/P for Subcontractor Delegation and Requirements		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of Subcontractors.	
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.	P/P for Subcontractor Delegation and Requirements		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of Subcontractors.	
The DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	P/P for Subcontractor Delegation and		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Requirements			Subcontractors. No new subcontracts were entered into during the review period.	
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.	P/P for Subcontractor Delegation and Requirements		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of Subcontractors.	
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.	P/P for Subcontractor Delegation and Requirements Evidence of Subcontractors Performance Evaluation		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of Subcontractors. MCNA provided quarterly practice scorecards.	
The DBPM shall identify deficiencies or areas for improvement, and take corrective action.	P/P for Subcontractor Delegation and Requirements Evidence of a Corrective Action Plan		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of Subcontractors. MCNA stated that two providers have been placed on prepayment review due to Program Integrity issues.	
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.	P/P for Subcontractor Delegation and Requirements Evidence of LDH approval Evidence of communication with LDH		Full	This requirement is addressed in policy 1.200LA - Contracting and Oversight of Subcontractors.	
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	P/P for Subcontractor Delegation and Requirements P/P Subcontractor Standards		Full	This requirement is addressed in policy 6.309 - Medicare/Medicaid Sanctions.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
All subcontracts must provide for termination of the subcontract, or specify other remedies, when the DHH or DBPM determines that the subcontractor has not performed satisfactorily. 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.	P/P for Subcontractor Delegation and Requirements P/P Provider Subcontract Termination Evidence of communication with LDH Notification to Provider		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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.	P/P Provider Subcontract Termination Notification to LDH Notification to Members P/P for use of out-of-network providers		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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).	P/P Provider Subcontract Termination Notification to Provider Notification to Members		Full	This requirement is addressed in policy 10.107LA - Material Changes to the Provider Network.	
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	P/P for Subcontractor Delegation and Requirements		Full	MCNA Provided an executed agreement with MCNA of Texas that complies with the requirements.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
supersede the requirements in Section III.F.					
Indians, Indian Healthcare Providers Network and coverage requirements.					
The DBPM shall demonstrate that there are sufficient IHCPs participating in the provider network of the Plan to ensure timely access to services available under the Contract from such providers for Indian enrollees who are eligible to receive services.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The DBPM shall pay IHCPs, whether participating or not, for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows: (i) At a rate negotiated between the DBPM and the IHCP, or (ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the DBPM would make for the services to a participating provider which is not an IHCP; and (iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. § 447.45 and § 447.46.					
The DBPM shall permit any Indian who is enrolled in the Plan that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The Plan shall permit Indian enrollees to obtain services covered under the Contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Availability				
If timely access to covered services cannot be ensured due to few or no IHCPs, the Plan shall be considered to have met the requirement in paragraph 1.3.1.6.3.1(1) of this section if– (i) Indian enrollees are permitted by the Plan to access out of-State IHCPs; or (ii) If this circumstance is deemed to be good cause for disenrollment from both the Plan and the State's managed care program in accordance with § 438.56(c).	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
The Plan shall permit an out-of-network IHCP to refer an Indian enrollee to a network provider. Enrollment in IMCEs. An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. § 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in 42 C.F.R. § 438.3(d).	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in policy 10.300LA - Provider Network Development and Management.	
Provider-Member Communication Anti-Gag Clause.					
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 manual/handbook P/P for Provider Appointment Standards Member Handbook		Full	This requirement is addressed in the MCNA Provider Manual. MCNA also provided the template provider agreement that includes the required language.	
Any information the member needs in order to decide among relevant treatment options;	Provider manual/handbook Member Handbook		Full	This requirement is addressed in the MCNA Provider Manual.	

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]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	P/P Treatment Standards			MCNA also provided the template provider agreement that includes the required language.	
The risks, benefits and consequences of treatment or non-treatment; and	Provider manual/handbook Member Handbook P/P Treatment Standards		Full	This requirement is addressed in the MCNA Provider Manual. MCNA also provided the template provider agreement that includes the required language.	
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 manual/handbook Member Handbook P/P Treatment Standards		Full	This requirement is addressed in the MCNA Provider Manual. MCNA also provided the template provider agreement that includes the required language.	
Any DBPM that violates the anti-gag provisions set forth in 42 CFR §438.102 shall be subject to intermediate sanctions.			Full	This requirement is addressed in policy 10.502LA - Provider Contract Requirements.	
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.			Full	This requirement is addressed in policy 10.502LA - Provider Contract Requirements.	

