



**2025 External Quality Review
Compliance Review**

for

Managed Care North America

December 2025



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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 Managed Care North America (MCNA). 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	9	0	3	100%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	17	14	3	2	82%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	13	8	5	2	62%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	20	17	3	3	85%
VIII	Provider Selection	19	15	15	0	4	100%
IX	Subcontractual Relationships and Delegation	6	5	2	3	1	40%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	31	6	1	84%
XIV	Program Integrity	18	18	18	0	0	100%
Total Compliance Score		227	209	188	21	18	90%

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

MCNA 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 MCNA 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 MCNA into full compliance with the deficient requirements. MCNA must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). MCNA'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 MCNA 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 MCNA 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 MCNA in its submitted CAP.

Appendix A. Conclusions and Recommendations

Strengths	
	The MCE’s policies and procedures ensured that the MCE did not request disenrollment of a member because of an adverse change in the member’s health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. Furthermore, the MCE received 100 percent compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations.
	The MCE received 100 percent compliance with Standard II—Member Rights and Confidentiality, indicating that members were receiving timely and adequate access to information that could assist them in accessing care and services.
	The MCE received 100 percent compliance with Standard IV—Emergency and Poststabilization Services, demonstrating that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
	The MCE received 100 percent compliance with Standard VIII—Provider Selection, demonstrating that the MCE had appropriate provider monitoring and credentialing processes.
	The MCE effectively adopted practice guidelines in consensus with network providers and had a system in place for dissemination to providers and members. In addition, the MCE received 100 percent compliance with Standard X—Practice Guidelines.
	The MCE received 100 percent compliance with Standard XI—Health Information Systems, demonstrating that the MCE had processes in place for how information is captured, processed, and stored in the MCE’s data warehouse. The MCE had the capability to capture and report on utilization patterns, claims, complaints, grievances, appeals, and provider and member demographic information.
	The MCE received 100 percent compliance with Standard XII—Quality Assessment and Performance Improvement and demonstrated detailed documentation, indicated methods to monitor quality of care, analyzed over- and underutilization, and ensured improved outcomes for members with special health care needs.
	The MCE received 100 percent compliance with Standard XIV—Program Integrity, demonstrating that the MCE had appropriate processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. Furthermore, the MCE developed a compliance committee to ensure information sharing at the staff, management, and leadership levels.

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.
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Appendix B. 2025 Compliance Review Tool

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



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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		
<p>1. The MCE may request disenrollment of a member in the following circumstances:</p> <ul style="list-style-type: none"> a. <i>When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department</i> b. <i>Upon termination or expiration of the Contract</i> c. <i>Death of the member</i> d. <i>Confinement of the member in a facility or institution when confinement is not a covered service under the Contract</i> <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>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).</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.</i> <p style="text-align: right;">42 CFR §438.56(b)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.12.3.2 PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <i>MCE Description of Process</i>) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.403LA Disenrollment Page 1, Paragraph 2 • 11.404LA Involuntary Disenrollment. Pg 1, para 2 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA submits for cause disenrollments through MAXIMUS MaXeb system in accordance with LDH requirements. If any suspected fraudulent activity has been identified, the findings are reported to SIU who will initiate an investigation. Any identified fraudulent activity is reported to LDH and disenrollment will be requested through the MAXIMUS Maxeb system.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE does not request disenrollment because of: MCO & PAHP:</p> <ul style="list-style-type: none"> 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 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). <p>PIHP:</p> <ul style="list-style-type: none"> a. The member's adverse change in health status 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <i>MCE Description of Process</i>) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.404LA Involuntary Disenrollment. Pg 1, para 3. • MCNA has not requested disenrollments 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>b. The member’s utilization of medical services</p> <p>c. The member’s diminished mental capacity</p> <p>d. The member’s uncooperative or disruptive behavior resulting from his or her special needs</p> <p style="text-align: right;">42 CFR §438.56(b)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5</p>		
<p>MCE Description of Process: MCNA does not disenroll any members. Members can only be termed by using the Enrollment (834) files from the state or when the state directs us to do so.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract.</p> <p>MCO & PAHP:</p> <p>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.</p> <p>PIHP:</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.404LA Involuntary Disenrollment. Pg 2, para 2. • DBPM Request for Member Disenrollment (Attachment A of 11.404LA Involuntary Disenrollment) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>CSoC. Eligible members may choose to no longer participate in CSoC, in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge.</p> <p style="text-align: right;">42 CFR §438.56(b)(3) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6</p>		
<p>MCE Description of Process: MCNA only submits for cause disenrollment request for only the reasons listed on the DBPM Request for Member Disenrollment Form</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Disenrollment Requested by the Member		
<p>4. The member may request disenrollment from the MCE as follows:</p> <p>a. Without cause, at the following times:</p> <p>MCO:</p> <p>i. During the disenrollment period offered to Enrollees at the start of the contract.</p> <p>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.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.403LA Disenrollment by LDH. Pg 2, # 2 – • MCNA_mh-la-epsdt-en-v2.3 page 6 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Member Handbook (as identified in virtual review) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> iii. At least once every 12 months thereafter (during the enrollment period). iv. At least once every 12 months thereafter. 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. <p>PAHP:</p> <ul style="list-style-type: none"> 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 		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>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.</p> <p>v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</p> <p style="text-align: right;">42 CFR §438.56(c) 42 CFR §438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA</p>		
MCE Description of Process: MCNA directs the member to contact the agency for disenrollment request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Procedures for Disenrollment		
<p>5. The following are causes for disenrollment:</p> <p>MCO:</p> <p>a. The member moves out of the MCE’s service area;</p> <p>b. The MCE does not (due to moral or religious objections) cover the service the member seeks;</p> <p>c. 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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.403LA Disenrollment. Pg 1, #1. • MCNA_mh-la-epsdt-en-v2.3 page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>the services separately would subject the member to unnecessary risk;</p> <p>d. Poor quality of care;</p> <p>e. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs;</p> <p>f. The Contract between the MCE and LDH is terminated;</p> <p>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</p> <p>h. Any other reason deemed to be valid by LDH and/or its agent.</p> <p>PAHP:</p> <p>a. The MCE does not (due to moral or religious objections) cover the service the member seeks;</p> <p>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;</p> <p>c. Poor quality of care;</p> <p>d. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs;</p> <p>e. The Contract between the MCE and LDH is terminated;</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> • Member Handbook (as identified in virtual review) 	



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<p>f. Any other reason deemed to be valid by LDH and/or its agent.</p> <p style="text-align: right;">42 CFR §438.56(d)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA</p>		
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>6. The member must request disenrollment by submitting an oral or written request (as required by the State):</p> <p>a. To the State or its agent; or</p> <p>b. To the MCE, if the State permits MCEs to process disenrollment requests.</p> <p style="text-align: right;">42 CFR §438.56(d)(1) 42 CFR §457.1212</p> <p>MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.403 LA Enrollment and Disenrollment Page 1, Paragraph 1 • MCNA_mh-la-epsdt-en-v2.3 page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: MCNA only submits for cause disenrollment request for only the reasons listed on the DBPM Request for Member Disenrollment Form. This form is then submitted through MAXIMUS Maxeb system.		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.56(d)(3)(i) 42 CFR §457.1212</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • N/A 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> 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.		
Use of the MCE’s Grievance Process		
<p>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:</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA</p>	<ul style="list-style-type: none"> Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	
MCE Description of Process: NA		
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.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 11.403 LA Enrollment and Disenrollment Page 2, Paragraph 1 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: Upon notification from LDH that the member has been disenrolled, MCNA’s Client Services Department will update the system and maintain the files in an identifiable record. LDH will be responsible for notifying the member regarding the termination.		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.</p> <p>Required Actions: No action required.</p>		
Enrollment		
<p>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.</p> <p>MCO and PAHP:</p> <p>a. <i>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 Populations that meet the conditions set forth in 42 CFR §438.50(a).</i></p> <p>PIHP:</p> <p>a. <i>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</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.300LA Enrollment File Processing. Pg 2, para 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Virtual demonstration of enrollment file email 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>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.</i></p> <p style="text-align: right;">42 CFR §438.3(d)(1)</p> <p>MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2</p>		
<p>MCE Description of Process: MCNA Dental Plans to coordinate with LDH and its Medicaid Fiscal Intermediary (FI) for all enrollment functions and eligibility file processing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.3(d)(3-4)</p> <p>MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Enrollment policies and procedures • Member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 1.106 Non-Discriminatory Practices. Pg 1, para 1 • MCNA_mh-la-epsdt-en-v2.3. Pg 40, para 1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA Dental Plans will comply with the prohibition of discrimination in beneficiary enrollment. MCNA does not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll on the basis of health status or need for health care services, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>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.</p> <p>MCO:</p> <ul style="list-style-type: none"> a. The notice shall include: <ul style="list-style-type: none"> 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. <p>PAHP:</p> <ul style="list-style-type: none"> a. The notice shall include: <ul style="list-style-type: none"> 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. <p style="text-align: right;">42 CFR §438.56(d)(5)</p> <p>MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Enrollment policies and procedures • Member notification letter template <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.404LA Involuntary Disenrollment. Pg 2, para 2 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Discuss and decide.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	9	Total Score	=	9	
Total Score ÷ Total Applicable						=	100%



