LOUISIANA DEPARTMENT OF HEALTH

2025 External Quality Review Compliance Review

for

DentaQuest USA Insurance Company (DentaQuest)

December 2025

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (LDH) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review (CR) activity with each of the Healthy Louisiana MCOs, PAHPs, and PIHPs delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the CR, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Apr 2, 2025.

Summary of Compliance Review Results

Table 1-1 presents an overview of the results of the 2025 CR for <PAHP Name> (<PAHP>). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	7	2	3	78%
II	Member Rights and Confidentiality	24	24	21	3	0	88%
III	Member Information	19	16	9	7	3	56%
IV	Emergency and Poststabilization Services	13	13	7	6	0	54%
V	Adequate Capacity and Availability of Services	15	12	1	11	3	8%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	20	19	1	3	95%
VIII	Provider Selection	19	15	11	4	4	73%
IX	Subcontractual Relationships and Delegation	6	5	2	3	1	40%
X	Practice Guidelines	6	6	0	6	0	0%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	10	1	2	91%
XIII	Grievance and Appeal Systems	38	37	28	9	1	76%
XIV	Program Integrity	18	18	15	3	0	83%
Total Compliance Score		**227**	**207**	**150**	**57**	**20**	**72%**

M=*Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The **total** number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR Part438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDS to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the managed care entities (MCEs) for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 2-1 outlines the division of standards reviewed in calendar year (CY) 2021, CY 2022, CY 2023, and CY 2024.

Table 2-1—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III—Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓				-	✓	✓	✓
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

[1] The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).
* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the CR, HSAG developed data collection tools, referred to as "CR tools," to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted a review of delegation records.
- Conducted an information systems (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, case management, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service

authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for case management with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025–September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

3. Corrective Action Plan Process

DQ is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for DQ to use in preparing its plans of action to remediate any deficiencies identified during the 2025 CR. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring DQ into full compliance with the deficient requirements. DQ must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). DQ's CAP must be submitted to the HSAG SAFE site **no later than 60 calendar days from receipt of the final report**.

The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that DQ will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions brought DQ into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the PAHP until approved by HSAG and LDH. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by DQ in its submitted CAP.

Appendix A. Conclusions and Recommendations

Strengths	
+	The MCE received 100 percent compliance with Standard XI—Health Information Systems, demonstrating that the MCE had a robust health information system for processing and managing member data, provider data, and claims processing, while ensuring data security and facilitating data reporting.
Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations	
−	The MCE should review the CR tool and its detailed findings and recommendations. Specific required actions and recommendations are made, that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.

Appendix B. 2025 Compliance Review Tool

This appendix includes the completed review tool that HSAG used to evaluate DQ's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring DQ's performance into full compliance.

Standard I—Enrollment and Disenrollment Requirements and Limitations

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the MCE		
1. The MCE may request disenrollment of a member in the following circumstances: a. *When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department* b. *Upon termination or expiration of the Contract* c. *Death of the member* d. *Confinement of the member in a facility or institution when confinement is not a covered service under the Contract* PAHP: *a. The Contractor may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).* PIHP: a. *The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.* 42 CFR §438.56(b)(1) 42 CFR §457.1212	**HSAG Required Evidence:** • Policies and procedures • State-specific workflow for MCE-initiated disenrollment requests • Member materials, such as the member handbook • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the *MCE Description of Process*) **Evidence as Submitted by the MCE:** • NET13-INS-Disenrollment • LA Healthy Medicaid Member Handbook • ENR01 Standard 1.010 pg 13, 14, 15 • LA Medicaid ORM Disenrollment pg. 18-19	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.3.12.3.2 PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6		
MCE Description of Process: DentaQuest will follow the disenrollment process outlined in NET13 which is supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. The NET13-INS-Disenrollment policy did not specify all the requirements listed in this element ([a]-[d]) or the PAHP state-specific contract requirement. The LA Medicaid ORM Disenrollment policy included requirements (a)-(d) but omitted the PAHP state-specific contract requirement in the section that pertains to disenrollment. On page 49, the LA Medicaid ORM Disenrollment policy indicated reporting suspicion of a member fraud incident to LDH, but the policy did not delineate this as cause for a disenrollment request. ENR01-INS Member Enrollment policy (submitted for another element) included requirements (a)-(d) but did not specify the PAHP state-specific contract requirement. **Recommendations:** HSAG recommends that DQ align all policies and related documents pertaining to enrollment and disenrollment to ensure consistency, inclusion, and specification of all requirements in this element.		
Required Actions: No action required.		
2. The MCE does not request disenrollment because of: MCO & PAHP: a. An adverse change in the member's health status; or b. Because of the member's health diagnosis c. The member's utilization of medical services d. The member's diminished mental capacity e. The member's pre-existing medical condition f. The member's refusal of medical care or diagnostic testing g. The member's attempt to exercise his/her rights under the Contractor's Grievance system	**HSAG Required Evidence:** • Policies and procedures • Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested disenrollment of a member please state so under the *MCE Description of Process*) **Evidence as Submitted by the MCE:** • NET13-INS-Disenrollment pg.1 • Member Handbook • ENR01 Standard 1.010 pg 13, 14, 15	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
h. The member's attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either this particular member or other members). PIHP: a. The member's adverse change in health status b. The member's utilization of medical services c. The member's diminished mental capacity d. The member's uncooperative or disruptive behavior resulting from his or her special needs 42 CFR §438.56(b)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5	• LA Medicaid ORM Disenrollment pg. 18, 19	
MCE Description of Process: DentaQuest will follow the disenrollment process outlined in NET13 which supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The NET13-INS-Disenrollment policy included requirements (a), (c), (d), and (i). The LA Medicaid ORM Disenrollment policy included requirements (c), (d), and (i) and referenced compliance with 42 CFR §438.56(b)(2). However, that CFR reference did not encompass all the requirements for this element. The ENR01-INS Member Enrollment policy only included requirements (a), (c), (d), (i).		
Required Actions: The MCE must revise policies to state that the MCE does not request disenrollment because of: a. An adverse change in the member's health status; or		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
b. Because of the member's health diagnosis. c. The member's utilization of medical services d. The member's diminished mental capacity. e. The member's pre-existing medical condition. f. The member's refusal of medical care or diagnostic testing. g. The member's attempt to exercise his/her rights under the Contractor's Grievance system. h. The member's attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned. i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCE seriously impairs the MCE's ability to furnish services to either this particular member or other members). Additionally, the MCE must revise policies to include the correct CFR references.		
3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract. MCO & PAHP: a. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO/PAHP is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker. PIHP: a. The PIHP shall not request disenrollment for reasons other than those stated in the Contract. The PIHP may not disenroll Coordinated System of Care (CSoC) members for any reason other than discharge from CSoC. Eligible members may choose to no longer participate in CSoC, in which case specialized behavioral health services will be transitioned to the	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request **Evidence as Submitted by the MCE:** • CE: NET13-INS-Disenrollment • LA Healthy Medicaid Member Handbook – Pg 18 Change Plans • ENR01 Standard 1.010 – Pg 2 #3, Ex H • LA Medicaid ORM Disenrollment pg. 18-19	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge. 42 CFR §438.56(b)(3) 42 CFR §457.1212 MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6		
MCE Description of Process: DentaQuest will follow the disenrollment process outlined in NET13 which is supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Disenrollment Requested by the Member		
4. The member may request disenrollment from the MCE as follows: a. Without cause, at the following times: MCO: i. During the disenrollment period offered to Enrollees at the start of the contract. ii. During the 90 days following the date of the member's initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. iii. At least once every 12 months thereafter (during the enrollment period). iv. At least once every 12 months thereafter.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • ENR01 Standard 1.010 - Pg 2 #3, Ex H • LA Medicaid ORM Disenrollment pg. 19	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
v. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. vi. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. PAHP: i. During the 90 days following the date of the member's initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. ii. At least once every 12 months thereafter. iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. 42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212 MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA		
MCE Description of Process: DentaQuest will follow the disenrollment process outlined in NET13 which is supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The ENR01-INS Member Enrollment policy included that the PAHP may request disenrollment after the State notifies the MCE that it intends to terminate the contract, but this information was not included in the list of member-related reasons and was not included in the LA Medicaid ORM Disenrollment policy. DQ's process description for this element referenced the NET13-INS-Disenrollment policy though that document was not submitted for this element.		
Required Actions: The MCE must revise and align policies related to enrollment and disenrollment to include all requirements.		
Procedures for Disenrollment		
5. The following are causes for disenrollment: MCO: a. The member moves out of the MCE's service area; b. The MCE does not (due to moral or religious objections) cover the service the member seeks; c. The member needs related services to be performed at the same time; not all related services are available from	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • LA Medicaid ORM Disenrollment pg. 19 • ENR01-INS Member Enrollment pg. 16	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Poor quality of care; e. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; f. The Contract between the MCE and LDH is terminated; g. The member's active specialized behavioral health provider ceases to contract with the MCE for reasons other than noncompliance with the Network Provider Agreement of this Contract; or h. Any other reason deemed to be valid by LDH and/or its agent. PAHP: a. The MCE does not (due to moral or religious objections) cover the service the member seeks; b. The member needs related services to be performed at the same time, not all related services are available from the MCE's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; c. Poor quality of care; d. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs;		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
e. The Contract between the MCE and LDH is terminated; f. Any other reason deemed to be valid by LDH and/or its agent. 42 CFR §438.56(d)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA		
MCE Description of Process: DentaQuest will follow the enrollment process as outlined in ENR01 which is supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: Although this element is scored as *Met* for the purpose of not attributing additional findings to the same deficiency noted in a prior element, the MCE must revise and align its policies related to enrollment and disenrollment to include all requirements.		
6. The member must request disenrollment by submitting an oral or written request (as required by the State): a. To the State or its agent; or b. To the MCE, if the State permits MCEs to process disenrollment requests. 42 CFR §438.56(d)(1) 42 CFR §457.1212 MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow delineating State and MCE responsibilities • Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter) **Evidence as Submitted by the MCE:** • Medicaid Member Handbook-ENR01 Standard • ENR01-INS Member Enrollment pg16	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Page 18 of the member handbook addresses who the member needs to call to "Change Plans". • CS05-INS-DENT-SOP-CS Call Handling-Dental-2024 • CS05-INS-CS Program Overview-2024 • ENR01-INS-Member Enrollment-2024	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. When the MCE's contract with the State permits the MCE to process disenrollment requests, the MCE may either approve a request for disenrollment by or on behalf of a member or the MCE must refer the request to the State. 42 CFR §438.56(d)(3)(i) 42 CFR §457.1212 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter, review conducted by the MCE, decision made by the MCE, reporting to the State) **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: NA		
HSAG Findings: The State retains authority over all disenrollment decisions, so the MCE is not able to process a disenrollment request; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Use of the MCE's Grievance Process		
8. (If the State contract requires) The member must seek redress through the MCE's grievance process before making a determination on the member's request: a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1)—regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State. b. If, as a result of the grievance process, the MCE approves the disenrollment, the State agency is not required to make a determination to approve or disapprove the disenrollment request. 42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212 MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Three case examples of a member request for disenrollment grievance record, including the resolution letter • Referrals to the State for member termination from MCE • Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report) **Evidence as Submitted by the MCE:** • Not Required by state Contract	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: DentaQuest will follow the enrollment process as outlined in ENR01 which is supported by contractual requirements.		
HSAG Findings: The state contract does not require a grievance process as described in these requirements; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
9. If the MCE or State agency or its designee fails to make a disenrollment determination so that the member can be disenrolled within the timeframes specified in 42 CFR §438.56(e)(1), the disenrollment is considered approved. 42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212 MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • CE: NET13-INS-Disenrollment pg 1.D.& E. • Member Enrollment ENR01-INS pg 16	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: DentaQuest will follow the disenrollment process outlined in NET13 which is supported by contractual requirements.		
HSAG Findings: The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Enrollment		
10. The MCE agrees to accept individuals enrolled into its MCE in the order in which they apply without restriction (unless authorized by the Department). The MCE may not prescreen select potential members on the basis of pre-existing health problems. MCO and PAHP: a. *The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO*	**HSAG Required Evidence:** • **Evidence as Submitted by the MCE:** • ENR01 Standard 1.010 pg 1 • ENR01 Exhibit H 1.010 pg 4 • Member Enrollment ENR01-INS pg 15	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Populations that meet the conditions set forth in 42 CFR §438.50(a). PIHP: a. *The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member's choice. The WAA shall ensure that the independent assessment is conducted to determine clinical eligibility.* 42 CFR §438.3(d)(1) MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2		
MCE Description of Process: 10 a – The electronic enrollment process enrolls members from the LA file into our system based on the business rules developed during the implementation process. The process is automated and no data is manually updated during the loading procedure. Any errors produced are reviewed and referred to LA contacts as appropriate.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
11. The MCE does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. 42 CFR §438.3(d)(3-4) MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4	**HSAG Required Evidence:** • Enrollment policies and procedures • Member handbook **Evidence as Submitted by the MCE:** • LA Healthy Medicaid Member Handbook pg 38 • ENR01-INS Member Enrollment pg 15	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest will follow the enrollment process as outlined in ENR01 which is supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. If the Department approves the MCE's disenrollment request, the MCE gives the member 30 days written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing. MCO: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date of the disenrollment; iii. An instruction that the Enrollee choose a new MCO; and iv. A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing.	**HSAG Required Evidence:** • Enrollment policies and procedures • Member notification letter template **Evidence as Submitted by the MCE:** • CE: LA Healthy Medicaid Member Handbook- 16 and 17 • NET13-INS Involuntary Disenrollment, Exhibit D pg 6 • NET13-INS Involuntary Disenrollment pg 1 **Additional Documentation:** • The ENR01-INS: Member Enrollment policy has detailed information in Exhibit I that states: If the	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
PAHP: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date; iii. An instruction that the enrollee choose a new DBPM; and iv. A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing. 42 CFR §438.56(d)(5) MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA	Department approves the PAHP's disenrollment request, the PAHP gives the member written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing. • Also provided is ENR01-INS: Member Enrollment are the contractual disenrollment requirements in Exhibit I	
MCE Description of Process: DentaQuest will follow the enrollment process as outlined in ENR01 which is supported by contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No required action.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	7	X	1	=	7
	Not Met	=	2	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	9	**Total Score**		=	7

Total Score ÷ Total Applicable	=	**78%**

Standard II—Member Rights and Confidentiality

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2	**HSAG Required Evidence:** • Member rights policy **Evidence as Submitted by the MCE:** • MKT03-INS-COMM-Member Communications Distribution, pages 6-7 • MKT04 Exhibit D **Additional Documentation:** • Multiple policies and training materials.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest includes details about member rights and responsibilities in its member handbook and the relevant policy and procedure.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE develop an overarching policy that indicates how it ensures member rights, including its procedures for training and monitoring of its staff.		
Required Actions: No action required.		
2. The MCE complies with any applicable Federal and State laws that pertain to member rights and ensures that it's employees and contracted providers observe and protect those rights. 42 CFR §438.100(a)(2) 42 CFR §457.1220 MCO Contract: 2.13.1.1	**HSAG Required Evidence:** • Policies and Procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4	• Grievance log over the time period of review with member rights grievances **Evidence as Submitted by the MCE:** • PRIV-ENT, page 1 • COM15-ENT-Nondiscrimination Compliance Program, all pages • 2024 Privacy Computer Information Security Training, page 17 • 2024 Cultural Competency and NonDiscrimination Training, page 3 • MKT03-INS-COMM-Member Communications Distribution, pages 6-7 • DQ1833 LA_HealthyMedicaid_Member Handbook, page 7 **Additional Documentation:** • COM07-ENT Training and Education • CGA04-INS Monitoring of Complaints • CS06-INS Customer Service – Monitoring Outcomes	
MCE Description of Process: DentaQuest monitors applicable Federal and State laws that pertain to member rights such as HIPAA, Medicaid & Medicare rules, and civil rights statutes (e.g., Section 157 of the ACA). DentaQuest employees are educated on these rules and regulations upon hire and annually thereafter and can access policies and procedures that reflect these requirements (nondiscrimination, access to care, confidentiality and privacy, etc.) throughout the calendar year.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. After discussion in virtual review, DQ submitted a COM07-ENT Training and Education policy, but this policy did not address training its employees on member rights. DQ also submitted the CGA04-INS Monitoring of Complaints policy, but DQ failed to submit a grievance log or process document to demonstrate how it monitors grievances for rights-related complaints and remediates staff as appropriate to ensure member rights. The CS06-INS Customer Service–Monitoring Outcomes policy did not indicate that audits addressed monitoring of member rights and no evidence of an audit tool was submitted. The policy also did not indicate how this audit process was documented or tracked. DQ submitted evidence of policies related to safeguarding information and non-discrimination but nothing to demonstrate employee requirements to honor member rights or how this was monitored. In addition, no code of conduct documentation or training were submitted as requested in the virtual review.		
Required Actions: The MCE must develop policies and procedures that demonstrate the MCE complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights.		
Specific Rights		
3. The MCE complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, all pages **Additional Documentation:** • Member Rights Checklist (resubmission) • MKT04-INS Health Literacy	☐ Met ☒ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• COM15-ENT Non-Discrimination Compliance Program • CS06-INS Customer Service – Monitoring Outcomes	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The member handbook was insufficient evidence to demonstrate how DQ ensured compliance with the requirements in the Member Rights Checklist. In the initial submission to HSAG, the entire checklist only cited member handbook references. DQ resubmitted the member handbook and additional documentation but failed to provide evidence of compliance with all member rights. The MKT04-INS Health Literacy policy listed all member rights but pertained to DQ's requirements for written materials and correspondence. One portion of the policy indicated that "[m]ember-facing staff members receive training to enable them to assist members with accessing information needed for them to effectively access and exercise their health benefits and services, including strategies for interacting with members, and providing members with information about how to obtain prevention and wellness information." This information did not indicate that member-facing staff were trained about member rights, required to ensure member rights during interactions, or were monitored to ensure they were upholding member rights. DQ was unable to submit any staff training materials specific to member rights. The CS06-INS Customer Service–Monitoring Outcomes policy did not indicate that audits addressed monitoring of member rights and an audit tool was not submitted.		
Required Actions: The MCE must develop policies, procedures, or workflows, along with tracking mechanisms, to demonstrate compliance with the requirements in the Member Rights Checklist. Please see the Member Rights Checklist for the specific areas of noncompliance.		
General Rule		
4. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.	**HSAG Required Evidence:** • Policies and procedures (should address all components of 45 CFR part 164 subpart E) • Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO. b. The MCO designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520. c. The MCO trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the MCO as outlined in 45 CFR §164.530. d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. 42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12	• Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Staff training materials **Evidence as Submitted by the MCE:** • PRIV-ENT, page 23 • 2024 Privacy Computer Information Security Training, page 21 • COM07-ENT-SOP • COM05 **Additional documentation:** • COM07-ENT • Information Security Plan • Privacy Training - Individual Rights to Access • Privacy Training - Minimum Necessary • Privacy Training - Privacy Complaints • Privacy Training - Privacy Incidents and Breaches • Client Privacy Pages from SL_US_Employee Handbook	

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: DentaQuest has a designated HIPAA Privacy Officer, ensures that all members can report privacy incidents to a shared mailbox, and trains all employees on policies and procedures with respect to PHI. Additionally, DentaQuest's Chief Information Security Officer and IT Security team maintains appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosure of PHI		
5. The MCE and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCE is permitted to use or disclose PHI as follows: a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCE has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1-3)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement **Evidence as Submitted by the MCE:** • PRIV-ENT, pages 7-11 • 2024 Privacy Computer Information Security Training, page 9 • D as BA Template-CLEAN.docx (BAA with DentaQuest as Business Associate) • Trachmar Delegated Agreement - The entire document. This document cannot be edited **Additional Documentation:** • CS12-INS: Verification of Call Authority • CMS AOR form	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g) 45 CFR §164.530(c)(2)(ii) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2	• QA03-INS: Customer Service Quality Monitoring • CS06-INS: Customer Service Monitoring Outcomes • Office Reference Manual	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCE's compliance with 45 CFR §160 subpart C. 45 CFR §164.502(a)(2-4)	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement **Evidence as Submitted by the MCE:** • PRIV-ENT, page 11	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• COM11 – Delegation Oversight- Pg 3 section c • 2024 Privacy Computer Information Security Training, page 19 • D as BA Template-CLEAN.docx (BAA with DentaQuest as Business Associate)- Entire document • Trachmar Delegated Agreement- The entire document. This document cannot be edited **Additional Documentation:** • Office Reference Manual • HIPAA Privacy Policy • Notice of Privacy Practices • Internet Privacy Policy	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Minimum Necessary		
7. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCE makes reasonable efforts to limit PHI to the minimum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials	☒ Met ☐ Not Met

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
necessary to accomplish the intended purpose of the use, disclosure, or request. 45 CFR §164.502(b) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• Three examples of requests for PHI from another covered entity (e.g., member's previous MCE, dental benefits administrator, provider) **Evidence as Submitted by the MCE:** • PRIV-ENT, page(s) 10, 24 • COM11 Delegation Oversight- Entire document • 2024 Privacy Computer Information Security Training, page 9	☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf. It is also important to note that DentaQuest has not received requests for PHI from another Covered Entity, however, DentaQuest's Privacy Policy includes processes to manage such requests.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • PRIV-ENT, pages 10, 24 • 2024 Privacy Computer Information Security Training, page 9 • COM11 Delegation Oversight- Entire document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**Additional Documentation:** • Privacy Training - Minimum Necessary	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosures Requiring Authorizations		
9. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Authorization for use and disclosure form template • Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
entity provides the individual with a copy of the signed authorization. 45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4) 45 CFR Part 164 Subpart E 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**Evidence as Submitted by the MCE:** • PRIV-ENT • 2024 Privacy Computer Information Security Training- document • PHI Authorization Form updated 1016-DQ.docx • Redacted HIPAA Release ex. 1.pdf- Entire document • Redacted HIPAA Release ex. 2.pdf- - Entire document	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Privacy Rights		
10. The MCE complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for privacy protection • Two examples of member's request for privacy protection, including documentation of the	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	request and evidence to support completion of the privacy protection request	
	Evidence as Submitted by the MCE: • PRIV-ENT, pages 10, 24 • 2024 Privacy Computer Information Security Training, page 9 • DQ Long From Notice 2024.pdf (Notice of Privacy Practice- - Entire document **Additional Documentation:** • PHI Authorization Form • Notice of Privacy Practices | DentaQuest (link) • DQ Long Form Notice 2024 • LA_HealthyMedicaid_Member Handbook_July (02.23) Approved	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf. Also, DentaQuest has not received any member requests to protect their data or privacy.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE complies with the member's right to access PHI and the requirements under 45 CFR §164.524.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials	☒ Met ☐ Not Met