Provider Relations

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Provider Relations					
The DBPM shall, at a minimum, provide a Provider Relations function to provide support and assistance to all providers in their DBPM network. This function shall: • Be available Monday through Friday from 7 am to 5 pm Central Time to address non-emergency provider issues or requests; • Ensure each DBPM provider is provided all rights outlined in the Provider's Bill of Rights (see Appendix J); • Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and • Ensure regularly scheduled visits to provider sites, as well as ad hoc visits as circumstances dictate.	Provider Relations Policy Schedule of site visits		Full	This requirement is addressed in policy 5.100LA - Provider Relations Department Overview.	
Provider Toll-free Telephone Line					
The DBPM must operate a toll-free telephone line to respond to provider questions, comments and inquiries.	Provider Relations Policy		Full	This requirement is addressed in policy 5.100LA - Provider Relations Department Overview.	
The provider access component of the toll-free telephone line must be staffed between the hours of 7am-7pm Central Time Monday through Friday to respond to provider questions in all areas, including but not limited to prior authorization requests, provider appeals, provider processes, provider complaints, and regarding provider responsibilities.	Test phone availability		Full	This requirement is addressed in policy 5.100LA - Provider Relations Department Overview.	
The DBPM's call center system must have the capability to track provider call management metrics.	Metric reports for the review period		Full	This requirement is addressed in policy 5.100LA - Provider Relations Department Overview.	
After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information regarding normal business hours and instructions to verify enrollment for any	Provider Relations Policy		Full	This requirement is addressed in policy 5.100LA - Provider Relations Department Overview.	

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
DBPM member with an emergency or urgent dental condition. This shall not be construed to mean that the provider must obtain verification before providing emergency/urgent care.					
Provider Website					
The DBPM shall have a provider website. The provider website may be developed on a page within the DBPM's existing website (such as a portal) to meet these requirements.					
The DBPM provider website shall include general and up-to date information about the DBPM as it relates to the Louisiana program. This shall include, but is not limited to: • DBPM provider manual; • DBPM-relevant DHH bulletins; • Information on upcoming provider trainings; • A copy of the provider training manual; • Information on the provider complaint and dispute system; • Information on obtaining prior authorization and referrals; and • Information on how to contact the DBPM Provider Relations.	Provider Relations Policy Website		Full	This requirement is addressed in policy 12.800 Website Development and Maintenance. MCNA provided a demo of their provider portal.	
The DBPM provider website is considered marketing material and, as such, must be reviewed and approved by DHH in writing within thirty (30) calendar days of the date the DBPM signs the Contract.					
The DBPM must notify DHH when the provider website is in place and when any approved changes are made.	Provider Relations Policy		Full	This requirement is addressed in policy 12.800 - Website Development and Maintenance.	
The DBPM must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.	Provider Relations Policy HIPAA/Privacy policies		Full	This requirement is addressed in policy 12.800 - Website Development and Maintenance.	

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
The DBPM website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.	Provider Relations Policy 508 compliance test		Full	This requirement is addressed in policy 12.800 - Website Development and Maintenance.	
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:			Full	This requirement is addressed in policy 5.514LA - Provider Manual.	
Description of the DBPM;			Full	This requirement is addressed in the MCNA Provider Manual.	
Core dental benefits and services the DBPM must provide;			Full	This requirement is addressed in the MCNA Provider Manual.	
Emergency dental service responsibilities;			Full	This requirement is addressed in the MCNA Provider Manual.	
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;			Full	This requirement is addressed in the MCNA Provider Manual.	
Information about the DBPM's Grievance System, that the			Full	This requirement is addressed in the	

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
provider may file a grievance or appeal on behalf of the member with the member's written consent, the 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;				MCNA Provider Manual.	
Medical necessity standards as defined by DHH and practice guidelines;			Full	This requirement is addressed in the MCNA Provider Manual.	
Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;			Full	This requirement is addressed in the MCNA Provider Manual.	
Primary care dentist responsibilities;			Full	This requirement is addressed in the MCNA Provider Manual.	
Other provider responsibilities under the subcontract with the DBPM;			Full	This requirement is addressed in the MCNA Provider Manual.	
Prior authorization and referral procedures;			Full	This requirement is addressed in the MCNA Provider Manual.	
Dental records standards;			Full	This requirement is addressed in the MCNA Provider Manual.	
Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;			Full	This requirement is addressed in the MCNA Provider Manual.	
DBPM prompt pay requirements;			Full	This requirement is addressed in the MCNA Provider Manual.	
Notice that provider complaints regarding claims payment shall be sent to the DBPM;			Full	This requirement is addressed in the MCNA Provider Manual.	
Quality performance requirements; and			Full	This requirement is addressed in the MCNA Provider Manual.	
Provider rights and responsibilities.			Full	This requirement is addressed in the MCNA Provider Manual.	