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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. <div style="text-align: right;">42 CFR §438.100(a)(1) 42 CFR §457.1220</div> 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: <ul style="list-style-type: none"> Member rights policy Evidence as Submitted by the MCE: <ul style="list-style-type: none"> 4.100LA Member Rights and Responsibilities Page 1, Paragraph 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: It is the policy of MCNA’s Member Services Department to inform members of their rights and ensure members are treated in a way that protects their rights. The member’s Rights and Responsibilities will be communicated to them and will be made available to the Louisiana Department of Health.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
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. <div style="text-align: right;">42 CFR §438.100(a)(2) 42 CFR §457.1220</div> MCO Contract: 2.13.1.1 PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and Procedures Provider materials, such as the provider manual, provider contract, and provider training materials Employee training materials Auditing/oversight mechanisms Grievance log over the time period of review with member rights grievances Evidence as Submitted by the MCE: <ul style="list-style-type: none"> LA Member Handbook Version 2.3 Page 25 – 26 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 4.100LA Member Rights and Responsibilities Page 1, Paragraph 2 Provider Manual Page 70 LA Training Contract <p>Additional Documentation:</p> <ul style="list-style-type: none"> Member Hotline F.O.R.C.E. Factors Guide Employee Trend Log 	
<p>MCE Description of Process: MCNA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. MCNA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. MCNA did not receive any member rights grievances during the timeframe. Attached are the LA Training contracts showing that we have them review the Member Handbook which is where they review the Member Rights and Responsibilities.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Specific Rights		
<p>3. The MCE complies with the requirements listed in the Member Rights Checklist.</p> <p style="text-align: right;">42 CFR §438.100(b-d) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and Procedures Member materials, such as the member handbook HSAG will also use the results of the Member Rights Checklist <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 4.100LA Member Rights and Responsibilities Page 1, Paragraph 1 LA Member Handbook Version v2.3 Pages 2, 40 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: It is the policy of MCNA’s Member Services Department to inform members of their rights and ensure members are treated in a way that protects their rights.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
General Rule		
<p>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.</p> <p>a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO.</p> <p>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.</p> <p>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.</p> <p>d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.</p> <p style="text-align: right;">42 CFR §438.224 42 CFR §457.1110</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 7.400 HIPAA Compliance Program, Page 8 • Provider Manual Page 32, 1st bullet • Safe and Secure with Me Annual 2024 Employee Training Outline 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E</p> <p>MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> • 12.200 Information Data Protection & Security Omnibus, pages 25-29 	
<p>MCE Description of Process: MCNA has implemented policies and procedures that ensures MCNA providers, MCNA employees, and MCNA plan sponsors, MCNA Business associates may use PHI/IIHI for treatment, payment and health care operations. Use of information applies to internal sharing or utilization of PHI/IIHI. Disclosure applies to the release of PHI/IIHI to non-MCNA providers or entities and is restricted. MCNA provides and makes available to dental providers only that information which is required in the performance of duties and responsibilities in the provision of health care and services to members. We ensure that required and necessary member information is available to health care professionals in the provision of proper care, avoid disclosing or requesting more member information than needed in the performance of duties, and enforce our commitment to member confidentiality. We take the appropriate steps to disclose only the minimum amount of PHI/IIHI necessary to accomplish the particular use or disclosure. MCNA educates members about our notice of privacy practices through the MCNA member handbook. The notice of privacy practices are also posted on MCNA’s website. MCNA provides patients with the right to obtain a written notice explaining how MCNA will use and disclose their information, the right to access their medical information, the right to request that certain information be restricted from use or disclosure for purposes of treatment, payment, and health care operations, the right to request that information be communicated in particular ways, the right to refuse to authorize the release of PHI/IIHI for purposes not related to treatment, payment or health care operations or those required by law.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Use and Disclosure of PHI		
<p>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:</p> <p>a. To the individual.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506.</p> <p>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).</p> <p>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.</p> <p>e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510.</p> <p>f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g).</p> <p style="margin-left: 40px;">45 CFR §164.502(a)(1-3) 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</p> <p>MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 7.400 HIPAA Compliance Program, Page 4 Section I-II 7.101b Employee Privacy Awareness, Page 1 7.408 Business Associate Agreement Policy Fiserve-Amendment 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> LA Training Contract (identified in virtual review) Dental Admin Services Agreement (identified in virtual review) 	
<p>MCE Description of Process: MCNA ensures that it has Business Associate Agreements with all associates that outline the permitted uses of PHI in accord with the 45 CFR 160. All staff completes the mandatory HIPAA training on privacy laws and MCNA policies and procedures.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI:</p> <p style="margin-left: 20px;">a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528.</p> <p style="margin-left: 20px;">b. When required by the Secretary to investigate or determine the MCE’s compliance with 45 CFR §160 subpart C.</p> <p style="margin-left: 100px;">45 CFR §164.502(a)(2-4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C</p> <p>MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.400 HIPAA Compliance Program, Page 4 Section C • 7.402 Accounting of Disclosures Page 1-2 • 7.502 Granting Access to Inspect and Obtains a Copy Page 1 • DASA FiServv Amendment 1 to MSA and BAA 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA’s Privacy Officer is responsible for receiving and processing requests for access to PHI by individuals and will respond to such request within 30 days after receipt of the request. If an individual specifically requests electronic access to PHI that is maintain electronically, MCNA will provide the individual with access to the information in the requested electronic form and format. If the PHI is not readily producible in electronic form and format, then MCNA will provide it in an agreed upon alternative, readable electronic format. If the individual refuses to accept any of the electronic formats that are readily producible, then MCNA may provide the individual with a readable hard copy of the PHI.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
Minimum Necessary		
<p>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 necessary to accomplish the intended purpose of the use, disclosure, or request.</p> <p style="text-align: right;">45 CFR §164.502(b) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Three examples of requests for PHI from another covered entity (e.g., member’s previous MCE, dental benefits administrator, provider) <p>Evidence as Submitted by the MCE</p> <ul style="list-style-type: none"> • 7.400 HIPAA Compliance Program Page 4 Section II A-B <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Safe and Secure with Me Annual 2024 Employee Training Outline (identified in virtual review) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA providers and employees will make reasonable efforts to limit the PHI/IIHI requested, used, or disclosed to the minimum necessary to accomplish the patients care. MCNA will identify those in its workforce who need access to PHI/IIHI and limit access based on job scope and the need for the information. MCNA did not receive any request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>8. Minimum necessary does not apply to:</p> <p>a. Disclosures to or requests by a health care provider for treatment.</p> <p>b. Uses or disclosures made to the individual.</p> <p>c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.400 HIPAA Compliance Program Page 4, Section II C1-5 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160.</p> <p>e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a).</p> <p>f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502.</p> <p style="margin-left: 40px;">45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> • 7.602 Minimum Necessary PHI, Page 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Safe and Secure with Me Annual 2024 Employee Training Outline (identified in virtual review) 	
<p>MCE Description of Process: MCNA provides training and education to employees that includes uses and disclosures, and requests for PHI as a part of the necessary information to provide health care and services. Employees request only the minimum amount of member health information necessary to accomplish the specific purpose of the request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Use and Disclosures Requiring Authorizations		
<p>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.</p> <p>a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>entity provides the individual with a copy of the signed authorization.</p> <p style="text-align: right;">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</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 7.400 HIPAA Compliance Program, page 6, Section VIII MCNA_M_USE_DISCLOSURE_FORM[1.0] <p>Additional Documentation:</p> <ul style="list-style-type: none"> Safe and Secure with Me Annual 2024 Employee Training Outline (identified in virtual review) Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 MCNA only had one example. See PHI Request Example 1 	
<p>MCE Description of Process: If the request is focused on a particular use or disclosure, an authorization must be specific with regard to the information to be disclosed, who may disclose it, and who may receive it. Individuals have a right to request a copy of authorizations signed at to MCNA or one its providers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Privacy Rights		
<p>10. The MCE complies with the member’s right to request privacy protection for PHI and the requirements under 45 CFR §164.522.</p> <p style="text-align: right;">45 CFR §164.522 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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	<p>request and evidence to support completion of the privacy protection request</p> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> LA Member Handbook Version 2.3 Page 26 Policy 7.400 HIPAA Compliance Program, page 8, section XIII - Member Rights Regarding PHI/IIHI, 1-5. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Safe and Secure with Me Annual 2024 Employee Training Outline (identified in virtual review) Step action Use and Disclosure of Protected Health Information Authorization Form (submitted for another element) 	
<p>MCE Description of Process: MCNA adheres to HIPAA requirements that provide an individual with the right to request restrictions to the use and disclosure of his or her protected health information. Requests for PHI Restrictions from members are forwarded to the Privacy Officer. The Privacy Officer maintains a tracking mechanism for such requests, identifies applicable HIPAA regulations, and initiates a process to restrict or not to restrict based on regulations. The Privacy Officer documents the receipt of the request if it does honor restrictions request; or if it does not honor restrictions request. While MCNA is not required to permit the requested restrictions, it allows the member the option to request a restriction. If MCNA agrees to the requested restriction it will not make uses or disclosures that are inconsistent with such unless such uses or disclosures are mandated by law. The member will be notified in writing if the restriction request will be accepted or denied. MCNA has not received any requests for privacy protection.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>11. The MCE complies with the member’s right to access PHI and the requirements under 45 CFR §164.524.</p> <p style="margin-left: 20px;">a. The MCE acts on a request for access no later than 30 days after receipt of the request.</p> <p style="margin-left: 20px;">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.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.524 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 7.502 Granting Access to Inspect and Obtain a Copy, page 1, 1st paragraph 3rd paragraph & page 2, 4th paragraph PHI Request Examples <p>Additional Documentation:</p> <ul style="list-style-type: none"> Request for Access to Protected Health Information - Version 1.1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA’s Privacy Officer is responsible for receiving and processing requests for access to PHI by individuals and will respond to such requests within 30 days after receipt of the request. If an individual specifically requests electronic access to PHI that is maintain electronically, MCNA will provide the individual with access to the information in the requested electronic form and format. If the PHI is not readily producible in electronic form and format, then MCNA will provide it in an agreed upon alternative, readable electronic format. If the individual refuses to accept any of the electronic formats that are readily producible, then MCNA may provide the individual with a readable hard copy of the PHI.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>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.</p> <ul style="list-style-type: none"> • The MCE acts on the member’s request for an amendment no later than 60 days after receipt of such a request. <p style="text-align: right;">45 CFR §164.526 42 CFR §457.1110(e)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.505 Accepting Requests for Amendments to PHI, Page 2 (MCE stated in virtual review that this serves as process workflow) • Attachment A (Member request form to amend PHI) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Upon receipt of a request for amendment, MCNA’s Privacy Officer will make a determination to accept or deny the amendment after consultation with the appropriate staff, if needed. The Privacy will take action on the request for amendment within 60 days of receipt of the request. If the request is accepted, the privacy officer will make the amendment and notify the individual of the change. If the request is rejected, the Privacy Officer will notify the member in writing of the denial. MCNA Has not received any request to amend PHI. MCNA has not received any request to Amend PHI.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>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.</p> <p style="margin-left: 20px;">a. The MCE acts on the member’s request for an accounting, no later than 60 days after receipt of such a request.</p> <p style="margin-left: 20px;">b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j).</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.402 Accounting of Disclosures, page 1, 3 & 4 Also see attachments (MCE stated in virtual review that this serves as process workflow) Attachment A (Member request form for an accounting of disclosures of PHI) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Upon receipt of a member or member’s authorized representative’s request of an accounting of disclosures, the Privacy Officer will review and process the request. The Privacy Officer will provide a written accounting using an Accounting of disclosures log no later than 60 days after receipt. The Privacy Officer will also document and retain for six years from the date of the accounting; the information required to be included in the accounting. MCNA has not received any accounting of disclosure request.</p>		



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HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Breach of Unsecured PHI		
<p>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.</p> <p style="margin-left: 20px;">a. Breach and unsecured PHI are as defined in 45 CFR §164.402.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.402 45 CFR §164.404(a)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Pages 1-2 Attachment A (Breach notification letter template) Attachment B (Unauthorized disclosure/breach tracking mechanism) <p>Additional Documentation:</p> <ul style="list-style-type: none"> Breach Risk Assessment Template (identified in virtual review) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: MCNA complies with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et seq., and applicable contractual requirements. If, in the		



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<p>applicable state agency’s determination, MCNA has not provided notice in the manner or format prescribed by the HITECH Act, the state agency may require MCNA to provide notice. MCNA did not have any breaches during the period. MCNA’s Privacy Officer will coordinate the appropriate notifications with United Health’s Privacy Office. MCNA has not had any breaches.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p>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.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Pages 1 and attachments • Attachment B (Unauthorized disclosure/breach tracking mechanism) • Breach Risk Assessment Template 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA complies with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et seq., and applicable contractual requirements. If, in the applicable state agency’s determination, MCNA has not provided notice in the manner or format prescribed by the HITECH Act, the state agency may require MCNA to provide notice. MCNA did not have any breaches during the period. MCNA’s Privacy Officer will coordinate the appropriate notifications with United Health’s Privacy Office. MCNA has not had any breaches.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>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.</p> <p style="text-align: right;">45 CFR §164.404(b) 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Pages 2 & page 13 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA’s Privacy Officer will coordinate the appropriate notifications with United Health’s Privacy Office. Notifications to individuals will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach, except when law enforcement requests a delay. MCNA may provide the required information to individuals within the required time period in multiple mailings as the information becomes available. MCNA did not have any breaches during the period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible:</p> <p>a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.</p> <p>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,</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>account number, diagnosis, disability code, or other types of information were involved).</p> <p>c. Any steps individuals should take to protect themselves from potential harm resulting from the breach.</p> <p>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.</p> <p>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.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(c)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Pages 6-7 Attachment B (Breach notification letter template) 	
<p>MCE Description of Process: MCNA will ensure the notice will be written at the appropriate reading level and contains a brief description of: What occurred, including the date of the breach and the date of the discovery of the breach, if known; the types of unsecured protected health information that were involved in the breach. MCNA will not include a listing of the actual protected health information that was breached and should avoid including any sensitive information in the notification; the steps individuals should take to protect themselves from potential harm resulting from the breach; what MCNA is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and contact procedures for individuals to ask questions or learn additional information, which must include a toll-free telephone number, an e-mail address, Web site, or postal address. With respect to indicating in the notification the types of protected health information involved in a breach, we emphasize that this provision requires covered entities to describe only the types of information involved. Thus, MCNA should not include a listing of the actual protected health information that was breached (e.g., list in the notice the individual’s social security number or credit card number that was breached) and generally should avoid including any sensitive information in the notification itself. The notice will avoid any extraneous information and may be translated. MCNA did not have any breaches.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>18. The notification must be provided in the following form:</p> <ul style="list-style-type: none"> 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. <p style="text-align: right;">45 CFR §164.404(d)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Confirmation of first-class mailing <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Pages 2 & page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA will send written notification, in accordance with 45 C.F.R. 164.400-414 through first class mail to the last known address of the individual, the personal representative or the next-of-kin. Notice letters will be in MCNA’s name and on MCNA letterhead, unless otherwise directed. If the individual is known to be <i>deceased</i>, notice will be sent to the last known address of the next of kin or personal representative if this contact information is known and up-to-date. MCNA did not have any breaches</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <ul style="list-style-type: none"> a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>provided by an alternative form of written notice, telephone, or other means.</p> <p>b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must:</p> <p style="margin-left: 20px;">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.</p> <p style="margin-left: 20px;">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.</p> <p>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).</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Page 6 	
<p>MCE Description of Process: MCNA’s Privacy Officer will coordinate the appropriate notifications with United Health’s Privacy Office. Based on the volume of persons for which MCNA does not have good contact , MCNA will send an alternate form of written notification through telephone or other means. When there are more than 10 persons for which MCNA does not have good contact information, details of the breach will be posted on MCNA’s webpage for at least 90 calendar days and include contact information for individuals to call and confirm if their information was contacted. MCNA has not had any breaches during this period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
Required Actions: No action required.		
<p>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).</p> <p style="text-align: right;">45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: MCNA has not had any breaches during this period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>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.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(a-b)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: MCNA’s Privacy Officer will coordinate the appropriate notifications with United Health’s Privacy Office. If the breach involves the unsecured PHI of more than 500 people in a particular state or jurisdiction, MCNA also provides notification to		



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<p>prominent media outlets serving the state or jurisdiction where the individuals reside. (Jurisdiction is defined as a geographic area small than a state such as a county, city or town.) The media notification will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and will include the same information required for the individual notice. MCNA has not had any breaches during the period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary.</p> <p>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.</p> <p>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.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Page 7 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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<p>MCE Description of Process: MCNA’s Privacy Officer will coordinate the appropriate notifications with United Health’s Privacy Office. Notifications to individuals will be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach, except when law enforcement requests a delay. MCNA did not have any breaches.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>d. The MCE must require a business associate to provide the MCE with any other available information that the</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.612 Investigating and Reporting Breaches to HIPAA Privacy Rule, Page 8 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Dental Admin Services Agreement (identified in virtual review) • DASA FiServv Amendment 1 to MSA and BAA (identified in virtual review) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>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.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.410 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>		
<p>MCE Description of Process: As contractually required, MCNA will provide the notice to each of its members upon their enrollment in a State Medicaid or CHIP dental program administered by MCNA and annually thereafter MCNA’s policies and procedures regarding the collection, use and disclosure of member PHI/IIHI, as directed by a State Medicaid or CHIP program. MCNA shall describe, in plain language and in translation as required by the threshold languages list of the states we operate in, its privacy practices, including an individual’s rights related to his or her PHI/IIHI, MCNA’s routine use and disclosure of PHI/IIHI, use of authorizations, internal protection of oral, written and electronic PHI/IIHI within MCNA and protection of information disclosed to business associates. MCNA has not had any breaches reported by a subcontractor.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Notice of Privacy Practices		
<p>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.</p> <p>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).</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c).</p> <p style="margin-left: 40px;">45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 7.400 HIPAA Compliance Program, page 7, Section XII. 7.405 Notice of Privacy Practices Requirements (NPP) Content of Notice, Page 1 	
<p>MCE Description of Process: Upon enrollment, MCNA will notify each of its members MCNA’s policy and procedures regarding the collection, use and disclosure of member PHI. This notification is written in plain language and in translation as required by the threshold languages list of the states we operate in, its privacy practices. The "Notice of Privacy Practices" is also posted on MCNA’s website. The web site informs the member how MCNA uses any information collected on MCNA’s website.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

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

Total Score ÷ Total Applicable	=	100%
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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: <ul style="list-style-type: none"> LA Member Handbook Version 2.3 Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A categories Member Service and Access and Availability. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 25, 1st Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A category Quality of Care and Quality of Services. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
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: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 25, 7th Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows categories Member Service and Referral/Authorizations. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 25, 2nd Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows categories Quality of Care and Quality of Service, Treatment Plans and Referral/Authorizations. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 25, 3rd Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows categories Quality of Care and Quality of Services and Referral/Authorizations. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	
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 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9	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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 25, 4th Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows category Member Service. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	