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
a. The MCE acts on a request for access no later than 30 days after receipt of the request. b. The MCE provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCE and member. 45 CFR §164.524 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• Process workflow • Member request form to access PHI • Two examples of member's request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request **Evidence as Submitted by the MCE:** • PRIV-ENT, pages 15-16 • 2024 Privacy Computer Information Security Training, page 11 **Additional Documentation:** • LA_HealthyMedicaid_Member Handbook_July (02.23) Approved • PHI Authorization Form • Notice of Privacy Practices | DentaQuest (link) • DQ Long Form Notice 2024	☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf. Also, DentaQuest has not received any member requests to protect their data or privacy.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
12. The MCE complies with the member's right to have the MCE amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCE complies with the requirements under 45 CFR §164.526. • The MCE acts on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526 42 CFR §457.1110(e) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to amend PHI • Two examples of member's request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request • One example of a denial of an amendment and notification to the member **Evidence as Submitted by the MCE:** • PRIV-ENT, pages 15-16 • 2024 Privacy Computer Information Security Training, page 11 **Additional Documentation:** • LA_HealthyMedicaid_Member Handbook_July (02.23) Approved • PHI Authorization Form • Notice of Privacy Practices | DentaQuest (link) • DQ Long Form Notice 2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf. Also, DentaQuest has not received any member requests to amend their data or PHI.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. The MCE complies with the member's right to receive an accounting of disclosures of PHI made by the MCE in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The MCE acts on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for an accounting of disclosures of PHI • Mechanism to track disclosures (e.g., where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure) • Two examples of member's request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request • Documentation to demonstrate how the record of the accounting of disclosures is retained **Evidence as Submitted by the MCE:** • PRIV-ENT, page 17 • 2024 Privacy Computer Information Security Training, page 11	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• 2024 Privacy Incident Reporting Form and Tracker Client Example (redacted).xlsx- Entire document • Accounting Disclosure Request and Response Example 1.pdf - - Entire document • Accounting Disclosure Request and Response Example 2.pdf- - Entire document **Additional Documentation:** • LA_HealthyMedicaid_Member Handbook_July (02.23) Approved • Privacy Training - Individual Rights to Access – Screenshot • Narrative: The Privacy Incident Report form is included on intranet sites within the organization and tracked in Compliance 360.	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define permissible uses/disclosures (treatment, payment, and healthcare operations, legal requirements, etc.), minimum necessary standards. Additionally, DentaQuest has executed business associate agreements with all vendors and partners who create, receive, maintain, or transmit PHI on DentaQuest's behalf.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Breach of Unsecured PHI		
14. The MCE, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCE to have been accessed, acquired, used, or disclosed as a result of such breach. a. Breach and unsecured PHI are as defined in 45 CFR §164.402. 45 CFR §164.402 45 CFR §164.404(a)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members **Evidence as Submitted by the MCE:** • PRIV-ENT, page 21 • PRIV01-ENT Breach Workflow- Entire document • 2024 Privacy Computer Information Security Training, page 19 • 2024 Privacy Incident Reporting Form and Tracker Client Example (redacted).xlsx – Entire document **Additional Documentation:** • Privacy Employee Links	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define a clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. The MCE for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the MCE as of the first day on which such breach is known to the MCE, or, by exercising reasonable diligence would have been known to the MCE. a. The MCE shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the MCE. 45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • List of all breaches of unsecured PHI during the time period under review, including the date of discovery **Evidence as Submitted by the MCE:** • PRIV-ENT, page 21 • PRIV01-ENT Breach Workflow -Entire document • 2024 Privacy Computer Information Security Training, page 19 • 2024 Privacy Incident Reporting Form and Tracker Client Example (redacted).xlsx- Entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define a clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. There were no privacy incidents impacting our LA market in 2024.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
16. Except as provided in 45 CFR §164.412, the MCE must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach. 45 CFR §164.404(b) 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members • Three examples of breach notification letters to members **Evidence as Submitted by the MCE:** • PRIV-ENT, page 21 • PRIV01-ENT Breach Workflow- Entire document • 2024 Privacy Computer Information Security Training, page 19 • Notification Letter Examples Redacted.pdf - Entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible: a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach. d. A brief description of what the MCE is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches. e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address. 45 CFR §164.404(c) 45 CFR §164.406(c) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template • Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period **Evidence as Submitted by the MCE:** • PRIV-ENT, page 21 • PRIV01-ENT Breach Workflow- Entire document • 2024 Privacy Computer Information Security Training, page 19 • Notification Letter Examples Redacted.pdf - Entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The notification must be provided in the following form: a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. b. If the MCE knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. c. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Confirmation of first-class mailing **Evidence as Submitted by the MCE:** • PRIV-ENT, page 21 • 2024 Privacy Computer Information Security Training, page 19 • Notification Letter Examples Redacted.pdf – Entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
19. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided. a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means. b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must: i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the MCE's website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI may be included in the breach. c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii). 45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2) MCO Contract: HIPAA Business Associate Provisions	**HSAG Required Evidence:** • Policies and procedures • One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period • One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period **Evidence as Submitted by the MCE:** • PRIV-ENT, page 21 • 2024 Privacy Computer Information Security Training, page 19	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum		
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
20. In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1). 45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period **Evidence as Submitted by the MCE:** • PRIV-ENT, pages 21-22 • 2024 Privacy Computer Information Security Training, page 19	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The PRIV01-ENT Privacy policy and Privacy Computer Information Security Training did not specify that DQ will provide notice by telephone or other means when any case is deemed by DQ to require urgency.		
Required Actions: The MCE must revise or develop a policy that indicates the following:		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured protected health information (PHI), the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1).		
21. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the MCE must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. 45 CFR §164.404(c) 45 CFR §164.406(a-b) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period **Evidence as Submitted by the MCE:** • PRIV-ENT, page 22 • 2024 Privacy Computer Information Security Training, page 19	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements. DentaQuest has not had a breach of unsecured PHI involving more the 500 members		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary. a. For breaches of unsecured PHI involving 500 or more individuals, the MCE must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services (HHS) Web site. b. For breaches of unsecured PHI involving less than 500 individuals, the MCE must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS web site. 45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members • Annual notification to HHS of breaches of unsecured PHI, including the date of notification **Evidence as Submitted by the MCE:** • PRIV-ENT, page 22 • 2024 Privacy Computer Information Security Training, page 19 • HHS Breach Report 7166_Redacted.pdf – Entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
23. The MCE must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the MCE of such breach. a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate. b. Except as provided in 45 CFR §164.412, the MCE must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach. d. The MCE must require a business associate to provide the MCE with any other available information that the MCE is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available. 45 CFR §164.404(c)	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI reported by subcontractors • One example of executed business associate agreement • One example of executed subcontractor contract **Evidence as Submitted by the MCE:** • PRIV-ENT, page(s) 11, 21 • 2024 Privacy Computer Information Security Training, page 19	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.410 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum		
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that define clear and actionable process for discovery of a breach or unsecured PHI. DentaQuest receives potential breach alerts through various mechanisms, which include employee reports, IT Security alerts, audits or compliance reviews, member complaints or vendor communications. DentaQuest has appropriate reporting protocols to meet notification requirements. Additionally, our business associate agreements with our subcontractors include breach notification requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Privacy Practices		
24. The MCE's members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCE, and of the member's rights and the MCE's legal duties with respect to PHI. a. The MCE provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1). b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions	**HSAG Required Evidence:** • Policies and procedures • Process for disseminating Notice of Privacy Practices • Staff training materials • Copy of Notice of Privacy Practices • Link to Notice of Privacy Practices on the MCE's website **Evidence as Submitted by the MCE:** • PRIV-ENT, page 14 • DQ Long from Notice 2024.pdf (Notice of Privacy Practice- The entire document	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• Notice of Privacy Practices | DentaQuest	
MCE Description of Process: DentaQuest has developed and maintained formal HIPAA privacy policies and procedures that include the notice of privacy practices. Additionally, the NPP can be found on the DentaQuest external facing website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard II—Member Rights and Confidentiality							
Total	Met	=	21	X	1	=	21
	Not Met	=	3	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	24	**Total Score**		=	21

Total Score ÷ Total Applicable	=	**88%**

Member Rights Checklist

Standard II—Member Rights Checklist		
Reference	**Required Components**	
A member enrolled with the MCE has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; 2.14.8; MCO Manual PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.13.1.1.2	1. Receive information in accordance with 42 CFR §438.10. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D	Y ☐ N ☒ NA ☐
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220 MCO Contract: 2.13.1.4.6; 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.4	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D	Y ☐ N ☒ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220 MCO Contract: 2.9.32. 1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6	4. Participate in decisions regarding his or her health care, including the right to refuse treatment. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D	Y ☐ N ☒ NA ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D	Y ☐ N ☒ NA ☐
42 CFR §438.100(b)(2)(vi) 42 CFR §457.122045 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526 MCO Contract: 2.13.6.2.6; 2.13.6.6.3.11; MCO Manual	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • PRIV-ENT • MKT04-Health Literacy Exhibit D	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9		
42 CFR §438.100(b)(3) 42 CFR §438.206 through§438.210 42 CFR §457.1220 MCO Contract: 2.4.1.2; 2.13.6.2.6; MCO Manual PAHP Contract: 2.4.1.4; 2.9.1.9 PIHP Contract: 5.13.1.1.14	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D • DQ Case Management Program Description • NET05-INS-Provider Network Adequacy • NET07-INS-Access to Dental Services	Y ☒ N ☐ NA ☐
42 CFR §438.100(c) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.15	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its network providers or the State treat the member. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • MKT04-Health Literacy Exhibit D	Y ☐ N ☒ NA ☐
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX	9. The MCE shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA). **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
ADA, Titles II and III ACA, Section 1557 MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	• COM15-ENT-Nondiscrimination Compliance Program	

Standard III—Member Information

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Information Requirements		
1. The MCE provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members. *"Readily accessible" means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.* *Note: LA reading grade level should be no higher than a 6.9 reading grade level for MCOs and PAHPs and no higher than a 5.0 reading grade level for the PIHP.* 42 CFR §438.10(c)(1) 42 CFR §457.1207 MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance) **Evidence as Submitted by the MCE:** • UM04-INS-Notice of Action Letters, pages 1 and 3 • MKT04-Health Literacy, pages 2 and 3 • LA Medicaid Welcome Letter ID Card readability 6-20-2025 – entire doc • DentaQuest Website Accessibility-508 Compliance Assessment June 2025, Entire doc • DentaQuest Website Design Policy, pages 3-7 **Additional Documentation:** • Fulfillment Process Workflow – LA Medicaid	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: • UM04-INS-Notice of Action Letters: All authorization decisions are communicated in a written letter of determination to the Provider and to the Member. The content of the letter includes information required by State and/or Federal guidelines and by Plan contract and/or NCQA requirements. The Notice of Action Letter includes: Denial reason specific to the service denied. The denial reason for any clinical denial includes the clinical rationale in layman's terms. Included in the denial reason for any administrative denial is the specific benefit limitation involved. • MKT04-Health Literacy Policy and Procedure: All member facing written materials are created/written in plain language that is easily understood and accessible by members and potential members. Additional considerations when creating written materials include: reading levels, font size, language and contractual requirements. See attached example reading grade level of member welcome letter. • Standard III_DentaQuest Website Accessibility-508 Compliance Assessment June 2025: To ensure every user has an equal experience, DentaQuest.com is checked for 508 compliance regularly. Proof of website accessibility as of June, 2025 from Siteimprove tool.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE uses the definitions for managed care terminology developed by the State including: a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider,	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, page 17	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
rehabilitation services and devices, skilled nursing care, specialist, and urgent care. 42 CFR §438.10(c)(4)(i) 42 CFR §457.1207 MCO Contract: Part 1; Glossary and Acronyms PAHP Contract: Part 7; Glossary and Acronyms PIHP Contract: Glossary		
MCE Description of Process: As applicable, DentaQuest includes definitions of managed care terminology in its Louisiana Member Handbook.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE uses State-developed model member handbooks and member notices. PIHP: a. *The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements.* 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices) **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The DentaQuest Louisiana Member Handbook has been developed and maintained in accordance with applicable rules and regulations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Language and Format		
4. The MCE makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost. 42 CFR §438.10(d)(3) 42 CFR §457.1207 MCO Contract: 2.13.15.5 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15	**HSAG Required Evidence:** • Policies and procedures • Provider directory in English, including taglines • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines • Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials **Evidence as Submitted by the MCE:** • MKT04-Health Literacy, pages 2 and 3 • DQ1819 Healthy LA Welcome_ID Card entire doc • DQ1833 LA_HealthyMedicaid_Member Handbook p. 2	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • LA_Medicaid_Welcome Letter/ID Card_Non-Discrimination Notice with Taglines • LA_Medicaid_Welcome Letter_Non-Discrimination Notice with Taglines_Geo-Coded Directory • LA Auth NOA sample English	
MCE Description of Process: Auxiliary aids and services are made available upon request and at no cost to the member.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's written materials critical to obtaining services did not meet criteria related to taglines, request for auxiliary aids and services at no cost, and the toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) telephone number.		
Required Actions: The MCE must ensure written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, are available in the prevalent non-English languages in its service areas. a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost. b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE's member/customer services unit. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
5. The MCE makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. 42 CFR §438.10(d)(4) 42 CFR §457.1207 MCO Contract: 2.13.15.2 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services **Evidence as Submitted by the MCE:** • CS09-INS-Customer Service-Member Access with LEP, Page 1, Section A1-2 & Page 2, Section B • MKT04-Health Literacy, page 3	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • CS09-INS-Customer Service-Member Access with LEP, Page 1, Section A1-2 & Page 2, Section C • MKT04-Health Literacy, pages 2 and 3 • DQ1819 Healthy LA Welcome_ID Card	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1	• DQ1833 LA_HealthyMedicaid_Member Handbook p. 2	
MCE Description of Process: Auxiliary aids and services are made available upon request and at no cost to the member.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The member handbook did not include language that stated that auxiliary aids and services are available upon request and at no cost for members with disabilities.		
Required Actions: The MCE must include language in the member handbook that informs members that auxiliary aids and services are available upon request and at no cost for members with disabilities.		
7. The MCE provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. *"Limited English proficient (LEP)" means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.* 42 CFR §438.10(d)(6) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Member handbook • Provider directory • All member newsletters during the time period of review • Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.14.8; 2.14.8.1; 2.14.8.8 PAHP Contract: 2.9.2.1.3.2.3; 2.9.2.1.3.2.4 PIHP Contract: 5.6.1.1; 5.6.1.3	• Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services **Evidence as Submitted by the MCE:** • CS09-INS-Customer Service-Member Access with LEP, Page 2, Section C • MKT04-Health Literacy, pages 6 • DQ1819 Healthy LA Welcome_ID Card • DQ1833 LA_HealthyMedicaid_Member Handbook p. 2 • LA Medicaid Welcome Letter ID Card readability 6-20-2025	
MCE Description of Process: MKT04-Health Literacy Policy and Procedure: All member facing written materials are created/written in plain language that is easily understood and accessible by members and potential members. Additional considerations when creating written materials include: reading levels, font size, language and contractual requirements. See attached example reading grade level of member welcome letter.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information for Members		
8. The MCE makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of:	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Two examples of MCE-initiated provider terminations, including evidence of the effective	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice. PAHP: a. The PAHP shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. 42 CFR §438.10(f)(1) 42 CFR §457.1207 MCO Contract: 2.13.9.2 PAHP Contract:2.6.11.4 PIHP Contract: 5.14.1.2	date of the termination and the notice sent to affected members • Two examples of provider-initiated terminations when the effective date of the termination is in the future, including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Tracking or reporting mechanism that demonstrates timeliness **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, Pg 19, para 3 • NET05-INS-Provider Network Adequacy; Ex: D **Additional Documentation:** • The Member Notification process is in Member Notifications of Provider Terminations policy. A copy of this policy is included in the Supporting Docs folder under "Element 8 - CORR01-INS-Member Notifications of Provider Terminations."	

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• Examples were not able to be provided within the 2-business day turnaround time.	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not support that DQ made a good faith effort to give written notice, within the required time frames, of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.		
Required Actions: The MCE must ensure that it makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider, and the notice to the member must be provided by the later of: a. Thirty calendar days prior to the effective date of the termination; or b. Fifteen calendar days after receipt or issuance of the termination notice.		
9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207 MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1	**HSAG Required Evidence:** • Policies and procedures • List of physician incentive plans • Example of physician incentive plan provided to a member upon request (if the MCE does not have physician incentive plans, please state so under the *MCE Description of Process*) **Evidence as Submitted by the MCE:** • No incentive plan during time of **January 1, 2024**, and **December 31, 2024**	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: No incentive plan during time of **January 1, 2024**, and **December 31, 2024**		
HSAG Findings: The MCE did not have any physician incentive plans in place during the time period of review; therefore, HSAG has determined that this requirement is not applicable.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
Member Handbook		
10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE: a. Mails a printed copy of the information to the member's mailing address; b. Provides the information by email after obtaining the member's agreement to receive the information by email; c. Posts the information on the MCE's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. PAHP: a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled: i. A current enrollee handbook 42 CFR §438.10(g)(1)	**HSAG Required Evidence:** • Policies and procedures • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) • Member materials, such as member welcome packet • Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member **Evidence as Submitted by the MCE:** • MKT03-INS-COMM-Member Communication Distribution, pages 5 • DQ1819 Healthy LA Welcome_ID Card	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(g)(3) 42 CFR §457.1207 MCO Contract: 2.13.6.3 PAHP Contract: 2.9.7.2; 2.9.8.1; 2.9.8.1.2 PIHP Contract: 5.8.3.3		
MCE Description of Process: The member is mailed a printed copy of a welcome packet that include welcome letter/ID card, non-discrimination notice and taglines, with a link to the member handbook. The member handbook is available online for member review at any time.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on MCE's website • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • Member handbook is available on this page: https://www.dentaquest.com/en/members/louisiana-medicaid-dental-coverage/epsdt-dental-program • Direct link to the handbook is: https://www.dentaquest.com/content/dam/dentaqu	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	est/en/members/louisiana/la-member-handbook.pdf	
MCE Description of Process: DentaQuest, to the best of its ability, has cross-referenced its member handbook with the Member Handbook Checklist.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The member handbook did not include language regarding the availability of assistance in the filing process of appeals nor information on how members can obtain information from the State about how to access the services not provided by DQ because of moral or religious objections.		
Required Actions: The MCE must update the member handbook to include language that references the availability of assistance in the filing process of appeals. The MCE must also update the member handbook to inform members on how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections.		
12. The MCE gives each member notice of any change to the member handbook that the State defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change. *Note: LA defines significant as "important in effect or meaning."* 42 CFR §438.10(g) 42 CFR §457.1207 MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Policies and procedures • Workflow for member handbook changes • One example of a change to the member handbook due to a significant change and notice sent to members (if there were no significant changes during the past 12 months, state so in the *MCE Description of Process*) • Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook MKT03-INS-COMM-Member Communication Distribution, pages 5	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: MKT03-INS-COMM-Member Communication: Any significant changes made to the member handbook, DentaQuest will provide those changes to the member at least 30 calendar days before the effective date. There were no significant changes to the Louisiana Member Handbook during the past 12 months.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Provider Directory		
13. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 MCO Contract: 2.13.6.4 PAHP Contract: 2.9.8.3.1; 2.9.8.1.4 PIHP Contract: 5.8.3.1; 5.10.1	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand) • Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the MCE:** • MKT03-INS-COMM-Member Communication Distribution, pages 5 • MKT11-INS-FAD Online Directory, Entire Doc • Direct link to online provider directory: https://www.dentaquest.com/en/find-a-dentist	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Hard copy of the provider directory is available upon request.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's electronic and paper provider directory did not include the following components: • Website Uniform Resource Locater (URL), as appropriate. • A statement that some providers may choose not to perform certain services based on religious or moral beliefs. **Recommendations:** HSAG recommends that the MCE ensure its public, searchable provider directory is updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).		
Required Actions: The MCE must include the following components in the electronic and paper provider directory: • Website URL, as appropriate. • A statement that some providers may choose not to perform certain services based on religious or moral beliefs.		
14. Information included in the MCE's paper provider directory is updated at least: a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the MCE has a mobile-enabled electronic provider directory. PAHP: a. *The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.* 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.4; 2.13.8.4 PAHP Contract: 2.9.2.1.2.2; 2.9.2.1.2.3 PIHP Contract: 5.10.3	**HSAG Required Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow for updating paper provider directories • Three consecutive provider directory update examples, including the dates for when the updates were made **Evidence as Submitted by the MCE:** • NET17-INS-SOP-Government Website Provider Directory • DQ1833 LA_HealthyMedicaid_Member Handbook, Pg 19, para 3 • MKT11-INS -Find a Dentist (FAD) Online Directory, Entire doc	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	Directory located at: https://www.dentaquest.com/en/find-a-dentist	
MCE Description of Process: Website provider directories are updated on a regular basis. Paper directories are available upon request.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's policy time frame for updating the paper provider directory was outside of the federal requirement time frame.		
Required Actions: The MCE must update the printable version of the provider directory at least quarterly and include versioning.		
15. Information included in the MCE's electronic provider directory is updated no later than 30 calendar days after the MCE receives updated provider information. MCO: a. The web-based online version shall be updated in real time, but no less than weekly. PAHP: a. In accordance with 42 CFR §438.10(h), the PAHP must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete and updated no less than once weekly. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207 MCO Contract: 2.13.8.4 PAHP Contract: 2.9.2.1.2.1; 2.9.2.1.2.1 PIHP Contract: 5.10.3	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples, including evidence to demonstrate the date the MCE was made aware of the updated provider information and the date the change was reflected in the electronic provider directory • Tracking mechanisms to demonstrate timeliness **Evidence as Submitted by the MCE:** • NET17-INS-SOP-Government Website Provider Directory • MKT11-INS - Find a Dentist (FAD) Online Directory, Entire doc	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: DentaQuest's online provider directory (https://www.dentaquest.com/en/find-a-dentist) is updated in real time, nightly at 5pm ET. Any updates to the provider record in Windward before 5pm ET is reflected on the online provider directory tool the next day.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
16. The MCE's provider directory is made available on the MCE's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(h)(4) 42 CFR §457.1207 MCO Contract: 2.13.8.1.2 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • Link to the publicly available machine-readable provider directory on the MCE's website **Evidence as Submitted by the MCE:** • See Description of Process (below)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQeust has a .csv (machine readable) file up on its site for LA. https://www.dentaquest.com/content/dam/dentaquest/en/cms/la-medicaid-dental-program.csv		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Formulary		
17. The MCE makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand).	**HSAG Required Evidence:** • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable)	☐ Met ☐ Not Met ☒ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	• Link to the publicly available formulary on the MCE's website **Evidence as Submitted by the MCE:** • N/A for Dental.	
MCE Description of Process: N/A		
HSAG Findings: The MCE did not utilize a formulary; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
18. The MCE's formulary drug list is made available on the MCE's website in a machine-readable file and format as specified by the Secretary. 42 CFR §438.10(i)(3) 42 CFR §457.1207 MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable formulary (e.g., .JSON format) • Link to the publicly available machine-readable formulary on the MCE's website **Evidence as Submitted by the MCE:** • Not Applicable	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: N/A		
HSAG Findings: The MCE did not utilize a formulary; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Electronic Materials and Communications		
19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following: a. The format is readily accessible. b. The information is placed in a location on the MCE's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7	**HSAG Required Evidence:** • Policies and Procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to the MCE's homepage of its website • Tracking mechanisms related to requests for information in paper form that includes the date of the member's request and the date it was provided to the member (e.g., mailed) • Evidence for how members are informed that paper copies of information are available upon request and without charge **Evidence as Submitted by the MCE:** • www.dentaquest.com • DQ1819 Healthy LA Welcome_ID Card – entire doc • DQ1833 LA_HealthyMedicaid_Member Handbook	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Members are informed that materials are available in paper form, without charge and upon request through the welcome letter and member handbook. Information is placed conspicuously on the welcome letter and in the member handbook		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide evidence that the website included language informing the member that information available in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must inform members on the website that information provided in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days.		

Results for Standard III—Member Information							
Total	Met	=	9	X	1	=	9
	Not Met	=	7	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	16	**Total Score**		=	9

Total Score ÷ Total Applicable	=	**56%**

Member Handbook Checklist

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7; 2.13.6.2.26; 2.13.6.2.26 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	1. Benefits provided by the MCE. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8; 2.13.6.2.14 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11; 5.9.2.13	2. How and where to access any benefits provided by the State. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☒ NA ☐
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.24 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.27	3. How transportation is provided. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE.	Y ☐ N ☒ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	**Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207 MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4	5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☒ NA ☐
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. *For the MCOs, this also includes specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming.* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. *The PIHP must also include procedures for plan of care development.* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207	8. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14		
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	9. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	10. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	11. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	12. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.10 PAHP Contract: 2.9.7.2 PIHP Contract: None	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require members to obtain a referral before choosing a family planning provider. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207 MCO Contract: 6.36.1 PAHP Contract: 6.17.1 PIHP Contract: NA	14. Cost sharing (if any imposed under the State plan). **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 MCO Contract: 2.13.6.2.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.6	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member's primary care provider/primacy dental provider. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1	17. The right to file grievances and appeals. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	18. The requirements and timeframes for filing a grievance or appeal. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	19. The availability of assistance in the filing process for grievances and appeals. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☒ NA ☐
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	20. The right to request a state fair hearing (SFH) (or a State external review for the Children's Health Insurance Program [CHIP]) after the MCE has made a determination on a member's appeal which is adverse to the member. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xi)(E) MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) MCO Contract: 2.13.6.2.19; 2.13.6.2.19.1-2.13.6.2.19.4 PAHP Contract: NA PIHP Contract: 5.9.2.19	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j) *The MCOs must provide a description of advance directives which includes:* *The MCO's policies related to advance directives;* *The enrollee's rights under State Law, including the to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;* *Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana's Survey and Certification agency; and* *Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. *For the MCO, this instruction shall be included in all versions of the Member Handbook in English and Spanish.* *For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PIHP Contract: 5.6.1.5; 5.9.2.29	**Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.22; 2.13.6.2.23 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	25. Information on how to report suspected fraud or abuse. **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	26. *The MCOs must include a description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them.* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	27. *The MCOs must include information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	28. *The MCOs must include information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.28 PAHP Contract: NA PIHP Contract: NA	29. *The MCOs must include information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	30. *The MCOs must include reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.30 PAHP Contract: NA PIHP Contract: NA	31. *The MCOs must include enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.35 PAHP Contract: NA PIHP Contract: NA	32. *The MCOs must include the date of the last revision;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	33. *The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:* a. *A description of covered behavioral health services;* b. *Where and how to access behavioral health services and behavioral health providers;* c. *General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;* d. *Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and* e. *Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA	34. *The PIHP must include CSoC eligibility requirements;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PAHP Contract: NA PIHP Contract: 5.9.2.3		
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	35. *The PIHP must include Member's Bill of Rights;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	36. *The PIHP must include where to find medical necessity criteria on the Contractor's website and how to request hardcopies of medical necessity criteria;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	37. *The PIHP must include how to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a "no-show;"* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. *The PIHP must include family's/caregiver's or legal guardian's role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA	39. *The PIHP must include generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult's engagement, resilience, strength-based and evidence-based practice, and best/proven practices;*	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PAHP Contract: NA PIHP Contract: 5.9.2.23	**Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. *The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. *The PIHP must include any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. *The PIHP must include how to identify and contact the WAAs and FSO;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. *The PIHP must include names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook	

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. *The PIHP must include the date of the last revision;* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. *The PIHP must include the mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	46. *The PIHP must include additional information that is available upon request, including the following:* a. *Information on the structure and operation of the Contractor;* b. *Pharmacy location or medication information availability;* c. *Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and* d. *Service utilization policies* **Evidence as submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook	Y ☐ N ☐ NA ☒

Provider Directory Checklist

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
The MCE makes available in paper form upon request and searchable electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	1. The provider's name as well as any group affiliation. **Evidence as submitted by the MCE:** • https://dentaquest.com/state-plans/regions/louisiana/dentist-page/ • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	2. Street address(es). **Evidence as submitted by the MCE:** • https://dentaquest.com/state-plans/regions/louisiana/dentist-page/ • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	3. Telephone number(s). **Evidence as submitted by the MCE:** • https://dentaquest.com/state-plans/regions/louisiana/dentist-page/ • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☒ N ☐ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	4. Website Uniform Resource Locater (URL), as appropriate. **Evidence as submitted by the MCE:** • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☐ N ☒ NA ☐
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	5. Specialty, as appropriate. **Evidence as submitted by the MCE:** • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	6. Whether the provider will accept new members. **Evidence as submitted by the MCE:** • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.	Y ☒ N ☐ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	**Evidence as submitted by the MCE:** • N/A	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. **Evidence as submitted by the MCE:** • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(2) 42 CFR §457.1207 MCO Contract: 2.13.8.7.1 PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	9. The MCE provider directory components are included for the following provider types: a. Physicians, including specialists; b. Hospitals; c. Pharmacies; d. Behavioral health providers; The MCO provider directory components are included for the following provider types *and shall be delineated by parish and zip code*: a. *Hospital primary care physician (PCP) groups* b. *Clinic settings* c. *Home and community-based services* d. *Outpatient therapy* e. *Residential substance use* f. *Youth residential services* g. *Inpatient mental health and residential substance use services* h. *Federally qualified health centers (FQHCs)*	Y ☒ N ☐ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
	i. *Rural health clinics (RHCs)* j. *Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.* k. *Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.* l. *Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.* The PAHP provider directory components are included for the following provider types: a. *Endodontists* b. *Maxillofacial surgeons* c. *Oral surgeons* d. *Orthodontists* e. *Pedodontists* f. *Periodontists* g. *Prosthodontists* h. *Special needs pedodontists*	
	Evidence as submitted by the MCE: • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	10. *The PAHP provider directory must include the following:* a. *The provider's cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;* b. *Office hours;* c. *Specific performance indicators;* d. *A statement that some providers may choose not to perform certain services based on religious or moral beliefs;*	Y ☐ N ☒ NA ☐

