


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

Due date	Last edited	Edited by	Status
06/29/2023	06/28/2023	Teresa Bravo	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

Point of Contact


 Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Louisiana
A2a	Contact name First and last name of the contact person.	Cornelius Cole

States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.

A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	Cornelias.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.	06/29/2023

Reporting Period

 Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2022
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2022
A6	Program name Auto-populated from report dashboard.	Dental Benefit Management program

Add plans (A.7)

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



Find in the Excel Workbook

A_Program_Info

Indicator	Response
Plan name	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 Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.



Find in the Excel Workbook

A_Program_Info

Indicator	Response
BSS entity name	Maximus Health Services

Topic I. Program Characteristics and Enrollment



Find in the Excel Workbook

B_State

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

BI.1	Statewide Medicaid enrollment	2026014
	<p>Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.</p>	
BI.2	Statewide Medicaid managed care enrollment	1,880,315
	<p>Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.</p>	

Topic III. Encounter Data Report

 Find in the Excel Workbook
B_State

Number	Indicator	Response
BIII.1	Data validation entity	Other third-party vendor
	<p>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.</p>	

Topic X: Program Integrity



Find in the Excel Workbook

B_State

Number	Indicator	Response
BX.1	<p>Payment risks between the state and plans</p> <p>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.</p>	<p>The State's Program Integrity (PI) team performs a number of data mining runs/algorithms that include providers in both the Fee-For-Service (FFS) and Managed Care programs. Examples of the algorithms include date of death runs, excluded provider runs, spike/surge runs, and procedure code outlier runs. Some of the audits resulting from the algorithms mentioned are conducted by PI's Surveillance and Utilization Review Subsystem (SURS) or Unified Program Integrity Contractor (UPIC) contractors; other audits/leads are sent to the MCEs to review. In addition to data runs/algorithms, PI's SURS contractor operates a complaint hotline. Both FFS and managed care complaints are received via the hotline. The complaints are triaged and either worked by the SURS contractor or referred to the MCEs. The SURS contractor also works closely with the Medicaid Fraud Control Unit (MFCU) in the Attorney General's office. Based on information discovered in audits and complaints, SURS sends notices and referrals to MFCU to investigate. MFCU works with SURS to initiate payment suspensions based on credible allegations of fraud. PI, SURS, MFCU, and the MCE's Special Investigations Unit (SIU) have monthly calls and quarterly meetings with the MCEs.</p>
BX.2	<p>Contract standard for overpayments</p> <p>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p>State has established a hybrid system</p>
BX.3	<p>Location of contract provision stating overpayment standard</p>	<p>DBPM Contract, Attachment B: Statement of Work, Sections 2.12.6.4.2 - 2.12.6.4.3</p>

Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).

BX.4	Description of overpayment contract standard	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 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	All recoveries are reported by the MCEs on two quarterly reports. The PI Managed Care Oversight unit conducts review seeking compliance with reporting requirements.
BX.6	Changes in beneficiary circumstances	The State and the MCEs have a monthly and quarterly reconciliation 834 file.
BX.7a	Changes in provider circumstances: Monitoring plans	Yes
	Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	

BX.7b	Changes in provider circumstances: Metrics	No
	Does the state use a metric or indicator to assess plan reporting performance? Select one.	
BX.8a	Federal database checks: Excluded person or entities	No
	During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	Website posting of 5 percent or more ownership control	No
	Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	
BX.10	Periodic audits	EQR Protocol 5 reviews conducted during CY 2022 are published at https://ldh.la.gov/page/4802 .
	If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	


Topic I: Program Characteristics



Number	Indicator	Response
C11.1	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
C11.2	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/page/1763
C11.3	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)
C11.4a	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
C11.4b	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 EPSDT and Adult Waiver populations receive comprehensive services. Adults over 21 receive dentures only.

C11.5	Program enrollment Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	1,875,801
C11.6	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.	Coverage for the Adult Waiver population was added.


Topic III: Encounter Data Report

 Find in the Excel Workbook
C1_Program_Set

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
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	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.	Attachment B, 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.	Attachment B, Section 3.6.5(17)
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 period.	-Systems performance issues with the Fiscal Intermediary (FI) make it difficult to assess MCE non-compliance versus FI failures/non-compliance. -On occasion, the state system denied encounters and void encounter transactions that appears different from their corresponding cash disbursement journal (CDJ) transactions.