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
The DBPM shall disseminate bulletins as needed to incorporate any changes to the provider handbook.			Full	This requirement is addressed in the MCNA Provider Manual.	
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:			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
Identify a staff person specifically designated to receive and process provider complaints;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
Ensure that DBPM executives with the authority to require corrective action are involved in the provider complaint process as necessary.			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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:			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
DBPM and the resolution time;					
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;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
A process for giving providers (or their representatives) the opportunity to present their cases in person;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
Identification of specific individuals who have authority to administer the provider complaint process;			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
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			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	

Provider Relations					
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	
The DBPM shall include a description of the Provider 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.			Full	This requirement is addressed in policy 5.116MIC -Provider Complaint Process.	
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.			Full	This requirement is addressed in policy 5.116MIC - Provider Complaint Process.	

Quality Management

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO 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;	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Incorporate improvement strategies that include, but are not limited to: performance improvement projects; dental record audits; performance measures; and provider and member surveys;	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Detect underutilization and overutilization of services;	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description. MCNA provided their QAPI Impact and Effectiveness Report for CY 2018, which provides analysis of the UM function.	
Assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
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.	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
The DBPM shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed.					

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
QAPI Committee					
The DBPM shall form a QAPI Committee that shall, at a minimum include:	QAPI Plan QAPI Committee Charter		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
The DBPM Dental Director must serve as either the chairman or co-chairman;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Appropriate DBPM staff representing the various departments of the organization will have membership on the committee; and			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
The DBPM is encouraged to include a member advocate representative on the QAPI Committee.			Substantial	The QAPI Work Plan does mention the member advocate in passing. The requirement is "encouraged" rather than "must." MCNA has outreach specialists on the QI Committee. Dental Advisory Committee – has member and LSU Dental School. Meets quarterly/ **<u>Recommendation</u>** MCNA should include in its policy that it has a member advocate on its QI Committee.	Policy 2.103LA QI Program Description has been updated. See pages 8 & 17.
QAPI Committee Responsibilities					
The committee shall:					
Meet on a quarterly basis;	QAPI Quaterly meeting		Full	This requirement is addressed in policy	

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	minutes			2.103LA - QI Program Description/ QAPI Committee minutes and agendas for the four quarters of the review period were submitted.	
Direct and review quality improvement (QI) activities;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Assure than QAPI activities are implemented throughout the DBPM;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Review and suggest new and or improved QI activities;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Direct task forces/committees to review areas of concern in the provision of healthcare services to members;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Designate evaluation and study design procedures;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Conduct individual primary care dentist and primary care dentist practice quality performance measure profiling;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Report findings to appropriate executive authority, staff, and departments within the DBPM;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Direct and analyze periodic reviews of members' service utilization patterns;			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH with other quarterly reports;	QAPI Quarterly meeting minutes		Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
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			Full	This requirement is addressed in policy 2.103LA - QI Program Description. MCNA provided their QAPI Program Evaluation.	

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Ensure that a QAPI committee designee attends DHH Quality Committee meetings.			Full	This requirement is addressed in policy 2.103LA - QI Program Description.	
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:	QAPI Plan		Full	This requirement is addressed in policy 2.103LA - QI Program Description. MCNA provided the 2018 and 2019 QAPI Work Plans.	
Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;			Full	This requirement is addressed in policy 2.700LA - Quality Improvement Reporting Requirements.	
Include processes to evaluate the impact and effectiveness of the QAPI Program;			Full	This requirement is addressed in policy 2.700LA - Quality Improvement Reporting Requirements. Onsite discussion demonstrated strong monitoring of department performance, risk management training, and case management results.	
Include a description of the DBPM staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and			Full	This requirement is addressed in policy 2.700LA - Quality Improvement Reporting Requirements.	
Describe the role of its providers in giving input to the QAPI Program.			Full	This requirement is addressed in policy 2.700LA - Quality Improvement Reporting Requirements.	
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	Annual QAPI Report		Full	This requirement is addressed in policy 2.700LA - Quality Improvement Reporting Requirements.	

