

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

Due date	Last edited	Edited by	Status
06/28/2024	06/20/2024	Cornelius 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.	Cornelious Cole
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	Cornelious.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.	06/27/2024

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	01/01/2023
A5b	Reporting period end date Auto-populated from report dashboard.	12/31/2023
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.

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.

Indicator	Response
BSS entity name	Maximus Health Services

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	<p>Statewide Medicaid enrollment</p> <p>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.</p>	1,999,639
BI.2	<p>Statewide Medicaid managed care enrollment</p> <p>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.</p>	1,851,797

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.	Other third-party vendor

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p data-bbox="313 107 695 180">Payment risks between the state and plans</p> <p data-bbox="313 201 727 863">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.</p>	<p data-bbox="760 107 1377 1209">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. Some of the algorithms include date of death runs, excluded provider runs, spike/surge runs, procedure code outlier runs, etc. Some of the audits resulting from the algorithms mentioned above are conducted by PI's SURS or UPIC contractors; other audits/leads are sent to the Plans to review. In addition to data runs/algorithms, PI's SURS 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 SURS unit or the complaints are referred to the Plans. The SURS unit 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 Plan's Special Investigations Unit (SIU) have a monthly calls and quarterly meetings with the Plans.</p>
BX.2	<p data-bbox="313 1268 618 1341">Contract standard for overpayments</p> <p data-bbox="313 1362 727 1520">Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p data-bbox="760 1268 1247 1297">State has established a hybrid system</p>
BX.3	<p data-bbox="313 1577 634 1682">Location of contract provision stating overpayment standard</p> <p data-bbox="313 1703 727 1860">Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	<p data-bbox="760 1577 1333 1650">DBPM Contract, Attachment B: Statement of Work, Sections 2.12.6.4.2 - 2.12.6.4.3</p>
BX.4	<p data-bbox="313 1919 704 1992">Description of overpayment contract standard</p> <p data-bbox="313 2013 727 2070">Briefly describe the overpayment standard (for</p>	<p data-bbox="760 1919 1377 2070">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</p>

example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.

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 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 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 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	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** <https://ldh.la.gov/page/eqr-health-plan-results-2023>

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.

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<p>Program contract</p> <p>Enter the title of the contract between the state and plans participating in the managed care program.</p>	Dental Benefit Program Management
N/A	<p>Enter the date of the contract between the state and plans participating in the managed care program.</p>	1/1/2021-Present
C11.2	<p>Contract URL</p> <p>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.</p>	https://ldh.la.gov/page/1763
C11.3	<p>Program type</p> <p>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.</p>	Prepaid Ambulatory Health Plan (PAHP)
C11.4a	<p>Special program benefits</p> <p>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.</p> <p>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.</p>	Dental
C11.4b	<p>Variation in special benefits</p> <p>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.</p>	<p>The benefits received by the EPSDT and Adult Waiver populations are comprehensive. The Adult population receives only denture services. The ICF/IID population 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.</p>

C11.5	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).	1,851,687
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. 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.	Effective 7/1/23, Dental coverage for residents in ICF/IID facilities became shared by the facility and the PAHP. The ICF/IID population 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.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p data-bbox="313 107 634 136">Uses of encounter data</p> <p data-bbox="313 161 695 317">For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p data-bbox="313 321 727 569">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)).</p>	<p data-bbox="760 107 911 136">Rate setting</p> <p data-bbox="760 180 1219 210">Quality/performance measurement</p> <p data-bbox="760 254 1089 283">Monitoring and reporting</p> <p data-bbox="760 327 997 357">Contract oversight</p> <p data-bbox="760 401 987 430">Program integrity</p>
C1III.2	<p data-bbox="313 625 691 697">Criteria/measures to evaluate MCP performance</p> <p data-bbox="313 722 727 907">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.</p> <p data-bbox="313 911 727 1224">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).</p>	<p data-bbox="760 625 1240 655">Timeliness of initial data submissions</p> <p data-bbox="760 699 1333 968">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.</p>
C1III.3	<p data-bbox="313 1276 716 1348">Encounter data performance criteria contract language</p> <p data-bbox="313 1373 727 1654">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.</p>	Attachment B, Section 2.14.11
C1III.4	<p data-bbox="313 1707 699 1778">Financial penalties contract language</p> <p data-bbox="313 1803 727 2024">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</p>	Attachment B, Section 3.6.5(17)

standards. Use contract section references, not page numbers.

C1III.5 Incentives for encounter data quality N/A

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.