Topic IV. Appeals, State Fair Hearings & Grievances

 Find in the Excel Workbook
C1_Program_Set

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

C1IV.1	State's definition of "critical incident," as used for reporting purposes in its MLTSS program	N/A
	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.	
C1IV.2	State definition of "timely" resolution for standard appeals	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.
	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.	
C1IV.3	State definition of "timely" resolution for expedited appeals	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.
	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.	
C1IV.4	State definition of "timely" resolution for grievances	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.
	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.	

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy



Find in the Excel Workbook

C1_Program_Set

Number	Indicator	Response
C1V.1	<p>Gaps/challenges in network adequacy</p> <p>What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.</p>	<p>Many dental providers in the state do not want to serve Medicaid beneficiaries. For those that do, not all want to contract with two DBPM 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.</p>
C1V.2	<p>State response to gaps in network adequacy</p> <p>How does the state work with MCPs to address gaps in network adequacy?</p>	<p>The contracts with the DBPMs require payment to out of network providers if there are gaps. LDH also works with the DBPMs 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 DBPM to outreach to those available providers that are not contracted with them.</p>

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

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

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

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



Find in the Excel Workbook

C2_Program_State

Access measure total count: 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

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

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

Primary care

C2.V.5 Region

Urban

C2.V.6 Population

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

Special Dental Services

C2.V.5 Region

Statewide

C2.V.6 Population

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

Special Dental Services

C2.V.5 Region

Statewide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Reporting

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)



Find in the Excel Workbook

C1_Program_Set

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	myplan.healthy.la.gov, Healthy Louisiana mobile app (available in Google Play and Apple)
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



Find in the Excel Workbook

C1_Program_Set

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 I. Program Characteristics & Enrollment

 Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1I.1	Plan enrollment What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	DentaQuest 956,502 MCNA of Louisiana 919,299
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? <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1) 	DentaQuest 47.2% MCNA of Louisiana 45.4%
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? <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) 	DentaQuest 50.9% MCNA of Louisiana 48.9%

- Denominator: Statewide Medicaid managed care enrollment (B.I.2)

Topic II. Financial Performance




Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1II.1a	<p>Medical Loss Ratio (MLR)</p> <p>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.</p> <p>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.</p>	<p>DentaQuest</p> <p>56.5%</p>
		<p>MCNA of Louisiana</p> <p>70.7%</p>
D1II.1b	<p>Level of aggregation</p> <p>What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one.</p> <p>As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.</p>	<p>DentaQuest</p> <p>Other, specify – undefined</p>
		<p>MCNA of Louisiana</p> <p>Other, specify – undefined</p>
D1II.2	<p>Population specific MLR description</p> <p>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.</p> <p>See glossary for the regulatory definition of MLR.</p>	<p>DentaQuest</p> <p>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 32.9% and Non-Expansion is 80.0%.</p>
		<p>MCNA of Louisiana</p>

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 59.7% and Non-Expansion is 81.6%.

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 01/01/2021
		MCNA of Louisiana 01/01/2021
N/A	Enter the end date.	DentaQuest 12/31/2021
		MCNA of Louisiana 12/31/2021

Topic III. Encounter Data

 Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of	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

encounter within this program, please explain.

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

DentaQuest

86%

MCNA of Louisiana

100%

What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission?
If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.

D1III.3

Share of encounter data submissions that were HIPAA compliant

DentaQuest

86%

MCNA of Louisiana

100%

What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance?
If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion

received from the managed care plan for the reporting period.

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved as of the first day of the last month of 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 678
		MCNA of Louisiana 67
D1IV.2	Active appeals Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	DentaQuest 0
		MCNA of Louisiana 0
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	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal</p> <p>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A".</p> <p>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".</p> <p>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.</p> <p>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 an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.</p>	DentaQuest
		N/A
		MCNA of Louisiana
		N/A

D1IV.5a	<p>Standard appeals for which timely resolution was provided</p> <p>Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period.</p> <p>See 42 CFR §438.408(b)(2) for</p>	DentaQuest
		678
		MCNA of Louisiana
		67

requirements related to timely resolution of standard appeals.