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Standard II—Member Rights Checklist		
Reference	Required Components	
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: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 25, 5th Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows categories Member Service, Referrals/Authorizations and Access and Availability. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA Member Handbook Version 2.3, Page 26, 7th Bullet Point Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows categories Quality of Care and Quality of Services, Treatment Plans, Access and Availability and Member Service. Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
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 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	<p>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).</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • LA Member Handbook Version 2.3, Page 38 – 40 • Standard II_Member Rights and Confidentiality_Element 3_QIC Member Satisfaction Survey Results • 4.104LA was originally submitted and shows policy of reviewing member grievances for trends and attachment A shows categories Member Service and Quality of Care and Quality of Service. • Standard II_Member Rights and Confidentiality_Element 3_QIC Member Grievances Reporting and Trending • Standard II—Member Rights Checklist and Confidentiality Element 3 DentalTrac Grievance Natures 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Member Information

Standard III—Member Information		
Requirement	Supporting Documentation	Score
Information Requirements		
<p>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.</p> <p><i>“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.</i></p> <p><i>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.</i></p> <p style="text-align: right;">42 CFR §438.10(c)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.301 Distribution of Member Materials Page 1 • Examples of Flesch-Kincaid Grade Level Score • Documentation of Website Accessibility 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA will assist members and potential members with understanding the requirements and benefits of the plan, the availability of information and assistance for persons with limited English proficiency. All English member materials are submitted through a Flesch-Kincaid tool to determine the readability before submission to the plans for approval. All member materials are below a 6th grade reading level.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>2. The MCE uses the definitions for managed care terminology developed by the State including:</p> <p style="margin-left: 20px;">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, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(c)(4)(i) 42 CFR §457.1207</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations, page 9-10 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA includes LDH Terminology in the definitions portion of the policies and procedures.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE uses State-developed model member handbooks and member notices.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. <i>The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p><i>requirements in 42 CFR §438.10 and the written materials requirements.</i></p> <p style="text-align: right;">42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1</p>	<p>appeal notices (include any other template for all State-required model notices)</p> <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> LA Member Handbook V2.3 17.301 Development of Member Materials, page 10 	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Language and Format		
<p>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.</p> <p>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.</p> <p>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.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services.</p> <p>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.</p> <p>e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.</p> <p style="text-align: right;">42 CFR §438.10(d)(3) 42 CFR §457.1207</p> <p>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</p>	<ul style="list-style-type: none"> • Mechanisms to ensure taglines are included as part of all critical member materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 17.301 Development of Member Materials • LA Member Handbook (Spanish and Vietnamese) • LA Member Handbook, Page 3 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Standard III Element 4_ MEMBER-ACCESS-NOTICE[1.2] this document is sent with all member materials including the Member Handbook 	
<p>MCE Description of Process: MCNA provides customized state specific materials that are very clear and easy to use that direct the member to relevant, easy to read documents about their plan. There are plenty of references in the member handbook with taglines and accessibility options in multiple languages. The website doesn’t need any authentications so both enrolled and potential enrollees can access the member handbook to access the information.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE makes interpretation services available to each member free of charge.</p> <p>a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL).</p> <p>b. Oral interpretation requirements apply to all non-English languages, not just those that the State</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>identifies as prevalent.</p> <p style="text-align: right;">42 CFR §438.10(d)(4) 42 CFR §457.1207</p> <p>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</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 4.107MIC Call Center Operations Department Overview, page 4 Transperfect Agreement 	
<p>MCE Description of Process: MCNA ensures that members and potential members with communication needs are able to communicate through Transperfect Services (Over-the-phone interpretation) and those members with hearing communication needs are able to communicate through a Telecommunications Device for the Deaf (TTY/TDD) line free of charge.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE notifies members:</p> <p style="margin-left: 20px;">a. That oral interpretation is available for any language and written translation is available in prevalent languages;</p> <p style="margin-left: 20px;">b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and</p> <p style="margin-left: 20px;">c. How to access these services.</p> <p style="text-align: right;">42 CFR §438.10(d)(5) 42 CFR §457.1207</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 17.301 Development of Member Materials Page 4 LA Member Handbook Page 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> See previously submitted Member Handbooks. See titles “Welcome to MCNA,” “Access to Information,” “Interpreters,” Member Rights and Responsibilities, and “Notice of NonDiscrimination.” See Standard III Element 4_ MEMBER-ACCESS-NOTICE[1.2] 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
MCE Description of Process: Members are notified of the availability of auxiliary aids and services and via its website, Member Handbook and other materials.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>7. The MCE provides all written materials for potential members and members consistent with the following:</p> <ol style="list-style-type: none"> 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. <p><i>“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.</i></p> <p style="text-align: right;">42 CFR §438.10(d)(6) 42 CFR §457.1207</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • LA Member Handbook • IA Member Appeal resolution Letter sample 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> LA Member ABD Notice sample 17.301 Development of Member Materials, page 2 &3 <p>Additional Documentation:</p> <ul style="list-style-type: none"> See LA Member Appeal Resolution Letter (Upheld)_LDH approved 07282020 - with readability MCNA submitted the letter to LDH in 2020 with readability include as part of the approval process 	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The portion of the member appeal resolution (upheld) letter tested by the HSAG reviewer exceeded the 6.9 reading grade level. In addition, the follow-up documentation requested by the HSAG reviewer was not provided by MCNA.		
Required Actions: The MCE must ensure that all written materials for potential members and members use easily understood language and format.		
Information for Members		
<p>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:</p> <ol style="list-style-type: none"> Thirty calendar days prior to the effective date of the termination; or Fifteen calendar days after receipt or issuance of the termination notice. <p>PAHP:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow of provider termination process Two examples of MCE-initiated provider terminations, including evidence of the effective 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right;">42 CFR §438.10(f)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.9.2 PAHP Contract: 2.6.11.4 PIHP Contract: 5.14.1.2</p>	<p>from the provider (e.g., letter, email) and the notice sent to affected members</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 11.104 Member Notification of Terminated Providers, Page 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> The LA Termed Providers Doc is a report of all the termed providers, the Provider Term Member Notified List is used to see when member notices should be sent. See Standard III Element 8_insured_14947345_001 Standard III Element 8_insured_10260062_001 Standard III Element 8_Provider Terminations Members Notified List Dashboard Standard III Element 8_LA Termed Providers In 2024 Standard III Element 8_Provider 67906 Involuntary Termination Letter 	



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Standard III Element 8_Provider 27776 Voluntary Termination Notice Standard III Element 8_Provider 29934 Voluntary Provider Termination Notice 	
<p>MCE Description of Process: MCNA’s system runs a weekly report to identify providers pending termination for the previous week. If the provider is a General Dentist, the system will: a. Identify all members that have received services within the last 18 months of the termination date. b. Auto-assign (as applicable) the member to a new primary care dentist within the same office or the closest provider according to the member’s geographic location. c. Generate a letter to the members. If the provider is a Specialist, the system will: a. Use claims data from the past 60 days to populate a list of members seen by the provider. b. Generate the Member Notification of Specialist Termination to those members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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</p> <p>MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <i>MCE Description of Process</i>) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> TPL Third Part Liability Incentive Program Sealants Campaign 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA currently offers 2 Provider Incentive Plans. Third Party Liability Incentive Program and the Sealants Campaign</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Member Handbook		
<p>10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE:</p> <ol style="list-style-type: none"> 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. <p>PAHP:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> i. A current enrollee handbook 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.301 Distribution of Member Materials, Page 2, Page 4 • New Member Welcome Packet Tracking Report • Member Welcome Packet 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207</p> <p>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</p>		
<p>MCE Description of Process: New member materials will be mailed to the member’s payee address provided on the monthly enrollment file to MCNA. MCNA maintains a report that can be used to monitor the mailing of the member Welcome Packets.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The member handbook includes all requirements listed in the Member Handbook Checklist.</p> <p>42 CFR §438.10(g)(2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • LA Member Handbook • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on PAHP’s website <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Standard III_Member Information_Element 11_Member Handbook Adult (page 1-2, 30) 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Standard III_Member Information Element 11_Member Handbook Adult Waiver (1-2, & 31) (Previously submitted) Standard II Element 3_Member handbook-epsdt-en-v2.3 See Page 1 and Page 2, 40. 	
<p>MCE Description of Process: The member handbook was created using the LDH template and satisfies the contractual sections referenced in the requirement. The member handbook is available on the website,</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The LA EPSDT and Adult Denture member handbooks did not include language on how members can obtain information from the State about how to access the services not provided by MCNA because of moral or religious objections nor how transportation is provided to members. MCNA also did not submit evidence that the LA Adult Waiver member handbook was in effect during the review period.</p>		
<p>Required Actions: The MCE must ensure that all member handbooks include all required components listed in the Member Handbook Checklist that enable the member to understand how to effectively use the managed care program.</p>		
<p>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.</p> <p><i>Note: LA defines significant as “important in effect or meaning.”</i></p> <p style="text-align: right;">42 CFR §438.10(g) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <i>MCE Description of Process</i>) Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 11.301 Member Materials, Page 4 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA has not had any significant changes. The policy and procedure for Member materials states MCNAs policy for notification to members on state approved changes to member materials. The relevant passage is highlighted on page 7 of the document in the evidence section.</p> <p>MCNA did not send out member notification according to the requirements for a significant change to the Member Handbook.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Provider Directory		
<p>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.</p> <p style="text-align: right;">42 CFR §438.10(h)(1-2) 42 CFR §457.1207</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 17.301 Development of Member Materials, Page 6-7 • Provider Locator • Provider Directory • LA Member Handbook 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<p>Additional Documentation:</p> <ul style="list-style-type: none"> Standard III-Member Information Element 13 Provider Directory Plaquemines Parish Provider Directory Checklist Element 10d missing the following statement on the online provider locator. (A statement that some providers may choose not to perform certain services based on religious or moral beliefs) Added to the P drive folder 	
<p>MCE Description of Process: The electronic provider directory is an online form and is updated in real time. If a member wishes to print out a paper copy of the provider directory, they can do so from the website, and it will be up to date.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>14. Information included in the MCE’s paper provider directory is updated at least:</p> <p>a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or</p> <p>b. Quarterly, if the MCE has a mobile-enabled electronic provider directory.</p> <p>PAHP:</p> <p>a. <i>The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.</i></p> <p style="text-align: right;">42 CFR §438.10(h)(3)(i) 42 CFR §457.1207</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 11.301 Distribution of Member Materials, Page 4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>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.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. The web-based online version shall be updated in real time, but no less than weekly.</p> <p>PAHP:</p> <p style="margin-left: 20px;">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.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 11.301 Distribution of Member Materials p. 6 paragraph 1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right;">42 CFR §438.10(h)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.1.2 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Provider Locator (Provide Link) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The provider directory is available on the website https://locator.mcna.net/		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Formulary		
<p>17. The MCE makes available in electronic or paper form the following information about its formulary:</p> <p>a. Which medications are covered (both generic and name brand).</p> <p>b. What tier each medication is on.</p> <p style="text-align: right;">42 CFR §438.10(i)(1-2) 42 CFR §457.1207</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable) • Link to the publicly available formulary on the MCE’s website <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • NA 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: NA		
HSAG Findings: The MCE does not utilize a formulary; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right;">42 CFR §438.10(i)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> NA 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: NA		
HSAG Findings: The MCE does not utilize a formulary; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Electronic Materials and Communications		
<p>19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following:</p> <ol style="list-style-type: none"> The format is readily accessible. The information is placed in a location on the MCE’s website that is prominent and readily accessible. The information is provided in an electronic form which can be electronically retained and printed. The information is consistent with the content and language requirements of 42 CFR §438.10. 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. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
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	<div style="text-align: right; margin-bottom: 10px;"> 42 CFR §438.10(c)(6) 42 CFR §457.1207 </div> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 11.301 Distribution of Member Materials, page 5-6 New Member Welcome Packet <p>Additional Documentation:</p> <ul style="list-style-type: none"> Standard III_Member Information_Element 19_Website Paper version and 5 business days. This is a screenshot of what is on the website www.mcnala.net website. 	
<p>MCE Description of Process: MCNA will assist members and potential members with understanding the requirements and benefits of the plan, the availability of information and assistance for persons with limited English proficiency MCNA has a report that states when the Welcome Packet was mailed. Please see the attached report.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The additional documentation requested by the HSAG reviewer was not provided by MCNA.</p>		
<p>Required Actions: The MCE must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it within five business days.</p>		

Results for Standard III—Member Information							
Total	Met	=	14	X	1	=	14
	Not Met	=	3	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	17	Total Score	=	14	

Total Score ÷ Total Applicable	=	82%
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Member Handbook Checklist

MCNA submitted the EPSDT Member Handbook, Adult Member Handbook, and the Louisiana Adult Intermediate Care Facilities/Intellectual or Developmental Disabilities (ICF/IDD) Program Member Handbook (which is not applicable to this review). Findings in the checklist below indicated scoring for the EPSDT and adult handbooks. Despite listing it as evidence in their checklist submission, MCNA did not submit the LA Adult Waiver member handbook and HSAG received no evidence it was in effect during the review period.

