Managed Care Program Annual Report (MCPAR) for Louisiana: Dental Benefit Program Management

Due date	Last edited	Edited by	Status
06/29/2025	06/30/2025	Corneliaus Cole	Submitted

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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Louisiana
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Corneliaus Cole
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	corneliaus.cole@la.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Brandon Bueche
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	brandon.bueche@la.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/30/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
A6	**Program name** Auto-populated from report dashboard.	Dental Benefit Program Management

Add plans (A.7)

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

	Indicator	Response
	Plan name	DentaQuest MCNA of Louisiana

Add BSS entities (A.8)

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

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

Indicator	Response
BSS entity name	Maximus Health Services

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	1,726,145
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,578,450

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	LDH PI section utilizes data mining runs/algorithms, risk scoring and alerts which focus on providers in both the Fee-For-Service (FFS) and Managed Care programs. Some of the algorithms and alerts include date of death runs, excluded provider runs, spike/surge runs, procedure code outlier runs, etc. The audits resulting from the methods mentioned above are conducted by the PI Internal SURS Unit or UPIC contractors; other audits/leads are sent to the Plans to review. In addition to data review, PI operates a complaint hotline. Both fee-for-service and managed care complaints are received via the hotline. The complaints are triaged and either is worked by the PI Internal SURS or the complaints are referred to the Plans. The PI Internal SURS also works closely with the Medicaid Fraud Control Unit (MFCU) in the Attorney General's office. Based on information discovered in audits and complaints, PI Internal SURS sends referrals to MFCU to investigate. MFCU works with SURS to initiate payment suspensions based on credible allegations of fraud. PI, SURS, MFCU and the Plan's Special Investigations Unit (SIU) have a monthly calls and quarterly meetings with the Plans.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	DBPM Contract, Attachment B: Statement of Work, Sections 2.12.6.4.2 - 2.12.6.4.3
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain	All recoveries identified by the MCE are retained by the Plan. All recoveries identified by the State are retained by the State. If the MCE fails to collect at least a portion of the identified overpayment after 365 days the State may step

	overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	in and recover from the MCE and said funds would be retained by the State. If the MCE's recovery efforts are deemed sufficient then the State will not step in and recover the overpayment.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	All recoveries are reported by MCOs on two quarterly reports. The MCOs also report all identified overpayments and recovered overpayments on a monthly report. The PI MC Oversight unit conducts review seeking compliance with reporting requirements.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The State and the MCEs have a monthly and quarterly reconciliation 834 file.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state	No

	find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter "No such audits were conducted during the reporting year" as your response. "N/A" is not an acceptable response.	Reviews conducted during CY2024 are published at https://ldh.la.gov/resources?cat=&d=5&y=0&q=EQR

Topic XIII. Prior Authorization

Beginning June 2026, Indicators B.XIII.1a-b–2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?**	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Dental Benefit Program Management
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2021
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://ldh.la.gov/resources?q=Dental%20Benefit%20Program%20Manager%20%28DBPM%29%20Procurement%20Documents%2C%20Contracts%2C%20and%20Related%20Materials%20for%20Contracting%20Period%20%202021%20to%20present
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Ambulatory Health Plan (PAHP)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Dental
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	The benefits received by the EPSDT and Adult Waiver populations are comprehensive. The Adult population receives only denture services. The ICF/IID popuation receives some diagnostic services, such as exams and some radiographic images, from the ICF. These services include D0120, D0150, D0210, D0240, D0272 and D0330. The remainder of dental services are billed to and paid by the PAHP.

C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	1,582,520
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.	1) Covid Unwind - The Procedure where LDH began enrollment of policy and procedures used prior to the PHE and the changes LDH made to have individuals enrolled and stay enrolled in a Medicaid TOA. Unwind brought back income limits, wage checks, tax checks, etc. 2) Began renewals, LWC wage checks, COLA batch runs and enacted The Work Number to verify wages again. Done in phases from May 2024 - Dec 2024

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Other, specify – Encounter submission completeness measured bimonthly as comparison of payments as reported in encounters vs payments reported in cash disbursement journals; encounter data completeness and accuracy also periodically evaluated via optional EQR Protocol 5.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	DBPM Contract, Attachment B: Statement of Work Section 2.14.11

C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	DBPM Contract, Attachment B: Statement of Work Section 3.6.5, Table of Monetary Penalties
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	Systems performance issues with Fiscal Intermediary (FI)(Gainwell Technologies) make it difficult to assess MCO non-compliance versus FI failures/non-compliance. On occasion, the state system denied encounters and void encounter transactions that appear in different from their corresponding cash disbursement journal (CDJ) transactions.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	For resolution, an appeal shall be heard and notice of appeal resolution shall be sent to the enrollee no later than thirty (30) calendar days from the date the DBPM receives the appeal.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	The DBPM shall resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within established timeframes not to exceed seventy-two (72) hours after the DBPM receives the appeal request, whether the appeal was made orally or in writing.