D1IV.5b	Expedited appeals for which timely resolution was provided	DentaQuest 0
	Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	MCNA of Louisiana 0

D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service	DentaQuest 203
	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).	MCNA of Louisiana 1

D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service	DentaQuest 0
	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.	MCNA of Louisiana 0

D1IV.6c	Resolved appeals related to payment denial	DentaQuest 0
	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.	MCNA of Louisiana 0

D1IV.6d	Resolved appeals related to service timeliness	DentaQuest
----------------	---	-------------------

	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).	0
		MCNA of Louisiana
		0
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance	DentaQuest
		22
	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.	MCNA of Louisiana
		0
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	DentaQuest
		0
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	MCNA of Louisiana
		0
D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability	DentaQuest
		0
	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	MCNA of Louisiana
		0

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals by Service

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



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	DentaQuest
	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".	N/A
		MCNA of Louisiana
		N/A
D1IV.7e	Resolved appeals related to covered outpatient prescription drugs	DentaQuest
	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".	N/A
		MCNA of Louisiana
		N/A
D1IV.7f	Resolved appeals related to skilled nursing facility (SNF) services	DentaQuest
	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".	N/A
		MCNA of Louisiana
		N/A
D1IV.7g	Resolved appeals related to long-term services and supports (LTSS)	DentaQuest
	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".	N/A
		MCNA of Louisiana
		N/A
D1IV.7h	Resolved appeals related to dental services	DentaQuest

678
 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
 67

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, enter "N/A".	DentaQuest 0 MCNA of Louisiana 0

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

 Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	DentaQuest 1 MCNA of Louisiana 3
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee	DentaQuest 0

	Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	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 1
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) 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".	DentaQuest 0 MCNA of Louisiana 0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.10	Grievances resolved 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 94
		MCNA of Louisiana 39
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	DentaQuest 0
		MCNA of Louisiana 0
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	DentaQuest

period by (or on behalf of) an LTSS user who previously filed a grievance

N/A

MCNA of Louisiana

N/A

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

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	DentaQuest 94
	Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	MCNA of Louisiana 39

Topic IV. Appeals, State Fair Hearings & Grievances

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	DentaQuest N/A
	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".	MCNA of Louisiana N/A
D1IV.15b	Resolved grievances related to general outpatient services	DentaQuest N/A
	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	MCNA of Louisiana N/A

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".

D1IV.15c	Resolved grievances related to inpatient behavioral health services	DentaQuest N/A
	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".	MCNA of Louisiana N/A
<hr/>		
D1IV.15d	Resolved grievances related to outpatient behavioral health services	DentaQuest N/A
	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	MCNA of Louisiana N/A
<hr/>		
D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs	DentaQuest N/A
	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".	MCNA of Louisiana N/A
<hr/>		
D1IV.15f	Resolved grievances related to skilled nursing facility (SNF) services	DentaQuest N/A
	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".	MCNA of Louisiana N/A

D1IV.15g	Resolved grievances related to long-term services and supports (LTSS)	DentaQuest N/A
	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".	MCNA of Louisiana N/A
D1IV.15h	Resolved grievances related to dental services	DentaQuest 94
	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".	MCNA of Louisiana 39
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	DentaQuest 0
	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, enter "N/A".	MCNA of Louisiana 0

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

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



Find in the Excel Workbook

D1_Plan_Set

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service	DentaQuest
	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.	8
D1IV.16b	Resolved grievances related to plan or provider care management/case management	DentaQuest
	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.	0
D1IV.16c	Resolved grievances related to access to care/services from plan or provider	DentaQuest
	Enter the total number of grievances resolved by the plan	0
		MCNA of Louisiana

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.

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

8

MCNA of Louisiana

1

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

0

MCNA of Louisiana

0

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.

DentaQuest

0

MCNA of Louisiana

0

D1IV.16g

Resolved grievances related to suspected fraud

DentaQuest

0

Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

MCNA of Louisiana
0

D1IV.16h

Resolved grievances related to abuse, neglect or exploitation

DentaQuest

0

Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation.