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO 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.					
Performance Measures					
The DBPM shall report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by DHH.	Annual QAPI Report		Full	This requirement is addressed in policy 2.701LA - Performance Measures.	
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.	Performance Measure Reports		Full	This requirement is addressed in policy 2.701LA - Performance Measures. MCNA provided annual and quarterly reporting	
The DBPM shall have processes in place to monitor and report all performance measures.	PM Policy and Procedure		Full	This requirement is addressed in policy 2.701LA - Performance Measures.	
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.	Annual QAPI Report		Full	This requirement is addressed in policy 2.701LA - Performance Measures. MCNA provided monthly KPI, quarterly QIC, and annual QAPI reports.	
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.	Annual QAPI Report		Full	MCNA provided quarterly administrative PM reports.	
The reports and data shall demonstrate adherence to clinical practice guidelines and shall demonstrate changes in patient outcomes.	Annual QAPI Report		Full	This requirement is addressed in policy 2.701LA - Performance Measures.	

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					
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.	PM Reports		Full	This requirement is addressed in policy 2.701LA - Performance Measures.	
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%					

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 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.	PM Policy and procedure		Full	This requirement is addressed in policy 2.701LA - Performance Measures.	
The monitoring tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	PM Policy and procedure		Full	This requirement is addressed in policy 2.701LA - Performance Measures.	
The DBPM shall have processes in place to monitor and self-report performance measures including but not limited to measures listed in Appendix F.			Full	This requirement is addressed in policy 2.701LA - Performance Measures. MCNA provided its KPI dashboard as an example of self-monitoring.	
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					

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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%) - 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.	PM Policy and Procedure Individual quality profile reports		Full	This requirement is addressed in policy 2.203LA - Provider Profiling.	
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.					
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			Full	This requirement is addressed in policy 2.213LA - Collaboration with EQRO.	

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 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.					
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.					
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.	QAPI Plan If identified, CAPs for plan deficiencies submitting during the review period.		Full	This requirement is addressed in policy 2.701LA - Performance Measures. There were no CAPs during the 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.					
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.					
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	QAPI Plan		Full	This requirement is addressed in policy	

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year.				4.107MIC - Call Center Operations. MCNA provided copies of adult and child survey results for 2018.	
Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	QAPI Plan		Full	MCNA provided evidence of submitting report 132 – Non-CAHPS Survey to LDH.	
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.	QAPI Plan		Full	There is no sample, MCNA does 100%.	
The surveys shall provide valid and reliable data for results statewide and by parish.	QAPI Plan		Full	Results reported in Report 132 are not broken down by parish. MCNA states that the template for report 132 is set my LDH and does not have a column to provided parish. They also provided another report with parish breakdowns.	
Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	QAPI Plan	See above	Full	This requirement is addressed in the QAPI Evaluation CY 2018 Report.	
The most current CAHPS DBPM Survey (currently 4.0) for Medicaid Enrollees shall be used and include:					
Getting Needed Care					
Getting Care Quickly					
How Well Doctors Communicate					
DBPM Customer Service					
Global Ratings					
Member Satisfaction Survey Reports are due 120 days after the end of the contract year.					

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	QAPI Plan		Full	This requirement is addressed in policy 5.111LA – Provider Satisfaction Survey. MCNA provided copies of provider survey results for 2018. The analysis of results is addressed in the QAPI Evaluation CY 2018 Report.	
The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	QAPI Plan		Full	This requirement is addressed in policy 5.111LA - Provider Satisfaction Survey.	
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.	QAPI Plan Provider Survey Report		Full	This requirement is addressed in policy 5.111LA - Provider Satisfaction Survey.	
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.					
Upon any indication that the DBPM's quality performance is not acceptable, DHH may impose sanctions or terminate the contract.					
The DBPM shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other					

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Department designees during monitoring.					
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.)					
These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.					
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."					
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.					
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.					
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.					

Quality Management (QM)					
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.					

Reporting

Reporting					
State Contract Requirements [Federal Regulation: 438.242]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response 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.	P/P for Reporting P/P for The Health Information System Screen Shot of the Health Information System System Data Reports Evidence of Timely Submission of Reports to LDH Certification of Data Reports Copy of Certification Notice		Full	This requirement is addressed in policy – 12.600LA - Reporting Requirements. MCNA also provided proof of timely submission.	