Standard III—Provider Directory Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	11. *The PAHP Provider Directory must also include the following:* a. *Providers arranged by name in alphabetical order* b. *Showing the provider's specialty,* c. *Providers listed by specialty in alphabetical order by name.*	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Search Results | DentaQuest • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. *The PIHP Provider Directory must include the following:* a. *Indication of populations served by the provider (e.g., age range of clients) and specialties;* b. *Identification of any restrictions on the member's freedom of choice among providers;* c. *Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours);* d. *Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Search Results | DentaQuest; • NET01-INS-SOP Provider Demographic Validation pg 1 • NET01-INS-NETWORK DEVELOPMENT MAINTENANCE & USE pg. 3-#6a, pg. 4-#9	

Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
1. The MCE defines "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1; Glossary and Acronyms PAHP Contract: Part 7; Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10 • LA_Mediciaid_ORM.v6, page 86 **Additional Documentation:** The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest defines "Emergency Dental Condition" in its member handbook and provider office reference manual. Medical symptoms or conditions are outside the scope of DentaQuest's business operations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCE defines "emergency services" as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42. b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1; Glossary and Acronyms PAHP Contract: Part 7; Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10 • LA_Mediciaid_ORM.v6, page 86 **Additional Documentation:** The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest defines "Emergency Dental Services" in its member handbook and provider office reference manual. Medical symptoms or conditions are outside the scope of DentaQuest's business operations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE defines "poststabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. 42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: Part 1; Glossary and Acronyms PAHP Contract: 4.2.2 PIHP Contract: Glossary	**Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10 • LA_Mediciaid_ORM.v6, page 86 **Additional Documentation:** The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86	
MCE Description of Process: DentaQuest does not define "poststabilization care services" in its member handbook or provider reference manual. DentaQuest has protocols in place for post emergency dental services, as applicable.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment		
4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. 42 CFR §438.114(c)(1)(i) 42 CFR §457.1228 MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)	
	Evidence as Submitted by the MCE: • DQ1833 LA_HealthyMedicaid_Member Handbook, page(s) 10 • LA_Mediciaid_ORM.v6, page(s) 31 • UM08-INS-Authorization Review, page 4-5, numbers 8-11 **Additional Documentation:** The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86 • UM08-INS-Auth Review – policy now in scope of audit period • D9110 example #1 • D9110 example #2 • D9110 example #3	
MCE Description of Process: • DentaQuest covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with DentQuest.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
• Emergent/Urgent services are covered in the following situations: a. To screen and stabilize the member without prior approval, where a prudent layperson, acting reasonably; would have believed that an emergency medical condition existed. b. If an authorized representative acting for the organization, authorized the provision of emergency services. Although DentaQuest does not require an authorization for emergency services, in the instance where a dental provider insists on the submission of a request for authorization, an authorization to render "emergency service," as defined in this policy, is provided within seventy-two (72) hours of request. Upon receipt of the claim for payment, dental records are reviewed, and the claim paid in accordance with the guidelines for emergency services, as defined in this policy.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of "emergency medical condition." b. A representative of the MCE instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228 MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management) • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:**	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• DQ1833 LA_HealthyMedicaid_Member Handbook, page(s) 10 • LA_Mediciaid_ORM.v6, page 31 • UM08-INS-Authorization Review, page 4-5, number 11, letters a-f **Additional Documentation:** The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86 • UM08-INS-Auth Review – policy now in scope of audit period	
MCE Description of Process: DentaQuest covers and pays for emergency services. Expedited Authorization Request – Process and Procedure a. An emergent/urgent authorization request for Utilization Management review is received by DentaQuest's Office Services area, via fax (262-241-7150-Dental), or through the DentaQuest portal or electronic means. The request is scanned, imported, or keyed into the DentaQuest system which then creates a permanent file which contains all pertinent Member and Provider information. b. All Member plan benefit and eligibility data is stored in DentaQuest's system. Upon entering an authorization, the system requires the selection of an eligibility period prior to processing, allowing the verification of eligibility. All Member plan benefits are linked to each individual Member; assuring that only covered benefits are authorized. Any non-covered benefits are systematically denied. Provider eligibility data is stored		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
in DentaQuest's system. Any out of network or ineligible Providers are systemically denied. c. The request for emergency care and services is entered into DentaQuest's system. d. Only a licensed health care Provider makes the clinical denial of care determinations. e. The facility where the emergency/urgent service is rendered determines the dental emergency condition that requires emergent/urgent care, for the purposes of rendering needed emergent care. f. After emergency care is rendered and upon the receipt and review of a claim and corresponding dental records and if an emergency dental condition is present, the facility will be compensated for any covered services completed at their facility.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Additional Rules for Emergency Services		
6. The MCE does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCE, or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. 42 CFR §438.114(d)(1) 42 CFR §457.1228 MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:**	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
PIHP Contract: 8.8.1	• DQ1833 LA_HealthyMedicaid_Member Handbook, page(s) 10 • LA_Mediciaid_ORM.v6, page(s) 31, 86 • UM08-INS-Authorization Review, page 14-15 **Additional Documentation:** The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86 • UM08-INS-Auth Review – policy now in scope of audit period • D9110 example #1 • D9110 example #2 • D9110 example #3	
MCE Description of Process: DentaQuest covers and pays for emergency services. a. For expedited service authorization decisions where a provider indicates, or DentaQuest determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, DentaQuest must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. b. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the adverse benefit determination is to take effect. Certain exceptions apply: 1. By the date of the action when any of the following occur: ☐The enrollee has died; ☐ The enrollee submits a signed, dated, written statement requesting service		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result; ☐ The enrollee has been admitted to an institution where he or she is ineligible under the Dental Plan for further services; ☐ The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address; ☐ The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or ☐ The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. 42 CFR §438.114(d)(2) 42 CFR §457.1228 MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10 • LA_Mediciaid_ORM.v6, page(s) 31, 86	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: The ORM and member handbook are running documents. • DQ1833 LA_HealthyMedicaid_Member Handbook, page 10; • LA_Mediciaid_ORM.v6, page 86 • UM08-INS-Auth Review – policy now in scope of audit period • D9110 example #1 • D9110 example #2 • D9110 example #3	
MCE Description of Process: DentaQuest covers and pays for emergency services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE. 42 CFR §438.114(d)(3) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services **Evidence as Submitted by the MCE:** • N/A	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: N/A		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide sufficient evidence of compliance with federal regulations and state contract requirements regarding the binding authority of a treating physician's decision on a member's readiness for discharge or transfer.		
Required Actions: The MCE must develop, and maintain within its documentation, a process which outlines that the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE.		
Coverage and Payment of Poststabilization Care Services		
9. The MCE is financially responsible for post-stabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative. 42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for post stabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • N/A	☐ Met ☒ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide sufficient evidence of compliance with federal regulations and state contract requirements that the MCE is financially responsible for pre-approved poststabilization care services, whether obtained within or outside of its network.		
Required Actions: The MCE must develop, and maintain within its documentation, a process which outlines that the MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member's stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.1 PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services **Evidence as Submitted by the MCE:** • N/A	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide sufficient evidence of compliance with federal regulations and state contract requirements that outlined the financial responsibility for poststabilization care services, including services that are not pre-approved but are administered to maintain a member's stabilized condition within one hour of a pre-approval request.		
Required Actions: The MCE must develop, and maintain within its documentation, a process which outlines that the MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member's stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services.		
11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition if:	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services	☐ Met ☒ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
a. The MCE does not respond to a request for pre-approval within one hour. b. The MCE cannot be contacted. c. The MCE representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.2 PAHP Contract: 2.4.2.2.1.1; 2.4.2.2.1.2; 2.4.2.2.1.3 PIHP Contract: 8.8.1	• Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE's response • One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services **Evidence as Submitted by the MCE:** • N/A	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide sufficient evidence of compliance with federal regulations and state contract requirements that outline the financial responsibility for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition.		
Required Actions: The MCE must develop, and maintain within its documentation, a process which outlines that the MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition if: a. The MCE does not respond to a request for pre-approval within one hour.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
b. The MCE cannot be contacted. c. The MCE representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.		
12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow for claims review process for poststabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • This requirement does not apply to DentaQuest	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: DentaQuest does not define "poststabilization care services" in its member handbook or provider reference manual. DentaQuest has protocols in place for post emergency dental services, as applicable.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide sufficient evidence of compliance with federal regulations concerning the limitation of member charges for poststabilization care. DQ could not demonstrate that these charges were capped at an amount no greater than what the member would have been charged for in-network services.		
Required Actions: The MCE must develop, and maintain within its documentation, a process which outlines that the MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
End of the MCE's Financial Responsibility		
13. The MCE's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An MCE representative and the treating physician reach an agreement concerning the member's care. d. The member is discharged. 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • N/A	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: DentaQuest does not define "poststabilization care services" in its member handbook or provider reference manual. DentaQuest has protocols in place for post emergency dental services, as applicable.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide sufficient evidence of compliance with federal regulations that define when its financial responsibility for non-pre-approved poststabilization care services ends.		
Required Actions: The MCE must develop, and maintain within its documentation, a process which outlines that the MCE's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An MCE representative and the treating physician reach an agreement concerning the member's care. d. The member is discharged.		

Results for Standard IV—Emergency and Poststabilization Services							
Total	Met	=	7	X	1	=	7
	Not Met	=	6	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	13	**Total Score**		=	7

Total Score ÷ Total Applicable	=	**54%**

Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
1. The MCE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) MCO Contract: 2.9.2.1 PAHP Contract: 2.6.4.1.1; 2.6.4.1.2; 2.6.6.9 PIHP Contract: 6.1.1	**HSAG Required Evidence:** • Policies and procedures • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs • Provider materials, such as the provider manual • One example of each type of provider contract (ancillary, hospital, and individual/group) **Evidence as Submitted by the MCE:** • LA Provider Agreement-LA Medicaid ORM; entire doc • Net05-INS Provider Network Adequacy; pg. 2-D • Net07-INS-Access to Dental Service; pg. 4-D **Additional Documentation:** • LA Provider Agreement-LA Medicaid ORM; entire doc • Net05-INS Provider Network Adequacy; pg. 2-D & Exhibit D Louisiana • Net07-INS-Access to Dental Service; pg. 4-D	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: DentaQuest monitors network adequacy and accessibility through established procedures to ensure sufficient provider access for members. Assessments are conducted in each service area, evaluating factors such as geography, provider specialty, appointment availability, and out of network placement. DentaQuest is committed to promoting cultural and communication competency across the network. The organization also ensures full compliance with all applicable state and federal statutes as well as client-specific requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's provider agreement demonstrated its written agreements with providers. Additionally, DQ's Provider Network Adequacy and Access to Dental Service policies outlined DQ's commitment to monitor and maintain a provider network sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. Specifically, DQ's Provider Network Adequacy policy stated that it monitors its network through: "1. GeoReports to ensure adequate network coverage; 2. Tracking member and provider complaints and grievances to identify areas of need; 3. Appointment surveys given to one fourth of all active Provider locations each quarter to ensure the entire network is surveyed at least annually; 4. After-hours availability is surveyed at least annually; 5. Client notice of network deficiency; 6. In office wait time survey/monitoring, as applicable or required." Furthermore, DQ's Access to Dental Service policy stated that DQ requires its providers to "disclose their ability to treat Special Need and Circumstance members when they are credentialed and re-credentialed for participation" in DQ's network. During the interview, DQ's staff members stated that the MCE monitors its provider network; however, DQ's subsequent submission did not include analyses pertaining to the provider network's linguistic capabilities or its capabilities to serve members with special health care needs.		
Required Actions: The MCE must monitor its provider network to ensure adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.		
2. The MCE provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) 42 CFR §457.1230(a) MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: N/A Dental only…Not a women's health specialist provider		
HSAG Findings: Family planning services are not applicable to the PAHP; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) 42 CFR §457.1230(a) MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • List of provider types designated as family planning providers • Network adequacy analysis of family planning providers **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: N/A Dental only…not related to family planning.		
HSAG Findings: Family planning services are not applicable to the PAHP; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
4. The MCE provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member. 42 CFR §438.206(b)(3) 42 CFR §457.1230(a) MCO Contract: 2.13.6.2.32 PAHP Contract: 2.5.2.1.1.3; 2.6.6.2.5 PIHP Contract:7.2.8	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis • Coverage/authorization guidelines **Evidence as Submitted by the MCE:** • LA Medicaid ORM v6; pg 43 & 44	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • DentaQuest has attached a narrative to explain the Second Opinion policy • Member Handbook LDH Approval Email 2_2023 • LDH-ID MMEM2022-1625 DQ1833 LA_HealthyMedicaid_Member Handbook_July (02.23)Approved	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's Office Reference Manual (ORM) provided for an informal reconsideration following an adverse determination of a service authorization request, such as a second opinion, which did not appear relevant to this element. DQ's member handbook communicated the right to a second opinion to members and how to seek a second opinion at no cost to the member. However, DQ did not submit policies or procedures, second opinion tracking or analysis, nor coverage or authorization guidelines to support implementation of this requirement.		
Required Actions: The MCE must develop a process for implementing second opinions to its members, including but not limited to clinical or authorization guidelines and monitoring mechanisms.		
5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCE adequately and timely covers these services out of network for the member, for as long as the MCE provider network is unable to provide them. 42 CFR §438.206(b)(4) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Three examples of executed single case agreements **Evidence as Submitted by the MCE:** • NET07-INS-Access to Dental Service for Members; pg. 3-C • LA Medicaid ORM v6; pg. 64 C	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • NET07-INS-Access to Dental Service for Members; pg. 3-C • LA Medicaid ORM v6; pg. 64 C • LDH-ID MMEM2022-1625 DQ1833 LA_HealthyMedicaid_Member Handbook_July (02.23)Approved • Member Handbook LDH Approval Email 2_2023	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE requires out-of-network providers to coordinate with the MCE for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network. 42 CFR §438.206(b)(5) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	**HSAG Required Evidence:** • Policies and procedures • Claims processing guidelines • Member materials, such as the member handbook • Provider materials, such as materials on the MCE's website • Three examples of executed single case agreements **Evidence as Submitted by the MCE:** • LA Medicaid ORM pg 29 Section 3.03 • CL01-INS Claims Processing pg. 5-#7	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • LA Medicaid ORM pg 29 Section 3.03 • CL01-INS Claims Processing pg. 5-#7 • CL02-INS-Claims Payment 2024 • LDH-ID MMEM2022-1625 DQ1833 • LA_HealthyMedicaid_Member Handbook_July (02.23)Approved	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. While DQ's member handbook provided for a member's utilization of out-of-network providers, the member handbook did not state that the member's cost for the utilization of an out-of-network provider would be no greater than if the services were furnished within network. DQ provided an ORM citation regarding Medical Necessity Guidelines, which appeared to be irrelevant to this requirement. DQ also provided a Claims Processing policy citation concerning out-of-network benefits, which pertained to claims processing but did not include the language requiring the provider to coordinate with the MCE for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network. In its subsequent submission, DQ provided a written statement that it "did not perform any SCA in Louisiana during CY2024 for any LDH Child & Adult Medicaid member."		
Required Actions: The MCE must require out-of-network providers to coordinate with the MCE for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.		
42 CFR §438.206(b)(6) requires the MCE to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection. [this could change depending on each state's requirements]		
Timely Access		
7. The MCE meets and requires its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist.	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1	• Network analysis (e.g., appointment standards) • HSAG will also use the results of the Access Standards: Appointment Times Checklist **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D **Additional Documentation:** • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D • LA Medicaid ORM; entire doc and LA Dental Provider Agreement are included in Standard V Supporting Docs. • Our internal A&A Surveys Policy & Procedure is included in our Supporting Docs and helps illustrate our support.	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's Provider Network Adequacy policy outlined DQ's commitment to monitor and maintain a provider network sufficient to provide adequate access to all services covered under the contract for all members. Specifically, DQ's Provider Network Adequacy policy stated that it monitors its network through: "3. Appointment surveys given to one fourth of all active provider locations each quarter to ensure the entire network is surveyed at least annually; 4. After-hours availability is surveyed at least annually; and 6. In office wait time survey/monitoring, as applicable or required." Furthermore, DQ's Appointment Times Checklist was also used by the HSAG reviewer to evaluate this requirement, and identified areas of noncompliance. In its subsequent submission, DQ's Access and Availability Survey procedure illustrated how DQ implemented its access and availability surveys.		
Required Actions: The MCE must meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist for the specific areas of noncompliance.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
8. MCO: The MCE ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider serves only Medicaid members. PAHP: Network providers must offer office hours at least equal to those offered by commercial dental insurance plans. 42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D **Additional Documentation:** • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D • LA Medicaid ORM; entire doc. • LA Provider Agreement also included in files under Supporting Docs. • Our Audit/Secret Shopper results for 2024 is included in the Supporting Docs folder.	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided a Provider Network Adequacy policy citation related to network adequacy monitoring but did not address monitoring that its network providers offer office hours at least equal to those offered by commercial dental insurance plans. While DQ stated it provided the 2024 Audit/Secret Shopper results in its subsequent submission, HSAG could not locate this file.		
Required Actions: The MCE must ensure, through monitoring and data analysis, that its network providers offer office hours at least equal to those offered by commercial dental insurance plans.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Results of provider monitoring mechanisms • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D • UM10-INS-Access to UM Department – pg 1 **Additional Documentation:** • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D • New copy of UM10-INS-Access to UM Dept is within the scope of the audit. • LA Medicaid ORM; entire doc. • LA Provider Agreement also included in files under Standard V Supporting Docs. • PEC04-INS-Provider Directory Maintenance and On Going Monitoring Pg -5 • Additional Monitoring Mechanisms such as DQ Monthly Monitoring Letters also found under Supporting Documents in Standard VIII Supporting Docs	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Our Audit/Secret Shopper results for 2024 is included in the Supporting Docs folder.	
MCE Description of Process: UM10-INS-Access to UM Department: Systems and processes are established that provide access to all Company department areas, including Utilization Management. Providers are encouraged to discuss any clinical decision or utilization review criteria with appropriate clinical personnel during normal business hours. Members are instructed to discuss all clinical decisions with their attending Provider.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided Provider Network Adequacy and Access to UM Department policy citations, which did not appear to be relevant to this requirement. In its subsequent submission, DQ provided its monthly monitoring letters related to exclusion and sanction checks, which did not appear relevant to this element. While DQ stated it provided the PEC04-INS-Provider Directory Maintenance and On Going Monitoring policy and 2024 Audit/Secret Shopper results in its subsequent submission, HSAG could not locate these files.		
Required Actions: The MCE must make services included in the contract available 24 hours a day, seven days a week, when medically necessary. The MCE must demonstrate implementation, through monitoring and data analysis, for this requirement.		
10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The MCE monitors network providers regularly to determine compliance. b. The MCE takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a) MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Results of provider monitoring mechanisms • Audit or secret shopper results/reports • Three examples of corrective action taken when a provider fails to meet timely access standards **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy, pg 2 A & E **Additional Documentation:** • NET05-INS-Provider Network Adequacy, Pg 2 A & E	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• PEC04-INS-Provider Directory Maintenance and On Going Monitoring Pg -5 • Additional Monitoring Mechanisms such as DQ Monthly Monitoring Letters also found under Supporting Documents in Standard VIII Supporting Docs. • Our Audit/Secret Shopper results for 2024 is included in the Supporting Docs folder. • Examples included in the Supporting Docs Folder.	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided Provider Network Adequacy policy citations concerning geo reporting and network adequacy monitoring. Specifically, DQ's Provider Network Adequacy policy stated that it monitors its network through: "1. GeoReports to ensure adequate network coverage; 2. Tracking member and provider complaints and grievances to identify areas of need; 3. Appointment surveys given to one fourth of all active Provider locations each quarter to ensure the entire network is surveyed at least annually; 4. After-hours availability is surveyed at least annually; 5. Client notice of network deficiency; 6. In office wait time survey/monitoring, as applicable or required." In its subsequent submission, DQ provided its monthly monitoring letters related to exclusion and sanction checks, which did not appear relevant to this element. While DQ stated it provided the PEC04-INS-Provider Directory Maintenance and On Going Monitoring policy, 2024 Audit/Secret Shopper results, and examples of corrective action plans in its subsequent submission, HSAG could not locate these files. Therefore, DQ has not demonstrated implementation of any mechanisms it has established to ensure providers are complying with the access standards.		
Required Actions: The MCE must establish mechanisms ensuring compliance with timely access to care and services standards by network providers regularly to determine compliance and how it takes corrective action if there is a failure to comply by a network provider.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Access and Cultural Considerations		
11. The MCE participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex. 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) MCO Contract: 2.4.1.11 PAHP Contract: 2.1.2 PIHP Contract: 5.1.8	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence **Evidence as Submitted by the MCE:** • LA Provider Agreement; pg. 12- #13 • LA Medicaid ORM; pg.16 • NET07-INS-Access to Dental Service for Members; pg 2-B **Additional Documentation:** • LA Medicaid ORM; pg.16 • NET07-INS-Access to Dental Service for Members; pg 2-B and pg 4-D • DentaQuest has also attached a copy of our Q4 LA Survey Data we do when contacting providers about access and availability. We confirm with the offices their cultural and linguistic capabilities	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	as well as their ability to treat all members, office modalities, etc.	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided an Access to Dental Service for Members policy stating that it "incorporates measures to ensure access for vision and linguistically limited members and to track compliance." DQ's ORM stated that providers are required to comply with "federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP)." Additionally, DQ's provider agreement also required that providers provide all services in a "culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds." In its subsequent submission, DQ provided its 2024 Q4 Network Access Analyses, which related to the time and distance access standards and did not appear relevant to this element. DQ did not demonstrate that it participated in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse backgrounds, disabilities, and regardless of sex.		
Required Actions: The MCE must demonstrate, through monitoring and data analysis, that it participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.		
Accessibility Considerations		
12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a) MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility • Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts,	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	scales, bathrooms, grab bars, or other equipment)) on provider directory • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results	
	Evidence as Submitted by the MCE: • NET07-INS-Access to Dental Services for Members; pg. 4-D **Additional Documentation:** • NET07-INS-Access to Dental Service for Members; pg 2-B and pg 4-D • Q4 LA Survey Data we do when contacting providers about access and availability. We confirm with the offices their cultural and linguistic capabilities as well as their ability to treat all members with special needs. • DQ Louisiana Provider Directory • LA Medicaid ORM; pg.19, 54, 74, 75	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided an Access to Dental Service for Members policy stating that it "will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided with meaningful access to care, including but not limited to physical accommodations, auxiliary aids and services and language assistance services." In its subsequent submission, DQ provided ORM citations, which did not appear relevant to this element. DQ also provided its 2024 Q4 Network Access Analyses, which related to the time and distance access standards and did not appear		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
relevant to this element. While DQ stated that it provided the DQ Louisiana provider directory, HSAG was unable to locate this file. Therefore, DQ has not demonstrated implementation with how it ensures the network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.		
Required Actions: The MCE must ensure, through monitoring and data analysis, that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.		
Basic Rule		
13. The MCE gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. PIHP a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports/analyses • Exceptions approved by the State • HSAG will also use the results of the Access Standards: Time/Distance Checklist • HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy; Ex-D **Additional Documentation:** • NET05-INS-Provider Network Adequacy; Ex-D • No Exceptions were submitted by DentaQuest or granted by the State of Louisiana. Waivers & Exceptions are not customary from the program. • Yes, we are using the updated state guidelines for Specialty Dental Services which states Distance to Specialty Dental Services Travel distance shall	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population). 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2	not exceed sixty (60) miles one-way from the enrollee's place of residence for at least seventy-five (75) percent of enrollees and shall not exceed seventy-five (75) miles one-way from the enrollee's place of residence for all enrollees. We attached a Q4 2024 Geo Report depicting the standards. We then deduced the % of membership from that same data set to ensure compliance. • A Q4 2024 Updated Geo showing such is included in the Supporting Docs section.	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's Provider Network Adequacy policy stated that DQ "will report to LDH the total number of linkages per PDP, and remaining capacity of each individual PDP on a quarterly basis in the format and manner determined by LDH" and that it will "notify LDH of the termination as soon as the written notification of cancelation is sent to the provider, but no later than seven (7) calendar days." HSAG also reviewed the Time/Distance Checklist, but not the Member-to-Provider Ratio Checklist as it was not applicable to PAHPs. In its subsequent submission, DQ provided an updated Medicaid Network Access Analysis from Q4 of 2024, and upon review, HSAG found that DQ met the time and distance standards for general dental services for adults in rural parishes and pediatrics in urban and rural parishes. HSAG also identified that DQ did not meet the time and distance standards for dental services for adults in urban parishes (99.1 percent with access, 5,064 were without access) as well as for other specialties such as endodontists, oral surgeons, and orthodontists. Of note, DQ staff members stated that the MCE did not request any exceptions from the State.		
Required Actions: The MCE must give assurances to the State and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1). a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.		
Timing		
14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the MCE's operations that would affect the adequacy of capacity in services, including: i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE. 42 CFR §438.207(c) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2	**HSAG Required Evidence:** • Policies and procedures • Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State) • Assurances of adequate capacity and services submission to the State due to a significant change **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy; pg 2 A & D- Ex D **Additional Documentation:** • NET05-INS-Provider Network Adequacy; pg 2 A & D- Ex D	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's Provider Network Adequacy policy stated that it "will report to LDH the total number of linkages per PDP, and remaining capacity of each individual PDP on a quarterly basis in the format and manner determined by LDH" and that it will "notify LDH of the termination as soon as the written notification of cancelation is sent to the provider, but no later than seven (7) calendar days." DQ did not submit any evidence of assurances of adequate capacity and services		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
submissions to the State as required by the State. HSAG noted LDH's requirement for PAHP's to submit quarterly 0082 PCD Linkage files; however, evidence of this submission was not provided by DQ.		
Required Actions: The MCE must provide assurances, through monitoring and tracking, that it timely submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the MCE's operations that would affect the adequacy of capacity in services, including: i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE.		
Exceptions Process		
15. To the extent the State permits an exception to any of the provider-specific network standards, MCO: a. *The MCO must submit any requests for exceptions for distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.* PAHP: a. *Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.* PIHP: a. *Requests for exceptions as a result of prevailing community standards for geographic accessibility*	**HSAG Required Evidence:** • Policies and procedures • Network monitoring report(s) • Exceptions requested by the MCE, if applicable • Exceptions approved by the State, if applicable **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy; pg. 5-Ex D **Additional Documentation:** • NET05-INS-Provider Network Adequacy; pg 2 A & D- Ex D • PEC04-INS-Provider Directory Maintenance and On Going Monitoring Pg -5	☐ Met ☐ Not Met ☒ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
standards must be submitted in writing to LDH for approval. 42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b) MCO Contract: 2.9.5; 2.9.5.2 PAHP Contract: 2.6.1.8; 2.6.2.6 PIHP Contract: 6.3.1.1.3	• Additional Monitoring Mechanisms such as DQ Monthly Monitoring Letters also found under Supporting Documents in Standard VIII Supporting Docs • No exceptions by the MCE • No exceptions approved by State	
MCE Description of Process: DentaQuest monitors network scope to provide access to providers, as required, and has resources to submit requests for exceptions to LDH in writing.		
HSAG Findings: DQ staff members stated during the interview session that the MCE had no exceptions to any of the provider-specific network standards in 2024; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
Total	Met	=	1	X	1	=	1
	Not Met	=	11	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	12	**Total Score**		=	1