MCNA of Louisiana

0

Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

D1IV.16i

Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)

DentaQuest

0

Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

MCNA of Louisiana

0

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

DentaQuest

0

Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of

MCNA of Louisiana


0

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.


D1IV.16k	Resolved grievances filed for other reasons	DentaQuest
		0
	Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	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.

 Find in the Excel Workbook
D2_Plan_Measures

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, 10/01/2021 - 09/30/2022

D2.VII.8 Measure Description

"Numerator: line 12b of CMS 416 Denominator: line 1b 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: ADV

2 / 2

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

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

The percentage of beneficiaries 2–20 years of age who had at least one dental visit during the measurement year.

Measure results

DentaQuest

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

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.



Find in the Excel Workbook

D3_Plan_Sanctions

Sanction total count: 13



Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 13

D3.VIII.2 Intervention topic D3.VIII.3 Plan name

Administration DentaQuest

D3.VIII.4 Reason for intervention

Failure to maintain required business hours

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

\$ 2,000

D3.VIII.7 Date assessed

03/11/2022

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 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**

Claims and Encounter Management MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to comply with encounter data submission requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$ 50000

D3.VIII.7 Date assessed

01/06/2022

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

7 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**

Provider Services MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to meet call center standards

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

\$ 20000

D3.VIII.7 Date assessed

03/02/2022

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 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**
Reporting MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to timely submit required reports

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
\$ 80000

D3.VIII.7 Date assessed
03/23/2022

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 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**
Reporting MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to timely submit ad hoc reports

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
\$ 17500

D3.VIII.7 Date assessed
04/22/2022

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 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**
Reporting MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to timely submit required reports

Sanction details

D3.VIII.5 Instances of non-compliance
2

D3.VIII.6 Sanction amount
\$ 32500

D3.VIII.7 Date assessed
07/07/2022

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 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**
Reporting MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to submit complete and accurate reports

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
\$ 75000

D3.VIII.7 Date assessed
08/26/2022

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

12 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**
Quality Management MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to meet performance measures

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
\$ 190000

D3.VIII.7 Date assessed
09/08/2022

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

13 / 13

D3.VIII.2 Intervention topic **D3.VIII.3 Plan name**
Claims and Encounter MCNA of Louisiana
Management

D3.VIII.4 Reason for intervention

Failure to comply with encounter data submission requirements

Sanction details

D3.VIII.5 Instances of non-compliance
1

D3.VIII.6 Sanction amount
\$ 50000

D3.VIII.7 Date assessed
10/20/2022

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

D3.VIII.9 Corrective action plan
No

Topic X. Program Integrity



Find in the Excel Workbook

D1_Plan_Set

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 have been opened by the plan in the past year?	DentaQuest 10
		MCNA of Louisiana 16
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 per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	DentaQuest 10:956
		MCNA of Louisiana 16:922
D1X.4	Count of resolved program integrity investigations How many program integrity investigations have been resolved by the plan in the past year?	DentaQuest 13
		MCNA of Louisiana 6
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 per	DentaQuest 13:956
		MCNA of Louisiana

1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?

6:922

D1X.6

Referral path for program integrity referrals to the state

What is the referral path that the plan uses to make program integrity referrals to the state? Select one.

DentaQuest

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

MCNA of Louisiana

Makes referrals to the State Medicaid Agency (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

1

MCNA of Louisiana

0

D1X.8

Ratio of program integrity referral to the state

What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.

DentaQuest

0:956

MCNA of Louisiana

0:919

D1X.9

Plan overpayment reporting to the state

Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3).

Include, for example, the following information:

- The date of the report (rating period or calendar year).
- The dollar amount of overpayments recovered.
- The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).

DentaQuest

"Date of Report: 4/30/23 Overpayments Recovered: \$955,666"

MCNA of Louisiana

"Date of Report: 4/30/23 Overpayments Recovered: \$921,462"

D1X.10 **Changes in beneficiary circumstances**
Select the frequency the plan reports changes in beneficiary circumstances to the state.

DentaQuest

Daily

MCNA of Louisiana

Daily

Topic IX. Beneficiary Support System (BSS) Entities

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



Find in the Excel Workbook

E_BSS_Entities

Number	Indicator	Response
EIX.1	BSS entity type What type of entity was contracted to perform 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