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 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

Number	Indicator	Response
C1IV.1	<p>State's definition of "critical incident," as used for reporting purposes in its MLTSS program</p> <p>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.</p>	N/A
C1IV.2	<p>State definition of "timely" resolution for standard appeals</p> <p>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.</p>	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	<p>State definition of "timely" resolution for expedited appeals</p> <p>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.</p>	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	<p>State definition of "timely" resolution for grievances</p> <p>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</p>	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	<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 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.</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 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.</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 PAHPs require payment to out of network providers if there are gaps. Louisiana Department of Health (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 those available providers that are not contracted with them.</p>

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.



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



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



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)

Number	Indicator	Response
C1IX.1	<p data-bbox="313 107 480 136">BSS website</p> <p data-bbox="313 161 721 317">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.</p>	<p data-bbox="760 107 1373 178">myplan.healthy.la.gov, Healthy Louisiana mobile app (available in Google Play and Apple)</p>
C1IX.2	<p data-bbox="313 369 618 441">BSS auxiliary aids and services</p> <p data-bbox="313 466 708 873">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.</p>	<p data-bbox="760 369 1373 525">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.</p>
C1IX.3	<p data-bbox="313 926 631 955">BSS LTSS program data</p> <p data-bbox="313 980 721 1236">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).</p>	<p data-bbox="760 926 1287 955">LTSS is not coordinated through the BSS.</p>
C1IX.4	<p data-bbox="313 1289 721 1360">State evaluation of BSS entity performance</p> <p data-bbox="313 1386 721 1507">What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?</p>	<p data-bbox="760 1289 1357 1558">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. The State also monitors performance of the BSS call center through tracking of routine KPIs.</p>

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D11.1	<p>Plan enrollment</p> <p>Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).</p>	<p>DentaQuest</p> <p>948,233</p> <p>MCNA of Louisiana</p> <p>903,454</p>
D11.2	<p>Plan share of Medicaid</p> <p>What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment?</p> <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1) 	<p>DentaQuest</p> <p>47.4%</p> <p>MCNA of Louisiana</p> <p>45.2%</p>
D11.3	<p>Plan share of any Medicaid managed care</p> <p>What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?</p> <ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2) 	<p>DentaQuest</p> <p>51.2%</p> <p>MCNA of Louisiana</p> <p>48.8%</p>

Topic II. Financial Performance

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. Write MLR as a percentage: for example, write 92% rather than 0.92.</p>	<p>DentaQuest</p> <p>79.6%</p> <p>MCNA of Louisiana</p> <p>70.9%</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>Program-specific statewide</p> <p>MCNA of Louisiana</p> <p>Program-specific statewide</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 71.5% and Non-Expansion is 87.7%.</p> <p>MCNA of Louisiana</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 45.8% and Non-Expansion is 96.0%.</p>
D1II.3	<p>MLR reporting period discrepancies</p>	<p>DentaQuest</p> <p>Yes</p>

Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?

MCNA of Louisiana
Yes

N/A

Enter the start date.

DentaQuest

01/01/2022

MCNA of Louisiana

01/01/2022

N/A

Enter the end date.

DentaQuest

12/31/2022

MCNA of Louisiana

12/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p data-bbox="313 107 708 176">Definition of timely encounter data submissions</p> <p data-bbox="313 201 708 453">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.</p>	<p data-bbox="760 107 927 134">DentaQuest</p> <p data-bbox="760 163 1365 512">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.</p> <p data-bbox="760 585 1019 613">MCNA of Louisiana</p> <p data-bbox="760 642 1365 989">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.</p>
D1III.2	<p data-bbox="313 1077 727 1230">Share of encounter data submissions that met state's timely submission requirements</p> <p data-bbox="313 1255 727 1759">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.</p>	<p data-bbox="760 1077 927 1104">DentaQuest</p> <p data-bbox="760 1134 829 1161">100%</p> <p data-bbox="760 1234 1019 1262">MCNA of Louisiana</p> <p data-bbox="760 1291 829 1318">100%</p>

D1III.3	Share of encounter data submissions that were HIPAA compliant	DentaQuest
		98%

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance?

MCNA of Louisiana

100%

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 year.

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	<p>Appeals resolved (at the plan level)</p> <p>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.</p>	<p>DentaQuest</p> <p>575</p> <p>MCNA of Louisiana</p> <p>85</p>
D1IV.2	<p>Active appeals</p> <p>Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>DentaQuest</p> <p>18</p> <p>MCNA of Louisiana</p> <p>3</p>
D1IV.3	<p>Appeals filed on behalf of LTSS users</p> <p>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).</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>
D1IV.4	<p>Number of critical incidents filed during the reporting year 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 year by (or on behalf of) LTSS users who previously filed appeals in the</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>

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 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	DentaQuest 563
	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.	MCNA of Louisiana 81
D1IV.5b	Expedited appeals for which timely resolution was provided	DentaQuest 45
	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	MCNA of Louisiana 2

requirements related to timely resolution of standard appeals.