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: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 9 – 13 LA Adult Member Handbook Page 9 LA Adult Waiver Member Handbook Page 9 - 10 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 2 LA Adult Member Handbook Page 2 LA Adult Waiver Member Handbook Page 2 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> NA, page4 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	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 <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 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. <i>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.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • LA EPSDT Member Handbook Page 25 • LA Adult Member Handbook Page 16 • LA Adult Waiver Member Handbook 	
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. <i>The PIHP must also include procedures for plan of care development.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 22 LA Adult Member Handbook Page 12 LA Adult Waiver Member Handbook Page 19 	
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	8. The extent to which, and how, after-hours care is provided. Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 21 LA Adult Member Handbook Page 8 LA Adult Waiver Member Handbook 19 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 21 LA Adult Member Handbook Page 13 LA Adult Waiver Member Handbook Page 14 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 21 LA Adult Member Handbook Page 13 LA Adult Waiver Member Handbook 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 21 LA Adult Member Handbook Page 13 LA Adult Waiver Member Handbook 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
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.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 25 LA Adult Member Handbook LA Adult Waiver Member Handbook 	
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.	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook, Page 16 LA Adult Member Handbook LA Adult Waiver Member Handbook 	
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).	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 25 – 27 LA Adult Member Handbook Page 18 LA Adult Waiver Member Handbook 	



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Reference	Required Components	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 1 LA Adult Member Handbook Page 10 LA Adult Waiver Member Handbook Page 11 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 26 LA Adult Member Handbook Page 17 LA Adult Waiver Member Handbook Page 19 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 28, 31 LA Adult Member Handbook Page 21 LA Adult Waiver Member Handbook Page 21 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 31 LA Adult Member Handbook Page 21 LA Adult Waiver Member Handbook Page 21 	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207	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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 34 LA Adult Member Handbook Page 24 LA Adult Waiver Member Handbook Page 26 	
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: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 32 LA Adult Member Handbook LA Adult Waiver Member Handbook 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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) <i>The MCOs must provide a description of advance directives which includes:</i> <i>The MCO’s policies related to advance directives;</i> <i>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;</i> <i>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</i> <i>Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Reference	Required Components	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2 PIHP Contract: 5.6.1.5, 5.9.2.29	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. <i>For the MCO, this instruction shall be included in all versions of the Member Handbook in English and Spanish.</i> <i>For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 25 LA Adult Member Handbook Page 2 LA Adult Waiver Member Handbook Page 2 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 1 LA Adult Member Handbook Page 4 LA Adult Waiver Member Handbook Page 4 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 37 LA Adult Member Handbook Page 27 LA Adult Waiver Member Handbook Page 29 	



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Reference	Required Components	
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. <i>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.</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 7 LA Adult Member Handbook Page 6 LA Adult Waiver Member Handbook Page 8 	
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. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 6 LA Adult Member Handbook Page 4 LA Adult Waiver Member Handbook 	
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. <i>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";</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA EPSDT Member Handbook Page 17 LA Adult Member Handbook Page 11 LA Adult Waiver Member Handbook 12 	
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. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: N/A <ul style="list-style-type: none"> N/A 	



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Reference	Required Components	
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. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
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. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
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. <i>The MCOs must include the date of the last revision;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
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. <i>The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:</i> <ol style="list-style-type: none"> a. <i>A description of covered behavioral health services;</i> b. <i>Where and how to access behavioral health services and behavioral health providers;</i> c. <i>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;</i> d. <i>Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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	<p><i>promoting engagement, resilience, and the strengths of individuals and families; and</i></p> <p>e. <i>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.</i></p>	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	34. <i>The PIHP must include CSoC eligibility requirements;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	35. <i>The PIHP must include Member’s Bill of Rights;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	36. <i>The PIHP must include where to find medical necessity criteria on the Contractor’s website and how to request hardcopies of medical necessity criteria;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	37. <i>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”;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	



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Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. <i>The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. <i>The PIHP must include how to identify and contact the WAAs and FSO;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	



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Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. <i>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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. <i>The PIHP must include the date of the last revision;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. <i>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</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	46. <i>The PIHP must include additional information that is available upon request, including the following:</i> a. <i>Information on the structure and operation of the Contractor;</i> b. <i>Pharmacy location or medication information availability;</i> c. <i>Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and</i> d. <i>Service utilization policies</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • N/A 	



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Provider Directory Checklist

Standard II—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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	
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).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	
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).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	



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Standard II—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 Locator (URL), as appropriate.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	
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.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2	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 <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 and Page 5 	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1		
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	<p>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.</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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	<p>9. The MCE provider directory components are included for the following provider types:</p> <ol style="list-style-type: none"> Physicians, including specialists; Hospitals; Pharmacies; Behavioral health providers; <p>The MCO provider directory components are included for the following provider types <i>and shall be delineated by parish and zip code:</i></p> <ol style="list-style-type: none"> <i>Hospital primary care physician (PCP) groups</i> <i>Clinic settings</i> <i>Home and community-based services</i> <i>Outpatient therapy</i> <i>Residential substance use</i> <i>Youth residential services</i> <i>Inpatient mental health and residential substance use services</i> <i>Federally qualified health centers (FQHCs)</i> <i>Rural health clinics (RHCs)</i> <i>Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.</i> 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Provider Directory Checklist		
Reference	Required Components	
	<p>k. <i>Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.</i></p> <p>l. <i>Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.</i></p> <p>The PAHP provider directory components are included for the following provider types:</p> <p>a. <i>Endodontists</i></p> <p>b. <i>Maxillofacial surgeons</i></p> <p>c. <i>Oral surgeons</i></p> <p>d. <i>Orthodontists</i></p> <p>e. <i>Pedodontists</i></p> <p>f. <i>Periodontists</i></p> <p>g. <i>Prosthodontists</i></p> <p>h. <i>Special needs pedodontists</i></p>	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> Online Provider Directory Print out, Page 7 	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	<p>10. <i>The PAHP provider directory must include the following:</i></p> <p>a. <i>The provider’s cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;</i></p> <p>b. <i>Office hours;</i></p> <p>c. <i>Specific performance indicators;</i></p> <p>d. <i>A statement that some providers may choose not to perform certain services based on religious or moral beliefs;</i></p>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> Online Provider Directory Print out, Page 1 	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	<p>11. <i>The PAHP Provider Directory must also include the following:</i></p> <p>a. <i>Providers arranged by name in alphabetical order</i></p> <p>b. <i>Showing the provider’s specialty,</i></p> <p>c. <i>Providers listed by specialty in alphabetical order by name.</i></p>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Provider Directory Checklist		
Reference	Required Components	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Online Provider Directory Print out, Page 3 	
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. <i>The PIHP Provider Directory must include the following:</i> <ol style="list-style-type: none"> a. <i>Indication of populations served by the provider (e.g., age range of clients) and specialties;</i> b. <i>Identification of any restrictions on the member’s freedom of choice among providers;</i> c. <i>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);</i> d. <i>Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> N/A 	



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Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Definitions		
<p>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:</p> <ol style="list-style-type: none"> 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. <p style="text-align: right;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.115 Emergency Care p. 5 • MCNA EPSDT member handbook p. 23 “When Should I go to the emergency room or call 911” • Provider Master Agreement 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA uses the state’s definition for emergency medical condition in policies and procedures and the member handbook. MCNA’s clinical reviewers rely upon the treating dentist to determine emergent conditions. Clinical reviewers do not determine if the procedure is an emergency or not.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>2. The MCE defines “emergency services” as covered inpatient and outpatient services that are as follows:</p> <p style="margin-left: 20px;">a. Furnished by a provider that is qualified to furnish these services under Title 42.</p> <p style="margin-left: 20px;">b. Needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 5 MCNA member handbook, page 23, “What if I have an emergency?” MCNA provider manual p. 42 & 44 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA uses the state’s definition for emergency services and ensures that members have access to emergency dental care, within and outside the MCNA’s service area, without prior authorization, to services in accordance with contractual requirements. Health plans are responsible for coordinating with emergency physicians or other providers treating the member and for payment of treatment provided by emergency physician and other medical providers. MCNA’s Case Management team coordinates care for hospitalization with the member’s health plan as needed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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 circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 5 MCNA Member Handbook, page 23 “What if I have a dental emergency” 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA uses the state’s definition for poststabilization care services. Health plans are responsible for coordinating with emergency physicians or other providers treating the member and for payment of treatment provided by emergency physician and other medical providers. MCNA’s Case Management team coordinates care for hospitalization with the member’s health plan as needed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Coverage and Payment		
<p>4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE.</p> <p style="text-align: right;">42 CFR §438.114(c)(1)(i) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 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) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 1 Policy 9.110 Provider Reimbursement for Emergency Claims, Page 2 MCNA EPSDT member handbook p. 18, 23 MCNA provider manual p. 40, 41, Three examples of claims are provided however, we were unable to find an example done by an out of network provider. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed. While we capture any claims that have been identified as an emergency, there is not a claims payment algorithm specifically for these claims. This is due to us performing a medical necessity review with the claims that will pend claims for review with documentation. If a procedure would require a pre-authorization in the manual, as long as supporting documentation is submitted along with the claims submission, MCNA will instead do a pre-payment review for the services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE does not deny payment for treatment obtained under either of the following circumstances:</p> <p style="margin-left: 20px;">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.”</p> <p style="margin-left: 20px;">b. A representative of the MCE instructs the member to seek emergency services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.115 Emergency Care p. 1 • Policy 9.110 Provider Reimbursement for Emergency Claims, Page 1, #1Page 2, #8 • MCNA EPSDT member handbook p. 23 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> MCNA provider manual p. 41 – 42 Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim 	
<p>MCE Description of Process: MCNA’s clinical reviewers rely upon the treating dentist to determine emergent conditions. Clinical reviewers do not determine if a procedure is an emergency or not. While we capture any claims that have been identified as an emergency, there is not a claims payment algorithm specifically for these claims. This is due to us performing a medical necessity review with the claims that will pend claims for review with documentation. If a procedure would require a pre-authorization in the manual, as long as supporting documentation is submitted along with the claims submission, MCNA will instead do a pre-payment review for the services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Additional Rules for Emergency Services		
<p>6. The MCE does not:</p> <p>a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.114(d)(1) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 1 Policy 9.110 Provider Reimbursement for Emergency Claims, Page 2 Paragraph #3 and #4 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> MCNA provider manual, page 42 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim 	
<p>MCE Description of Process: MCNA’s clinical reviewers rely upon the treating dentist to determine emergent conditions. Clinical reviewers do not determine if a procedure is an emergency or not. MCNA’s Case Management team coordinates care for hospitalization with the member’s health plan as needed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.114(d)(2) 42 CFR §457.1228</p> <p>MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 2 MCNA EPSDT member handbook, page 23 MCNA provider manual, page44 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> Three case examples of a provider submitted claim for emergency services; MCNA had no examples of post-stabilization claims during the reporting period. 	
MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.114(d)(3) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA</p>	HSAG Required Evidence: <ul style="list-style-type: none"> 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Health plans are responsible for coordinating with emergency physicians or other providers treating the member and for payment of treatment provided by emergency physician and other medical providers. MCNA’s Case Management team coordinates care for hospitalization with the member’s health plan as needed.		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment of Poststabilization Care Services		
<p>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.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 3 Policy 9.110 Provider Reimbursement for Emergency Claims, Page 3 Paragraph 1 No cases of Poststabilization performed during 2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.7.2.1 PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.115 Emergency Care p. 3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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:</p> <p>a. The MCE does not respond to a request for pre-approval within one hour.</p> <p>b. The MCE cannot be contacted.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services • Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE’s response 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>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</p>	<ul style="list-style-type: none"> One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care 	
<p>MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed. MCNA does not have any peer-to peer examples pertaining to post-stabilization</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(iv)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1</p>	<p>42 CFR §438.114(e) 42 CFR §457.1228</p> <p>screenshots of the adjudicated claim (one example must be from an out-of-network provider)</p> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 4 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Three case examples of a provider submitted claim for emergency services; MCNA had no examples of post-stabilization claims during the reporting period. 	
<p>MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed. MCNA does not have any claims for post-stabilization.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
End of the MCE’s Financial Responsibility		
<p>13. The MCE’s financial responsibility for poststabilization care services it has not pre-approved ends when:</p> <ol style="list-style-type: none"> A plan physician with privileges at the treating hospital assumes responsibility for the member’s care. A plan physician assumes responsibility for the member’s care through transfer. An MCE representative and the treating physician reach an agreement concerning the member’s care. The member is discharged. <p style="text-align: right;">42 CFR §422.113(c)(3)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.115 Emergency Care p. 4 Policy 9.110 Prvider Reimbursement for Emergency Claims, page 2 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1	42 CFR §438.114(e) 42 CFR §457.1228	
MCE Description of Process: Health plans are responsible for coordinating post-stabilization care with the treating provider and for payment of post-stabilization services. MCNA’s Case Management team coordinates care for post-stabilization services with the member’s health plan as needed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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

Total Score ÷ Total Applicable	=	100%
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Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
Delivery Network		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(b)(1) 42 CFR §457.1230(a)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 10.104LA Network Adequacy. Pg 2, “<i>Cultural Competency</i>” section • 5.105LA Availability & Accessibility of Services. Pgs 2/3, <i>Cultural Competency</i>” section • Master Provider Agreement <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Narratives • Standard V Element 1_LA Linguistic Report by County 2024 Percentages • Standard V Element 1_LA Linguistic Report by County 2024 Counts 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Standard V Element 1_MY2023 Analysis Year 2024 LA CAHPS Analysis Standard V_Element 1_LA 2024 QAPI Evaluation Standard V Element 1_Provider Manual Section 15.6-Availability and Coordination of Linguistic Services 	
<p>MCE Description of Process: MCNA maintains a network of credentialed providers with written agreements to ensure timely access to all covered services. The network complies with ADA standards for physical accessibility and includes provisions for culturally competent care, including free interpreter services for members with limited English proficiency. MCNA monitors network adequacy and accessibility through credentialing, site visits, quality improvement activities, and member feedback to ensure equitable access for all members, including those with disabilities.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA did not provide evidence that it monitored its provider network’s capabilities to ensure adequate access to members with physical disabilities.</p>		
<p>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 physical disabilities.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(b)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Coverage/authorization guidelines <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Not applicable to dental 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p>MCE Description of Process: This element is <i>not applicable</i> to Dental.</p>		