C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	The DBPM shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) calendar days from the date the DBPM receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	Many dental providers in the state do not want to serve Medicaid beneficiaries. For those that do, not all want to contract with two PAHPs due to the administrative burden. The burden is due primarily to prior authorization and claims denial rates being higher compared to the rates for commercial insurance carriers. Provider rates are another hindrance, as they are lower compared to commercial insurance carriers.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The contracts with the PAHPs require payment to out of network providers if there are gaps. LDH also works with the PAHPs when complaints are made regarding the lack of a provider in a certain area by looking at the existing providers in the service area and requiring the PAHPs to conduct outreach to those available providers that are not contracted with them.

Access Measures

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

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

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

Access measure total count: 4

Complete

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

1 / 4

C2.V.2 Measure standard

30 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

2 / 4

C2.V.2 Measure standard

10 miles

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

3 / 4

C2.V.2 Measure standard

60 miles for at least 75% of enrollees.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Special Dental Services	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Complete

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

4 / 4

C2.V.2 Measure standard

90 miles for all enrollees.

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Special Dental Services	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	Healthy Louisiana mobile app (available for download on Apple and Android), https://myplan.healthy.la.gov/en
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	All correspondence informs enrollees that they can request assistance or auxiliary aids. This information is also provided on the website and in the mobile app.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	LTSS is not coordinated through the BSS.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Every interaction includes a customer satisfaction survey. There is also a complaint process through which enrollees can provide feedback. All complaints come directly to the State.

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If “Yes”, please complete the following questions.	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**DentaQuest** 824,456 **MCNA of Louisiana** 757,794
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**DentaQuest** 47.8% **MCNA of Louisiana** 43.9%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**DentaQuest** 52.2% **MCNA of Louisiana** 48%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**DentaQuest** 104.3% **MCNA of Louisiana** 112.05%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**DentaQuest** Program-specific statewide **MCNA of Louisiana** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter “N/A” if not applicable. See glossary for the regulatory definition of MLR.	**DentaQuest** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 125.6% and Non-Expansion is 83.0%. **MCNA of Louisiana** Louisiana has a requirement to submit two separate MLRs, one for the expansion and non-expansion populations. D1.II.1a reflects an average of both populations. MLR ratio for Expansion is 130.3% and Non-Expansion is 93.8%.

D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**DentaQuest** Yes **MCNA of Louisiana** Yes
N/A	Enter the start date.	**DentaQuest** 07/01/2023 **MCNA of Louisiana** 07/01/2023
N/A	Enter the end date.	**DentaQuest** 06/30/2024 **MCNA of Louisiana** 06/30/2024

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**DentaQuest** The DBPM is responsible for ensuring accurate and complete encounter reporting from their providers. The DBPM must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. **MCNA of Louisiana** The DBPM is responsible for ensuring accurate and complete encounter reporting from their providers. The DBPM must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**DentaQuest** 96% **MCNA of Louisiana** 99%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for	**DentaQuest** NA **MCNA of Louisiana** NA

	the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

> **Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".**

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**DentaQuest** 351 **MCNA of Louisiana** 117
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**DentaQuest** 6 **MCNA of Louisiana** 79
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**DentaQuest** 6 **MCNA of Louisiana** 79
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**DentaQuest** 67 **MCNA of Louisiana** 9
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**DentaQuest** 145 **MCNA of Louisiana** 28

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

	enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**DentaQuest** 351 **MCNA of Louisiana** 117
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**DentaQuest** 0 **MCNA of Louisiana** 0
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**DentaQuest** 348 **MCNA of Louisiana** 65

D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**DentaQuest** 0 **MCNA of Louisiana** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**DentaQuest** 6 **MCNA of Louisiana** 79
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**DentaQuest** 0 **MCNA of Louisiana** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**DentaQuest** 5 **MCNA of Louisiana** 0
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain	**DentaQuest** 0 **MCNA of Louisiana** 0

	services outside the network (only applicable to residents of rural areas with only one MCO).	
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**DentaQuest** 0 **MCNA of Louisiana** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A

D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7h	**Resolved appeals related to dental services**	**DentaQuest** 351

	Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter “N/A”.	**MCNA of Louisiana** 117
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter “N/A”.	**DentaQuest** 0 **MCNA of Louisiana** 0

State Fair Hearings

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

D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**DentaQuest** 0 **MCNA of Louisiana** 0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**DentaQuest** 101 **MCNA of Louisiana** 42
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**DentaQuest** 58 **MCNA of Louisiana** 19
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the	**DentaQuest** N/A **MCNA of Louisiana** N/A

	same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**DentaQuest** 101 **MCNA of Louisiana** 42

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or	**DentaQuest** N/A **MCNA of Louisiana** N/A

	substance use services. If the managed care plan does not cover this type of service, enter "N/A".	
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** N/A **MCNA of Louisiana** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**DentaQuest** 101 **MCNA of Louisiana** 42
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)**	**DentaQuest** N/A

	Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter “N/A”.	**MCNA of Louisiana** N/A
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter “N/A”.	**DentaQuest** N/A **MCNA of Louisiana** N/A

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**DentaQuest** 13 **MCNA of Louisiana** 0
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**DentaQuest** 0 **MCNA of Louisiana** 0

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**DentaQuest** 29 **MCNA of Louisiana** 0
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**DentaQuest** 42 **MCNA of Louisiana** 29
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**DentaQuest** 10 **MCNA of Louisiana** 13

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**DentaQuest** 13 **MCNA of Louisiana** 17
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**DentaQuest** 0 **MCNA of Louisiana** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**DentaQuest** 0 **MCNA of Louisiana** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of	**DentaQuest** 0 **MCNA of Louisiana** 0

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

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 2

Complete

D2.VII.1 Measure Name: CMS 416

1 / 2

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS 416

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

No, 10/01/2023 - 09/30/2024

D2.VII.8 Measure Description

Increase the percentage of EPSDT enrollees, age 1-20, receiving at least 1 preventative dental service. (Line 12b of CMS 416)

Measure results

DentaQuest

Plan-specific data is not available as of the date of submission of this report.

MCNA of Louisiana

Plan-specific data is not available as of the date of submission of this report.

Complete

D2.VII.1 Measure Name: HEDIS OED

2 / 2

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

Increase the percentage of members under 21 years of age receiving a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Measure results

DentaQuest

Plan-specific data is not available as of the date of submission of this report.

MCNA of Louisiana

Plan-specific data is not available as of the date of submission of this report.

Topic VIII. Sanctions

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

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

Sanction total count: 20

Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Quality Management] Failure to meet performance measures.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$69,700

D3.VIII.7 Date assessed

10/22/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

2 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

01/12/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

05/22/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Provider Network] Failure to Maintain an Adequate Provider

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$485,000

D3.VIII.7 Date assessed

06/14/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

5 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Reporting] Failure to Submit Accurate Reports

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

09/05/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

6 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Reporting] Failure to Submit Accurate Reports

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

3

$10,000

D3.VIII.7 Date assessed

10/01/2024

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

Yes, remediated 10/29/2024

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

7 / 20

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Reporting] Failure to Submit Accurate Reports

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

$27,500

D3.VIII.7 Date assessed

10/30/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

8 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Encounter Submission] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

05/15/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

9 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Encounter Submission] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

06/25/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

10 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Encounter Submission] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

10/17/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

11 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Encounter Submission] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

12/27/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

12 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Services and Benefits] Medical Necessity Determinations

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

05/09/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

13 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

DentaQuest

D3.VIII.4 Reason for intervention

[Meeting Attendance] Failure to attend mandatory meeting

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

12/03/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

14 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Quality Management] Failure to meet performance measures

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$190,000

D3.VIII.7 Date assessed

09/08/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

15 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Quality Management] Failure to meet performance measures

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

$62,700

D3.VIII.7 Date assessed

10/22/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

16 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounter Management] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

05/15/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

17 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounter Management] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

06/25/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

18 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounter Management] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

10/17/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Liquidated damages

19 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Claims and Encounter Management] Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

12/27/2024

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Compliance letter

20 / 20

D3.VIII.2 Plan performance issue

Performance improvement

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

[Quality Management] Failure to demonstrate full compliance in an external quality review

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

NA

D3.VIII.7 Date assessed

01/12/2024

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

Yes, remediated 04/30/2024

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**DentaQuest** 1 **MCNA of Louisiana** 1
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**DentaQuest** 6 **MCNA of Louisiana** 7
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**DentaQuest** 0.01:1,000 **MCNA of Louisiana** 0.01:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**DentaQuest** 9 **MCNA of Louisiana** 4
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**DentaQuest** 0.01:1,000 **MCNA of Louisiana** 0.01:1,000
D1X.6	**Referral path for program integrity referrals to the state**	**DentaQuest** Makes referrals to the SMA and MFCU concurrently

	What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**MCNA of Louisiana** Makes referrals to the SMA and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	**DentaQuest** 0 **MCNA of Louisiana** 1
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**DentaQuest** 0:1,000 **MCNA of Louisiana** 0:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**DentaQuest** 04/01/2025 **MCNA of Louisiana** 04/01/2025
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**DentaQuest** 04/30/2025 **MCNA of Louisiana** 04/30/2025
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**DentaQuest** $1,366,440 **MCNA of Louisiana** $100,974
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue**	**DentaQuest** N/A

	What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**MCNA of Louisiana** N/A
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**DentaQuest** Promptly when plan receives information about the change **MCNA of Louisiana** Promptly when plan receives information about the change

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**DentaQuest** Not answered **MCNA of Louisiana** Not answered

Topic XIII. Prior Authorization

Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	**Are you reporting data prior to June 2026?** If "Yes", please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Maximus Health Services** Enrollment Broker/Choice Counseling Beneficiary Outreach