Utilization Management

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO 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.	Policy for UM Evidence of timely submission of Policy for UM		Full	This requirement is addressed in the Authorizations Policy on page 1.	
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.	Policy for UM		Full	This requirement is addressed in the Utilization Management Criteria Updates Policy on page 1.	
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;	Policy for UM Policy for medical management criteria Provider Manual/Handbook		Full	This requirement is addressed in section 6.4 Medically Necessary Services and section 13.1 Decision-Making Criteria in the Provider Manual on pages 22, 50, and 51.	
The data sources and clinical review criteria used in decision making;	Policy for UM Policy for medical management criteria Provider Manual/Handbook		Full	This requirement is addressed in the Utilization Management Criteria Updates Policy on page 2.	
The appropriateness of clinical review shall be fully documented;	Policy for UM Policy for medical management criteria		Full	This requirement is addressed in the Utilization Management Criteria Updates Policy on page 1.	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Provider Manual/Handbook				
The process for conducting informal reconsiderations for adverse determinations;	Policy for UM Policy for medical management criteria Provider Manual/Handbook		Full	This requirement is addressed in the Informal Reconsideration Process Policy and Procedures.	
Mechanisms to ensure consistent application of review criteria and compatible decisions;	Policy for UM Policy for medical management criteria Provider Manual/Handbook Compliance reports		Full	This requirement is addressed in the Inter-Rater Reliability Audits Policy and Procedures on page 1.	
Data collection processes and analytical methods used in assessing utilization of dental care services; and	Policy for UM Policy Coordination of services Utilization Report		Full	This requirement is addressed in the Monitoring for Over- and Under- Utilization of Dental Services Policy on page 1.	
Provisions for assuring confidentiality of clinical and proprietary information.	Policy for UM Policy Coordination of services Policy for medical management criteria		Full	This requirement is addressed in the Confidentiality for Patient-Specific Information Policy and Procedure.	
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.	Policy for UM Practice Guidelines Sample adopted guidelines Policy for guideline dissemination		Full	This requirement is addressed in the Clinical Practice Guidelines Policy on page 1.	
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;	Policy for Dental Management Criteria Policy for Vendors		Not applicable	The criteria were not purchased.	
The association or society must be identified if the criteria are	Policy for Dental		Full	This requirement is addressed in the	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
developed/recommended or endorsed by a national or state dental care provider association or society;	Management Criteria Policy Service Authorization Requests			Utilization Management Criteria Updates Policy and Procedure on page 2.	
The guideline source must be identified if the criteria are based on national best practice guidelines; and	Policy for Dental Management Criteria Policy Service Authorization Requests		Full	This requirement is addressed in the Utilization Management Criteria Updates Policy and Procedure on page 3.	
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.	Policy for Dental Management Criteria		Not applicable	All medical necessity determinations are made by a licensed dentist.	
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.	Policy for UM Policy for Dental Management Criteria Practice Guidelines Sample adopted guidelines Policy for guideline dissemination		Full	This requirement is addressed in the Clinical Practice Guidelines Policy on page 1.	
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.	Policy for UM Policy Coordination of services Member/Provider Handbook Policy for required information		Full	This requirement is addressed in the Adverse Determination Policy on page 5.	
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).	Policy for UM Policy for required information		Full	This requirement is addressed in the Adverse Determination Policy on page 5.	
The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management	Policy for UM Policy for Medical		Full	This requirement is addressed in the Utilization Management Staff Responsibilities	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
criteria and practice guidelines.	Management Criteria Evidence of Training Information			for Utilization Management Decision Making Policy and Procedure on page 1.	
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.	Policy for UM Policy Medical Necessity		Full	This requirement is addressed in the Authorizations Policy on page 5.	
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.	Policy for UM Policy Dental Benefits/Services		Full	This requirement is addressed in the Authorizations Policy on page 1.	
The DBPM must identify the qualification of staff who will determine medical necessity.	Policy for UM Policy for Medical Management Criteria Staffing plan Policy Medical Necessity		Full	This requirement is addressed in the Utilization Management Staff Responsibilities for Utilization Management Decision Making Policy and Procedure on page 2.	
Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Policy Medical Necessity Policy for Service Authorization		Full	This requirement is addressed in the Utilization Management Staff Responsibilities for Utilization Management Decision Making Policy and Procedure on page 2.	
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.	Policy for Service Authorization		Full	This requirement is addressed in the Adverse Determinations Policy on pages 3 and 4. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed were reviewed by a licensed clinical professional.	
The individual(s) making these determinations shall have no	Policy for Service		Full	This requirement is addressed in the Adverse	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 the clinical peer reviewer's physical, mental, or professional or moral character.	Authorization			Determinations Policy on page 4.	
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.	Policy for Service Authorization		Full	This requirement is addressed in the Adverse Determinations Policy on page 4.	
The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of health care services.	Policy for Service Authorization Policy Service utilization		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2.	
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.	Policy for Service Authorization Policy Service utilization		Full	This requirement is addressed in the Authorizations Policy on page 1.	
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.	Policy for Service Authorization Policy Service utilization		Full	This requirement is addressed in the Adverse Determinations Policy on page 1.	
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.	Policy for Service Authorization Policy Service utilization Policy Medically Necessary		Full	This requirement is addressed in the Adverse Determinations Policy on page 1.	
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.	Policy for UM Policy Service utilization		Full	This requirement is addressed in the Authorizations Policy on page 2.	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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).	Policy for UM Policy Service utilization Policy for Fraud and Abuse		Full	This requirement is addressed in the Adverse Determinations Policy on pages 9 and 10.	
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;	Policy for UM utilization Utilization Review Plan		Full	This requirement is addressed in the Authorizations Policy on page 6.	
The name of the enrollee's dentist;	Policy for UM utilization Utilization Review Plan		Full	This requirement is addressed in the Authorizations policy on page 6.	
Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Policy for UM utilization Utilization Review Plan		Not applicable	There were no cases that met these criteria during the review period.	
The plan of care;	Policy for UM utilization Utilization Review Plan Care Plan		Not applicable	There were no cases that met these criteria during the review period.	
Date of operating room reservation, if applicable; and	Policy for UM utilization Utilization Review Plan Care Plan		Not applicable	There were no cases that met these criteria during the review period.	
Justification of emergency admission, if applicable.	Policy for UM utilization Utilization Review Plan Care Plan		Not applicable	There were no cases that met these criteria during the review period.	
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).	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
The UM Committee shall provide utilization review and monitoring of UM activities of both the DBPM and its providers					