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 549 MCNA of Louisiana 43
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 1 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 21 MCNA of Louisiana 42
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	DentaQuest 0

	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 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).	DentaQuest 0 MCNA of Louisiana 0
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 4 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	<p data-bbox="313 107 699 180">Resolved appeals related to general inpatient services</p> <p data-bbox="313 205 727 472">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.</p> <p data-bbox="313 483 727 751">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".</p>	<p data-bbox="760 107 927 136">DentaQuest</p> <p data-bbox="760 163 808 193">N/A</p> <p data-bbox="760 268 1023 298">MCNA of Louisiana</p> <p data-bbox="760 325 808 354">N/A</p>
D1IV.7b	<p data-bbox="313 806 699 879">Resolved appeals related to general outpatient services</p> <p data-bbox="313 905 727 1346">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".</p>	<p data-bbox="760 806 927 835">DentaQuest</p> <p data-bbox="760 863 808 892">N/A</p> <p data-bbox="760 968 1023 997">MCNA of Louisiana</p> <p data-bbox="760 1024 808 1054">N/A</p>
D1IV.7c	<p data-bbox="313 1400 699 1509">Resolved appeals related to inpatient behavioral health services</p> <p data-bbox="313 1535 727 1814">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".</p>	<p data-bbox="760 1400 927 1430">DentaQuest</p> <p data-bbox="760 1457 808 1486">N/A</p> <p data-bbox="760 1562 1023 1591">MCNA of Louisiana</p> <p data-bbox="760 1619 808 1648">N/A</p>
D1IV.7d	<p data-bbox="313 1869 716 1978">Resolved appeals related to outpatient behavioral health services</p> <p data-bbox="313 2003 727 2100">Enter the total number of appeals resolved by the plan during the reporting year that</p>	<p data-bbox="760 1869 927 1898">DentaQuest</p> <p data-bbox="760 1925 808 1955">N/A</p> <p data-bbox="760 2030 1023 2060">MCNA of Louisiana</p>

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

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

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".

DentaQuest

N/A

MCNA of Louisiana

N/A

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 N/A MCNA of Louisiana N/A

State Fair Hearings

Number	Indicator	Response
D1IV.8a	<p>State Fair Hearing requests</p> <p>Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.</p>	<p>DentaQuest</p> <p>5</p> <p>MCNA of Louisiana</p> <p>4</p>
D1IV.8b	<p>State Fair Hearings resulting in a favorable decision for the enrollee</p> <p>Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>
D1IV.8c	<p>State Fair Hearings resulting in an adverse decision for the enrollee</p> <p>Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.</p>	<p>DentaQuest</p> <p>2</p> <p>MCNA of Louisiana</p> <p>0</p>
D1IV.8d	<p>State Fair Hearings retracted prior to reaching a decision</p> <p>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.</p>	<p>DentaQuest</p> <p>2</p> <p>MCNA of Louisiana</p> <p>2</p>
D1IV.9a	<p>External Medical Reviews resulting in a favorable decision for the enrollee</p> <p>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".</p>	<p>DentaQuest</p> <p>0</p> <p>MCNA of Louisiana</p> <p>0</p>

External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

D1IV.9b	External Medical Reviews resulting in an adverse decision for the enrollee	DentaQuest
		0
	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".	MCNA of Louisiana
		0
	External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	

Grievances Overview

Number	Indicator	Response
D1IV.10	<p>Grievances resolved</p> <p>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.</p>	<p>DentaQuest</p> <p>122</p> <p>MCNA of Louisiana</p> <p>59</p>
D1IV.11	<p>Active grievances</p> <p>Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>DentaQuest</p> <p>81</p> <p>MCNA of Louisiana</p> <p>29</p>
D1IV.12	<p>Grievances filed on behalf of LTSS users</p> <p>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.</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>
D1IV.13	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance</p> <p>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</p>	<p>DentaQuest</p> <p>N/A</p> <p>MCNA of Louisiana</p> <p>N/A</p>

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
		122
	Enter the number of grievances for which timely resolution was provided by plan during the reporting year.	MCNA of Louisiana
	See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	59