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
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.		
<p>3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.</p> <p style="text-align: right;">42 CFR §438.206(b)(7) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Not applicable to dental 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: This element is <i>not applicable</i> to Dental.		
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.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(b)(3) 42 CFR §457.1230(a)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis • Coverage/authorization guidelines <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 3.206 Second Opinion. Pg 1, policy section 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> MCNA_mh-la-epsdt-en-v2.3. Pg 20 (What is a Second Opinion) section <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narrative Standard V Element 4_Member Handbook EPSDT Section 10.13-Second Opinion] Provider Manual (page 39) 	
<p>MCE Description of Process: MCNA directs the provider to discuss all aspects of a member’s treatment plan with the member and parent/guardian prior to beginning treatment. If the member or parent/guardian indicates they would like a second opinion, the provider should let them know that MCNA will have to authorize the second opinion visit to a provider in the MCNA network.</p> <p>If no appropriate provider is available within the network to provide the second opinion, MCNA will cover the cost of seeing a non-network dentist. The provider must provide copies of the chart, radiographs, and any other information to the non-network dentist performing the second opinion upon request.</p> <p>Members interested in a second opinion are directed to contact the Member Hotline for direct, further assistance.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(b)(4) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Network adequacy monitoring mechanisms Three examples of executed single case agreements <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 10.104LA Network Adequacy. Pg 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 5.201MIC Letter of Agreement MCNA_mh-la-epsdt-en-v2.3. Pg 16 (What if I choose to go to a dentist that is out of MCNA’s network?) section LOA Examples <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narrative Standard V Element 5[Screenshot DT LOA Location] Standard V Element 5-[LOA CARC Indicator] Standard V Element 5_[LOA Claim] Standard V Element 5_[LOA2Claim] 	
<p>MCE Description of Process: If there are no contracted MCNA network general dentists or pediatric dentists available to treat MCNA members within a geographic area, MCNA will process an out-of-network referral. We will initiate the process with select dentists in the area and advise them of the guidelines for payment. All out-of-network treatment must be pre-authorized unless for emergency treatment services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(b)(5) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Claims processing guidelines Member materials, such as the member handbook Provider materials, such as materials on the MCE’s website 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	<ul style="list-style-type: none"> Three examples of executed single case agreements <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 10.104LA Network Adequacy. Pg 2 3.206 Second Opinion. Pg 1, policy section <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narratives Standard V- Element 6 [Member Handbook Citation - no cost].png Standard V_Element 6_[provloaltr] Standard V Element 6_[provloaltr2.....] Standard V Element 6_[provloaltr1.....] Standard V Element 6_[provloaltr3.....] 	
<p>MCE Description of Process: MCNA requires no cost sharing with Members whether they are receiving in-network or out-of-network covered services. MCNA’s LOA specifies that there will be no costs to the Member and that the provider should seek compensation solely from MCNA.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p><i>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]</i></p>		
Timely Access		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Network analysis (e.g., appointment standards) HSAG will also use the results of the Access Standards: Appointment Times Checklist <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 10.104LA Network Adequacy. Pg 1, para 3 LA Provider Portal Availability and Accessibility Survey <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narratives Standard V Element 7[P&P 5.105LA - Availability and Accessibility of Services].pdf Provider Manual provision (page 31) Standard V Element 7_Appt.AvailSurveyResults Standard V Element 1_MY2023 Analysis Year 2024 LA CAHPS Analysis Standard V-Element 8 [Appointment Availability Survey Results] 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA ensures timely access to care by requiring its network providers to meet Louisiana Department of Health (LDH) standards for appointment availability. These include urgent care within 24 (without Pre auth)–48 hours (with Pre auth needed), primary dental care within 30 days, and follow-up care within 30 days of assessment. MCNA monitors compliance through annual access survey, and member complaint tracking, and implements corrective action plans when standards are not met.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The Appointment Times Checklist was also used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified. Specifically, MCNA’s LA Provider Portal—Availability and Accessibility Survey demonstrated noncompliance for the following appointment time standards: primary dental care and follow-up primary care dental services, referrals to participating specialists, and referrals to hospital and emergency services.</p>		
<p>Required Actions: The MCO 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.</p>		
<p>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)</p> <p>MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 5.105LA Availability & Accessibility of Services. Pg 2, para 1 • LA Provider Portal Availability and Accessibility Survey <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Narratives • Standard V _Element 8 _[AccessSurvey] 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Standard V Element 8_Appointment Availability Survey Results Standard V_Element 1_LA 2024 QAPI Evaluation 	
<p>MCE Description of Process: MCNA prohibits providers from discriminating against our Members, including by offering less or different hours than they would a patient that has a commercial plan. MCNA. MCNA monitors Member complaints and will take corrective action when necessary. MCNA is currently revising our Provider Manual and Orientation Manual to make this requirement more explicit to Participating Providers. Effective 01/01/2025, MCNA updated our Accessibility and Availability Survey to ensure this requirement is met and that we can take corrective action when necessary.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA provided evidence of site visit audits; however, the MCE stated that the 2024 site visit audit tool did not contain the requirements for this element.</p>		
<p>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.</p>		
<p>9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Results of provider monitoring mechanisms Audit or secret shopper results/reports <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 4.700MIC Provider Hotline, page 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narratives Standard V Element 9_4.115MIC Monitoring Member Hotline Performance 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Standard V- Element 9 4.107MIC Call Center Operations Department Overview, bottom of page 2 and top of page 3 has the hours and after hours language Standard V- Element 9-[Provider Manual Citation on Member Hotline] Standard V Element 9 QIC Member Satisfaction Survey Results Provider Monitoring Mechanism S5 E9 MSR Audit Sheet Aug Week 1 	
<p>MCE Description of Process: Members can access support at any time through MCNA’s toll-free number, 1-855-702-6262, which connects them to qualified staff for assistance with urgent needs. MCNA ensures that medically necessary services covered under the contract are available 24 hours a day, seven days a week. Emergency dental services do not require prior authorization and are accessible through direct provider care or coordinated arrangements, ensuring continuous access to urgent care as required by LDH and federal regulations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers.</p> <p>a. The MCE monitors network providers regularly to determine compliance.</p> <p>b. The MCE takes corrective action if there is a failure to comply by a network provider.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 5.105LA Availability & Accessibility of Services. Pg 1. Pg 2, para 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> Narratives Standard V Element 8 [Appointment Availability Survey Results] Standard V Element 1_LA 2024 QAPI Evaluation Standard V Element 8 [SiteContact] 	
<p>MCE Description of Process: MCNA monitors provider compliance with timely access standards through the LA Provider Portal – Availability and Accessibility Survey. This survey is conducted at the access point level (each provider at each facility), is repeatable every 365 days, and allows up to two skips. Survey results consistently show high compliance, with scores ranging from 96–99%, and to date, no corrective action plans have been necessary.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Access and Cultural Considerations		
<p>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.</p> <p style="text-align: right;">42 CFR §438.206(c)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.4.1.11 PAHP Contract: 2.1.2 PIHP Contract: 5.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 5.105LA Availability & Accessibility of Services. Pgs 2/3, <i>Cultural Competency</i>” section • Provider Agreement page 14 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Narratives • Standard V Element 11-[Screenshot from Provider Locator] • Standard V Element 11-[Screenshot from Provider Locator] • Standard V Element 11-[Screenshot from Provider Locator] • Standard V Element 1 _LA Linguistic Report by County 2024 Percentages • Standard V _Element 1 _LA Linguistic Report by County 2024 Counts • Standard V Element 1 _MY2023 Analysis Year 2024 LA CAHPS Analysis • Standard V _LA 2024 QAPI Evaluation 	
<p>MCE Description of Process: MCNA will ensure that its providers will comply with the requirements of the Americans with Disabilities Act (ADA), including, but not limited to, providing physical access for Medicaid members with disabilities. MCNA will ensure that its Provider Network is responsive to the linguistic, cultural, and other unique needs of its members including disabled individuals, and other special needs populations. This includes the capacity to communicate with members with limited proficiency in English, when necessary, as well as those who are deaf or hearing impaired. MCNA monitors the provision of care to these members through provider site audits, member complaints, and analysis of member demographic information from claims data.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
Accessibility Considerations		
<p>12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(c)(3) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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, 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 10.502LA Provider Contract Requirements. Pg 1, bullet #4 Fac#72551 Provider Locator tool <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narratives Standard V Element 12_[AccessSurvey].png Standard V Element 12-[Screenshot from Provider LocatorLDC] 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Standard V Element 12-[Screenshot from Provider LocatorNewOrleans CDC).png] Standard V Element 12-Screenshot from Provider LocatorPediatric..... Standard V Element 1_LA 2024 QAPI Evaluation 	
<p>MCE Description of Process: MCNA ensures that network providers offer physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. In compliance with the Americans with Disabilities Act (ADA), MCNA requires that all provider facilities be accessible and adequately equipped. Compliance is monitored through annual availability and accessibility surveys, member feedback, and the Access to Care tab within MCNA’s DentalTrac (DT) system, which captures and tracks all ADA-related requirements. This information is also relayed to MCNA’s public-facing provider locator tool to help members identify accessible providers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA did not provide evidence that it ensured, through monitoring and data analysis, that network providers provided physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p>		
<p>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.</p>		
Basic Rule		
<p>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).</p> <p>a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>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.</p> <p>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.</p> <p>PIHP</p> <p>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 operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population).</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 10.104LA Network Adequacy. Bottom of page 2 Network Analysis Reports (220 MCNA 2024 SA1 Resubmit 1; 220 MCNA 2024 SA2) <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narratives Standard V Element _13_Vc_[220 MCNA 2024 SA1 Resubmit 2 (3)] Standard V Element _13_Vc_[225 MCNA 2024 Q4] Standard V 13_Vc_[225 MCNA 2024 Q3] Standard V 13_Vc_[225 MCNA 2024 Q2] Standard V Element _13_Vc_[225 MCNA 2024 Q1] Standard V Element _13_Vc_[220 MCNA 2024 SA2 (1)] 	
<p>MCE Description of Process: MCNA provides assurances to the State and submits supporting documentation demonstrating its capacity to serve the expected enrollment in its service area in accordance with 42 CFR §438.207. This includes compliance with access standards outlined in §438.68 and §438.206(c)(1). MCNA meets these requirements through its Network Adequacy and Provider Network Development and Management policies, regular submission of Network Adequacy Reports, and ongoing monitoring of provider capacity and geographic distribution. These efforts are supported by provider data captured in DentalTrac, detailed in the Provider Manual, and reinforced through provider orientation and contractual obligations outlined in the Product Attachment to the Provider Agreement.</p>		



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA’s Time/Distance Checklist was also used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified.</p>		
<p>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).</p> <p>a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:</p> <ul style="list-style-type: none"> 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. 		
Timing		
<p>14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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. <p style="text-align: right;">42 CFR §438.207(c) 42 CFR §457.1230(b)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 10.300LA Provider Network Development and Management Program. Pg 1, policy section <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Narratives 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2	<ul style="list-style-type: none"> 10.300LA Provider Network Development and Management Standard V Element 14_[0220 Upload History] Standard V Element 14_[0225 Upload History] 	
<p>MCE Description of Process: In accordance with 42 CFR §438.207, MCNA submits semi-annual Network Adequacy Reports to the Louisiana Department of Health (LDH), demonstrating its capacity to serve the expected enrollment across all 64 parishes. Each submission includes a signed attestation by the Vice President of Network Development affirming that the provider network meets LDH standards as outlined in Report 220 and the DBPM contract. If deficiencies are identified, MCNA includes a corrective work plan and ensures access to services via out-of-network providers as needed, including transportation and lodging when local access is unavailable.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Exceptions Process		
<p>15. To the extent the State permits an exception to any of the provider-specific network standards,</p> <p>MCO:</p> <p>a. <i>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.</i></p> <p>PAHP:</p> <p>a. <i>Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Network monitoring report(s) Exceptions requested by the MCE, if applicable Exceptions approved by the State, if applicable <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 10.104LA Network Adequacy 10.103LA Exception Justification – Attachment A Network Adequacy Reports Exception Request 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <p>a. <i>Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.</i></p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b)</p> <p>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</p>		
<p>MCE Description of Process: The Network Development Team conducts a market analysis to identify available Medicaid dental providers, including general, pediatric, and specialty care. If the number of providers does not meet time and distance access standards, the Network Specialist documents the issue in the Exception Justification spreadsheet. Justifications fall into four categories: all local providers are already contracted (insufficient providers), no providers exist in the area (no providers), members typically seek care in another parish (patterns of care), or an in-network provider is certified to offer equivalent services (alternate provider). In all cases, the Network Development Team will attempt to contract with the next available provider within a 90-mile radius.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard V—Adequate Capacity and Availability of Services						
Total	Met	8	X	1	=	8
	Not Met	=	5	X	0	=
	Not Applicable	=	2			
Total Applicable	=	13	Total Score	=	8	

Total Score ÷ Total Applicable	=	62%
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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. <i>MCO:</i> a. <i>PCP appointments are available as follows:</i> i. <i>Non-urgent sick primary care: 72 hours</i> ii. <i>Non-urgent routine primary care: 6 weeks</i> <i>PAHP:</i> a. <i>Primary dental care: within 30 days</i> b. <i>Follow-up dental services: within 30 days after assessment</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 5.105LA Availability and Accessibility of Services, Page 1, 3rd paragraph LA Provider Manual MCNA_la-provider-orientation-v2.0 LA Provider Portal - Availability and Accessibility Survey Louisiana Provider Agreement and Attachment 	
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. <i>MCO:</i> a. <i>For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide:</i> b. <i>Specialist appointments: one month</i> c. <i>Non-urgent routine behavioral health care: 14 days</i> d. <i>Urgent non-emergency behavioral health care: 48 hours</i> e. <i>ASAM Level 3.3, 3.5, and 3.7: 10 business days</i> f. <i>Residential withdrawal management: 24 hours when medically necessary</i> g. <i>Psychiatric Residential Treatment Facility (PRTF): 20 calendar days</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	<p><i>PAHP:</i></p> <ul style="list-style-type: none"> a. <i>Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:</i> <ul style="list-style-type: none"> i. <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;</i> ii. <i>Primary dental care: within 30 days</i> iii. <i>Follow-up dental services: within 30 days after assessment</i> <p><i>PIHP:</i></p> <ul style="list-style-type: none"> a. <i>Urgent non-emergency behavioral health care: 48 hours</i> 	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 5.105LA Availability and Accessibility of Services, Page 1, 3rd paragraph • LA Provider Manual • MCNA_la-provider-orientation-v2.0 • LA Provider Portal - Availability and Accessibility Survey • Louisiana Provider Agreement and Attachment 	
Hospital and Emergency Services Access Standards		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1</p>	<p>3. <i>MCO:</i></p> <ul style="list-style-type: none"> a. <i>Emergency care: 24 hours, 7 days/week within one hour of request</i> b. <i>Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request</i> c. <i>After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes</i> <p><i>PAHP:</i></p> <ul style="list-style-type: none"> a. <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;</i> 	<p>Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/></p>



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Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	<p><i>PIHP:</i></p> <p>a. <i>Emergent care: 24 hours, 7 days/week within one hour of request</i></p> <p>b. <i>Emergent, crisis or emergency services must be available at all times.</i></p> <p>c. <i>Urgent care: 24 hours, 7 days/week within 48 hours of request</i></p>	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • LA Provider Manual • MCNA_la-provider-orientation-v2.0 • LA Provider Portal - Availability and Accessibility Survey • 5.105LA Availability and Accessibility of Services • Louisiana Provider Agreement and Attachment 	
Prenatal Care and Family Planning Access Standards		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA</p>	<p>4. <i>MCO:</i></p> <p>a. <i>OB/GYN care for pregnant women:</i></p> <p>i. <i>1st trimester: 14 days</i></p> <p>ii. <i>2nd trimester: 7 days</i></p> <p>iii. <i>3rd trimester: 3 days</i></p> <p>iv. <i>High risk pregnancy, any trimester: 3 days</i></p> <p>b. <i>Family planning appointments: 1 week</i></p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/></p>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 	
Office Waiting Times		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: None</p>	<p>5. <i>MCO:</i></p> <p><i>PAHP:</i></p> <p><i>PIHP:</i></p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/></p>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • 	