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 minutes to LDH with other quarterly reports. UM Committee responsibilities include:					
Monitoring providers' requests for rendering healthcare services to its members;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
Monitoring consistent application of "medical necessity" criteria;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
Application of clinical practice guidelines;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 2 and Utilization Management	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				Committee Meeting Agendas and Meeting Minutes.	
Monitoring over- and under-utilization;	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 3 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
Review of outliers, and	Policy for UM utilization Committee meeting minutes		Full	This requirement is addressed in the Utilization Management Committee Policy on page 3 and Utilization Management Committee Meeting Agendas and Meeting Minutes.	
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.	Policy for UM utilization Committee meeting minutes Evidence of Dental Record Reviews Policy Record Reviews		Full	This requirement is addressed in the Dental Record Review Policy on page 1.	
Dental Record Review Strategy					
The DBPM shall maintain a written strategy for 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.).	Policy Record Reviews Record Review Strategy Evidence of Timely Submission of Record Review Strategy		Full	This requirement is addressed in the Dental Record Review Policy on page 2 and in the quarterly Utilization Management Reports.	
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	Policy Record Reviews Record Review Strategy Record Review Schedule		Full	This requirement is addressed in the Dental Record Review Policy on page 1.	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
group facilities. The DBPM shall review each site at least one (1) time during each five (5) year period.					
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.	Policy Record Reviews Record Review Strategy Record Review Schedule		Full	This requirement is addressed in the Dental Record Review Policy on page 2.	
The DBPM shall report the results of all record reviews to LDH quarterly with an annual summary.	Policy Record Reviews Record Review Strategy Record Review Schedule Record Review Reports		Full	This requirement is addressed in the Dental Record Review Policy on page 4 and in the quarterly Utilization Management Reports.	
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.	Policy for UM utilization Utilization Management Reports Evidence of communication to LDH		Full	This requirement is addressed in the Utilization Management Reporting Requirements Policy on page 1 and in the quarterly Utilization Management Reports.	
Service Authorization					
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;	Policy for Initial and Continuing Service Authorization		Full	This requirement is addressed in the Authorizations Policy on page 1.	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Policy for Initial and Continuing Service Authorization		Full	This requirement is addressed in the Inter-Rater Reliability Audits Policy on page 1.	
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;	Policy for Initial and Continuing Service Authorization Policy/ for Denials of Authorization		Full	This requirement is addressed in the Adverse Determinations Policy on page 1. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed were reviewed by a licensed clinical professional.	
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;	Policy for Initial and Continuing Service Authorization		Full	This requirement is addressed in the Authorizations Policy on page 1, in the Referral Authorization Process Policy on page 1, and in the member handbook on page 34.	
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	Policy for Initial and Continuing Service Authorization Includes File Review or System Demonstration		Full	This requirement is addressed in the Authorizations Policy on page 2. MCNA demonstrated the service authorization system while onsite.	
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.	Policy for Initial and Continuing Service Authorization Includes File Review or System Demonstration		Full	This requirement is addressed in the Authorizations Policy on page 2. MCNA demonstrated the service authorization system while onsite.	
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.	Policy for Initial and Continuing Service Authorization Policy for Standard Service Authorization		Full	This requirement is addressed in the Adverse Determinations Policy on page 1.	
Timing of Service Authorization Decisions					
Standard Service Authorization					