Total Score ÷ Total Applicable	=	**1%**

Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
Primary Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3.2; 2.6.5.3.3 PIHP Contract: NA	1. *MCO:* a. *PCP appointments are available as follows:* i. *Non-urgent sick primary care: 72 hours* ii. *Non-urgent routine primary care: 6 weeks* *PAHP:* a. *Primary dental care: within 30 days* b. *Follow-up dental services: within 30 days after assessment* **Evidence as submitted by the MCE:** • LA Medicaid ORM v6	Y ☐ N ☒ NA ☐
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. *MCO:* a. *For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide*: b. *Specialist appointments: one month* c. *Non-urgent routine behavioral health care: 14 days* d. *Urgent non-emergency behavioral health care: 48 hours* e. *ASAM Level 3.3, 3.5, and 3.7: 10 business days* f. *Residential withdrawal management: 24 hours when medically necessary* g. *Psychiatric Residential Treatment Facility (PRTF): 20 calendar days*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	PAHP: a. *Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:* i. *Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;* ii. *Primary dental care: within 30 days* iii. *Follow-up dental services: within 30 days after assessment* *PIHP:* a. *Urgent non-emergency behavioral health care: 48 hours*	
	Evidence as submitted by the MCE: • LA Medicaid ORM v6	
Hospital and Emergency Services Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1	3. *MCO:* a. *Emergency care: 24 hours, 7 days/week within one hour of request* b. *Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request* c. *After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes* *PAHP:* a. *Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;* *PIHP:* a. *Emergent care: 24 hours, 7 days/week within one hour of request* b. *Emergent, crisis or emergency services must be available at all times.* c. *Urgent care: 24 hours, 7 days/week within 48 hours of request*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • LA Medicaid ORM v6	
Prenatal Care and Family Planning Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	4. *MCO:* a. *OB/GYN care for pregnant women:* i. *1st trimester: 14 days* ii. *2nd trimester: 7 days* iii. *3rd trimester: 3 days* iv. *High risk pregnancy, any trimester: 3 days* b. *Family planning appointments: 1 week*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • N/A	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: None PAHP Contract: None PIHP Contract: None	5. *MCO:* *PAHP:* *PIHP:*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • LA Medicaid ORM v6	

Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* **Evidence as submitted by the MCE:** • LA Dept of Health Medicaid GEO Analysis Q4 2024	Y ☐ N ☐ NA ☒
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: None PAHP Contract: None PIHP Contract: None	3. *Acute Inpatient Hospitals* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	4. *Laboratory* 5. *Radiology* 6. *Pharmacy* 7. *Hemodialysis Centers* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	8. *OB/GYN: 1:10,000* 9. *Allergy/Immunology: 1:100,000* 10. *Cardiology: 1:20,000* 11. *Dermatology: 1:40,000* 12. *Endocrinology and Metabolism: 1:25,000* 13. *Gastroenterology: 1:30,000* 14. *Hematology/Oncology: 1:80,000* 15. *Nephrology: 1:50,000* 16. *Neurology: 1:35,000* 17. *Ophthalmology: 1:20,000* 18. *Orthopedics: 1:15,000* 19. *Otorhinolaryngology/Otolaryngology: 1:30,000* 20. *Urology: 1:30,000* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒
Linkage Ratio Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	21. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	22. *Adult Physician Extenders: 1:1,000* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	23. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	24. *Pediatric Physician Extenders: 1: 1,000* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒

Access Standards: Time/Distance Checklist

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: 2.6.2.6.1 PIHP Contract: None	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 3. *Primary Dental Services:* *a. Rural Parishes: 30 miles one-way* *b. Urban Parishes: 10 miles one-way* **Evidence as submitted by the MCE:** • LA Dept of Health Medicaid GEO Analysis Q4 2024	Y ☐ N ☐ NA ☐
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	4. *Acute Inpatient Hospitals* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	5. *Laboratory:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 20 miles* 6. *Radiology:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 20 miles* 7. *Pharmacy:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 8. *Hemodialysis Centers:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: 2.6.2.6.2 PIHP Contract: None	9. *OB/GYN:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* 10. *Allergy/Immunology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 11. *Cardiology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	12. *Dermatology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 13. *Endocrinology and Metabolism:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 14. *Gastroenterology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 15. *Hematology/Oncology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 16. *Nephrology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 17. *Neurology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 18. *Ophthalmology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 19. *Orthopedics:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 20. *Otorhinolaryngology/Otolaryngology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles*	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	21. *Urology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 22. *Psychiatrists:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* 23. *Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 24. *Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 25. *Specialty Dental Services* *a. Travel distance shall not exceed 60 miles one-way from the enrollee's place of residence for at least 75% of enrollees.* *b. Travel distance shall not exceed 75 miles one-way from the enrollee's place of residence for all enrollees.*	
	Evidence as submitted by the MCE: • LA Dept of Health Medicaid GEO Analysis Q4 2024	
Licensed Mental Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	26. *Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles*	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	**Evidence as submitted by the MCE:** • N/A	
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	27. *PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization* *a. Rural and Urban Parishes: 200 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
Substance Abuse and Alcohol Abuse Center - Outpatient		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	28. *ASAM Level 1:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* 29. *ASAM Level 2.1:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* 30. *ASAM Level 2WM:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Substance Use Residential Treatment Facilities (adult)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	31. *ASAM Levels 3.1* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 32. *ASAM Levels 3.3* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 33. *ASAM Levels 3.5* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 34. *ASAM Levels 3.2-Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 35. *ASAM Level 3.7* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 36. *ASAM Level 3.7-Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • N/A	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	37. *ASAM Level 3.1* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	38. *ASAM Level 3.2 Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 39. *ASAM Level 3.5* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* **Evidence as submitted by the MCE:** • N/A	
Psychiatric Inpatient Hospital Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	40. *Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 90 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
Behavioral Health Rehabilitation Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	41. *Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Behavioral Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.1; 6.3.1.1.1.2	42. *For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • N/A	Y ☐ N ☐ NA ☒
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	43. *For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 60 miles* **Evidence as submitted by the MCE:** •	Y ☐ N ☐ NA ☒

Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination and Services		
Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).		
1. The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or member notice • Primary care provider (PCP) assignment algorithm • Screenshot of member identification (ID) card • Screenshot of fields designating the assigned PCP and assigned case manager • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • CM01-INS-MCD-Care Coordination and Referral pg 1A,C • CM02-INS-MCD-Continuity and Coordination of Care Procedure, pg 2 B 3,6,7 • DQT2024091CMPD pg 1, 8	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • DQT20240915CMPD • Standard VI-Coordination and Continuity of Care Part 2 Case Management Documentation Guidelines	
MCE Description of Process: Members will receive information on how to contact DentaQuest for assistance and if members receive Care Coordination or Case Management will they will be provided with contact information to help provide support ongoing when necessary.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE coordinates the services the MCE furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid. d. With the services the member receives from community and social support providers. MCO: a. *Coordinate care between network PCPs and specialists, including specialized behavioral health providers;* b. *Coordinate care for out-of-network services, including specialty care services;*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Transition of care program • Workflow for coordinating with other MCOs/ PIHPs/PAHPs • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • CM01-INS-MCD-Care Coordination and Referral p1-2 Procedure A,C,D	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
c. *Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;* d. *Coordinate with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed.* PAHP: a. Coordination with the enrollee's MCO: i. *for oral health issues exceeding the coverage of the Contract;* ii. *for transportation to and from covered dental services; and* iii. *regarding value-added dental benefits offered by the enrollee's MCO.* PIHP: a. *Coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the intellectual and developmental disabilities (I/DD) co-occurring population.* b. *Coordinate care for out-of-network services.* c. *Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.* d. *Coordinate timely with Integrated Medicaid Managed Care Programs and the member's family following an inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for*	• CM02-INS-MCD-Continuity and Coordination of Care pg 2 B3-7 • DQT20240915CMPD pg 6 **Additional Documentation:** • DentaQuest Case Management Record Review Tool	

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
members when a return to home placement is not possible. 42 CFR §438.208(b)(2) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.3; 2.8.1.4.4; 2.8.1.4.5; 2.8.1.4.10 PAHP Contract: 2.4.7.1; 2.4.6.2.1.3; 2.4.6.2.1.4; 2.4.6.2.1.5 PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7		
MCE Description of Process: All enrollees will receive the support needed to coordinate care, receive services needed to improve health and reduce barriers to care. This is done through collaboration and communication with the Medical Health Plan, Dental Health Plan, state agency, community service providers, medical providers and dental providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that DQ consider revisions to its Case Management Record Review Tool to assess the appropriateness of case closures to ensure case management episodes remain open while ongoing care is being received.		
Required Actions: No action required.		
3. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. MCO: a. *The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care. These procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and*	**HSAG Required Evidence:** • **Evidence as Submitted by the MCE:** • CM02-INS-MCD-Continuity and Coordination of Care pg 2 B2 • DQT20240915CMPD pg 4 **Additional Documentation:** • DQT20240915CMPD	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
agencies and require complex coordination of benefits and services. 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8	• Standard VI-Coordination and Continuity of Care Part 2 Case Management Documentation Guidelines	
MCE Description of Process: Assessment of enrollee needs will be shared with the applicable agencies involved in the care of the enrollee to ensure there is no duplication of services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information Sharing		
4. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities MCO: a. *Upon written request* 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2	**HSAG Required Evidence:** • Policies and procedures • Workflow for sharing assessment results with the State • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description • Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs **Evidence as Submitted by the MCE:** • CM02-INS-MCD pg 2 B2 • DQT20240915CMPD pg 4	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Assessment of enrollee needs will be shared with the applicable agencies involved in the care of the enrollee to ensure there is no duplication of services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.7 PAHP Contract: 2.4.8.1; 2.4.8.2; 2.4.8.3.1 PIHP Contract: 16.15	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Provider materials, such as the provider manual and provider contract • Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices **Evidence as Submitted by the MCE** • CM01-INS MCD pg 2 F	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: For member directed care coordination, referrals will be documented in the member's dental record. Care management staff will work to obtain any necessary information required to facilitate needed care and support for the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160	**HSAG Required Evidence:** • Policies and procedures • Care management program description **Evidence as Submitted by the MCE:**	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
45 CFR Part 164, Subparts A and E MCO Contract: 2.8.2.2.4; 2.9.11.5.1.7; 6.22 PAHP Contract: 2.1.4.1; 2.6.9.5.21 PIHP Contract: 20.12	• CM02-INS-MCD-Continuity and Coordination of Care pg 1 Procedure • PRIV-ENT- Entire policy pgs 1-25	
MCE Description of Process: Members privacy will be protected during all applicable care coordination activities.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Initial Health Risk Screening		
7. The MCE makes a best effort to conduct an initial screening of each member's needs within MCO: a. 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. *The MCO shall attempt to conduct, and document its efforts to conduct, the health needs assessment on at least three (3) different occasions, at different times of the day and on different days of the week.* PAHP: a. *The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee's enrollment to conduct an initial screening of the enrollee's needs and to offer to schedule the enrollee's initial appointment with the primary dental provider (PDP), which should occur within one hundred eighty (180) days of enrollment.* 42 CFR §438.208(b)(3)	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Initial screening template • Initial screening tracking and monitoring mechanisms and subsequent results/reports • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • CM02-INS-MCD-Continuity and Coordination of Care pg 2 B1 • DQT20240915CMPD pg 1-2; 5-7 **Additional Documentation:** • Standard VI-Coordination and Continuity of Care Part 3HRA Calls	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1230(c) MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA		
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Although the documents submitted by DQ described the requirement to contact each new enrollee within 90 days of the enrollee's enrollment, DQ was unable to produce documentation to support that its vendor was conducting two outreach calls within 90 days. Vendor documentation provided one call date per enrollee with disposition. Successful call rates reported by the vendor did not surpass 7 percent over a six-month period.		
Required Actions: The MCE must implement a process to monitor its vendor to ensure each new enrollee is contacted at least twice within 90 days of enrollment and evaluate the vendor's success rate.		
Comprehensive Assessment		
8. The MCE implements mechanisms to comprehensively assess each Medicaid member identified by the State and identified to the MCE by the State as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate. PAHP: a. *The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS • Comprehensive assessment template • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • CM01-INS-MCD-Care Coordination and Referral pg 1 C • DQT20240915CMPD pg1-3; 7	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
service utilization, intensive dental care needs, or who consistently access services at the highest level of care. 42 CFR §438.208(c)(2) 42 CFR §457.1230(c) MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1		
MCE Description of Process: Assessments and referrals allow DentaQuest to identify members that require additional support and care coordination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Treatment/Service Plan		
9. The MCE produces a treatment or service plan for members who require LTSS and, if the State requires, members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. 42 CFR §438.208(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Person centered treatment plan template • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • DQT20240915CMPD pg 7-8	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Enrollees in this risk category will be enrolled in case management where a comprehensive risk assessment is completed a care plan developed and needs/barriers to care are addressed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
10. The treatment or service plan is: a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. c. Approved by the MCE in a timely manner, if this approval is required by the MCE. d. In accordance with any applicable State quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process • Mechanisms to actively involve the member and the member's formal and informal supports in the development of the treatment plan • Mechanisms to actively involve the member's PCP (and any other providers involved in the member's care) in the development of the treatment plan • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • DQT20240915CMPD **Additional Documentation:** • DQT20240915CMPD • Standard VI-Coordination and Continuity of Care Part 2 Case Management Documentation Guidelines	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3). 42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Care plan and service plan review and revision tracking mechanism • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • DQT20240915CMPD pg 8	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The care plan will be evaluated at least every six months, and specific intervals will be determined during the planning phase and documentation of progress to goal, goals met or any significant change impacting the plan of care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Direct Access to Specialists		
12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. 42 CFR §438.208(c)(4) 42 CFR §457.1230(c) MCO Contract: 2.9.12.7	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts **Evidence as Submitted by the MCE:**	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1	• CM01-INS-MCD-Care Coordination and Referral pg 2-3 C	
MCE Description of Process: Members with SHCN identified through assessment will be enrolled in Case Management program. Case management staff will work to meet the needs of each individual member including but not limited to facilitating access to specialists without the need for a referral appropriate for their conditions and needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VI—Coordination and Continuity of Care							
Total	Met	=	11	X	1	=	11
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	12	**Total Score**		=	11

Total Score ÷ Total Applicable	=	**92%**

Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The MCE: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer. b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. 42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d) MCO Contract: 2.4.1.1; 2.4.1.2; 2.4.1.3 PAHP Contract: 2.4.1.4 PIHP Contract: 4.1.2; 4.1.7	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and benefits grid • Utilization Management (UM) program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms a. Page 2, numbers 9-10 b. Page 2, numbers 9-10 c. Page 2, numbers 9-10	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must: • Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
• May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms Page 2, numbers 9-10	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must: • Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. • May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
3. The MCE may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that: MCO, PAHP, and PIHP: a. The services furnished can reasonably achieve their purpose. MCO and PIHP: a. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member's ongoing need for such services and supports. b. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10	**HSAG Required Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms Page 2 • #9 a&b: NA for dental	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must:		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
• Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE specifies what constitutes "medically necessary services" in a manner that: a. Is no more restrictive than that used by the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses the extent to which the MCE is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity. 42 CFR §438.210(a)(5) MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms a. Page 1 b. Page 2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: a. Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on: Medicare and State Medicaid guidelines, *National Correct Coding Initiatives*, professional educational materials (e.g. Best Practice Guidelines of AOA,		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, current evidence in widely used treatment guidelines or clinical literature when criteria are not fully established, as well as the information contained in the current CDT© and CPT© Manual published by the American Medical Association. b. Medical necessity and benefit guidelines may be further defined by CMS, the State, the Plan, or through the adoption of other outside source written criterion or guidelines. Reference to the source of such guideline and criterion may be found in the Provider Office Reference Manual. All clinically based guidelines and criterion implemented and utilized for making medical necessity determinations shall meet the following overriding goals; in that they must: 1. Provide for consistency. 2. Allow for individualized application. 3. Be consistent with generally accepted professional medical standards. 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available. 5. Ensure the ability to achieve age-appropriate growth and development and the ability to attain, maintain, or regain functional capacity. 6. Be necessary to prevent, diagnosis, and treat a member's disease, condition, and/or disorder that results in health impairments and/or disability. 7. Be formulated in a manner not primarily intended for the convenience of the Member, the Member's caretaker, or the Provider; e.g. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or a service does not, in itself, make such care, goods or services medically necessary or a medical necessity. 8. Not be established based in any way on the goal of limiting services, access, or financial incentive. 9. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. 10. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. 11. Practice guidelines are consistent with other areas to which the guidelines apply.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Authorization of Services		
5. The MCE and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services. 42 CFR §438.210(b)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing utilization management • Delegated written contract (for entities responsible for delegated UM functions) • Delegation oversight of policies and procedures (e.g., audit results) **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review • UM17-INS-GOV-Continuation of Care **Additional Documentation:** • See 2024 UM Program Evaluation page 3 for verbiage of the process of the IRR and page 9 for 2024 IRR results	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UM08: It is DentaQuest's policy that services that require medical necessity review are reviewed by licensed professionals within its Utilization Management (UM) Department. Providers may submit requests as a prior authorization or prepayment review where appropriate and as defined within the Office Reference Manual, with the exception of orthodontics services. As DentaQuest permits all providers to obtain prior authorization, non-emergency treatment started prior to/without obtaining UM Review is at the financial risk of the provider's office and may not be charged to the member unless balance billing is allowed by regulation. Where urgent or emergent services are necessary, defined as those services necessary to treat pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury (or		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
what a prudent layperson, possessing an average knowledge of health and medicine, would believe to require immediate care), DentaQuest encourages the provider to treat the member and submit a completed claim and any necessary documentation marked for "Prepayment Review." DentaQuest encourages providers to perform services in an office-based setting and not via an Emergency Room visit. Verbal notification is considered delivered on the date (and time, if applicable) a delegated vendor speaks directly to or leaves a voicemail for an enrollee or enrollee's representative. Delegated vendors may initially provide verbal notification to enrollees prior to issuing written notification. In circumstances when verbal notification is permitted per regulatory requirements and the delegated vendor successfully provides verbal notice (e.g., spoke with the person that submitted the request or was able to leave a voicemail message), the required written notification must be sent by the delegated vendor within 3 calendar days of the verbal notice. If the delegated vendor is not able to successfully provide verbal notice (i.e., when a delegated vendor has an enrollee's telephone number on file but is unable to reach the enrollee at the number provided because, for example, it is either incorrect, out-of-service, or no person (or no voicemail system) answers), written notice must be sent within the applicable timeframe. The delegated vendor may choose to initially provide verbal notification of the decision, but the required written notification must be issued within the applicable adjudication timeframe. UM17: The Company is committed to assisting members in the continuation of care for services previously provided by another Plan. Unless otherwise established by state law or client contract, the transfer of a prior authorization is valid up to one hundred and eighty (180) days and is subject to all policies and procedures of the Company and the Plan. During the transition period, the Member's care shall be transferred to a comparable, participating provider, where available. This transfer of care is subject to the Company procedures for such transfer of care. Services provided are subject to all other UM policies and procedures of the Company and the Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d) MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Results of inter-rater reliability (IRR) activities	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • UM01-INS-DENT-SOP-Clinical Algorithm Development and Implementation • UM Program Description, page 10, Inter-Rater Reliability Program section	
MCE Description of Process: In order to ensure a consistent application of review criteria by all members of the clinical review staff, there is a quarterly reliability review performed. All clinical staff, including Dental Consultants, who participate in the determination of benefits, are required to participate in these evaluations in which a minimum of 10 cases are reviewed and evaluated. Opportunities for improvement in training are identified through this program. Individuals identified with deficiencies are provided additional training and reevaluated at the next quarterly review to measure the success of the additional training. This process is evaluated at least annually to monitor for necessary changes in workflow or criteria and recommended changes are reported to the Quality Assurance Committee responsible for Utilization Management issues. To ensure consistent and equitable determination of coverage for certain covered dental services, the following guidelines are applied in the development and review of clinical algorithms. A decision model of algorithms has been developed to support all clinical criteria and guidelines as applied to the current American Dental Association's Code of Dental Terminology (CDT). All decisions are defendable from a clinical perspective; a denial on an algorithm score sheet always produces a specific denial reason due to failed clinical criteria. Generally accepted dental practice guidelines are applied in all decisions in conjunction with respective State and Plan requirements. The specifics of criteria applicable are outlined or referenced within the Provider Office Reference Manual. Affected parties may request a copy of all applied criteria. Clinical algorithms are developed and implemented based on the clinical criteria.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
7. The MCE consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults **Evidence as Submitted by the MCE:** • UM04-INS-Notice of Action Letters, page 3, number 2, letter f • UM08-INS-SOP-Peer to Peer Review, page 1 **Additional Documentation:** • New copy of UM08-INS-SOP-Peer to Peer Review is in the audit review period • Narrative: Confirming there are no peer-to-peer screenshots to share in 2024 for Louisiana Medicaid. A follow-up queue is utilized by the CRS team to review the peer-to-peer inquiries. The CRS manages the queue in sequential order by inquiry number, reviews the initial submission, and determined whether the reconsideration is required. These are tracked in the Windward system. A follow-up queue is utilized by the CRS team to review the peer-to-peer inquiries. The CRS manages the queue in sequential order by inquiry number, reviews the initial submission, and determined whether the reconsideration is	☐ Met ☐ Not Met ☒ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	required. These are tracked in the Windward system. • Prior Authorization Workflow PDF, entire doc	
MCE Description of Process: To ensure each DentaQuest provider has an opportunity to discuss authorization and claims denials with a licensed peer within DentaQuest. DentaQuest consistently and equitably makes determinations of coverage for certain covered dental services. All clinical criteria and guidelines meet the current American Medical Association's generally accepted medical standard of care and common community standards. DentaQuest providers may contact Customer Care, Provider Services and/or Complaints & Grievances by telephone or fax to schedule a phone call with a DentaQuest peer. A Peer to Peer request has a limited number of days to be initiated based upon state and federal regulatory requirements as well as client contract requirements. The Notice of Action Letter includes: a. List of service(s) requested. b. Identification of the Provider requesting the service(s) c. Date the request was received for the prior authorization. d. Denial reason specific to the service denied. The denial reason for any clinical denial includes the clinical rationale in layman's terms. Included in the denial reason for any administrative denial is the specific benefit limitation involved. e. Identification and credentials of the Clinical Consultant making the adverse determination decision for clinical denials. f. f. A statement to indicate the provider may contact DentaQuest and discuss any clinical decision with the Clinical Consultant involved in making the determination.		
HSAG Findings: HSAG has scored this element as not applicable since State requirements differ from federal requirements. While the contract allows for an "informal reconsideration" process in which a denial is overturned following a peer-to-peer discussion, CMS has articulated that the MCEs' practice of adjusting prior authorization denial decisions based on peer-to-peer discussions occurring after the MCE sends a member a notice of adverse benefit determination (ABD) is inconsistent with Medicaid managed care regulations and, rather, is consistent with CMS' definition of an appeal. HSAG has communicated this information to LDH.		
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
8. The MCE authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Three examples of authorized LTSS and copies of the corresponding person-centered service plans **Evidence as Submitted by the MCE:** • LTSS is N/A for Dental	☐ Met ☐ Not Met ☒ NA
MCE Description of Process:		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
9. The MCE ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health. MCO: a. *The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • N/A for Medical, BH • UM Program Description, page 3-4	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
PAHP: a. *Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee's condition.* 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3	**Additional Documentation:** • Prior Authorization Workflow PDF, entire doc	
MCE Description of Process: Dental Consultants are appropriately licensed to make medical necessity denials. Dental Consultants are of the same or similar specialty as the treating provider. Dental Consultants are responsible for the monitoring of benefit decisions that have been initially reviewed by a Clinical Review Specialist to ensure they are made in a consistent, fair, and equitable manner. Clinical Review Specialists and non-clinical staff may not deny and medical necessity cases. Dental Consultants are appropriately licensed to make medical necessity denials.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Adverse Benefit Determination		
10. The MCE notifies the requesting provider of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. MCO: a. *The MCO shall provide written notification to the provider rendering the service, whether a health care*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
professional or facility or both, within two (2) Business Days of making the determination. PIHP: a. *The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested. The PIHP shall notify the provider rendering the service, verbally as expeditiously as the member's health condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.* 42 CFR §438.210(c) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2	**Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, page 11, Exhibit U • UM04-INS-Notice of Action Letters, section B	
MCE Description of Process: a. DentaQuest shall make standard service authorization determinations within two (2) business days of obtaining appropriate dental information regarding a proposed procedure or service requiring a review determination. All standard authorization decisions shall be made within no more than (14) calendar days following receipt of the request for service. b. UM04: For any standard authorizations denied, DentaQuest sends the member a Notice of Action (NOA) or Integrated Denial Letter (IDN). The requesting Provider is also sent a copy of the member letter. The Utilization Management Department delivers the written notification to the mail room. DentaQuest ensures the notification remains within the timeline for notification required by either regulatory and/or contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
11. The MCE defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an ABD. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network. g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. 42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, page 2 and page 11	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2) MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1		
MCE Description of Process: "Adverse Benefit Determination" as defined in 42 CFR Part 438.400(b) **Notice of Adverse Benefit Determination:** DentaQuest shall mail the notice of adverse benefit determinations for termination, suspension, or reduction of previously authorized covered services no later than ten (10) days before the adverse benefit determination is to take effect, by the date of the action when any of the following occur: 1. The enrollee has died. 2. The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result. 3. The enrollee has been admitted to a facility where he or she is ineligible under DentaQuest for further services. 4. The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address. 5. The enrollee is accepted for Medicaid services by another state. 6. The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care. 7. For denial of payment, at the time of any adverse benefit determination affecting the clean claim. 8. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE gives members written notice of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
less than requested. The ABD notice includes the following: a. The ABD the MCE has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member's right to request an appeal of the MCE's ABD, including information on exhausting the MCE's one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. f. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services. g. The notice must be consistent with the requirements of 42 CFR §438.10. 42 CFR §438.10	• HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM04-INS-Notice of Action Letters, page 2, section B • UM Program Description, page 8 **Additional Documentation:** • CORR-02 INS Claim Letter Templates, page 2, letter d • CORR-04-INS-Letter Template Implementation and Revisions, entire doc	

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2		

MCE Description of Process:

B. Denial Notification

1. For any standard authorizations denied, DentaQuest sends the member a Notice of Action (NOA) or Integrated Denial Letter (IDN). The requesting Provider is also sent a copy of the member letter. The Utilization Management Department delivers the written notification to the mail room. DentaQuest ensures the notification remains within the timeline for notification required by either regulatory and/or contractual requirements.
2. The Notice of Action Letter includes:
a. List of service(s) requested.
b. Identification of the Provider requesting the service(s)
c. Date the request was received for the prior authorization.
d. Denial reason specific to the service denied. The denial reason for any clinical denial includes the clinical rationale in layman's terms. Included in the denial reason for any administrative denial is the specific benefit limitation involved.
e. Identification and credentials of the Clinical Consultant making the adverse determination decision for clinical denials.
f. A statement to indicate the provider may contact DentaQuest and discuss any clinical decision with the Clinical Consultant involved in making the determination.
g. Identification of any State citation as it relates to the reason for the denial, as applicable by State.
h. Member appeal rights. This information includes the process for filing a complaint or grievance and the process for requesting an internal appeal. This information includes the address to submit written requests and the toll-free telephone number for verbal requests.
i. A statement that provides an address to submit written requests and the toll-free number for verbal requests for a copy of the clinical criteria used to make the determination.