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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. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i> 2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
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. <i>Acute Inpatient Hospitals</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
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. <i>Laboratory</i> 5. <i>Radiology</i> 6. <i>Pharmacy</i> 7. <i>Hemodialysis Centers</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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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. <i>OB/GYN: 1:10,000</i> 9. <i>Allergy/Immunology: 1:100,000</i> 10. <i>Cardiology: 1:20,000</i> 11. <i>Dermatology: 1:40,000</i> 12. <i>Endocrinology and Metabolism: 1:25,000</i> 13. <i>Gastroenterology: 1:30,000</i> 14. <i>Hematology/Oncology: 1:80,000</i> 15. <i>Nephrology: 1:50,000</i> 16. <i>Neurology: 1:35,000</i> 17. <i>Ophthalmology: 1:20,000</i> 18. <i>Orthopedics: 1:15,000</i> 19. <i>Otorhinolaryngology/Otolaryngology: 1:30,000</i> 20. <i>Urology: 1:30,000</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	22. <i>Adult Physician Extenders: 1:1,000</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	



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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): <i>1: 2,500</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
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: <ul style="list-style-type: none"> • 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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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	<ol style="list-style-type: none"> 1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 3. <i>Primary Dental Services:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles one-way</i> b. <i>Urban Parishes: 10 miles</i> 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
Evidence as submitted by the MCE: <ul style="list-style-type: none"> Standard V Element _13_Vc_[220 MCNA 2024 SA1 Resubmit 2 (3)] Standard V Element _13_Vc_[225 MCNA 2024 Q4] Standard V 13_Vc_[225 MCNA 2024 Q3] Standard V 13_Vc_[225 MCNA 2024 Q2] Standard V Element _13_Vc_[225 MCNA 2024 Q1] Standard V Element _13_Vc_[220 MCNA 2024 SA2 (1)] 		
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	<ol style="list-style-type: none"> 4. <i>Acute Inpatient Hospitals</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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. <i>Laboratory:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 20 miles</i> 6. <i>Radiology:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 20 miles</i> 7. <i>Pharmacy:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i> 8. <i>Hemodialysis Centers:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F	9. <i>OB/GYN:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 10. <i>Allergy/Immunology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist	
Reference	Required Components
PAHP Contract: 2.6.2.6.2 PIHP Contract: None	<ol style="list-style-type: none"> 11. <i>Cardiology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 12. <i>Dermatology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 13. <i>Endocrinology and Metabolism:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 14. <i>Gastroenterology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 15. <i>Hematology/Oncology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 16. <i>Nephrology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 17. <i>Neurology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 18. <i>Ophthalmology:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> 19. <i>Orthopedics:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i>



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Standard V—Access Standards: Time/Distance Checklist	
Reference	Required Components
	<p>20. <i>Otorhinolaryngology/Otolaryngology:</i></p> <p style="margin-left: 20px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;"><i>b. Urban Parishes: 60 miles</i></p> <p>21. <i>Urology:</i></p> <p style="margin-left: 20px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;"><i>b. Urban Parishes: 60 miles</i></p> <p>22. <i>Psychiatrists:</i></p> <p style="margin-left: 20px;"><i>a. Rural Parishes: 30 miles</i></p> <p style="margin-left: 20px;"><i>b. Urban Parishes: 15 miles</i></p> <p>23. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:</i></p> <p style="margin-left: 20px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;"><i>b. Urban Parishes: 60 miles</i></p> <p>24. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:</i></p> <p style="margin-left: 20px;"><i>a. Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;"><i>b. Urban Parishes: 60 miles</i></p> <p>25. <i>Specialty Dental Services</i></p> <p style="margin-left: 20px;"><i>a. Travel distance shall not exceed 60 miles one-way from the enrollee’s place of residence for at least 75% of enrollees.</i></p> <p style="margin-left: 20px;"><i>b. Travel distance shall not exceed 75 miles one-way from the enrollee’s place of residence for all enrollees.</i></p>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • Standard V Element _13_Vc_[220 MCNA 2024 SA1 Resubmit 2 (3)] • Standard V Element _13_Vc_[225 MCNA 2024 Q4] • Standard V 13_Vc_[225 MCNA 2024 Q3] • Standard V 13_Vc_[225 MCNA 2024 Q2]



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<ul style="list-style-type: none"> Standard V Element _13_Vc_[225 MCNA 2024 Q1] Standard VElement _13_Vc_[220 MCNA 2024 SA2 (1)] 	
Licensed Mental Health Specialists		
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	26. <i>Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 	
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. <i>PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization</i> <i>a. Rural and Urban Parishes: 200 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> 	
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	28. <i>ASAM Level 1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 29. <i>ASAM Level 2.1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
PIHP Contract: None	30. <i>ASAM Level 2WM:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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. <i>ASAM Levels 3.1</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	32. <i>ASAM Levels 3.3</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i>	
	33. <i>ASAM Levels 3.5</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i>	
	34. <i>ASAM Levels 3.2-Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	35. <i>ASAM Level 3.7</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	36. <i>ASAM Level 3.7-Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Substance Use Residential Treatment Facilities (pediatric)		
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	37. <i>ASAM Level 3.1</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 38. <i>ASAM Level 3.2 Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 39. <i>ASAM Level 3.5</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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. <i>Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit</i> <i>a. Rural Parishes: 90 miles</i> <i>b. Urban Parishes: 90 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
Behavioral Health Rehabilitation Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	41. <i>Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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. <i>For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	
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. <i>For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):</i> <i>a. Rural Parishes: 90 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • 	



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Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Care Coordination and Services		
<i>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).</i>		
<p>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.</p> <p style="margin-left: 20px;">a. The member is provided information on how to contact their designated person or entity.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(1) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.303 Coordination of Care p. 1 & 3 MCNA does not have an LA Care management program description MCNA member handbook p. 1, 12, 14, & 15 11.304LA Member Assignment to a Primary Care Dentist Screenshot of member identification (ID) card 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Screenshot of fields designating the assigned PCP and assigned case manager 	
<p>MCE Description of Process: Upon enrollment, each Member is assigned a Primary Dental Provider who will provide appropriate and necessary primary dental health care services covered by the member’s plan. The assignment of a member to a PDP is done automatically by MCNA’s DentalTrac™ system and is based on the proximity of the member’s primary residence to the PDP’s dental office. The member may also choose their primary care provider. Members are not required to choose PDP. Claims will be paid to PDPs regardless of whether the PDP is assigned to the member. Members are notified of how to contact their PDP via the member handbook and the Member Services Department. The member’s PDP is displayed in DentalTrac.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE coordinates the services the MCE furnishes to the member:</p> <ol style="list-style-type: none"> 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. <p>MCO:</p> <ol style="list-style-type: none"> a. <i>Coordinate care between network PCPs and specialists, including specialized behavioral health providers;</i> b. <i>Coordinate care for out-of-network services, including specialty care services;</i> 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.303 Coordination of Care p. 1 MCNA does not have an LA Care management program description 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>c. <i>Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;</i></p> <p>d. <i>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.</i></p> <p>PAHP:</p> <p>a. Coordination with the enrollee’s MCO:</p> <p style="margin-left: 20px;">i. <i>for oral health issues exceeding the coverage of the Contract;</i></p> <p style="margin-left: 20px;">ii. <i>for transportation to and from covered dental services; and</i></p> <p style="margin-left: 20px;">iii. <i>regarding value-added dental benefits offered by the enrollee’s MCO.</i></p> <p>PIHP:</p> <p>a. <i>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.</i></p> <p>b. <i>Coordinate care for out-of-network services.</i></p> <p>c. <i>Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.</i></p> <p>d. <i>Coordinate timely with Integrated Medicaid Managed Care Programs and the member’s family following an inpatient, psychiatric residential treatment facility</i></p>	<ul style="list-style-type: none"> Policy 3.303b Continuity of Care and Transition of Care Workflow for coordinating with other MCOs/ PIHPs/PAHPs members requiring health plan assistance Workflow for coordinating with other MCOs/ PIHPs/PAHPs all members Care coordination with fee-for-service Medicaid is not available Workflow for coordinating with community and social support resources <p>Additional Documentation:</p> <ul style="list-style-type: none"> CM Initial Training LA health plan guide CM audit tool Oct 2024 audit Nov 2024 audit Dec 2024 audit Attestation of understanding training related to capitated services CM Coordinator checklist for non-capitated services 	



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Requirement	Supporting Documentation	Score
<p><i>(PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(2) 42 CFR §457.1230(c)</p> <p>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</p>		
<p>MCE Description of Process: MCNA’s Case Management (CM) team reached out to LA MCOs to determine a care coordination plan and contact points. MCOs choose to have MCNA notify them of all their members or their members who require their assistance. After the Dental Health Assessment is completed with the member and the member’s MCO is determined MCNA reaches out to the MCO according to the care coordination plan. MCNA continues to coordinate care with the MCO or fee-for-service for members who require dental treatment covered by the health plan, dental treatment in the hospital as needed, transportation, medical or behavioral health referrals, and for members we have lost contact with.</p> <p>CM determines members who are assisted by a community and social support providers when a provider calls MCNA for assistance, notification from the Louisiana Department of Health, or after the Dental Health Assessment is completed with the member. CM obtains authorization to speak with the community resource to coordinate care as needed. Care coordination with community resources typically includes identifying appropriate dental providers, scheduling appointments, and ensuring all medically necessary services are completed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p>MCO:</p> <p>a. <i>The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> ● <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ● Policy 3.303 Coordination of Care p. 1 & 2 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>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 agencies and require complex coordination of benefits and services.</i></p> <p>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</p>		
<p>MCE Description of Process: MCNA’s CM team reached out to LA MCOs to determine a care coordination plan and contact points. MCOs choose to have MCNA notify them of all their members or their members who require their assistance. Upon referral to MCNA’s CM team, the DHA is completed with the member or responsible party to determine the member’s medical and behavioral diagnoses, medication taken, assistance with social determinants of health needed, dental complaints, MCO, community and social providers, etc. After the Dental Health Assessment is completed with the member and the member’s MCO is determined MCNA reaches out to the MCO or according to the care coordination plan. The MCO is notified of the member’s medical and behavioral diagnoses and immediate dental need. The state is notified upon request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Information Sharing		
<p>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</p> <p>MCO: a. <i>Upon written request</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Workflow for sharing assessment results with the State • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2</p>	<p>42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <ul style="list-style-type: none"> Care management program description Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.303 Coordination of Care p. 1 & 2 Workflow for sharing assessment results with the State Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs MCNA does not have a LA Care management program description Two examples of sharing assessment results with the MCO. MCNA did not receive requests from the state to share assessment results during the audit timeframe. Case notes were provided detailing sharing assessment results with two MCOs. The email notification is not available as the MCNA Case Manager who worked on LA cases during the reporting period is no longer with MCNA. 	
<p>MCE Description of Process: MCNA’s CM team reached out to LA MCOs to determine a care coordination plan and contact points. MCOs choose to have MCNA notify them of all their members or their members who require their assistance. Upon referral to MCNA’s CM team, the DHA is completed with the member or responsible party to determine the member’s medical and behavioral diagnoses, medication taken, assistance with social determinants of health needed, dental complaints, MCO, community and social providers, etc. After the Dental Health Assessment is completed with the member and the member’s MCO is determined MCNA reaches out to the MCO according to the care coordination plan. The MCO is notified of the member’s medical and behavioral diagnoses and immediate dental need. The state is notified upon request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
Required Actions: No action required.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.208(b)(5) 42 CFR §457.1230(c)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.303 Coordination of Care p. 2 Policy Dental Record Review, page 1 MCNA does not have a LA Care management program description MCNA Provider Manual Report 069 MCNA 2024 Q3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA process is to outline the process for conducting dental record reviews to ensure provider compliance with state, federal, and Louisiana Department of Health (LDH) dental record keeping standards and to monitor provider’s compliance with the American Academy of Pediatrics’ (AAPD) Periodicity Schedule.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
Required Actions: No action required.		
<p>6. The MCE ensures that in the process of coordinating care, each member’s privacy is protected in accordance with the</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Requirement	Supporting Documentation	Score
<p>privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.</p> <p style="text-align: right;">42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E</p> <p>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</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.303 Coordination of Care p. 4 & 5 MCNA does not have a LA Care management program description <p>Additional Documentation:</p> <ul style="list-style-type: none"> Safe and Secure with Me (HIPAA) Annual 2025 Safe and Secure with Me (HIPAA) New Hire 2025 UHC Training_Education Policy 	<p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA CMs receive training related to protecting members’ privacy upon hire and annually. Prior to discussing a member’s case, the CM verifies three identifying pieces of information to ensure he or she is speaking with the member or responsible party. If the person calling MCNA is not listed as a responsible party, and the member is unable to communicate, the appropriate documentation is obtained (e.g., Power of Attorney, guardianship papers, etc.). Additional people MCNA has authorization to speak to regarding the member is documented in DentalTrac™ and is accessible to all MCNA employees. Secure email is used when sharing protected health information.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Initial Health Risk Screening		
<p>7. The MCE makes a best effort to conduct an initial screening of each member’s needs within</p> <p>MCO:</p> <p>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.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Initial screening template Initial screening tracking and monitoring mechanisms and subsequent results/reports 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>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.</i></p> <p>PAHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA</p>	<ul style="list-style-type: none"> • HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 4.303LA New Member Contacts Page 2 • MCNA does not have a LA Care management program description • LA BAYOU SCRIPT • Initial screening tracking and monitoring mechanisms and subsequent results/reports (LA Bayou May 2024 Completion Report) <p>Additional Documentation</p> <ul style="list-style-type: none"> • LA Welcome Call Project Script • OHA Documented in DentalTrac • LA Welcome Call Project Process • Training Module for When to Complete OHAs • Blank OHA MCNA • OHAs Completed for 2024 • MCNA_LA-M_GETTING STARTED[1.0] • 2024_05_May LA Bayou OHA Welcome Call Completion Report 	
<p>MCE Description of Process: Care Connections does a Welcome Call each month. This is a manual dial call. When we speak with the member/AR we use the attached script. Then we assist as needed. That may include completing an OHA, it may include a referral to Case Management depending on the conversation.</p> <p>Regarding Initial assessments (OHA), we send the member an OHA in the member handbook, the OHA form is available on our website 24/7.</p>		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p> <p>Recommendations: Although the MCE was able to provide evidence of initial screening attempts, the MCE may consider strengthening the ability to collect and report data on second attempts.</p>		
<p>Required Actions: No action required.</p>		
Comprehensive Assessment		
<p>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.</p> <p>a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate.</p> <p>PAHP:</p> <p>a. <i>The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(c)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions p. 1& 3 MCNA does not have a LA Care management program description Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions contains definition on p. 3. MCNA does not have the definition for LTSS documented. Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions contains the assessment tool on p. 8. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Upon referral to MCNA’s CM team, the DHA is completed with the member or responsible party to determine the member’s preferred contact information and method, PDP, medical and behavioral diagnoses, medication taken, cognitive ability, pain level, assistance with social determinants of health needed, dental complaints, MCO, community and social providers, etc. The information is used to create the member’s care plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Treatment/Service Plan		
<p>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.</p> <p style="text-align: right;">42 CFR §438.208(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Person centered treatment plan template HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions p. 1 MCNA does not have a LA Care management program description Care plan <p>Additional Documentation:</p> <ul style="list-style-type: none"> Care plan 2024 (1) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: After completion of the DHA the CM creates a care plan that includes all dental, medical, behavioral, education, and social determinants of health needs. The care plan is updated after each need is provided for.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>Recommendations: Although the MCE was able to provide evidence of care plan notes in the case management log notes, the MCE may consider the ability to produce an independent treatment/service plan that displays the enrollee’s needs and the progress toward completion.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The treatment or service plan is:</p> <ul style="list-style-type: none"> 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. <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions p. 1 • Items a – b are not in the policy. • MCNA does not have a LA Care management program description • CM Coordinator Job Description • Service plan approval is not required 	