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	<p data-bbox="318 107 727 180">Resolved grievances related to general inpatient services</p> <p data-bbox="318 201 727 642">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".</p>	<p data-bbox="764 107 932 136">DentaQuest</p> <p data-bbox="764 163 813 193">N/A</p> <p data-bbox="764 268 1024 298">MCNA of Louisiana</p> <p data-bbox="764 325 813 354">N/A</p>
D1IV.15b	<p data-bbox="318 695 727 810">Resolved grievances related to general outpatient services</p> <p data-bbox="318 831 727 1272">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".</p>	<p data-bbox="764 695 932 724">DentaQuest</p> <p data-bbox="764 751 813 781">N/A</p> <p data-bbox="764 856 1024 886">MCNA of Louisiana</p> <p data-bbox="764 913 813 942">N/A</p>
D1IV.15c	<p data-bbox="318 1325 727 1440">Resolved grievances related to inpatient behavioral health services</p> <p data-bbox="318 1461 727 1745">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".</p>	<p data-bbox="764 1325 932 1354">DentaQuest</p> <p data-bbox="764 1381 813 1411">N/A</p> <p data-bbox="764 1486 1024 1516">MCNA of Louisiana</p> <p data-bbox="764 1543 813 1572">N/A</p>

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
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
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 122
	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
59

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

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".

DentaQuest
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
0

MCNA of Louisiana
0

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	<p>Resolved grievances related to plan or provider customer service</p> <p>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.</p>	<p>DentaQuest</p> <p>4</p>
		<p>MCNA of Louisiana</p> <p>6</p>
D1IV.16b	<p>Resolved grievances related to plan or provider care management/case management</p> <p>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.</p>	<p>DentaQuest</p> <p>0</p>
		<p>MCNA of Louisiana</p> <p>0</p>
D1IV.16c	<p>Resolved grievances related to access to care/services from plan or provider</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.</p>	<p>DentaQuest</p> <p>31</p>
		<p>MCNA of Louisiana</p> <p>7</p>

Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.

D1IV.16d	Resolved grievances related to quality of care	DentaQuest 63
	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.	MCNA of Louisiana 24

D1IV.16e	Resolved grievances related to plan communications	DentaQuest 0
	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.	MCNA of Louisiana 4

D1IV.16f	Resolved grievances related to payment or billing issues	DentaQuest 38
	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.	MCNA of Louisiana 35

D1IV.16g	Resolved grievances related to suspected fraud	DentaQuest 0
	Enter the total number of grievances resolved by the plan during the reporting year that	MCNA of Louisiana

were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated 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.

0

D1IV.16h

Resolved grievances related to abuse, neglect or exploitation

DentaQuest

0

Enter the total number of grievances resolved by the plan 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

5

Enter the total number of grievances resolved by the plan 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 by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.

MCNA of Louisiana

0

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
	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.	2
		MCNA of Louisiana
		7

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.



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, 10/01/2022 - 09/30/2023

D2.VII.8 Measure Description

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

Measure results

DentaQuest

N/A

MCNA of Louisiana

N/A



Complete

D2.VII.1 Measure Name: 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

N/A

MCNA of Louisiana

N/A

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.



Complete

D3.VIII.1 Intervention type: Liquidated damages

1 / 20

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

Claims and Encounter Management DentaQuest

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

\$50,000

D3.VIII.7 Date assessed

01/05/2023

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

2 / 20

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

Quality Management DentaQuest

D3.VIII.4 Reason for intervention

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

\$30,000

D3.VIII.7 Date assessed

07/27/2023

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

3 / 20

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

Quality Management DentaQuest

D3.VIII.4 Reason for intervention

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

N/A

D3.VIII.7 Date assessed

04/19/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

4 / 20

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

Services and Benefits DentaQuest

D3.VIII.4 Reason for intervention

Failure to Assign Enrollees to Appropriate Program

Sanction details

D3.VIII.5 Instances of non-compliance

2

D3.VIII.6 Sanction amount

\$87,500

D3.VIII.7 Date assessed

07/11/2023

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

Claims and Encounter Management DentaQuest

D3.VIII.4 Reason for intervention

Failure to Assign Enrollees to Appropriate Program

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

\$150,000

D3.VIII.7 Date assessed

07/14/2023

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

Provider Network DentaQuest

D3.VIII.4 Reason for intervention

Failure to Maintain an Adequate Provider

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

\$40,000

D3.VIII.7 Date assessed

08/11/2023

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 / 20

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

Claims and Encounters DentaQuest

D3.VIII.4 Reason for intervention

Failure to Update Provider Rates and Failure to Pay Providers at the Contracted Negotiated Rate

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

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

09/01/2023

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

Claims and Encounters DentaQuest

D3.VIII.4 Reason for intervention

Failure to Update Provider Rates and Failure to Pay Providers at the Contracted Negotiated Rate