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Policy for Standard Service Authorization Evidence of timely Service Authorization Determinations Evidence of communication with LDH		Full	This requirement is addressed in the Authorizations Policy on page 3. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed demonstrated the standard service authorization determination was made within two business days of obtaining appropriate dental information.	
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 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.	Policy for Standard Service Authorization		Full	This requirement is addressed in the Authorizations Policy on page 3. **File Review Results** Not applicable. Zero (0) out of 10 Utilization Management files reviewed required an extension.	
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.	Policy for Standard Service Authorization		Full	This requirement is addressed in the Adverse Determinations Policy on page 6.	
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.	Policy for Standard Service Authorization		Full	This requirement is addressed in the Authorizations Policy on page 3.	
Post Authorization					
The DBPM shall make retrospective review determinations within	Policy for Standard Service		Full	This requirement is addressed in the	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Authorization Evidence of Timely Review Determination			Authorizations Policy on page 4.	
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.	Policy for Standard Service Authorization		Full	This requirement is addressed in the Authorizations Policy on page 5.	
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.	Policy Service Authorization Approval Provider Notification Evidence of Timely Notification		Full	This requirement is addressed in the Authorizations Policy on page 3.	
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.	Policy Service Authorization Approval Provider Notification Evidence of Timely Service		Full	This requirement is addressed in the Authorizations Policy on pages 4 and 7.	
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	Policy Service Authorization Denial Member Notification Letter		Full	This requirement is addressed in the Adverse Determinations Policy on page 1 and 2. **File Review Results** Ten (10) out of 10 Utilization Management	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.				files reviewed notified the member in writing, using language that is easily understood.	
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 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.	Policy Service Authorization Denial Provider Notification		Full	This requirement is addressed in the Adverse Determination Policy on page 2. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed notified the provider within two business days of making the initial certification.	
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.	Policy for Member Service Appeals		Full	This requirement is addressed in the Informal Reconsiderations Process Policy on page 1.	
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.	Policy for Member Service Appeals		Full	This requirement is addressed in the Informal Reconsiderations Process Policy on page 1. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed directed the member how to request an informal reconsideration of an adverse determination.	
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.	Policy for Member Service Appeals Evidence of Timely Reconsideration		Full	This requirement is addressed in the Informal Reconsiderations Process Policy on page 1.	

Utilization Management					
State Contract Requirements [Federal Regulation: 438.210, 438.236, 438.404]	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.	Policy for Member Service Appeals		Full	This requirement is addressed in the Informal Reconsiderations Process Policy on page 1.	
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.	Policy Standard Service Authorization Policy for Emergency Services		Full	This requirement is addressed in the Authorizations Policy on page 1.	
The DBPM shall not require service authorization or referral for EPSDT dental screening services.	Policy for EPSDT Services		Full	This requirement is addressed in the Authorizations Policy on page 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.	Policy Standard Service Authorization		Full	This requirement is addressed in the Continuity of Care for New Members Policy on page 1.	
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.	Policy for UM Primary Care Dentist Utilization Reports		Full	This requirement is addressed in the Provider Profiling Policy on page 1.	
The DBPM shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Policy for UM Policy for Quality of Care		Full	This requirement is addressed in the Provider Profiling Policy on page 1.	
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.			Full	This requirement is addressed in the Provider Profiling Policy on page 1.	