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Mechanisms to actively involve the member and the member’s formal and informal supports in the development of the treatment plan are included in the Description of Process below 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 are included in the Description of Process below <p>Additional documentation:</p> <ul style="list-style-type: none"> CM initial training LA health plan guide Attestation of understanding training related to non-capitated services CM Coordinator checklist for non-capitated services 	
<p>MCE Description of Process: The member or the member’s responsible party, treating dentist(s), and the MCNA CM are involved in the creation and evolution of the care plan. The member or member’s responsible party completes the DHA with the CM. The CM obtains office notes and treatment plans from all dental providers the member has seen in the past year. The care plan is updated based on the information received. The CM speaks to the member or responsible party and the dental offices after each visit. The information is used to update the care plan. Communication is ongoing until the care plan is complete.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The MCE was unable to demonstrate that treatment or service plans were developed by an individual meeting long-term services and supports (LTSS) service coordination requirements or by a person trained in person-centered planning.</p>		
<p>Required Actions: The MCE must research, establish training, and ensure staff members are trained in person-centered planning.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>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).</p> <p style="text-align: right;">42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions p. 1 MCNA does not have a LA Care management program description Care plan and service plan review and revision tracking mechanism are listed in the Description of Process Below 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The member or the member’s responsible party, treating dentist(s), and the MCNA CM are involved in the creation and evolution of the care plan. The care plan is stored in the member’s logs. The member or member’s responsible party completes the DHA with the CM. The CM obtains office notes and treatment plans from all dental providers the member has seen in the past year. The care plan is updated based on the information received. The CM speaks to the member or responsible party and the dental offices after each visit. The information is used to update the care plan. Communication is ongoing until the care plan is complete. Typically, dental care plans are completed within six months.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Direct Access to Specialists		
<p>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.</p> <p style="text-align: right;">42 CFR §438.208(c)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions p. 1 MCNA does not have a LA Care management program description MCNA EPSDT member handbook p. 14 The information is not in MCNA’s provider manual 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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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%
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Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Coverage		
<p>1. The MCE:</p> <p>a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer.</p> <p>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.</p> <p>c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.</p> <p style="margin-left: 40px;">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)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook and benefits grid Utilization Management (UM) program description Coverage guidelines/criteria <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.201LA Authorizations and Adverse Determinations p.1 MCNA EPSDT Member Handbook p. 9 – 11 3.101LA Utilization Management Program Description p. 12 Coverage guidelines are listed in the MCNA Provider Manual p. 79 – 261 and criteria is on p.264 - 272 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA follows the benefits and guidelines provided in the state of LA’s Dental Services Provider Manual. Benefits, limitations, guidelines, and an abbreviated list of clinical criteria are listed in the provider manual. Providers and members may call to request a complete list of clinical criteria. A list of benefits and limitations are also listed in the member handbook. In addition, any request for a member under 21 is reviewed under EPSDT regardless of it being a covered benefit or if benefit limitations are met.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right;">42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Coverage guidelines/criteria <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 4 • 3.101LA Utilization Management Program Description p. 12 • Coverage guidelines are listed in the MCNA Provider Manual p. 79 – 261 and criteria is on p.264 - 272 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA clinical reviewers do not use the member’s diagnosis, type of illness, or condition to deny services. In fact, this information is used to determine if benefits should be extended for a member.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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:</p> <p>MCO, PAHP, and PIHP:</p> <p>a. The services furnished can reasonably achieve their purpose.</p> <p>MCO and PIHP:</p> <p>a. The services supporting individuals with ongoing or chronic conditions or who require long-term services</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Utilization management plan • Member materials, such as the member handbook • Coverage guidelines/criteria <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p.1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>and supports (LTSS) are authorized in a manner that reflects the member’s ongoing need for such services and supports.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10</p>	<ul style="list-style-type: none"> MCNA does not have a utilization management plan MCNA EPSDT Member Handbook p. 9 – 11 Coverage guidelines are listed in the MCNA Provider Manual p. 79 – 261 and criteria is on p.264 – 272 State of LA’s Dental Services Provider Manual 	
<p>MCE Description of Process: MCNA follows the benefits and guidelines provided in the state of LA’s Dental Services Provider Manual. Benefits, limitations, guidelines, and an abbreviated list of clinical criteria are listed in the provider manual. Providers and members may call to request a complete list of clinical criteria. A list of benefits and limitations are also listed in the member handbook. In addition, any request for a member under 21 is reviewed under EPSDT regardless of it being a covered benefit or if benefit limitations are met.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>4. The MCE specifies what constitutes “medically necessary services” in a manner that:</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Member materials, such as the member handbook Provider materials, such as the provider manual 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. Addresses the extent to which the MCE is responsible for covering services that address:</p> <ul style="list-style-type: none"> 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. <p style="text-align: right;">42 CFR §438.210(a)(5)</p> <p>MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 8 • The information is not in the 3.101LA Utilization Management Program Description • MCNA EPSDT Member Handbook p. 18 • MCNA Provider Manual p. 27 - 28 	
<p>MCE Description of Process: MCNA uses the definition provided by the state in the MME Companion Guide. The definition is used by Louisiana licensed dentists to perform clinical review.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Recommendations: HSAG recommends that the MCE revise the 3.201LA Authorizations and Adverse Determinations policy to ensure robust inclusion of all requirements.</p>		
<p>Required Actions: No action required.</p>		
Authorization of Services		
<p>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.</p> <p style="text-align: right;">42 CFR §438.210(b)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing utilization management 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Delegated written contract (for entities responsible for delegated UM functions) Delegation oversight of policies and procedures (e.g., audit results) 	
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.201LA Authorizations and Adverse Determinations p. 1 This information is not in the 3.101LA Utilization Management Program Description This information is not in the coverage guidelines/criteria MCNA does not delegate utilization management activities 	
<p>MCE Description of Process: MCNA does not delegate UM activities. All pre-authorizations (PAs) are reviewed and processed according to our policies and procedures.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Coverage guidelines/criteria Results of inter-rater reliability (IRR) activities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.702 Inter-rater Reliability Audit 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 3.101LA Utilization Management Program Description p. 23 Coverage guidelines are listed in the MCNA Provider Manual p. 79 – 261 and criteria is on p.264 – 272 The 2024 IRR score was 91% <p>Additional Documentation:</p> <ul style="list-style-type: none"> MCNA’s UM team maintains a log of all claims and pre-authorizations that require a second review. Second clinical reviews are needed when the initial review contains an error such as an incorrect CARC. MCNA’s Clinical Research Data Analyst completes an analysis that is presented to the Chief Dental Officer. An example is, “Standard VII_Element 6_ example of monthly analysis of UM reviewers.” The analysis trends at individual clinical reviewers, types of errors made, procedure type, and network. The Chief Dental Officer uses the analysis to identify issues with specific clinical reviewers, create agenda items for the bimonthly clinical reviewer meetings, initiate training for providers, etc. For example, in 2025, it was identified that one of the top denied procedures was scaling and root planning. MCNA located the ADA’s guide for submission of scaling and root planning and began sharing with providers when the office has a high denial rate. This document is “Standard VII Element 6_ADA SRP guideline.” 	



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA conducts an annual inter-rater reliability audit to ensure consistent application of review criteria for authorization decisions. The audit is divided by specialty into three groups (orthodontics, oral surgery, and general dentistry/pediatrics/endodontics/periodontics). Each group receives a minimum of five cases. At least one case is for a member with special healthcare needs. The clinical reviewers are given about two weeks to complete the test. The tests are scored, and a meeting is scheduled to discuss the results. Clinical reviewers are required to score a minimum of 90%. A corrective action plan is implemented for those who do not meet the minimum score requirement.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE consults with the requesting provider for medical services when appropriate.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 10 • 3.101LA Utilization Management Program Description p. 4 • MCNA Provider Manual p. 56 & 59 • Peer-to-peer example. There is only one example available during the reported period. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Workflow for processing PAs 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Clinical reviewers request consults with requesting providers by entering a note on PAs. The UM team contacts the office and schedules the meeting during a mutually agreeable time. The conversation is documented in DentalTrac™.</p>		
<p>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.</p>		
<p>Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.</p>		
<p>8. The MCE authorizes LTSS based on a member’s current needs assessment and consistent with the person-centered service plan.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(iii)</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This is not applicable to dental 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: This is not applicable to dental.</p>		
<p>HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>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.</p> <p>MCO:</p> <p>a. <i>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.</i></p> <p>PAHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.210(b)(3) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 3 • 3.101LA Utilization Management Program Description p. 4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: All clinical decisions made at MCNA are made by licensed Louisiana dentists. If a clinical reviewer does not have the expertise to make a decision, he or she may refer the case to a specialist.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Notice of Adverse Benefit Determination		
<p>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.</p> <p>MCO:</p> <p>a. <i>The MCO shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.</i></p> <p>PIHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 5 • 3.101LA Utilization Management Program Description p. 20 • The provider notice template is on p. 17 of policy 3.201LA Authorizations and Adverse Determinations 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>MCE Description of Process: After the clinical reviewer makes his or her decision on a PA request, the UM Coordinator finalizes the request per the clinical review and sends the request to the print queue. DentalTrac™ creates a NABD for all requests that include a denied procedure. The NABD is mailed to the member and provider if the provider does not have portal access.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Case file review results identified noncompliance with timely provider notification. In the virtual review, MCNA staff described a glitch in its prior authorization (PA) processing system that resulted in noncompliance that has been rectified.</p>		
<p>Required Actions: The MCE must ensure the processing of PA requests includes timely notification of providers.</p>		
<p>11. The MCE defines an adverse benefit determination (ABD) as:</p> <ol style="list-style-type: none"> 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 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 8 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2)</p> <p>MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1</p>		
<p>MCE Description of Process: MCNA uses the adverse benefit determination provided in Amd 2 Attachment B2.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policy submitted did not include the requirements of this element.</p>		
<p>Required Actions: The MCE must revise its policy to define ABDs in accordance with the requirements.</p>		
<p>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 less than requested. The ABD notice includes the following:</p> <p>a. The ABD the MCE has made or intends to make.</p> <p>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,</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 6 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>strategies, or evidentiary standards used in setting coverage limits.</p> <p>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).</p> <p>d. The procedures for exercising the rights specified in 42 CFR §438.402(b).</p> <p>e. The circumstances under which an appeal process can be expedited and how to request it.</p> <p>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.</p> <p>g. The notice must be consistent with the requirements of 42 CFR §438.10.</p> <p style="text-align: right;">42 CFR §438.10 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)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2</p>	<ul style="list-style-type: none"> The ABD notice template is on p. 17 of policy 3.201LA Authorizations and Adverse Determinations Tagline 	
<p>MCE Description of Process: MCNA uses the NABD approved by LDH to notify members and providers of denied requests.</p>		



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<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Case file review results identified noncompliance with member notification and reading grade level. In the virtual review, MCNA staff described a glitch in its PA processing system that resulted in noncompliance that has been rectified.</p>		
<p>Required Actions: The MCE must ensure the processing of PA requests includes timely notification of members, using notices of ABD that meet requirements. Additionally, HSAG recommends that the MCE add functionality to the system that houses and tracks PA requests and resolutions so that users may document that notices of ABD include all requirements and indicate that the reading grade level has been verified.</p>		
Timeframe for Decisions		
<p>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.</p> <p style="text-align: right;">42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 6 • 3.101LA Utilization Management Program Description p. 14 • PA inventory report standard requests • 2024 LA EPSDT, Adult Denture, & Adult Waiver Program KPI Dashboard • 188 MCNA 2024 Q1 	