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
j. State Fair Hearing request information, if applicable k. A reference to the External Appeal processes available for all final adverse determinations. l. A reference to any external organization that may be available to assist the member with the content of the letter, the appeal process, or filing a complaint. m. Information for the member on how to obtain the information in the Notice of Action Letter in a language other than English. n. Language tag lines in the top 15 languages spoken in the state. The tag line instructs the members how to get the document translated into different languages. i. The 15 languages may be based on the client's member population and the top language spoken as primary language rather than the languages prevalent in the state. o. A non-discrimination notice that indicates DentaQuest does not discriminate. The notice also gives the member information and instruction how to file a complaint with DentaQuest or with HHS if they feel they have been discriminated against. i. Based on client preference, the non-discrimination notice may be client specific and direct all discrimination complaints to the client, rather than to DentaQuest. p. Right of enrollee to be provided upon request and free of charge, copies of documents, records, and other information relevant to the determination. The written notification for all adverse decisions contains the following information: • Information and instructions for the appeal process. This includes: o A description of the appeal rights, including the right to submit all relevant documentation and information relating to the appeal. o An explanation of the appeal process, including the member's right to representation and the appeal timeframes. o A description of the expedited appeal process for urgent preservice appeals. • A list of the services that have been denied. • Specific reasons for the denial. o The denial reasons are written in understandable language and at the reading grade level required by the State or CMS o Denial reasons are specific to the member's condition and the request received.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
• A reference to the benefit provision, guideline, or clinical criteria upon which the decision was made o This to include instructions on how the member and provider can request a written copy of the benefit provisions, guidelines or clinical criteria, when applicable • A statement with instructions for the provider to request a discussion with the Dental Consultant who made the clinical decision.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. File review results did not demonstrate that DQ tested the reading grade level of ABD notices nor that notices complied with the state-required reading level. Additional documentation demonstrated that DQ had a policy that denial notices must meet required reading levels; however, no procedure or process demonstrated how DQ complied with the requirement.		
Required Actions: The MCE must ensure that the ABD notification process includes reading grade-level verification and that ABD notices meet the state-required reading level. The MCE should add functionality to the system that houses and tracks prior authorization requests and resolutions so users may document that ABD notices include all requirements and indicate that the reading grade level has been verified.		
Timeframe for Decisions		
13. For standard authorization decisions, the MCE provides notice as expeditiously as the member's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, page 11, Exhibit U, section V	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: All standard authorization decisions shall be made within no more than (14) calendar days following receipt of the request for service.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
14. For cases in which a provider indicates, or the MCE determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later 72 hours after receipt of the request for service. 42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, page 14-15, exhibit AE	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: For expedited service authorization decisions where a provider indicates, or DentaQuest determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, DentaQuest must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if: a. The member, or the provider, requests the extension; or b. The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member's interest. 42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.1.3 PAHP Contract: 2.5.7.2.4 PIHP Contract: 11.3.3.1.5; 11.3.3.1.9	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template • Three case examples of authorizations with an extension, including the date of receipt of the authorization request and date of the decision to extend the time frame • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, exhibit AE, page 14 **Additional Documentation:** • Narrative: Confirming there were no prior auths in 2024 that required an extension for Louisiana Medicaid.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: the member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or DentaQuest justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
16. If the MCE meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it: a. Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d) MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Three case examples of authorizations with an extension, including the written notice of the extension • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, exhibit AE, page 14 **Additional Documentation:** • Narrative: Confirming there were no prior auths in 2024 that required an extension for Louisiana Medicaid.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: • If DentaQuest extends the timeframe in accordance, it must: give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
• On the date the timeframe for service authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA). a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. 42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A) MCO Contract: None PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • UM program description • Three examples of notice **Evidence as Submitted by the MCE:** • Outpatient drug auth decisions is N/A for dental.	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: NA		
HSAG Findings: The MCE reported it did not authorize outpatient drug decisions; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCE mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214. 42 CFR §431.211	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1	• Three case examples of advance notices, including the ABD notice and the effective date of decision • HSAG will also use the data from the universe file • HSAG will also use the results of the service authorization denial file review	
	Evidence as Submitted by the MCE: • UM08-INS-Authorization Review, exhibit AE, page 14	

MCE Description of Process: For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the adverse benefit determination is to take effect. Certain exceptions apply:

1. By the date of the action when any of the following occur:
   - The enrollee has died;
   - The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result;
   - The enrollee has been admitted to an institution where he or she is ineligible under the Dental Plan for further services;
   - The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address;
   - The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or
   - The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.
2. DentaQuest may shorten the period of advance notice to five (5) days before the date of action if:
   - The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and
   - The facts have been verified, if possible, through secondary sources.

HSAG Findings: HSAG has determined that the MCE met the requirements for this element.

Required Actions: No action required.

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
19. The MCE may send a notice not later than the date of action if: a. The MCE has factual information confirming the death of a member; b. The MCE receives a clear written statement signed by a member that: i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address; e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member that meets one of the criteria of this element (one example must apply to a deceased member, one example must apply to a member who no longer wishes to receive services, and one example must apply to a member who is no longer eligible for services through the MHP) • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, exhibit AE, page 14	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i). 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3		

MCE Description of Process: For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the adverse benefit determination is to take effect. Certain exceptions apply:

1. By the date of the action when any of the following occur:
   - The enrollee has died;
   - The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result;
   - The enrollee has been admitted to an institution where he or she is ineligible under the Dental Plan for further services;
   - The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address;
   - The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or
   - The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care.
2. DentaQuest may shorten the period of advance notice to five (5) days before the date of action if:
   - The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and
   - The facts have been verified, if possible, through secondary sources.

HSAG Findings: HSAG has determined that the MCE met the requirements for this element.

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
20. The MCE may shorten the period of advance notice to five days before the date of action if: a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member due to probable fraud • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, exhibit AE, page 14	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the adverse benefit determination is to take effect. Certain exceptions apply: 1. By the date of the action when any of the following occur: ☐ The enrollee has died; ☐ The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result; ☐ The enrollee has been admitted to an institution where he or she is ineligible under the Dental Plan for further services; ☐ The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address; ☐ The enrollee is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or ☐ The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care. 2. DentaQuest may shorten the period of advance notice to five (5) days before the date of action if: ☐ The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and ☐ The facts have been verified, if possible, through secondary sources.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • Three case examples of the denial of payment on a claim, including date of the denial and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • UM08-INS-Authorization Review, Exhibit U, pages 11-12, section VI	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: VI. **Notice of Adverse Benefit Determination:** DentaQuest shall mail the notice of adverse benefit determinations for termination, suspension, or reduction of previously authorized covered services no later than ten (10) days before the adverse benefit determination is to take effect, by the date of the action when any of the following occur: 1. The enrollee has died.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
2. The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result. 3. The enrollee has been admitted to a facility where he or she is ineligible under DentaQuest for further services. 4. The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address. 5. The enrollee is accepted for Medicaid services by another state. 6. The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care. 7. For denial of payment, at the time of any adverse benefit determination affecting the clean claim. 8. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCE provides notice on the date that the timeframes expire. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • UM08-INS-Authorization Review, Exhibit U-Louisiana Medicaid, page 12, number 8	
MCE Description of Process: For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Compensation for Utilization Management Activities		
23. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27	**HSAG Required Evidence:** • Policies and procedures • UM program description • New hire and ongoing training for staff • Three examples of staff attestations **Evidence as Submitted by the MCE:** • UM22-ENT-UM Staff De-Incentives • UM01-INS-Clinical Algorithms, page 2, number 8 **Additional Documentation:** • UM Staff De-Incentive Attestation	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UM01: Not be established based in any way on the goal of limiting services, access, or financial incentive. UM22: The purpose of a clinical review is to ensure that each Member's benefit is considered individually according to established practice guidelines. It is DentaQuest's policy not to use incentives that encourage barriers to care and service, including encouragement that may result in underutilization, and not to make decisions about hiring, promoting, or terminating clinical review staff based on the likelihood, or on the		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
perceived likelihood, that clinical review staff member supports, or tends to support, denial of benefits. Providers are ensured independence and impartiality in making referral decisions that will not influence hiring, compensation, termination or promotion.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VII—Coverage and Authorization of Services							
Total	Met	=	19	X	1	=	19
	Not Met	=	1	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	20	**Total Score**		=	19

Total Score ÷ Total Applicable	=	**95%**

Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214. MCO: *For the MCOs, additional requirements must be followed according to 2.9.30.1, 2.9.30.3 in the MCO Contract, and in the MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff.* 42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.9.29.3; 2.9.30.1; 2.9.9.4; 2.9.30.3; MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff PAHP Contract: 2.6.9.11 PIHP Contract: 6.8.3	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • NET05-INS-Provider Network Adequacy – Pg 1, Para 2 **Additional Documentation:** • NET05 policy for 2024 • Please see 2024 Policies folder for a copy of all policies in 2024	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: DentaQuest ensures that its provider network complies with State and/or CMS standards as applicable, related to geographical requirements, appointment availability, and provider office wait times.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not implement written policies and procedures for retention of network providers.		
Required Actions: The MCE must implement written policies and procedures for retention of network providers that at a minimum meet the requirements of 42 CFR §438.214.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
2. The MCE follows a documented process for credentialing and recredentialing of network providers that meets the State requirements for each of the following provider types: a. Acute; b. Primary; c. Mental health; d. Substance use disorders. 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.4; 2.9.30.1 PAHP Contract: 2.6.9.11.1 PIHP Contract: 6.7.4	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • N/A, as our company only credentials dentists.	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: N/A as noted above; our company only credentials dentists.		
HSAG Findings: The MCE only credentials dental providers; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Nondiscrimination		
3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c)	**HSAG Required Evidence:** • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.12 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1	**Evidence as Submitted by the MCE:** • Credentials Committee Charter (Page 1; Responsibilities section) • Credentials Committee Charter (Page 3; Meetings section) • PEC01-INS-Credentialing Guidelines (Page 1; Policy section)	
MCE Description of Process: The Company does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification, including providers that serve high risk populations or specialize in conditions that require costly treatment or any other federally protected class or status. Additionally, no provider shall be denied network participation on the basis of gender, race, creed, color, ethnic/national origin, age, disability, sexual orientation, veteran or marital status or any unlawful basis not specifically mentioned herein. To ensure credentialing decisions are made in a non-discriminatory manner, applications are presented to the Credentials Committee de-identified of any demographic information.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.	**HSAG Required Evidence:** • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Examples of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a) MCO Contract: 2.9.7.8; 2.9.9.1; 2.9.9.2 PAHP Contract: 2.6.8.1; 2.6.9.10; 2.6.10.1 PIHP Contract: 6.1.12.3; 6.1.16.2; 6.1.17	• HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • Credentials Committee Charter (Page 1; Responsibilities section) • Credentials Committee Charter (Page 3; Meetings section) • PEC01-INS-Credentialing Guidelines (Page 9; Section F: Credentials Committee Review, #3) **Additional Documentation:** • Denial initial with cause • PEC05 D • PEC05 Exhibit I	
MCE Description of Process: The Company does not make credentialing or re-credentialing decisions based solely on an applicant's race, religion, ethnicity, national identity, gender, age, sexual orientation, marital status, disability or the type of procedures or types of patients (e.g., Medicaid) the practitioner treats. All decisions are communicated to the Applicant by a letter signed by Credentialing Management, within 30 business days of the Credentials Committee decisions. a. If the Committee's decision involves provider discipline or termination from the network, that decision is communicated by the designated Company employee to the Client or State, National Practitioner Data Bank and the appropriate state licensing agency after the entire appeal process has been exhausted.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Excluded Providers		
5. The MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3 MCO Contract: 2.9.8.1; 6.5.6; 2.2.2.1.4 PAHP Contract: 2.6.3.3.1; 2.6.3.3.2; 6.7.3.1 PIHP Contract: 6.8.8; 13.4.3	**HSAG Required Evidence:** • Policies and procedures • Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) • Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) • Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC04-INS-Provider Directory Maintenance and On-Going Monitoring – Page 4 Sections F&G • DQ Monthly Monitoring Letter_Mar 2025 // Entire Document • DQ Monthly Monitoring Letter_Apr 2025 // Entire Document • DQ Monthly Monitoring Letter_May 2025 // Entire Document	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Included 2024 Audit Summary Letter for all LA delegated groups.	
MCE Description of Process: Please see policies and example of documentation above.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
State Requirements		
6. The MCE complies with any additional requirements established by the State. MCO: i. *The MCO, through its Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the debarment/suspension/exclusion section or that it has verified and confirmed that the provider is enrolled with the State.* ii. *The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.* iii. *The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous*	**HSAG Required Evidence:** • Policies and procedures • Three consecutive months of attestations submitted to LDH • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC04-INS-Provider Directory Maintenance and On-Going Monitoring – Page 4 Sections F&G • Three consecutive months of attestations submitted to LDH: April, May, June 2025	☐ Met ☐ Not Met ☒ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).] PIHP: a. *An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.* b. *The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.* 42 CFR §438.214(e) 42 CFR §457.1233(a) MCO Contract: 2.20.3.7; 2.20.3.11; 2.20.5.3 PAHP Contract: None PIHP Contract: 13.2.2; 13.2.4		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The DentaQuest Compliance Officer or their designee signs monthly attestations certifying to LDH that DentaQuest has screened all providers as specified in the debarment/suspension/exclusion section or that DentaQuest has verified and confirmed that the provider is enrolled with the State. The DentaQuest credentialing team has policies and procedures to perform such exclusions sanctions screenings.		
HSAG Findings: There are no additional requirements established by the State for a PAHP; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Practitioner Verification of Credentials		
7. For credentialing and recredentialing, the MCE primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision. a. *The MCE verifies the license directly from the state licensing or certification agency (or its website).* 42 CFR §438.214(e) MCO Contract: 2.9.7.3; 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3; 2.6.9.2 PIHP Contract: 6.5.6; 6.7.4	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines (Page 5; Section A Credentialing Process, # 2 Primary Source Verification (first paragraph and letter b)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Company verifies the Applicant possess valid, unrestricted license(s) in all states where the Applicant seeks to be credentialed. Verification is a complete history look back and includes state disciplinary reports according to the frequency of publication. Verifications must be less than one hundred twenty (120) days old at the time of the Credentials Committee decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Verification of Credentials		
8. For credentialing and recredentialing, the MCE primary source verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision. a. *This requirement does not apply to practitioners who are not qualified to write prescriptions.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 5; Section A Credentialing Process, # 2 Primary Source Verification, letter e)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Company verifies the presence of a current DEA/CDS license/permit with appropriate agency, as applicable, for each state in which the Applicant provides services to the Company's Members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
9. For credentialing, the MCE verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision: a. *Board certification;* b. *Residency; or* c. *Graduation from medical or professional school.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 5; Section A Credentialing Process, # 2 Primary Source Verification; letters a and c)	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The Company verifies the Applicant 's highest level of education from the applicable educational institution or agency that provides primary source education verifications. (Initial/Reapply applications only). The Company verifies completion of American Board Certification with the appropriate specialty board, if applicable.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. For credentialing and recredentialing, the MCE verifies the practitioner's board certification status, if applicable, within 180 calendar days of the credentialing decision. a. *Verification of board certification does not apply to nurse practitioners (NPS) or other health care professionals unless the MCO communicates board certification to members.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 5; Section A Credentialing Process, # 2 Primary Source Verification)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Verifications must be less than one hundred twenty (120) days old at the time of the Credentials Committee decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. For credentialing, the MCE verifies the practitioner's work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision.	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
a. *If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.* b. *If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner's credentialing file.* c. *If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 4; Section A Credentialing Process, # 1 Credentialing Application; letter h)	
MCE Description of Process: Applicants must submit detailed work history as requested by the application, prior to the date of signature on the application, or from the date of the Applicant's graduation or completion of a residency program. Employment history may be provided via the Application and/or curriculum vitae (CV). For work history gaps greater than six (6) months the Company obtains a written explanation from the Applicant.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's policy and procedure did not include language that stated verification of the practitioner's work history included a minimum of the most recent five years of work history.		
Required Actions: For credentialing, the MCE must verify the practitioner's work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision. Additionally, the following must be noted: a. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date. b. If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner's credentialing file. c. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
12. For credentialing and recredentialing, the MCE verifies a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 6; Section A Credentialing Process, #1 Credentialing Application letter f)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Company reviews the National Practitioner Data Bank (NPDB) to verify malpractice claims history, Medicare/Medicaid sanction history, loss of hospital privileges, sanctions and/or disciplinary actions imposed by state licensing agencies. For malpractice clams, it reviews a minimum period of five (5) years.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Sanction Information		
13. For credentialing and recredentialing, the MCE verifies the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. a. *The MCE verifies State sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines (Page 5; Section A Credentialing Process, # 2 Primary Source Verification first paragraph and letter b)	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The Company verifies the Applicant possess valid, unrestricted license(s) in all states where the Applicant seeks to be credentialed. Verification is a complete history look back and includes state disciplinary reports according to the frequency of publication. Verifications must be less than one hundred twenty (120) days old at the time of the Credentials Committee decision.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not verify compliance with verification of state sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision.		
Required Actions: For credentialing and recredentialing, the MCE must complete primary source verification for State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision.		
14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 5; Section A Credentialing Process, # 2 Primary Source Verification) • PEC01 Credentialing Guidelines; (Page 6; Section A Credentialing Process, # 3 Additional Sanctions and Exclusions)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: At Initial/Reapply Credentialing and Recredentialing, all Providers, any Disclosing Entity, its Owners, and Managing Employees are screened against state and federal sanction and exclusion databases, including but not limited to: a. Federal and State Sanction and Exclusion Lists: The Company conducts screenings at the time of initial application: i. Office of the Inspector General (OIG), List of Excluded Individuals and Entities (LEIE) ii. General Services Administration, System of Award Management (SAM) iii. Social Security Administration Death Master File (SSADM) (Initial/Reapply Only) iv. Office of Foreign Assets Control, Specially Designated Nationals, and Blocked Persons List (OFAC/SDN)		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
v. Medicare Opt Out Report vi. State Medicaid Exclusion Lists vii. CMS Preclusion List (Initial/Reapply only) Verifications must be less than one hundred twenty (120) days old at the time of the Credentials Committee decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Credentialing Application/Attestation		
15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include: a. *Reasons for inability to perform the essential functions of the position;* b. *Lack of present illegal drug use;* c. *History of loss of license and felony convictions;* d. *History of loss or limitation of privileges or disciplinary actions;* e. *Current malpractice insurance coverage; and* f. *Current and signed attestation confirming the correctness and completeness of the application.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 4; Section A Credentialing Process, #1. Credentialing Application letter g) **Additional Documentation:** • PEC01 A 1 i	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: A signed and dated attestation that is less than one hundred eighty (180) days old at the time of the Credentials Committee decision. Attestation signatures may be digital, electronic, photocopied, scanned or sent by facsimile but a stamped signature is not acceptable unless the practitioner is physically imparted, and the disability is documented in the practitioner's file: i. authorizing the Company to collect any information necessary to verify the information on the credentialing application; and releasing from liability any such entity, institution or organization that provides information as part of the application process.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
ii. acknowledging that a report is submitted to NPDB, state licensing board and/or other appropriate institutions if the Applicant is terminated for reasons pertaining to professional conduct, or quality of care. iii. attesting to the lack of present illegal drug use or any substance abuse. iv. attesting to history of loss of license and felony or misdemeanor convictions. v. identifying any inability to perform essential job functions, with or without accommodation. vi. disclosing any history of loss or limitation of privileges or disciplinary activity. vii. attesting that the information submitted with the application is complete and accurate to the Applicant 's knowledge. viii. documenting any legal name change by the Applicant.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the credentialing and recredentialing file review did not include a copy of the provider's current certificate of insurance.		
Required Actions: For credentialing and recredentialing, the MCE must ensure the application and attestation include current malpractice insurance coverage.		
Practitioner Monitoring		
16. The MCE develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identified occurrences of poor quality. The MCE develops and implements ongoing monitoring and makes appropriate interventions by: a. *Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);* b. *Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and* c. *Implementing appropriate interventions when it identifies instances of poor quality.*	**HSAG Required Evidence:** • Policies and procedures • Provider complaints tracking reports • Provider adverse events tracking reports • Credentialing committee meeting minutes • Two examples of interventions taken based on poor quality of care **Evidence as Submitted by the MCE:** • DentaQuest May Committee Minutes attached • PEC04-INS-Provider Directory Maintenance and On-Going Monitoring – Page 4 Sections F&G	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
2 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**Additional Documentation:** • PEC01 A 4 d, PEC01 B, CGA04	
MCE Description of Process: Please see policies and committee meeting minutes listed above.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Organizational Verification of Credentials		
17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • List of organizational provider types and corresponding licensing body in the State of Louisiana • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines (Page 5; Section A Credentialing Process, # 2 Primary Source Verification letter b) • PEC01 Credentialing Guidelines; (Page 6; Section A Credentialing Process, # 3 Additional Sanctions and Exclusions)	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: At the time of initial/reapply credentialing and recredentialing, the Company verifies the following: a. Applicant possess valid, unrestricted license(s) in all states where the Applicant seeks to be credentialed. Verification is a complete history look back and includes state disciplinary reports according to the frequency of publication.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
b. Federal and State Sanction and Exclusion Lists: The Company conducts screenings at the time of initial application: i. Office of the Inspector General (OIG), List of Excluded Individuals and Entities (LEIE) ii. General Services Administration, System of Award Management (SAM) iii. Social Security Administration Death Master File (SSADM) (Initial/Reapply Only) iv. Office of Foreign Assets Control, Specially Designated Nationals, and Blocked Persons List (OFAC/SDN) v. Medicare Opt Out Report vi. State Medicaid Exclusion Lists vii. CMS Preclusion List (Initial/Reapply only) Verifications must be less than one hundred twenty (120) days old at the time of the Credentials Committee decision.		
HSAG Findings: The MCE did not conduct organizational credentialing and recredentialing; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body. a. *If the provider is not accredited, the MCE conducts an onsite quality assessment.* i. *The MCE has a process for ensuring that the provider credentials their practitioners.* 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 1.2.1.2.; 6.5.6; 6.7.4; 6.7.6; 6.7.8	**HSAG Required Evidence:** • Policies and procedures • Onsite assessment review tool/template • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines (Page 5; Section A Credentialing Process, # 2 Primary Source Verification letter b) • PEC01 Credentialing Guidelines; (Page 6; Section A Credentialing Process, # 3 Additional Sanctions and Exclusions) • PECO6 -INS- Site Review and Record Review-FINAL (Pages 1 and 2; Section A Procedure (1-4))	☐ Met ☐ Not Met ☒ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: At the time of initial/reapply credentialing and recredentialing, the Company verifies the following: a. Applicant possess valid, unrestricted license(s) in all states where the Applicant seeks to be credentialed. Verification is a complete history look back and includes state disciplinary reports according to the frequency of publication. b. Federal and State Sanction and Exclusion Lists: The Company conducts screenings at the time of initial application: i. Office of the Inspector General (OIG), List of Excluded Individuals and Entities (LEIE) ii. General Services Administration, System of Award Management (SAM) iii. Social Security Administration Death Master File (SSADM) (Initial/Reapply Only) iv. Office of Foreign Assets Control, Specially Designated Nationals, and Blocked Persons List (OFAC/SDN) v. Medicare Opt Out Report vi. State Medicaid Exclusion Lists vii. CMS Preclusion List (Initial/Reapply only) Verifications must be less than one hundred twenty (120) days old at the time of the Credentials Committee decision. The Company will perform an on-site review of a provider location under the following circumstances: 1. Member Complaints: If the Company receives member complaints regarding a specific practice location or provider, it may determine that a Site Review of the location is warranted. Site Review Requests are based on severity of issue and are conducted within sixty (60) days of receipt of the third such complaint. 2. Patient Safety: Complaints alleging or raising concerns regarding patient safety will necessitate an immediate Site Review. Risk to patient safety includes all applicable OSHA standards Centers for Disease Control (CDC) infection control standards. 3. Client/State Requirements: Client(s)/State(s) may require a site and/or record review as a prerequisite for participation in the Client or State network. A site review of the location is set up and performed according to the Site Review and/or Record Review Tools. If the review receives a passing score, then the location is made active. If the review fails, then the location will not be made active until it receives a passing score. 4. Record Review: A review of treatment records will include, but not be limited to, a site visit that is conducted as a result of a patient complaint or a Client/State requirement. If the Credentialing Department determines that an applicant meets the administrative requirements, or a review is requested from Peer Review (a review may be conducted at any time complaints are received and is not associated with a credentialing episode), the Company conducts an on-site review, where required by the client, of the applicant's practice site.		
HSAG Findings: The MCE did not conduct organizational credentialing and recredentialing; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Time Frames		
19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements. 42 CFR §438.214(e) MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • Recredentialing timeliness report during the review period • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • PEC01 Credentialing Guidelines; (Page 7; Section C Initial/Recredential/Re-Apply/Reinstatement #1)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: All existing providers must be reviewed every 36 months from the date of their previous credentialing action. Performance indicators such as utilization, grievances or satisfaction surveys will also be reviewed at this time.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VIII—Provider Selection							
Total	Met	=	11	X	1	=	11
	Not Met	=	4	X	0	=	0
	Not Applicable	=	4				
Total Applicable		=	15	**Total Score**		=	11