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

1

D3.VIII.6 Sanction amount

\$240,000

D3.VIII.7 Date assessed

09/26/2023

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

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Compliance letter

9 / 20

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

Reporting

DentaQuest

D3.VIII.4 Reason for intervention

Failure to Submit Accurate Reports

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

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

11/02/2023

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

Encounter Submission

DentaQuest

D3.VIII.4 Reason for intervention

Meet Encounter Data Submission Requirements

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

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

11/03/2023

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

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

11 / 20

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

Claims and Encounters DentaQuest

D3.VIII.4 Reason for intervention

Meet Encounter Data Submission Requirements

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

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

11/03/2023

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 / 20

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

Claims and Encounters DentaQuest

D3.VIII.4 Reason for intervention

Claims and Encounters

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

1

D3.VIII.6 Sanction amount

\$5,000

D3.VIII.7 Date assessed

12/09/2023

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

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Liquidated damages

13 / 20

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

\$2,000

D3.VIII.7 Date assessed

02/01/2023

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 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

\$50,000

D3.VIII.7 Date assessed

01/05/2023

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 Intervention topicClaims and Encounter
Management**D3.VIII.3 Plan name**

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

\$50,000

D3.VIII.7 Date assessed

05/09/2023

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 Intervention topicClaims and Encounter
Management**D3.VIII.3 Plan name**

MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

3

D3.VIII.6 Sanction amount

\$150,000

D3.VIII.7 Date assessed

07/14/2023

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 Intervention topic

Reporting

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to Submit Required Reports

Sanction details

D3.VIII.5 Instances of non-compliance

4

D3.VIII.6 Sanction amount

\$170,000

D3.VIII.7 Date assessed

08/17/2023

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

18 / 20

D3.VIII.2 Intervention topic

Claims and Encounter
Management

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to Meet Prompt Pay Standards

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/22/2023

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 Intervention topic

Claims and Encounter Management

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

09/01/2023

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

20 / 20

D3.VIII.2 Intervention topic

Claims and Encounter Management

D3.VIII.3 Plan name

MCNA of Louisiana

D3.VIII.4 Reason for intervention

Failure to Meet Encounter Data Submission Requirements

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

\$50,000

D3.VIII.7 Date assessed

11/03/2023

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

Remediation in progress

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<p>Dedicated program integrity staff</p> <p>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).</p>	<p>DentaQuest</p> <p>1</p> <p>MCNA of Louisiana</p> <p>1</p>
D1X.2	<p>Count of opened program integrity investigations</p> <p>How many program integrity investigations were opened by the plan during the reporting year?</p>	<p>DentaQuest</p> <p>8</p> <p>MCNA of Louisiana</p> <p>1</p>
D1X.3	<p>Ratio of opened program integrity investigations to enrollees</p> <p>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.</p>	<p>DentaQuest</p> <p>0.05:1,000</p> <p>MCNA of Louisiana</p> <p>0:1,000</p>
D1X.4	<p>Count of resolved program integrity investigations</p> <p>How many program integrity investigations were resolved by the plan during the reporting year?</p>	<p>DentaQuest</p> <p>8</p> <p>MCNA of Louisiana</p> <p>7</p>
D1X.5	<p>Ratio of resolved program integrity investigations to enrollees</p> <p>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.</p>	<p>DentaQuest</p> <p>0.05:1,000</p> <p>MCNA of Louisiana</p> <p>0.03:1,000</p>

D1X.6	Referral path for program integrity referrals to the state	DentaQuest
	What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	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	DentaQuest
	Enter the total number of program integrity referrals made during the reporting year.	2
		MCNA of Louisiana
		1
D1X.8	Ratio of program integrity referral to the state	DentaQuest
	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.	0.01:1,000
		MCNA of Louisiana
		0:1,000
D1X.9	Plan overpayment reporting to the state	DentaQuest
	Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: <ul style="list-style-type: none"> • 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 42 CFR 438.8(f)(2). 	Date of Report: 1/31/24 Overpayments Recovered: \$984,174 LDH PI does not have information on the MCE's premium revenue as defined in MLR reporting under 438.8(f)(2).
		MCNA of Louisiana
		Date of Report: 1/31/24 Overpayments Recovered: \$149,042 LDH PI does not have information on the MCE's premium revenue as defined in MLR reporting under 438.8(f)(2).
D1X.10	Changes in beneficiary circumstances	DentaQuest
		Promptly when plan receives information about

Select the frequency the plan reports changes in beneficiary circumstances to the state.

the change

MCNA of Louisiana

Promptly when plan receives information about the change

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