Total Score ÷ Total Applicable	=	**73%**

Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. Notwithstanding any relationship(s) that the MCE may have with any delegate, MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. 42 CFR §438.230(b)(1) 42 CFR §457.1233(b) MCO Contract: 2.2.3.8; 2.2.3.9 PAHP Contract: 1.4.2; 2.15.3; 2.15.6 PIHP Contract: 1.5.1	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • See attached each sub-delegated vendors signed Regulatory Compliance Addendum (RCA).	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations. c. The contract or written arrangement must either provide for revocation of the delegation of activities or	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • See attached each sub-delegated vendors signed Regulatory Compliance Addendum (RCA). – Section 2.1 / 3.2	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily. *42 CFR §438.230(b)(2)* *42 CFR §438.230(c)(1)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.1; 2.2.3.4.2; 2.2.3.4.3 PAHP Contract: 2.15.6.3; 2.15.9 PIHP Contract: 1.5.3.1	– Section 2.1 / 2.2 / 3.2 – Section 3.2 / 7.2 **Additional Documentation:** • Provider Trust_MSA_08.06.2020 • Provider Trust_SOW CO No.4_06.03.2025 (HSAG Review) • Optomi, LLC bda Provalus_MSA_05.10.2021 • Optomi LLC dba ProValus_SOW CO No 6_Call Center Contract (HSAG Review) • Certified Language International_SOW_01.08.2021 (HSAG Review) • Certified Language International_MSA_12.21.2020 • Downstream - Attachment A Attestation	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and MCO: a. *rules, policies, procedures, manuals, the State Plan, and Waivers.* *42 CFR §438.230(c)(2)*	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • See attached each sub-delegated vendors signed Regulatory Compliance Addendum (RCA).	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1233(b) MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1	• Section 2.1 / 2.3 / 3.6 /5.1	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided 14 executed Regulatory Compliance Addenda (RCAs) and one executed Business Associate Agreement (BAA) for review. DQ's RCAs included a provision requiring that vendors "shall comply, and shall require all of its subcontractors to comply, with all applicable state, federal, and local laws and regulations, including but not limited to: 42 CFR §§438.230, 438.3(k), 455.104, 455.105, and 455.106 and all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance." DQ's RCAs did not include the state contractual requirements that delegates comply with "rules, policies, procedures, manuals, the State Plan, and Waivers." DQ's BAA did not include a provision for this requirement. Furthermore DQ's delegation file submissions were also used by the HSAG reviewer to assess this requirement. DQ's executed RCAs for all three file submissions contained the same language. DQ's RCA did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: The MCE must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions, and rules, policies, procedures, manuals, the State Plan, and Waivers.		
4. The contract or written arrangement indicates, and the delegate agrees that: a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State.	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • See attached each sub-delegated vendors signed Regulatory Compliance Addendum (RCA). – Section 4	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time. *42 CFR §438.230(c)(3)* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.5; 2.2.3.5.1; 2.2.3.5.2 PAHP Contract: 2.15.11.1; 2.15.11.1.1; 2.15.11.1.2; 2.15.11.1.3 PIHP Contract: 1.5.3.1		
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided 14 executed RCAs and one executed BAA. DQ's RCAs, sections 4.3-4.4, contained the following language: "(a) Vendor shall permit timely access by all Governmental Entities including access by DentaQuest and its counsel, clients, accountants or designated representatives to its premises and physical facilities and to inspect, copy, and audit the Books and Records and any other related books of the Vendor and any of its subcontractors related to the Services. Such access shall include the right to access any computer or other electronic systems of Vendor that pertain to any aspect of the services and activities performed. Vendor shall cooperate with DentaQuest in all auditing or monitoring activity required by Governmental Entities and/or regulatory or accreditation agencies, including NCQA and URAC. DentaQuest will endeavor to provide at least five (5) days prior written notice of an Audit, but Vendor understands that DentaQuest cannot guarantee that such notice will be possible or will occur. (b) In addition to the above, DentaQuest shall have the right, to conduct a pre-delegation audit and review and thereafter on-site reviews ("Delegation		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Audit") of Vendor's management practices, protocols and procedures (including security and data protection procedures) and, upon request, to receive an annual certified statement of financial solvency from Vendor's auditor, in order to give DentaQuest assurances and the ability to verify that Vendor is maintaining fiscal stability, and is providing the requisite level and quality of services in conformity with the requirements of this Regulatory Addendum and applicable Laws. (c) Notwithstanding any terms to the contrary, if DentaQuest, its Clients or a Governmental Entity determines that there is that there is a reasonable possibility of fraud or similar risk said entity may inspect, evaluate, and audit Vendor at any time without notice" and "Vendor shall afford DentaQuest and any of its counsel, clients, regulators (including all Governmental Entities), accountants or designated representatives, with access to all personnel, facilities, properties and IT systems and Books and Records identified in Section 4.3, relating to the Services for such period as this Addendum is in effect and for ten (10) years following the termination of the Addendum. To the extent any Books and Records or other books and records maintained by Vendor include other information unrelated to the Business, Vendor may, within a reasonable time period, redact such other information from such books and records prior to providing access." DQ's BAA did not include provisions compliant with this requirement. DQ's delegation file submissions were also used by the HSAG reviewer to evaluate this requirement. DQ's executed RCAs for all three file submissions contained the same language. DQ's RCAs did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: The MCE must ensure that all contract or written arrangements indicate, and the delegate agrees that: a. The State, Centers for Medicare & Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State. b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members. **c.** The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.		
5. The contract or written arrangement: MCO: a. *Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a*	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review	☐ Met ☐ Not Met ☒ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
conflict between the State law where the Subcontractor is based and Louisiana law. *42 CFR §438.230* *42 CFR §457.1233(b)* MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA	**Evidence as Submitted by the MCE:** • See attached each sub-delegated vendors signed Regulatory Compliance Addendum (RCA). – Section: 3.6 / 9.2	
MCE Description of Process: N/A		
HSAG Findings: The PAHP does not have a state contract requirement related to this element; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Monitoring and Auditing		
6. Monitoring subcontractor's performance shall be monitored: MCO: a. *On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.* PAHP: a. *On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.* PIHP: a. *The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.* *42 CFR §438.230*	**HSAG Required Evidence:** • Delegation agreement/contract template • Monitoring and audit documentation • Annual formal review • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • See attached each sub-delegated vendors signed Regulatory Compliance Addendum (RCA). a) Section 2.1/5.1 **Additional Documentation:** • Template Vendor Compliance Due Diligence Questionnaire (2)	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1233(b) MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3	• Scaorecard_Ansafone Contact Centers LLC • Scaorecard_BANCTEC, INC • Scaorecard_Cathedral Corporation • Scorecard_Health Management Systems, Inc (HMS) (Gladwell) • Scorecard_Ibex GLobal Solutions • Scorecard_Optomi LLC dba ProValus • Scorecard_Provider Trust Inc • Scorecard_Qualtrics, LLC • Scorecard_Sagility, LLC • Scorecard_SEPIRE, LLC • Scorecard_TRACHMAR, LLC	
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ provided 14 executed RCAs and one executed BAA. DQ's RCAs included a provision requiring oversight for the vendors' performance that includes "ongoing monitoring." DQ's RCAs also provided for reporting requirements and stated that DQ will convene a meeting within 30 days to discuss remediation when noncompliance is established. In the initial submission, DQ did not provide evidence of ongoing monitoring nor any noncompliant reports, subsequent meetings, or remediation efforts. During the interview, DQ staff members stated that the MCE conducted ongoing monitoring of its delegates and subcontractors and that no corrective action plans were issued in 2024. DQ's subsequent submission included a scoring template and 11 scorecards demonstrating monitoring of delegates. However, DQ's scoring template and scorecards only monitored the subcontractors' compliance program and not the subcontractors' performance under the contract.		
Required Actions: The MCE must monitor each subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	2	X	1	=	2
	Not Met	=	3	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	5	**Total Score**		=	2

Total Score ÷ Total Applicable	=	**40%**

Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236(b)(1) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms, page 1 **Additional Documentation:** • Meeting Minutes for LA DAC Q4 2024(st) • 05132024 UM01 Utilization Review Meeting Minutes, entire doc EK/UM	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on: Medicare and State Medicaid guidelines, *National Correct Coding Initiatives*, professional educational materials (e.g. Best Practice Guidelines of AOA, AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, current evidence in widely used treatment guidelines or clinical literature when criteria are not fully established, as well as the information contained in the current CDT© and CPT© Manual published by the American Medical Association.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's documentation referenced valid and reliable clinical evidence. Additionally, DQ's Clinical Algorithms policy referenced the American Association of Prosthodontics and American Dental Association, the American Society of Endodontics and American Dental Association, the Center for Devices and Radiological Health and the American Dental Association, and others. However, the policy and associated exhibits focused on provider documentation standards, authorization procedures, and claims payments. DQ did not include clinical practice guidelines (PGs) as defined by CMS in which "CPGs seek to close the gap between the clinician and relevant literature by providing information, recommendations, and/or best practices on healthcare for		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
specific circumstances, diagnostic and treatment options, or patient management."[2] Further, the Institute of Medicine defines clinical PGs as "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[3]		
Required Actions: The MCE must develop a distinct list of PGs that are separate from utilization management (UM) criteria. The PGs must be adopted and based on valid and reliable clinical evidence or a consensus of providers in the particular field.		
2. The MCE adopts practice guidelines that consider the needs of the MCE's members and: MCO: a. adopts clinical practice guidelines for at least the conditions listed below: i. Schizophrenia; ii. Attention Deficit Hyperactivity Disorder (ADHD); iii. Autism Spectrum Disorder; iv. Depression; v. Generalized Anxiety Disorder; vi. Post-Traumatic Stress Disorder; vii. Suicidal Behavior; viii. Oppositional Defiant Disorder; ix. Bipolar Disorder; and x. Substance Use Disorders. PIHP: a. develops clinical practice guidelines for:	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • N/A for dental, please see above for dental practice guidelines. **Additional Documentation:** • Meeting Minutes for LA DAC Q4 2024(st) • 05132024 UM01 Utilization Review Meeting Minutes, entire doc EK/UM	☐ Met ☒ Not Met ☐ NA

[2] Centers for Medicare & Medicaid Services. *Measure Management & You*, Newsletter, February 2018.
[3] Institute of Medicine. *Clinical Practice Guidelines We Can Trust*; 2011.

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
i. ADHD ii. Trauma Informed Care iii. Depression and Conduct Disorder 42 CFR §438.236(b)(2) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.2; 2.12.12.3 PAHP Contract: 2.5.5.1.2 PIHP Contract: 7.4.5.3; 7.4.7.1		
MCE Description of Process: Written criteria and clinical guidelines utilized in the process of benefit determination are developed based on: Medicare and State Medicaid guidelines, *National Correct Coding Initiatives*, professional educational materials (e.g. Best Practice Guidelines of AOA, AAO), specific health plan developed guidelines, accepted industry standards of care, State and Health Plan specific requirements, current evidence in widely used treatment guidelines or clinical literature when criteria are not fully established, as well as the information contained in the current CDT© and CPT© Manual published by the American Medical Association.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide a list of adopted PGs that provided evidence of 42 CFR §438.236(b)(1-2). DQ also did not provide evidence of a distinct list of PGs that were separate from UM criteria and that considered the needs of the MCE's members.		
Required Actions: The MCE must provide evidence of adopted PGs that consider the needs of the MCE's members.		
3. The MCE adopts practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236(b)(3) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval • Evidence of consultation of network providers **Evidence as Submitted by the MCE:** • NETWORK:NET01-INS-Network Development Maintenance & Use	☐ Met ☒ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Meeting Minutes for LA DAC Q4 2024(st) • 05132024 UM01 Utilization Review Meeting Minutes, entire doc EK/UM	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide a list of adopted PGs that provided evidence of 42 CFR §438.236(b)(3). DQ also did not submit evidence of a distinct list of PGs that were separate from UM criteria and that were adopted in consultation with network providers.		
Required Actions: The MCE must provide evidence of PGs that are adopted in consultation with network providers.		
4. The MCE adopts practice guidelines that are: MCO/PAHP: a. reviewed and updated periodically as appropriate. PIHP: a. Reviewed annually and updated periodically as appropriate. b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines. 42 CFR §438.236(b)(4) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract:7.4.5.4; 7.4.7.2	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline • MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms, page 3, section D **Additional Documentation:** • Meeting Minutes for LA DAC Q4 2024(st) • 05132024 UM01 Utilization Review Meeting Minutes, entire doc EK/UM	☐ Met ☒ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The development and implementation processes and all current criteria will be assessed on an ongoing basis and modified, when indicated, based on updated professional literature, emerging technology, and evolving standards of care. Established Clinical Guidelines are reviewed for acceptance by the Peer Review Committee on a yearly basis. The Clinical Director shall be responsible for distributing the current guidelines to Committee members during the first quarter each calendar year. Committee minutes shall reflect Committee assessment, documentation of recommended revisions, and approval of final versions. Final Annual Approval shall be completed not later than May 31st of the subsequent year. To evaluate the consistent application of standardized criteria, DentaQuest performs an interrater reliability audit for those making approval and denial decisions. Any changes to criteria are communicated to the internal Intent of Deal (IOD) email. Those on the distribution list consist of Operations, Client Engagement and Provider Engagement. Client Engagement ensures any Office Reference Manual changes are made and Provider and Member communication is disseminated, as appropriate.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide a list of adopted PGs and did not submit evidence of its last reviewed/revised date for each PG.		
Required Actions: The MCE must provide evidence of adopted PGs that are reviewed and updated periodically as appropriate.		
Dissemination of Guidelines		
5. The MCE disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236(c) 42 CFR §457.1233(c) MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7	**HSAG Required Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCE:** • MKT03-INS-COMM-Member Communications page 2, sections A and B • LA Medicaid ORM v6 • www.dentaquest.com	☐ Met ☒ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Copy of LA Provider Newsletter included under Supporting Documents for Standard X. • Provider ORM found in Section X under Supporting Documents (ORM)	
MCE Description of Process: Member handbook is disseminated to members upon request. The request is submitted and fulfilled by a print vendor within the required turnaround time.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide a list of adopted PGs and did not provide evidence that it disseminated the guidelines to members and potential members. DQ did not provide evidence that the guidelines were disseminated.		
Required Actions: The MCE must provide evidence of adopted PGs and evidence that it disseminates the guidelines to all affected providers and to members and potential members, upon request.		
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236(d) 42 CFR §457.1233(c) MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Coverage guidelines/criteria • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices **Evidence as Submitted by the MCE:** • UM01-INS-Clinical Algorithms • UM08-INS-Authorization Review	☐ Met ☒ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • NET05-INS-Provider Network Adequacy; pg. 5 Ex. D • LA Medicaid ORM • LDH-ID MMEM2022-1625 DQ1833 LA_ HealthyMedicaid_Member Handbook_July (02.23)Approved • Member Handbook LDH Approval Email 2_2023 • Redacted denial notices #1-3 EK/UM	
MCE Description of Process: • Decisions for UM (UM08): It is DentaQuest's policy that services that require medical necessity review are reviewed by licensed professionals within its Utilization Management (UM) Department. Providers may submit requests as a prior authorization or prepayment review where appropriate and as defined within the Office Reference Manual, with the exception of orthodontics services. As DentaQuest permits all providers to obtain prior authorization, non-emergency treatment started prior to/without obtaining UM Review is at the financial risk of the provider's office and may not be charged to the member unless balance billing is allowed by regulation. Where urgent or emergent services are necessary, defined as those services necessary to treat pain, swelling, infection, uncontrolled hemorrhage, or traumatic injury (or what a prudent layperson, possessing an average knowledge of health and medicine, would believe to require immediate care), DentaQuest encourages the provider to treat the member and submit a completed claim and any necessary documentation marked for "Prepayment Review". DentaQuest encourages providers to perform services in an office-based setting and not via an Emergency Room visit. • Coverage of Services for UM (UM01): To ensure consistent and equitable determination of coverage for certain covered services, the Company has implemented a process for establishing clinical criteria for many services, where applicable and reasonable. The specifics of criteria applicable are outlined or referenced within the Provider Office Reference Manual. Affected parties may request a copy of all applied criteria.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide a list of adopted PGs nor evidence of member education guidance or member materials to meet the federal requirement. DQ was unable to provide evidence of how it		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
aligned the PGs with UM, member education, and coverage of services, and how the guidelines were actually used consistently in decision-making.		
Required Actions: The MCE must provide evidence of how decisions for UM, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.		

Results for Standard X—Practice Guidelines							
Total	Met	=	0	X	1	=	0
	Not Met	=	6	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	0

Total Score ÷ Total Applicable	=	**0%**

Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to: a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. 42 CFR §438.242(a) 42 CFR §457.1233(d) MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by the State • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations **Evidence as Submitted by the MCE:** • CL01-INS-Claims Processing, entire document • CL02-INS-Claims Payment, entire document • CL01-INS-Claim Adjudication Process, entire document	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• CL01-INS-SHP-Claim Submission Process, entire document • DQ-WW-ClaimRulesClient, entire document • UM01-INS-Clinical Algorithms • UM09-INS-Monitoring UM Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes; Attachment A & B • CGA01-INS-MCD-Member Appeals-Medicaid; Section B & C • CGA06-INS-Member Complaints and Grievances; Section C & D **Additional Documents:** • CL01-INS-Claims Processing, entire document • CL02-INS-Claims Payment, entire document CL01-INS-Claim Adjudication Process, entire document • CL01-INS-SHP-Claim Submission Process, entire document • UM01-INS-Clinical Algorithms • CGA01-INS-MCD-Member Appeals-Medicaid; Section B & C • CGA06-INS-Member Complaints and Grievances; Section C & D • Policy ENR01-INS: Member Enrollment speaks to disenrollment transaction processes. However,	

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	disenrollments are not managed by DQ. They are managed by LDH. Exhibit H speaks to the enrollment file transactions for LDH.	

MCE Description of Process:

- Claims (CL01 and CL02): It is DentaQuest's policy to process provider claims submissions and pay for insured individuals' treatment according to established Federal and State guidelines and contractual obligations. In addition to this policy, claims payments are subject to other requirements for processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements. DentaQuest is able to receive electronically transmitted claims from providers in HIPAA-compliant formats. DentaQuest uses electronic transmission of claims, HIPAA-compliant transactions, notices, documents, forms, and payments to the greatest extent possible.
- DQ-WW-ClaimRulesClient: This document describes the DentaQuest Windward system claims rules and claims processing edits designed to maintain financial, utilization, clinical, and general industry standard dental claims administration integrity. The Windward system claims rules or claims processing edits are highly flexible and can vary in the goal or focus, specific logical or technical approaches, clinical application, outcome options, error messaging and correspondence or communication outcomes. Windward claims rules are generally deployed based on a combination of standard DentaQuest requirements for maintaining clinical and financial program integrity and to enforce the specific benefit program requirements for procedure coverage, frequency, allowance, and clinical requirements for the various benefit programs administered.
- Utilization Management (UM01): To ensure consistent and equitable determination of coverage for certain covered services, the Company has implemented a process for establishing clinical criteria for many services, where applicable and reasonable. The specifics of criteria applicable are outlined or referenced within the Provider Office Reference Manual. Affected parties may request a copy of all applied criteria.
- Utilization Management (UM09): The Utilization Management Department has established these mechanisms to ensure that authorization determinations are made within the timeframes required by regulation or contract.

HSAG Findings: HSAG has determined that the MCE met the requirements for this element.

Required Actions: No action required.

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Basic Elements of a Health Information System		
2. The MCE collects data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State. 42 CFR §438.242(b)(2) 42 CFR §457.1233(d) MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Please see CDM02-INS	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: N/A – Full doc		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE ensures that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
State Medicaid quality improvement and care coordination efforts. 42 CFR §438.242(b)(3) 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2	**Evidence as Submitted by the MCE:** • CL01-INS-Claims Processing, Section A, page 3 • CL02-INS-Claims Payment, Section A, page 2 • CL01-INS-Claim Adjudication Process, entire document • CL01-INS-SHP-Claim Submission Process, entire document • DQ-WW-ClaimRulesClient, entire document **Additional Documentation:** • CL01-INS-Claims Processing, Section A, page 3 • CL02-INS-Claims Payment, Section A, page 2 • CL01-INS-Claim Adjudication Process, entire document • CL01-INS-SHP-Claim Submission Process, entire document • 221 DentaQuest 2024 11Claims Payment Summaryxlsx • 221 DentaQuest 2024 11Claims Payment SummaryLDH Approved	
MCE Description of Process: • Claims (CL01 and CL02): It is DentaQuest's policy to process provider claims submissions and pay for insured individuals' treatment according to established Federal and State guidelines and contractual obligations. In addition to this policy, claims payments are subject to other requirements for processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements. DentaQuest is able to receive electronically transmitted claims		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
from providers in HIPAA-compliant formats. DentaQuest uses electronic transmission of claims, HIPAA-compliant transactions, notices, documents, forms, and payments to the greatest extent possible. • DQ-WW-ClaimRulesClient: This document describes the DentaQuest Windward system claims rules and claims processing edits designed to maintain financial, utilization, clinical, and general industry standard dental claims administration integrity. The Windward system claims rules or claims processing edits are highly flexible and can vary in the goal or focus, specific logical or technical approaches, clinical application, outcome options, error messaging and correspondence or communication outcomes. Windward claims rules are generally deployed based on a combination of standard DentaQuest requirements for maintaining clinical and financial program integrity and to enforce the specific benefit program requirements for procedure coverage, frequency, allowance, and clinical requirements for the various benefit programs administered.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE makes all collected data available to the State and upon request to CMS. 42 CFR § 438.242(b)(4) 42 CFR §457.1233(d) MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • 2024 LA PAHP_PMV_NAV_ISCAT_F1_LB 5.31.24	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Claims Processing		
5. The MCE complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission). 42 CFR §438.242(b)(1) 42 CFR §457.1233(d) Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F) MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • CDM02-INS • CL01-INS-Claims Processing, Section A, page 3 • CL01-INS-Claim Adjudication Process, entire document • CL01-INS-SHP-Claim Submission Process, entire document • DQ-WW-ClaimRulesClient, entire document **Additional Documentation:** • CL01-INS-Claims Processing, Section A, page 3 • CL01-INS-Claim Adjudication Process, entire document • CL01-INS-SHP-Claim Submission Process, entire document	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: • Claims (CL01 and CL02): It is DentaQuest's policy to process provider claims submissions and pay for insured individuals' treatment according to established Federal and State guidelines and contractual obligations. In addition to this policy, claims payments are subject to other requirements for processing and payment of claims, including, but not limited to, requirements of medical necessity and reasonableness and applicable referral or authorization requirements. DentaQuest is able to receive electronically transmitted claims from providers in HIPAA-compliant formats. DentaQuest uses electronic transmission of claims, HIPAA-compliant transactions, notices, documents, forms, and payments to the greatest extent possible. • DQ-WW-ClaimRulesClient: This document describes the DentaQuest Windward system claims rules and claims processing edits designed to maintain financial, utilization, clinical, and general industry standard dental claims administration integrity. The Windward system claims rules or claims processing edits are highly flexible and can vary in the goal or focus, specific logical or technical approaches, clinical application, outcome options, error messaging and correspondence or communication outcomes. Windward claims rules are generally deployed based on a combination of standard DentaQuest requirements for maintaining clinical and financial program integrity and to enforce the specific benefit program requirements for procedure coverage, frequency, allowance, and clinical requirements for the various benefit programs administered.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Application Programming Interface		
6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members' personal representatives through the API as follows: a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the API demonstration	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed; b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE; e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information. 42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213 MCO Contract: None PAHP Contract: None PIHP Contract: None	**Evidence as Submitted by the MCE:** • API_6_Interoperability API Access Request Process – Standard Operating Procedure – Annotated, Pg 2 and Pg 3 • API_6_Interoperability Education for Members • API_6_FHIR_Services_Security_Architecture	
MCE Process Description: DentaQuest provides an Application Programming Interface (API), as required by 42 CFR §431.60, to ensure current members or their personal representatives can access necessary information. This is accomplished through providing a publicly accessible link whereby users may fill out a form that allows them to request access via the API. Once the request is filled out and submitted, a notification will be sent from LogicManager automatically, to the IT Security Governance Team. The IT Security Governance Team will: 1. Review the form for completion 2. Vet the Requestor leveraging the Recorded Future Third Party Risk Application		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
3. Obtain approval from the AVP of Information Security to process the request. 4. Upon approval, create a task for Security Engineering to issue the API Key to the requestor. Upon creation of the API Key, DentaQuest Information Security team will send via secure communications the API Key to the requestor. All API keys are stored in the DentaQuest Secrets Vault in the ordinary course of business and are inventoried and certified on an annual basis.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR §431.60(d), and is accessible via a public-facing digital endpoint on the MCO's website. 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d) MCO Contract: -2.13.2.3 PAHP Contract: 2.9.2.1.2.1; 2.9.8.3.1; 2.13.1.6 PIHP Contract: 5.9.2.30; 5.10.1; 6.1.20	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the MCE:** • NET01-INS-Network Development Maintenance & Use-LA Medicaid ORM • API_7_Interoperability API Access Request Process – Standard Operating Procedure – Annotated, Pg 2 and Pg 3 • API_7_Interoperability Education for Members	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest provides an Application Programming Interface (API), as required by 42 CFR §431.60, to ensure current members or their personal representatives can access necessary information. This is accomplished through providing a publicly accessible link whereby users may fill out a form that allows them to request access via the API. Once the request is filled out and submitted, a notification will be sent from LogicManager automatically, to the IT Security Governance Team. The IT Security Governance Team will:		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
1. Review the form for completion 2. Vet the Requestor leveraging the Recorded Future Third Party Risk Application 3. Obtain approval from the AVP of Information Security to process the request. 4. Upon approval, create a task for Security Engineering to issue the API Key to the requestor. Upon creation of the API Key, DentaQuest Information Security team will send via secure communications the API Key to the requestor. All API keys are stored in the DentaQuest Secrets Vault in the ordinary course of business and are inventoried and certified on an annual basis.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).		
Required Actions: No action required.		
Member Encounter Data		
8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) 42 CFR §457.1233(d) MCO Contract: 2.18.1.1.1; 2.18.1.1.5 PAHP Contract: 2.14.2.1.3.1; 2.14.2.1.3.5 PIHP Contract: 15.2.2.3; 15.2.2.9	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Please see CDM02-INS	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Child LOB Example • Adult LOB Example	
MCE Description of Process: N/A – Full Doc		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
9. The MCO submits member encounter data to the State at a frequency and level of detail, based on program administration, oversight, and program integrity needs. a. The member encounter data includes all State-specific requirements for encounter data submissions, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818. b. The member encounter data is submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. MCO: a. *Submit complete and accurate encounter data at least monthly for all dates of service during the term of this Contract to LDH or the Fiscal Intermediary (FI) as directed by LDH* PAHP: a. *Submit complete and accurate encounter data at least monthly.*	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent months/quarters of submission compliance (acceptance/rejection reports) • Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Please see CDM02-INS	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *Submit complete and accurate encounter data at least weekly* 42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.4 PAHP Contract: 2.14.2.1.3.5; 2.14.11.10; 2.14.11.4 PIHP Contract: 14.3.3.1; 15.2.2.9; 15.6.2.1		
MCE Description of Process: N/A – Full Doc		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XI—Health Information Systems							
Total	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	**100%**

Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan **Evidence as Submitted by the MCE:** • National Quality Improvement Program – entire doc **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • Quality Improvement Workplan_2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest has a QAPI program that convenes quarterly and is reviewed annually.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Basic Elements of QAPI Programs		
2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) 42 CFR §457.1240(b)	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2	• QAPI program evaluation • Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports) • Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports)	
	Evidence as Submitted by the MCE: • National Quality Improvement Program pg. 12 • National Quality Improvement Program_LDH • Quality Improvement Workplan – Entire doc **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • Quality Improvement Workplan_2024 • Utilization Monitoring Reports for Q1-Q4 • National Quality Improvement Program 2024_Highlighted pg 5 and pg 19 • National Quality Improvement Program Evaluation_2024_LDH	
MCE Description of Process: The QAPI program runs utilization reports quarterly and discuss performance at the quarterly meetings.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
3. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy. 42 CFR §438.330(b)(4) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Definition of members with special health care needs • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the MCE:** • National Quality Improvement Program pg 15 • National Quality Improvement Program_LDH pg 13 • Quality Improvement Workplan • National Quality Improvement Committee meeting minutes. **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • Quality Improvement Workplan_2024	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
	• National Quality Improvement Program Evaluation_2024_LDH • NET07-INS-Access to Dental Services for Members-Section D page 2 • LA Dept of Health Medicaid ICF and Waivers Network Access Analysis • We use subgroups to identify our SHCN members CH Subgroup Number • 7003702007 LA Adult Waiver • 7003702008 LA Adult ICF/IID • NET01 Exhibit G • Each SHCN has it's on subgroup with providers identified as accepting. • 133 DentaQuest 2024 A - Satisfaction Survey • 132 DentaQuest 2024 A Member Satisfaction Survey Report • 2024_LA Dental Survey_Full Report_Final HSAG	
MCE Description of Process: The QAPI Program reviews Special Healthcare needs on a quarterly basis.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
4. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including: a. Assessment of care between care settings; and b. Comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b) MCO Contract: NA PAHP Contract: None PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Medical record audit tools and results **Evidence as Submitted by the MCE:** • National Quality Improvement Program • National Quality Improvement Program_LDH • Quality Improvement Workplan	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: N/A		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Performance Measurement		
5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually: a. Measures and reports to the State on its performance, using the standard measures required by the State;	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
b. Submits to the State data, specified by the State, which enables the State to calculate the MCO's performance using the standard measures identified by the State; or c. Performs a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.4; 2.16.1.5 PAHP Contract: 2.11.1.1.2.3 PIHP Contract: 12.4.3.1	• QAPI program evaluation • Performance measures reports • Evidence of submission of performance measurement reports to the State **Evidence as Submitted by the MCE:** • National Quality Improvement Program • National Quality Improvement Program_LDH • Quality Improvement Workplan • QAPI Receipt Confirmation_LDH **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • Quality Improvement Workplan_2024 • National Quality Improvement Program Evaluation_2024_LDH • QM03-INS-GOV • State of Louisiana 2024 PIP Submission Form • Performance Improvement Project (PIP)	
MCE Description of Process: Client Engagement annually submits all QAPI required documents to LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
Performance Improvement Projects		
6. The QAPI program includes performance improvement projects (PIPs). a. The MCE conducts PIPs that focus on both clinical and nonclinical areas. MCO: a. *The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.* PIHP: a. *The PIHP shall perform a minimum of one LDH approved PIP.* 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • List of all active PIPs, including which PIPs are considered clinical and non-clinical • Documentation for all active PIPs **Evidence as Submitted by the MCE:** • No PIP was submitted for 2024. **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • Quality Improvement Workplan_2024 • National Quality Improvement Program Evaluation_2024_LDH • QM03-INS-GOV • State of Louisiana 2024 PIP Submission Form • Performance Improvement Project (PIP)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) 42 CFR §457.1240(b) MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3	**HSAG Required Evidence:** • QAPI program description • QAPI program work plan • QAPI program evaluation • Policies and procedures • Documentation for all active PIPs **Evidence as Submitted by the MCE:** • No PIP was submitted for 2024. **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • Quality Improvement Workplan_2024 • National Quality Improvement Program Evaluation_2024_LDH	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year. 42 CFR §438.330(d)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4	**HSAG Required Evidence:** • Policies and procedures • Evidence of annual submission of all PIPs to the State **Evidence as Submitted by the MCE:** • No PIP was submitted for 2024.	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Critical Incidents		
9. The QAPI program includes participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h). 42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a) 42 CFR §457.1240(b) MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Three examples of critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the MCE:** • National Quality Improvement Program pg 20	☐ Met ☐ Not Met ☒ NA
MCE Description of Process:		
HSAG Findings: Home and Community-Based Services waiver responsibilities are managed by the State through the fee-for-service (FFS) program and not through the MCEs; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
QAPI Program Reviews, Analysis, and Evaluation		
10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes:	**HSAG Required Evidence:** • Committee meeting minutes (with discussion of QAPI evaluation)	☐ Met ☒ Not Met

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. MCO: a. *The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.* 42 CFR §438.330(e) 42 CFR §457.1240(b) MCO Contract: 2.16.6.2; 2.16.3.1; 2.16.7.1.2; 2.16.7.1.3 PAHP Contract: 2.11.2.3.1.2; 2.11.2.4.1.3 PIHP Contract: 12.2.3.4	**Evidence as Submitted by the MCE:** • QAPI Committee Meeting Minutes • National Quality Improvement Program Evaluation_LDH -entire document **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted • National Quality Improvement Program Evaluation_2024_LDH • 119 DentaQuest 2024 Q1 Louisiana specific QAPI meeting minutes, Page 17 • DentaQuest Internal State of the State Meeting Minutes Page 2 Measures discussed	☐ NA
MCE Description of Process: The QAPI Program is evaluated annually to initiate improvements where indicated, and sustained improvements from the previous year.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ completed an annual evaluation for calendar year 2024. However, the evaluation did not document an assessment of the impact and effectiveness of all the aspects of the quality assessment and performance improvement (QAPI) program. The Louisiana-specific evaluation stated audit results; described campaigns and quality initiatives, a well program, and quality outreach; and mentioned performance improvement topics and a summary of the network. The evaluation lacked an assessment of strengths, opportunities for improvement, goals achieved, goals discontinued of QAPI activities (e.g., performance measures, performance improvement projects [PIPs], under- and overutilization, assessment of the quality and appropriateness of care furnished to members with special health care needs [SHCN], etc.). Furthermore, the Quality Improvement Workplan documented activities for each quarter during calendar year 2024, but outcomes or an assessment of progress were not included.		
Required Actions: The MCE must develop a more robust evaluation to assess the impact and effectiveness of its QAPI program (e.g., documentation strengths, opportunities, and goals). Additionally, the QAPI program evaluation must include:		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP.		
11. QAPI Committee Requirements: MCO: a. *The MCO forms a QAPI Committee that at a minimum includes:* i. *The MCO's Medical Director who must serve as either the chairman or co-chairman;* ii. *The MCO's Behavioral Health Director;* iii. *Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;* iv. *Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and* v. *An Enrollee representative(s) and/or advocate(s).* PAHP: a. *The PAHP shall form a QAPI Committee that shall, at a minimum include:* i. *The Dental Director who must serve as either the chairman or co-chairman;* ii. *Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and* iii. *The PAHP shall include an enrollee advocate representative on the QAPI Committee.*	**HSAG Required Evidence:** • QAPI committee meeting minutes **Evidence as Submitted by the MCE:** • QAPI Committee Meeting Minutes **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *The PIHP shall form a QAPI committee that shall, at a minimum include:* i. *The PIHP's Medical Director, who must serve as the chair or co-chair and* ii. *Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.* MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1		
MCE Description of Process: The QAPI meeting minutes captures the attendance of the co-chairs which are the AVP of Clinical Management and the AVAP of Compliance and Quality Management.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. QAPI Committee Responsibilities: MCO: a. *The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:* i. *Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;*	**HSAG Required Evidence:** • Policies and procedures • QAPI committee meeting minutes • Evidence of submission to the State • Evidence of working with other Contractor staff and Subcontractors • Evidence of updates to the Provider Manual • Evidence of provider network performance reviews	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
ii. *Ensure that QAPI activities take place throughout the MCO's organization and ensure that providers are involved in the QAPI Program;* iii. *Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;* iv. *Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;* v. *Designate evaluation and study design procedures;* vi. *Review provider network performance, including individual primary care provider (PCP), specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;* vii. *Report findings to appropriate executive authority, staff, and departments within the MCO's organization;* viii. *Direct and analyze periodic reviews of Enrollees' service utilization patterns;* ix. *Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for*	• Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members' service utilization patterns **Evidence as Submitted by the MCE:** • QAPI Committee Meeting Minutes • National Quality Improvement Program • National Quality Improvement Program Evaluation_LDH **Additional Documentation:** • National Quality Improvement Program 2024_Highlighted	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
review upon request and during EQRO reviews and during NCQA accreditation reviews; x. *Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;* xi. *Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required;* xii. *Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and* xiii. *Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.* PAHP: a. *The QAPI Committee shall:* i. *Meet on a quarterly basis;* ii. *Direct and review quality improvement (QI) activities;* iii. *Ensure that QAPI activities are implemented throughout the PAHP;* iv. *Review and suggest new and/or improved QI activities;*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
v. *Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;* vi. *Designate evaluation and study design procedures;* vii. *Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;* viii. *Report findings to appropriate executive authority, staff, and departments within the PAHP;* ix. *Direct and analyze periodic reviews of enrollees' service utilization patterns;* x. *Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and* xi. *Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.* PIHP: a. *QAPI committee responsibilities shall include:* i. *Directing and reviewing QI activities;* ii. *Ensuring that QAPI activities take place throughout the organization;* iii. *Suggesting new and/or improved QI activities;* iv. *Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;* v. *Conducting provider quality performance measure profiling;*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
vi. *Reporting findings to appropriate executive authority, staff, and departments within the PIHP;* vii. *Directing and analyzing periodic reviews of members' service utilization patterns; and* viii. *Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The PIHP shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.* MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2		
MCE Description of Process: The QAPI Program convenes quarterly to monitor performance and address areas of improvement. This is all captured in the meeting minutes which are approved quarterly.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. QAPI Plan Requirements: MCO: a. *The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.*	**HSAG Required Evidence:** • QAPI Plan • Evidence of submission to the State **Evidence as Submitted by the MCE:** • QAPI Receipt Confirmation_LDH	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
b. *The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.* c. *The QAPI Plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;* iv. *Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;* v. *Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and* vi. *Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects Network Providers' adherence to clinical practice guidelines as appropriate.* PAHP: a. *The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.*	**Additional Documentation:** • National Quality Improvement Program 2024_Highlighted	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
b. *The QAPI plan shall be submitted to LDH annually, and prior to revisions.* c. *The QAPI plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and* iv. *Describe the role of providers in giving input to the QAPI Program.* PIHP: a. *The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of Division of Administration, Office of State Procurement (DOA/OSP) approval of the signed Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by Office of Behavioral Health, Louisiana Department of Health (OBH).* b. *The QAPI program description at a minimum, shall:* i. *Include a description of the Contractor staff assigned to the QAPI program, their specific*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
training, how they are organized, and their responsibilities. ii. *Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.* iii. *Specify the remediation actions that will be implemented when system performance is less than the required threshold.* iv. *Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention's effectiveness.* v. *Describe how the Contractor will obtain feedback from providers and members.* vi. *Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.* vii. *Be exclusive to the Coordinated System of Care (CSoC) Program and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor.* c. *The QAPI work plan at a minimum shall: Include objectives for the Contract year, inclusive of associated action steps and timelines.*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
i. *Include metrics and associated benchmarks for the wraparound agency scorecard.* ii. *Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the wraparound agencies (WAAs) adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.* iii. *Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with National Wraparound Initiative (NWI) standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of wraparound facilitator's (WF) demonstration of established wraparound competencies on a quarterly basis.* MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3		
MCE Description of Process: Client Engagement annually submits all QAPI required documents to LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard XII—Quality Assessment and Performance Improvement							
Total	Met	=	10	X	1	=	10
	Not Met	=	1	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	11	**Total Score**		=	10

Total Score ÷ Total Applicable	=	**91%**

Standard XIII—Grievance and Appeal Systems

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
1. The MCE defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • CGA06-INS-MCD-Member Complaints and Grievances-Primary Delegation; Definitions Section	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA06 policy includes this definition on page 2		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. A member may file a grievance with the MCE at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member. 42 CFR §438.228	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1	• HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • CGA06-INS-Member Complaints and Grievances; Section A, page 2 • CGA Client Requirements Document (CRD); • Member Grievance Section • a. Member Appeals Process; Special Instructions Section	
MCE Description of Process: CGA06 and the Client Requirements document details the authorized representative procedure		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documents submitted for desk review did not provide evidence of compliance with the requirements for this element. The documents did not include that with the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.		
Required Actions: The MCE must revise its policies and any applicable documents to comply with the requirement that with the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.		
3. The member may file a grievance either orally or in writing. 42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.1.8; 11.3.6.1; 11.3.6.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCE:** • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section B, Item 2, page 3	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: CGA06 Section B, item 7, includes members may file grievances verbally or in writing		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Grievances		
4. The MCE acknowledges receipt of each grievance. MCO and PAHP: a. *The MCO's/PAHP's process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.* PIHP: a. *Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1	**HSAG Required Evidence:** • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 2, page 3-4 • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section C, Item 2, page 4 **Additional Documentation:** • Medicaid Grievance Acknowledgement • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01, Section B, Item 2, and CGA06, Section C, Item 2, list the acknowledgement process for grievances and appeals.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3; 11.4.1.1.3.3	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section C; Item 5, page 5-6	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Section C, item 5, of this policy explains the clinical review process that meets this requirement		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Timely Resolution and Notification of Grievances		
6. The MCE resolves each grievance, and provides notice, as expeditiously as the member's health condition requires, within State-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408. MCO and PAHP Standard Grievances a. *The MCO/PAHP 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 MCO/PAHP receives the grievance.* PIHP Standard Grievances a. *For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.* 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12) MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section C **Additional Documentation:** • Medicaid Grievance Resolution	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Section C of this policy details the grievance timeframes and correspondence requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Five of the 10 grievance case files did not include the date on the resolution letter.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must ensure that grievance resolution letters are dated and sent to the member no later than 90 calendar days from the date the MCE receives the grievance.		
7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if: a. The member requests the extension; or b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of a grievance with extensions with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 5, page 7-8 **Additional Documentation** • Grievance extensions are approved by internal DQ management, not by LDH. Therefore, the examples do not exist. • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The extension process is detailed in Section C, Item 5, of this policy		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Of note, the MCE does not need to ask the State for permission prior to requesting an extension as that would be a barrier. The MCE should proceed if an extension is needed and be prepared to justify if the State requests.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • Two examples of grievances with extensions with oral and written notice • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • CGA05-Monitoring Resolution Timeframes; Exhibit A, item 4 and 5, page 2 **Additional Documentation:** • Medicaid Grievance Extension	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: CGA05 Exhibit A. items 4 and 5, detail the extension process.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's policies and procedures did not include the requirement to inform the member of the right to file a grievance if he or she disagrees with that decision.		
Required Actions: The MCE must revise its policies and procedures to include the requirement to inform the member of the right to file a grievance if he or she disagrees with the MCE's decision to extend the grievance resolution time frame.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Appeals General Requirements		
9. The MCE defines an appeal as a review by the MCE of an ABD. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Definitions Section, page 1	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 definition of Appeal meets this requirement		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE has only one level of appeal for members. 42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1) MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section A, Item 1, page 2	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: CGA01, Section A, Item 1 explains one level of appeal is offered.		
HSAG Findings: During the compliance review, HSAG identified that LDH's contract with the MCEs required the MCEs to maintain an informal reconsideration/peer-to-peer process. HSAG has scored this element as not applicable since State requirements differ from federal requirements. HSAG has communicated this information to LDH.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
11. The MCE establishes and maintains an expedited review process for appeals, when the MCE determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f) MCO Contract: 2.15.3.4.1; 2.15.4.11 PAHP Contract: 2.10.4.1; 2.10.6.12 PIHP Contract: 11.4.9.1; 11.5.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 5, page 4-5	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The expedited review appeals process is detailed in CGA01, Section B, Item 5.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
12. Following receipt of a notification of an ABD by an MCE, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the MCE. 42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1) MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section A, page 2 **Additional Documentation** • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes • Medicaid Initial Denial template	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01, Section A, Item 1(a) details the appeals timeframe		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3) MCO Contract: 2.15.1.11; 2.15.3.1.1 PAHP Contract: 2.10.1.11; 2.10.3.1.1 PIHP Contract: 11.3.6.2	• Member consent form template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section A. Item 1, page 2	
MCE Description of Process: CGA01, Section A, Item 1 states members may file verbally or in writing. This section also speaks to the authorized representative process.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not provide evidence of a member consent form template and reported that it does not store this form. All five appeal case files required written member consent; however, none of the case files included member consent forms.		
Required Actions: The MCE must develop and maintain a member consent form template. If a provider or an authorized representative is requesting an appeal on behalf of the member, written consent is required of the member.		
Handling of Appeals		
14. If the MCE denies a request for expedited resolution of an appeal, it: a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2). b. Follows the requirements in 42 CFR §438.408(c)(2), including: i. Makes reasonable efforts to give the member prompt oral notice of the delay. ii. Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a	**HSAG Required Evidence:** • Policies and procedures • Denied expedited resolution letter template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 5(d-g), page 5	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
grievance if the member disagrees with that decision. 42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f) MCO Contract: 2.15.3.4.4; 2.15.3.4.5 PAHP Contract: 2.10.4.4; 2.10.4.5 PIHP Contract: 11.4.9.1.1.1; 11.4.9.1.1.2; 11.4.9.2		
MCE Description of Process: CGA01, Section 5, Item 5, details the process if expedited criteria is not met and the case is processed as a standard appeal.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's policy submitted for desk review did not include the requirement to inform the member of the right to file a grievance if he or she disagrees with the decision to deny the expedited appeal resolution time frame.		
Required Actions: The MCE must develop and implement a denied expedited resolution letter template. The MCE must implement a process to make reasonable efforts to give the member prompt oral notice of the delay rather than delegating the responsibility for oral notice to the provider. The MCE must revise its policies and procedures to include the requirement to inform the member of the right to file a grievance if he or she disagrees with the decision to deny the expedited appeal resolution time frame.		
15. The MCE acknowledges receipt of each appeal. MCO and PAHP: a. *The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.* PIHP: a. *Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs*	**HSAG Required Evidence:** • Policies and procedures • Appeal acknowledgment template • Tracking and reporting mechanisms • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Exhibit L, page 12	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log. 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1	• CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section C, Item 2, page 4 **Additional Documentation:** • Medicaid appeal written acknowledgement • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes	
MCE Description of Process: Both policies submitted include the acknowledgement timeframes for appeals and grievances.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ's policies and tracking mechanisms demonstrated compliance with this requirement; however, all 10 of the appeal case files did not include the date on the acknowledgement letter.		
Required Actions: The MCE must ensure that appeal acknowledgement letters are dated and sent to the member timely. Additionally, The MCO/PAHP shall acknowledge each appeal in writing within five business days of receipt of each appeal unless the enrollee requests an expedited resolution.		
16. The MCE ensures that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: i. An appeal of a denial that is based on lack of medical necessity.	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of appeal staff members, including credentials • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 6, page 5-6	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
ii. An appeal that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3		
MCE Description of Process: Section B, Item 6 of this policy explains the clinical review process that meets this requirement		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The MCE treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section A and Exhibit L, page 12	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 Section A, explains verbal appeals are treated the same as written appeals.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The MCE provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCE informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.4; 2.15.3.4.3 PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 2(b) and Exhibit L, page 3 and 12 • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section C, Item 2(b) **Additional Documentation:** • Medicaid Initial Denial template • Medicaid appeal written acknowledgement	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The policies provided explain how the member may present evidence and details the timeframes applicable.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD. a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). MCO and PAHP: a. *Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and any other documents and records considered or relied upon by the MCO/PAHP regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the enrollee or an authorized Representative to examine the record. The MCO/PAHP shall provide such records free of charge and within seven (7) calendar days of receipt of the request.* 42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 2(c)- page 3-4 and Exhibit L, page 12	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: CGA01 Section B, Item 2(c) and Exhibit L support that case files are available to members and their authorized representatives.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Resolution and Notification of Appeals		
20. The MCE resolves standard appeals and sends notice to the affected parties as expeditiously as the member's health condition requires, but no later than 30 calendar days from the day the MCE receives the appeal. 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Tracking documentation • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 2, page 6	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: CGA01, Section C, item 2, explains the timeframes for resolution notices.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Nine out of the 10 appeal case files did not include the date on the resolution letter.		
Required Actions: The MCE must ensure that appeal resolution letters are dated and sent to the member timely.		
21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal.	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms	☒ Met ☐ Not Met

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1	• HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 1, page 6	☐ NA
MCE Description of Process: CGA01, Section C, item 1, explains the timeframes for resolution notices related to expedited appeals.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if: a. The member requests the extension; or b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member's interest. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of appeals with extended time frame with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 5, page 6-7 and Exhibit L, page 12	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes • Extension are approved by management not by LDH	
MCE Description of Process: CGA01, Section C, Item 5, and Exhibit L of this policy explain the extension process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Of note, the MCE does not need to ask the State for permission prior to requesting an extension as that would be a barrier. The MCE should proceed if an extension is needed and be prepared to justify if the State requests.		
Required Actions: No action required.		
23. If the MCE extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.5.2	**HSAG Required Evidence:** • Policies and procedures • Two examples of appeals with extended time frame with oral and written notice • Appeal extension template letter • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 5, page 5-6 and Exhibit L, page 12 **Additional Documentation:** • Medicaid Appeal Extension	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2	• There were no extended appeals during this timeframe.	
MCE Description of Process: CGA01, Section C, Item 5, and Exhibit L of this policy explain the expedited appeal process and timeframes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
24. In the case that the MCE fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCE's appeals process. The member may initiate a State fair hearing (SFH). 42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section E, Item 4, page 10 **Additional Documentation:** • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: CGA01, Section E, Item 4, details this requirement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
25. For all appeals, the MCE provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCE's ABD related to the appeal. MCO: a. *The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.* b. *The MCO shall include on the notice a unique identifying number, corresponding to the number on the notice of ABD that gave rise to the appeal.* c. *For Appeals not resolved wholly in favor of the enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 6, page 7-8	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
limited to, informing the enrollee of their right to seek a State Fair Hearing if the enrollee is not satisfied with the MCO's decision in response to an appeal, and the process for doing so. PAHP: a. *The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.* b. *The PAHP shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the appeal.* c. *The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the PAHP's decision in response to an appeal, and the process for doing so.* 42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4) MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13		
MCE Description of Process: CGA01, Section C, Item 6 details the appeals resolution process and speak to notification content related to additional appeal rights.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ did not submit the appeal resolution template or proof of LDH approval of the appeal resolution template.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must obtain approval from LDH of the appeal resolution template.		
26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice. MCO and PAHP: a. *In the case of an expedited appeal denial, the MCO/PAHP shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition.* 42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 1 and Item 4, page 6	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 Section C, Item 1 and Item 4 explain the expedited oral notification process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
State Fair Hearings and State External Review		
27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal. a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member.	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.4.03 MCO Contract: 2.15.1.11; 2.15.4.1 PAHP Contract: 2.10.2.11; 2.10.6.1 PIHP Contract: 11.3.4.2; 11.4.14.2	**Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section E, Item 1 and Item 2, page 9	
MCE Description of Process: CGA01 Section E, Item 1 and Item 2, explain the process to request a SFH and that an authorized representative may act on behalf of the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
28. The member has *120 calendar days* from the date of the MCE's notice of appeal resolution to request an SFH. MCO: a. *An enrollee or other party to the appeal, who has completed the MCO's appeal procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of appeal resolution indicating that the MCO is upholding, in whole or in part, the ABD, or after the MCO fails to adhere to the notice and timing requirements applicable to appeals.* PAHP: a. *An enrollee or authorized representative, who has completed the PAHP's appeal process, may request a state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section E, Item 1-4, page 9-10	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
whole or in part, the adverse benefit determination, or after the PAHP fails to adhere to the notice and timing requirements applicable to appeals. PIHP: a. *The member may request a State Fair Hearing only after receiving notice that the PIHP is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the PIHP's notice of resolution.* 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2		
MCE Description of Process: CGA01 Section E, Item 1-4 details the timeframes and requirements surrounding a SFH request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Continuation of Benefits		
29. The MCE continues the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. MCO/PAHP/PIHP: a. *Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.* *Timely files* means on or before the later of the following: within 10 calendar days of the MCE sending the notice of ABD, or the intended effective date of the MCE's proposed ABD. 42 CFR §438.228 42 CFR §438.420(a-b) MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2	**Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section F, Item 1 and Item 2, page 10-11 **Additional Documentation:** • Medicaid Initial Denial template	
MCE Description of Process: CGA01 Section F, Item 1 and Item 2 explain the Continuation of Benefits process		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
30. If, at the member's request, the MCE continues or reinstates the member's benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs: a. The member withdraws the appeal or request for SFH. b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the MCE sends the notice of an adverse resolution to the member's appeal. c. A SFH office issues a hearing decision adverse to the member. MCO and PAHP: a. Appeals i. *The time period or service limits of a previously authorized service has been met.* 42 CFR §438.228 42 CFR §438.420(c) MCO Contract: 2.15.3.2.2; 2.15.4.8 PAHP Contract: 2.10.3.5; 2.10.6.9 PIHP Contract: 11.6.3	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section F, Item 3, page 11	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 Section F, Item 3 mirrors this requirement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
31. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE's ABD, the MCE may, consistent with the state's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE's contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420. 42 CFR §438.228 42 CFR §438.420(d) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section F, Item 3(d), page 11	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 Section F, Item 3(d) explains the process for an upheld SFH decision as well as recovering payment for services provided in a Continuation of Benefits scenario.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations. 42 CFR §438.228 42 CFR §438.424(b) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section F, Item 4, page 11	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: CGA01 Section F, Item 4 explains the process when a SFH determination is to overturn the denial.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Reinstatement of Services		
33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i) MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section E, Item 12, page 10 **Additional Documentation:** • CGA05-INS-Monitoring Resolution Timeframes • CGA05-INS-SOP-Monitoring Resolution Timeframes	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 Section E, Item 12 explains the effectuation process for an overturned SFH determination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievances, Appeals, and State Fair Hearings		
34. In handling grievances and appeals, the MCE gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. 42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d) MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 11.4.1.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Example of assistance to members on filing a grievance **Evidence as Submitted by the MCE:** • DQ1833 LA_HealthyMedicaid_Member Handbook • CS09-INS-CS Member Access with LEP **Additional Documentation:** • Example for Grievance Assistance	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
35. The MCE provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10. 42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1)	**HSAG Required Evidence:** • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1) MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 5.15.2; 5.15.3	• HSAG will also use the results of the Grievances and Appeals File Reviews **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section C, Item 6, page 7-8 • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section D, Item 4, page 6 **Additional Documentation:** • The Correspondence team uses the reading level assessment tool within Microsoft Word under the Editor Function. The documentation stats provided the Flesch – Kincaid Grade Level. • 2-CGA operating system allows specialists to check reading level throughout case creation. Information pulls from system into letter template. See word document "labeled element 35 readability screen shot."	
MCE Description of Process: CGA01, Section C, Item 6 and CGA06 Section D, Item 4 describes the resolution notification process.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The resolution letter for one of the 10 grievance case files and the resolution letters for six of the 10 appeal case files did not meet the reading grade level required by the State.		
Required Actions: The MCE must ensure grievance and appeal resolution letters meet the reading grade levels required by the State.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
36. The MCE provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. 42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g) MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Provider contract • Subcontractor agreement template **Evidence as Submitted by the MCE:** • LA Dental Provider Agreement	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
37. The MCE includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the MCE. 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.3.1.6 PAHP Contract: 2.10.3.1.5 PIHP Contract: 11.4.2.4.2; 11.4.14.5	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or notice templates **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section E, item 1, page 9	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: CGA01 Section E, item1 details that authorized representatives would also be treated as parties to the appeal.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Recordkeeping Requirements		
38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. PIHP: a. Medicaid number b. Summary of grievances and appeals; c. Current status; d. Resolution with date of resolution and resulting corrective action; e. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members;	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration **Evidence as Submitted by the MCE:** • CGA01-INS-MCD-Member Appeals-Medicaid; Section B, Item 1 and Item 2, page 3-4 • CGA06-INS-Member Complaints and Grievances-Primary Delegation; Section C, Item 1(a), page 4	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
f. The status and resolution of all claims disputes; g. Trends and types of grievances and appeals; h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and i. The number of State Fair Hearings and resolution during the reporting period. 42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h) MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2		
MCE Description of Process: DentaQuest maintains grievances and appeals records in accordance with CMS retention requirements and confirms that the data is reportable. DentaQuest has resources to validate the field set(s) and ensure that reporting capabilities are available.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIII—Grievance and Appeal Systems							
Total	Met	=	28	X	1	=	28
	Not Met	=	9	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	**Total Score**		=	28

Total Score ÷ Total Applicable	=	**76%**

Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Certification		
1. Documentation or information the MCE submits to LDH is certified by the MCE's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer (CEO) or Chief Financial Officer (CFO) with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful. b. The MCE submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b). 42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o) MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6	**HSAG Required Evidence:** • Policies and procedures to certify the data specified in 42 CFR §438.604 • Position and job description of individual responsible for certification **Evidence as Submitted by the MCE:** • COM08-ENT-Annual Attestation Policy > Entire doc • NET21-INS-SOP-Written Disclosures **Additional Documentation:** • Louisiana Key Personnel Staff Org Chart	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The DentaQuest Client Engagement team works collaboratively with each business area to validate the data is accurate prior to coordinating signatures or signoffs from the CEO or CFO for final data certifications. For data reports, the Contract Operations Manager (who reports to the CEO) completes the attestation.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. However, the COM08-ENT-Annual Attestation policy did not accurately reflect the requirements for this element as it did not specify that DQ's Chief Executive Officer (CEO) or Chief Financial Officer (CFO) is ultimately responsible for certification and did not identify the designee of certification authority within the organization. **Recommendation:** HSAG recommends that the MCE revise its COM08-ENT-Annual Attestation policy to more clearly delineate the requirements for this element and positions responsible for these requirements.		
Required Actions: No action required.		
Compliance Program/Program Integrity Plan		
2. The MCE develops a compliance program that includes: a. Written policies, procedures, and standards of conduct that articulate the MCE or subcontractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements. b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors. c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Compliance Officer job description • Organizational chart • Regulatory Compliance Committee charter • Compliance training plan • Compliance training materials • Training tracking mechanisms • Communication protocol for Compliance issues (e.g., hotline) • Code of Ethics • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
d. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees, for the Federal and State standards and requirements under the Contract. MCO and PAHP: a. *Fraud, waste, and abuse training shall include, but not be limited to:* i. *Annual training of all employees; and* ii. *New hire training within thirty (30) Calendar Days of beginning date of employment.* b. *The MCO/PAHP shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:* i. *MCO/PAHP Code of Conduct Training;* ii. *Privacy and Security - Health Insurance Portability and Accountability Act;* iii. *Fraud, Waste, and Abuse identification and reporting procedures;* iv. *The False Claims Act and employee whistleblower protections;* v. *Procedures for Timely consistent exchange of information and collaboration with LDH;* vi. *Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and*	**Evidence as Submitted by the MCE:** • SFY 2024 Program Integrity Plan 20240130 • Compliance Program Work Plan for 2024 • SVP Risk Mgmt Chief Ethics Comply Officer • Compliance Org Chart 04.21.2025 • Corporate Compliance Committee Charter • COM07-ENT-Training and Education • COM03-ENT-Code of Conduct Standards • COM09-ENT-Duty to Report Noncompliance; Non-retaliation • Code of Conduct_DentaQuest • Compliance Program Overview • 2024 CofC T&D_FINAL • 2024 General Compliance Training FWA Training Final • 2024 Privacy Computer Information Security Training **Additional Documentation:** • Compliance360 demonstration (in virtual review)	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
vii. *Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.* c. *Effective lines of communication between the compliance officer and the organization's employees.* d. *Enforcement of standards through well-publicized disciplinary guidelines.* e. *Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.* PIHP: a. *Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Integrity Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel; b. *A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;* c. *Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;* d. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly; and* e. *Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the PIHP. The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.* 42 CFR §438.608(a)(1) MCO Contract: 2.20.2.2.1; 2.20.2.2.2; 2.20.2.2.3; 2.20.2.2.4; 2.20.2.2.5; 2.20.2.2.6; 2.20.2.2.7		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.12.5.2.1; 2.12.5.2.2; 2.12.5.2.3; 2.12.5.2.4; 2.12.5.2.5; 2.12.5.2.6; 2.12.5.2.7; 2.12.5.2.8; 2.12.5.2.9 PIHP Contract: 13.1.2.3.1; 13.1.2.3.2; 13.1.2.3.4; 13.1.2.3.5; 13.1.2.3.6; 13.1.2.3.7; 13.1.2.3.8; 13.1.2.3.9; 13.1.2.3.10; 13.1.2.3.11		
MCE Description of Process: The Compliance Organization, led by Courtney Barnes Ransom, consists of compliance professionals who provide compliance and risk management support to the DentaQuest businesses unit. This includes oversight of all dental practices which have different risks and requirements. The Compliance Organization reports to the DentaQuest Board of Directors on internally identified risks, externally applied Corrective Action Plans, and organizational responses.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP: a. *The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.* MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • SFY 2024 Program Integrity Plan 20240130	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Compliance Organization, led by Courtney Barnes Ransom, consists of compliance professionals who provide compliance and risk management support to the DentaQuest businesses unit. This includes oversight of all dental practices which have different risks and requirements. The Compliance Organization reports to the DentaQuest Board of Directors on internally identified risks, externally applied Corrective Action Plans, and organizational responses.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
4. Additional compliance program requirements: MCO: a. *The MCO's compliance program shall incorporate the following requirements:* i. *Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.* ii. *Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.* iii. *Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the contract compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.* iv. *Written policies and procedures for conducting both announced and unannounced site visits and field*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • SFY 2024 Program Integrity Plan 20240130	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
audits on providers to ensure services are rendered and billed correctly. PAHP: a. *Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.* b. *Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of prepayment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement* c. *Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.* d. *Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
e. *Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, PAHP employees and the public on the PAHP's website required under the contract. The PAHP must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.* PIHP: a. *The PIHP's fraud, waste and abuse policies and procedures shall provide and certify that the PIHP's fraud, waste and abuse unit has access to records of providers.* i. *The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP's senior management.* b. *Description of effective training and education for the compliance officer, the organization's employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it* c. *A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.* MCO Contract: 2.20.2.3 PAHP Contract: 2.12.5.3 PIHP Contract: 13.1.2.5; 13.1.2.11; 13.1.2.12		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The Compliance Organization, led by Courtney Barnes Ransom, consists of compliance professionals who provide compliance and risk management support to the DentaQuest businesses unit. This includes oversight of all dental practices which have different risks and requirements. The Compliance Organization reports to the DentaQuest Board of Directors on internally identified risks, externally applied Corrective Action Plans, and organizational responses. All employees are required to complete required training upon hire and annually thereafter. Additionally, the compliance hotline is well-publicized internally and externally for all employees, contractors, agents, network providers, and members to report incidents of non-compliance or fraud, waste and abuse.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. Publicized email address: MCO and PAHP: a. *Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to Enrollees, providers, MCO/PAHP employees and the public on the MCO's/PAHP's website.* b. *The MCO/PAHP shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.* MCO: a. *The MCO shall submit to LDH or its designee the fraud, waste, and abuse compliance plan as part of readiness review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) calendar days in advance of making them effective.*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Evidence of publicized email address **Evidence as Submitted by the MCE:** • SFY 2024 Program Integrity Plan 20240130 • COM09-ENT-Duty to Report Noncompliance; Non-retaliation **Additional Documentation:** • RE 2024 FWA Compliance Plans.msg – LDH acknowledging receipt of submission	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PAHP: a. *The PAHP shall submit the fraud and abuse compliance plan to LDH. The PAHP shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the PAHP modify its compliance plan.* MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA		
MCE Description of Process: DentaQuest has a process to submit its Program Integrity Compliance Plan to LDH in accordance with established reporting requirements. Additionally, the compliance hotline is well-publicized internally and externally for all employees, contractors, agents, network providers, and members to report incidents of non-compliance or fraud, waste and abuse.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Overpayments and Treatment of Recoveries		
6. The MCE implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to LDH. 42 CFR §438.608(a)(2) MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9	**HSAG Required Evidence:** • Policies and procedures, including timeline for prompt reporting of overpayments • Special investigations unit (SIU) workflows • Identification mechanisms • Reporting mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • FPR01-INS-DENT-FPR Program- FINAL; page 8-9 (Exhibit L: Louisiana) **Additional Documentation:** • FPR 01-INS-DENT-FPR Program 2024	
MCE Description of Process: DQ has a deconfliction process to promptly notify LDH of any overpayments identified or recovered.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE follows the retention policies for the treatment of recoveries of all overpayments from the MCE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments. b. The MCE complies with the process, timeframes, and documentation LDH requires for payment of recoveries of overpayments to LDH in situations where the MCE is not permitted to retain some or all of the recoveries of overpayments. c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.	**HSAG Required Evidence:** • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials • Most recent report of recoveries of overpayments to State **Evidence as Submitted by the MCE:** • 2024 General Compliance Training FWA Training Final • COM10-ENT-False Claims Act Information • FPR03-INS-DENT-Financial Recovery-Final; Entire document	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCO: a. *Report annually to LDH, in a form and format specified by LDH, on the MCO's recoveries of overpayments in accordance with 42 CFR §438.608.* PAHP: a. *The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.* b. *The PAHP shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.* PIHP: a. *The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.* b. *The PIHP shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.* 42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3) MCO Contract: 2.20.2.2.15; 2.20.7.3	**Additional Documentation:** • FPR 03-INS-DENT-Financial Recovery - 2024 • LDH Approved Q4 145 Report • Screenshot of LDH Approved 145 Report Q1 through Q4.	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.12.2.4; 2.12.5.2.15; 2.12.6.3.1.4; 2.12.6.3.1.5; 6.3.6.3; 2.12.6.3.2; 2.12.6.3.3; 2.12.6.3.4 PIHP Contract: 13.5.5; 13.5.6		
MCE Description of Process: DQ's FPR unit has a process to send identified overpayments to the claims department for adjudication and monitors to ensure confirmation from the claims department that the adjudication occurred is received.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The MCE requires and has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment. 42 CFR §438.608(d)(2) MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12	**HSAG Required Evidence:** • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • CL02_INS (Page 4, Section D) **Additional Documentation**: • FPR03-INSDENT Financial Recovery • FPR01-INSDENT Fraud Prevention and Recovery • CL02-INS Claims Payment • Program – Dental	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Notification of Member and Provider Changes		
9. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for prompt notification to LDH when it receives information about changes in a member's circumstances that may affect the member's eligibility including all of the following: a. Changes in the member's residence; b. The death of a member. 42 CFR §438.608(a)(3) MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10 PIHP Contract: 14.8.1.4	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • SFY 2024 Program Integrity Plan 20240130	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for notification to LDH when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • SFY 2024 Program Integrity Plan 20240130 • CORR01-INS-Member Notifications of Provider Terminations, page 3, Exhibit J	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
PAHP: a. *The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for enrollees due to provider illness, a provider dies, the provider moves from the service area and fails to notify the PAHP, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification shall include:* i. *Information about how the provider network change will affect the delivery of covered services; and* ii. *The PAHP's plan for maintaining the quality of enrollee care if the provider network change is likely to affect the delivery of covered services.* PIHP: a. *The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:* i. *Information about how the provider network change will affect the delivery of covered services, and* ii. *The PIHP's plan for maintaining the quality of member care if the provider network change is likely to affect the delivery of covered services.*	**Additional Documentation:** • NET05-Provider Network Adequacy Exhibit D	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.608(a)(4) MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5		
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Verification of Services Provided		
11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. MCO: a. *On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice shall specify:* i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;*	**HSAG Required Evidence:** • Policies and procedures • Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials **Evidence as Submitted by the MCE:** • CL02-INS-SOP Member Verification of Services • UM08-INS-Authorization Review, page 6/11 • LDH Verification of Services Response Data_06.2025 • LDH Verification of Services Tracker • LDH_Member_Verification_2025.06.01 **Additional Documentation:** • CL02-INS-SOP Member Verification of Services	☐ Met ☒ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
iii. *The date on which the service was furnished;* iv. *The amount of the payment made for the service; and* v. *The method for notifying the Contractor of services not rendered.* b. *The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis.* c. *The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).* d. *The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* e. *Within three (3) business days of receipt of a response from an enrollee, results indicating that paid services may not have been received shall be referred to the*	• The various data sets (originally submitted) included the following information – Monthly tracker – count of member surveys sent for prior month claim sample, surveys as a % of claims paid, counts of responses, detail on responses and count of unverified surveys – File of claims generated from prior month paid claims sent to Qualtrics to generate member verification surveys/emails (June 1, 2025, surveys) – File of responses to surveys submitted by members (June 1, 2025, surveys) – If necessary, a communication is sent to Fraud Prevention & Recovery for any unverified responses in the response population (evidence not available to be provided within timeframe)	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCO's fraud and abuse department for review and to the LDH Program Integrity contact. f. *Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.* PAHP: a. *On a monthly basis, the PAHP shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manger that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:* i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
(2%) percent of claims paid per month to be reported on a quarterly basis. c. *The PAHP shall also perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and* d. *Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.* e. *Within three (3) business days, results indicating that paid services may not have been received shall be referred to the PAHP's fraud and abuse department for review and to the LDH Program Integrity contact.* f. *Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review.* PIHP: a. *On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:* i. *The service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
iv. *The amount of the payment made for the service.* b. *The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.* c. *Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.* d. *The Contractor shall over sample particular provider groups upon request by LDH.* e. *The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* f. *Within five (5) business days, results indicating that paid services may not have been received shall be referred to the Contractor's fraud and abuse department for review and to LDH's designated Program Integrity contact.* g. *The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were developed*		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH. 42 CFR §438.608(a)(5) MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4		

MCE Description of Process:

- UM08, page 11, exhibit U-Louisiana Medicaid: I. DentaQuest shall have written procedures listing the information required from an enrollee or dental care provider to make medical necessity determinations. DentaQuest policies and procedures are consistent with 42 CFR 438.210 and state laws and regulations and the court-ordered requirements of Chisholm v. Kliebert and Wells v. Kliebert for initial and continuing authorization of services. Such procedures shall be given verbally or in writing to the enrollee, the enrollee's authorized representative, or healthcare provider within ten (10) calendar days when requested. The procedures shall outline the process to be followed in the event DentaQuest determines the need for additional information not initially requested. VI. **Notice of Adverse Benefit Determination:** DentaQuest shall mail the notice of adverse benefit determinations for termination, suspension, or reduction of previously authorized covered services no later than ten (10) days before the adverse benefit determination is to take effect, by the date of the action when any of the following occur: 1. The enrollee has died. 2. The enrollee submits a signed, dated, written statement requesting service termination that includes information that requires service termination or reduction and indicates that he or she understands that the service termination or reduction will result. 3. The enrollee has been admitted to a facility where he or she is ineligible under DentaQuest for further services. 4. The enrollee's whereabouts is determined unknown based on returned mail with no forwarding address. 5. The enrollee is accepted for Medicaid services by another state. 6. The enrollee's dentist or specialty dental provider prescribes a change in the level of dental care. 7. For denial of payment, at the time of any adverse benefit determination affecting the clean claim. 8. For service authorization decisions not reached within required timeframes, on the date the timeframes expire. Such failures constitute a denial and are, therefore, an adverse benefit determination.
- UM08-INS-Authorization Review, page 6, section B: **B. Retrospective Review or Prepayment Review**: All retrospective reviews are determined in compliance with UM standards established by NCQA, URAC, regulation, and/or plan contract. The strictest timeliness standard is applied for all review decisions.

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The L02-INS-SOP Member Verification of Services policy was not submitted for review; therefore, DQ did not demonstrate its policies and procedures for complying with the requirements for this element.		
Required Actions: The MCE must develop a policy to comply with the requirements for this element.		
Whistleblower Protection		
12. In the case of MCEs that make or receive annual payments under the contract of at least $5,000,000, the MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. MCO: a. Include in any employee handbook for the MCO, a specific discussion of the laws, the rights of employees to be protected as whistleblowers and the MCO's policies and procedures for detecting and preventing fraud, waste and abuse. 42 CFR §438.608(a)(6) MCO Contract: 6.18.1; 6.18.3 PAHP Contract: 2.12.5.2.6.4; 2.12.5.2.6.7 PIHP Contract: 13.1.1.2.; 13.1.2.8	**HSAG Required Evidence:** • Policies and procedures • Program integrity/compliance plan • Staff, Provider, and Subcontractor training/informational materials **Evidence as Submitted by the MCE:** • COM10-ENT-False Claims Act Information • 2024 General Compliance Training FWA Training Final • SFY 2024 Program Integrity Plan 20240130 • FCA Page from SL_US_Employee Handbook	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: To ensure full compliance with the Deficit Reduction Act, DentaQuest provides detailed information regarding False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including employee rights and		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
protections. All employees, contractors, and agents are educated on how to identify, report, and prevent fraud, waste, and abuse. DentaQuest is committed to fostering a culture of integrity and transparency, and encourage reporting of any concerns without fear of retaliation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Fraud, Waste, and Abuse		
13. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures: a. That are designed to detect and prevent fraud, waste, and abuse. b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH's program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU). PAHP: a. *The PAHP shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).* PIHP: a. *The PIHP shall establish policies and procedures for referral of suspected fraud, waste and abuse to the LDH Program Integrity Office and Law Enforcement. A*	**HSAG Required Evidence:** • Policies and procedures • Fraud, waste, and abuse plan • SIU workflow • Reporting mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • FPR01-INS-DENT-FPR Program-Final; Entire document • FPR04-INS-DENT- Fraud Detection- Final; Entire document **Additional Documentation:** • FPR01-INS-DENT-FPR Program-FINAL Exhibit L to be Updated. Policy will be updated with the highlighted section.	☐ Met ☒ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
standardized referral process should be developed to expedite information for appropriate disposition. 42 CFR §438.608(a) 42 CFR §438.608(a)(7) MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4		
MCE Description of Process: We have policies to perform data analysis to detect possible FWA and policies to determine if possible FWA exists through our investigation process.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policies submitted did not indicate reporting within three business days. After discussion in the virtual review, DQ submitted draft language that mentioned that it will be making revisions to its policy; however, this was not in effect during the review period.		
Required Actions: The MCE must revise its policies to indicate that the MCE will promptly report suspected fraud, abuse, waste, and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).		
Suspension of Payments		
14. The MCE, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which LDH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23. 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow • Staff training materials **Evidence as Submitted by the MCE:** • FPR05-INS-MCD- Credible Allegation of Fraud-Final; Entire document	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Once a CAF payment hold notification is received, DQ's FPR unit submits the appropriate ticket to have the claims system updated to reflect the CAF payment hold.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
15. The MCE, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c). 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow, including applicable timeframes • Notice of payment suspension letter template • Staff training materials • HSAG will also use findings from the provider payment suspensions tracking system demonstration **Evidence as Submitted by the MCE:** • FRAUD- DQ/FPR doesn't issue suspension letters. • FPR05-INS-MCD- Credible Allegation of Fraud-Final; Entire document **Additional Documentation:** • FPR05-INS-MCD-Credible Allegation of Fraud Hold-2024 • DentaQuest does not send letters related to CAF payment holds. The letter is sent by the state as they have determined the CAF payment hold is warranted.	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Once a CAF payment hold notification is received, DQ's FPR unit submits the appropriate ticket to have the claims system updated to reflect the CAF payment hold.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. DQ staff stated that DQ is not responsible for issuing notices of payment suspension and did not submit a policy demonstrating compliance with the requirements. Of note, LDH confirmed that this is a contract requirement.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must develop a policy for issuing notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c).		
Provider Screening and Enrollment Requirements		
16. The MCE ensures that all network providers are enrolled with LDH as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E. 42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications • Staff training materials **Evidence as Submitted by the MCE:** • PEC04-INS-Provider Directory Maintenance and On-Going Monitoring // Page 4 Section F • Provider Data Reconciliation - Master Provider File and Windward // Entire Document • LA PML // Entire Document **Additional Documentation:** • PEC04-INS-Provider Maintenance and Ongoing Monitoring (2024 version)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Please see attached LA PML and Provider Data Reconciliation – Master Provider File and Windward documents. These documents outline how we use the Medicaid file from the state and our reconciliation process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days. a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members. 42 CFR §438.602(b)(2) MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment timeliness tracking mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • NET28-INS-Provider Termination-LA Dental Provider Agreement- • PEC01-INS-Credentialing Guidelines **Additional Documentation:** • PEC01-INS Credentialing Guidelines (2024 version) • Credentialing Plan Description • Credentials Committee Charter • PEC04-INS-Provider Maintenance and Ongoing Monitoring • PEC05-INS-Provider Disciplinary Action CAP and Provider Appeals • PEC06-INS-Site Review and Record Review-FINAL • PEC10-INS-Sub Delegation-FINAL	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Disclosures and Prohibited Affiliations		
18. The MCE, and any subcontractors: a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610. b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104. c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. MCO: a. *Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars ($25,000), even if there is no suspicion of fraudulent activity.* 42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610 MCO Contract: 2.20.3.6; 2.20.7.2 PAHP Contract: 6.7.3.1; 2.15.12 PIHP Contract: 13.2.1; 13.2.2.1; 13.1.2.13	**HSAG Required Evidence:** • Policies and procedures that apply to provider/contracted entities and the MCE • Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership) • Disclosure of ownership and control notice template (required for completion by contracted entities) • Confirmation MCE disclosures were provided to LDH upon contract execution • Staff training materials **Evidence as Submitted by the MCE:** • COM23-ENT-Client Notifications Policy-Key Personnel • COM12-ENT-OIG-GSA Exclusion Review **Additional Documentation:** • Requirement (c) is not applicable; MCE does not capitate provider payment in Louisiana.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: DentaQuest maintains a standardized process to identify and document any prohibited affiliations and ownership or control interests through periodic internal reviews, initial and monthly exclusions screenings, and disclosure of ownership requests. Written disclosures of ownership are provided to regulatory agencies, upon request as required by federal and state regulations. All such disclosures are reviewed by the Compliance Organization to ensure accuracy, completeness, and timely submission.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Results for Standard XIV—Program Integrity							
Total	Met	=	15	X	1	=	15
	Not Met	=	3	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	18	**Total Score**		=	15

Total Score ÷ Total Applicable	=	**83%**

Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	**Evidence as Submitted by the MCE**		**Score**
1. <Insert federal CFR citation> Contract: <Insert Citation(s)>	**MCE Document Submission:** •		☐ Met ☐ Not Met
HSAG Findings:			
Required Actions:			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			
Submission:			