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: PA requests are loaded in the UM Coordinators’ queue throughout each weekday. At 3 pm, it is the UM Coordinator’s responsibility to check the queue and notify the UM Manager if any PAs are in danger of going out of compliance so that additional intervention may be implemented. At 4 pm, the UM Manager uses the PA inventory report to check to see if any PAs due that day are still pending and notifies the UM Director if any PAs are in danger of going out of compliance so that additional intervention may be implemented.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 6 • 3.101LA Utilization Management Program Description p. 14 • PA inventory report standard requests • 2024 LA EPSDT, Adult Denture, & Adult Waiver Program KPI Dashboard • 188 MCNA 2024 Q1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: PA requests are loaded in the UM Coordinators’ queue throughout each weekday. UM Coordinators and clinical reviewers work on urgent requests first and throughout the day. At 3 pm, it is the UM Coordinator’s responsibility to check the queue and notify the UM Manager if any PAs are in danger of going out of compliance so that additional intervention may be implemented. At 4 pm, the UM Manager uses the PA inventory report to check to see if any PAs due that day are still pending and notifies the UM Director if any PAs are in danger of going out of compliance so that additional intervention may be implemented.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member, or the provider, requests the extension; or</p> <p style="margin-left: 20px;">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.</p> <p style="margin-left: 100px;">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)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 6 • 3.101LA Utilization Management Program Description p. 14 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> MCNA does not have any PAs extended during the audit timeframe The extension notice template is on p. 16 of Policy 3.201LA Authorizations and Adverse Determinations 	
<p>MCE Description of Process: PA requests that include supporting documents or a narrative are sent for clinical review. If information is missing, the UM Coordinator enters a denial reason that details the missing information on the applicable procedure. The member and provider are notified of the missing information via letter or the provider portal. The PA is reviewed and processed once the missing information is received.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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:</p> <p>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</p> <p>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.</p> <p style="text-align: right;">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)</p> <p>MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.201LA Authorizations and Adverse Determinations p. 6 3.101LA Utilization Management Program Description p. 14 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> MCNA does not have any PAs extended during the audit timeframe The extension notice template is on p. 16 of Policy 3.201LA Authorizations and Adverse Determinations 	
<p>MCE Description of Process: PA requests that include supporting documents or a narrative are sent for clinical review. If information is missing, the UM Coordinator enters a denial reason that details the missing information on the applicable procedure. The member and provider are notified of the missing information via letter or the provider portal. The PA is reviewed and processed once the missing information is received.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA).</p> <p>a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.</p> <p style="text-align: right;">42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A)</p> <p>MCO Contract: None PAHP Contract: NA PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Three examples of notice <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> MCNA does not authorize or cover outpatient drugs. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p>MCE Description of Process: MCNA does not authorize or cover outpatient drugs. Receive no reporting from the PBM.</p>		
<p>HSAG Findings: The MCE reported it did authorize outpatient drug decisions; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		



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<p>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.</p> <p style="text-align: right;">42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 5 • MCNA does not terminate, suspend, or reduce previously authorized services. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA does not terminate, suspend, or reduce previously authorized services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>19. The MCE may send a notice not later than the date of action if:</p> <p style="padding-left: 20px;">a. The MCE has factual information confirming the death of a member;</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template(s) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>b. The MCE receives a clear written statement signed by a member that:</p> <p style="margin-left: 20px;">i. The member no longer wishes services; or</p> <p style="margin-left: 20px;">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;</p> <p>c. The member has been admitted to an institution where the member is ineligible under the plan for further services;</p> <p>d. The member’s whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address;</p> <p>e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;</p> <p>f. A change in the level of medical care is prescribed by the member’s physician;</p> <p>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</p> <p>h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i).</p> <p style="text-align: right; margin-right: 50px;">42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii)</p>	<ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.201LA Authorizations and Adverse Determinations p. 5 MCNA does not receive data related to these situations 	



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<p style="text-align: right;">42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3</p>		
MCE Description of Process: MCNA does not receive data related to these situations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>20. The MCE may shorten the period of advance notice to five days before the date of action if:</p> <p style="padding-left: 20px;">a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and</p> <p style="padding-left: 20px;">b. The facts have been verified, if possible, through secondary sources.</p> <p style="text-align: right;">42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 3.201LA Authorizations and Adverse Determinations p. 5 • MCNA does not receive data related to these situations 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: MCNA does not receive data related to these situations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		



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Required Actions: No action required.		
<p>21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim.</p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 9.301 Adverse Determination • Three examples 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: Adverse determination notices including appeal rights are sent to the member and his/her provider of the claim being denied in whole or in part at the time of any action affecting the claim.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>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.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 3.201LA Authorization and Adverse Determinations p. 5 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: In virtual review, staff confirmed there no authorizations that were outside of timeframe.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Compensation for Utilization Management Activities		
<p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>



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Requirement	Supporting Documentation	Score
<p>or entity to deny, limit, or discontinue medically necessary services to any member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27</p>	<ul style="list-style-type: none"> New hire and ongoing training for staff Three examples of staff attestations <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 3.101LA UM Program Description, page 3 <p>Additional Documentation:</p> <ul style="list-style-type: none"> FWA New Hire Training (demonstrated in virtual review) Example 1 Example 2 Example 3 	<input type="checkbox"/> NA
MCE Description of Process:		
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	=	17	X	1	=	17
	Not Met	=	3	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	20	Total Score	=	17	

Total Score ÷ Total Applicable	=	85%
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Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
General Rules		
<p>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.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 10.106LA Provider Selection and Retention, pg 1, para 1 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA’s policy is to review and approve the credentials of individual dental health providers who wish to join or remain in MCNA’s provider network to ensure that they meet MCNA, State, and Federal standards for individual providers, in accordance with 42 CFR 438.214 and LDH contractual requirements. MCNA’s provider network will comply with the State’s credentialing and re-credentialing policy, State policies, Federal laws, and all other applicable requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>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:</p> <ul style="list-style-type: none"> a. Acute; b. Primary; c. Mental health; d. Substance use disorders. <p style="text-align: right;">42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 6.301 Initial Credentialing Application (pages 6-7, procedure section) • 6.401 Re-Credentialing, pages 4-6, procedure section) 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: The MCNA Dental Plans Dental Care Professionals Credentialing Program is comprehensive and provides the oversight and evaluation of Dentists prior to acceptance into, the on-going monitoring and the re-credentialing of, the MCNA Dental Plans Provider network. The Program ensures that the network of Dentists has met the rules, regulations and requirements of the governing Quality Improvement Program and Quality Improvement Committee. These requirements include standards as indicated by: Centers for Medicare and Medicaid Services (CMS), Louisiana Department of Health (LDH), Approved State and Federal Accreditation Organizations o MCNA Dental Plans Credentialing Committee, NCQA, and URAC. The Program is managed by the Credentialing Department within the Quality Improvement Division. The Program is based on processes to evaluate the professional qualifications of Dentists, verification of education and experience, and evaluation of any quality-of-care indicators or cases. The Program includes evaluation of each potential Dentist against established credentialing criteria via an application and verification process, including expedited credentialing of ‘clean’ applicant/provider files and Credentialing Committee review which provides the method for dental care professionals input in the credentialing process. In addition to initial credentialing-approval or denial, the Program also includes activities for re-credentialing, on-going monitoring, and termination of those who no longer meet the criteria for continued participation as a dental care professional in the MCNA network. The Program also allows for expedited credentialing of each potential Dentist recommended by Network Management to meet the business needs of MCNA to facilitate coverage concerns or meet gap exceptions.</p>		
<p>HSAG Findings: The MCE only credentials dental providers; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Nondiscrimination		
<p>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.</p> <p style="text-align: right;">42 CFR §438.214(c) 42 CFR §438.12 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 10.102MIC Provider Contracting Anti-Discrimination. Pg 1, para 1 • 6.104 Non-Discrimination and Credentialing. Pg 1, para 1 • Blank Confidentiality, Conflict & Non-Discrimination Signature Form • Committee Member statements <p>Additional Documentation:</p> <ul style="list-style-type: none"> • The Compliance Department conducts twice annual audits of monthly credentialing committee decisions to ensure that provider discrimination does not occur during the credentialing process for network participation as outlined in our LDH contract requirements, Section 2.6.10.1. Further detail regarding the process is outlined in the scope of audit section of the report. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • Reports covering periods January – June 2024 and July 2024 and December 2024 are attached and labeled as follows: <ul style="list-style-type: none"> – Standard VIII_Element 3 LA Credentialing Non Discrimination Audit Q1 and Q2 2024 – Standard VIII_Element 3 LA Credentialing Non Discrimination Audit Q3 and Q4 2024 	
<p>MCE Description of Process: It is policy of MCNA Dental Plans' Credentialing Program to ensure decisions are made based on the needs of the population served and contractual agreements, which follow Federal (CMS), State and National Accreditation guidelines. MCNA Credentialing Program does not discriminate against any applicant/provider seeking participation in the Network. This includes providers that serve high-risk populations or specialize in conditions that require costly treatment. MCNA complies with any additional provider selections requirements established by the state. No applicant or existing provider shall be denied/terminated from network participation, continued participation or discriminated against based on any of the following: 1. Gender 2. Age 3. Race 4. Creed 5. Color 6. National Origin 7. Ethnic Origin 8. Religious Affiliation 9. Sexual Orientation 10. Disability 11. Nature of Population Served 12. Licensure 13. Gender Identity 14. Certification. If MCNA declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="padding-left: 20px;">a. If the MCE declines to include individual or groups of providers in its provider network, it must give the</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>affected providers written notice of the reason for its decision.</p> <p>b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214.</p> <p style="text-align: right;">42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a)</p> <p>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</p>	<ul style="list-style-type: none"> Mechanism for monitoring for discriminatory practices HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 10.102MIC Provider Contracting Anti-Discrimination, pg 1, para 1 Element 4a: 10.102MIC Provider Contracting Anti-Discrimination, pg 2, para 1 Element 4b: 10.106LA Provider Selection and Retention, pg 1, para 1 	
<p>MCE Description of Process: It is the policy of MCNA Dental Plans not to discriminate against providers for any reason. Denials or terminations that are not related to non-compliance to re-credentialing are based on “For Cause” Reasons which include; Any action taken against the provider’s license or certification, where applicable; Any legal or governmental action initiated against the provider whenever the existence or outcome of such action could materially affect the provider’s ability to perform agreed upon services; Suspension or loss of liability coverage; Failure to notify MCNA of any changes in clinical privileges, scope of practice, sanctions, restrictions or any changes in medical or mental status that could affect patient care; Malpractice litigation in which the provider is a defendant; Quality of care concerns; Current or previous history of felony conviction or criminal record affecting professional practice; Current physical or mental condition that may significantly affect the provider’s ability to practice within the full scope of licensure and qualifications or may pose a risk of harm to patients; Submission of inaccurate or misleading information on the application or failure to disclose relevant information; Practice inconsistent with professional standards of care; History of significant patient complaints documented by licensing authority, healthcare facility, health plan or network administrator; Failure to cooperate with MCNA’s Quality Improvement Program and data reporting; Inadequate dental record keeping practices or inappropriate billing practices; Acts of fraud, deceit, dishonesty or moral turpitude; and Peer Review Committee determinations relating to professional competence or conduct, which will adversely affect privileges or membership; and, Provider that are terminated from Medicaid. If MCNA terminates a provider and removes a provider from its provider network for reasons other than failure to comply with the re-credentialing process, MCNA will provide immediate electronic notice to the provider, followed by written notice of termination via certified mail to the last known mailing address submitted by the provider within one (1) business day. The termination notice will include the effective date of the termination. The termination date will be 15 calendar days from the date of the notice if the termination is pursuant to</p>		



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Requirement	Supporting Documentation	Score
<p>R.S.46:460.73(A). The termination will be immediately, if the termination is pursuant to R.S. 46:460.73(B) or due to loss of required license. MCNA will notify LDH of the termination as soon as the written notification of termination is sent to the provider, but no later than seven (7) calendar days after notification is given to the provider.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Excluded Providers		
<p>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.</p> <p style="text-align: right;">42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 6.309 Medicare-Medicaid Sanctions (pg 1. para 1) • August, September, October OIG SAM Roster verification 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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<p>MCE Description of Process: It is the policy of MCNA Dental to not execute contracts with providers who have been barred, suspended or excluded or terminated from participation in Federal health care programs. or who are otherwise barred from participating in the Medicaid and/or Medicare program. During the initial and re-credentialing process, exclusions are verified through Louisiana Medicaid Exclusions, https://adverseactions.ldh.la.gov/SelSearch, Office of Inspector General (OIG), https://exclusions.oig.hhs.gov/, System for Award Management (SAM), https://sam.gov/content/home, National Practitioner Data Bank (NPDB), https://www.npdb.hrsa.gov/, provider are also enrolled as continuous queries for any new reports, and Office of Foreign Control (OFAC), https://sanctionssearch.ofac.treas.gov/. Providers are also verified monthly through the OIG/SAM websites, and any matches are verified using the provider's social security number.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
State Requirements		
<p>6. The MCE complies with any additional requirements established by the State.</p> <p>MCO:</p> <p>i. <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.</i></p> <p>ii. <i>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.</i></p> <p>iii. <i>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</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • LA 148 Monthly Debarment Exclusion Verification Attestations 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous 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).]</i></p> <p>PIHP:</p> <p>a. <i>An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.</i></p> <p>b. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>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</p>		



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Requirement	Supporting Documentation	Score
MCE Description of Process:		
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		
<p>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.</p> <p style="margin-left: 20px;">a. <i>The MCE verifies the license directly from the state licensing or certification agency (or its website).</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 1, 1st arrow) pg 4, # 17 6.602 Staff Training and Self Audit of Credentialing Process 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: During the initial and re-credentialing process, it is the policy of MCNA Dental Plans' Credentialing Department to verify that the applicant holds a current, valid, in good standing State Professional License with no restrictions or limitations in accordance with State requirements. License verifications will be verified through the State Department of Health verbally or via the Internet, e.g., http://www.lsbdo.org/licenseverification.htm . Applicants with restrictions or limitations on their license within the last 5 years or those that show a pattern of quality-of-care problems even if they fall outside the threshold limits of 5 years will be flagged as having an issue and brought before the Credentialing Committee for discussion toward a determination. The License must be current, and the date stamp must not be older than 180 days at the time of the credentialing decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
Practitioner Verification of Credentials		
<p>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.</p> <p style="margin-left: 20px;">a. <i>This requirement does not apply to practitioners who are not qualified to write prescriptions.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 1, 2nd arrow) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: During the initial and re-credentialing process, it is the policy of MCNA Dental Plans to verify applicants/providers who prescribe medications or controlled substances. If the applicant’s DEA certificate is pending issuance or if they have lost their privilege to hold a certificate, the applicant shall submit signed documentation stating who will write necessary prescriptions until the issuance of their own certificate or in lieu of having one. Orthodontists are not required to carry a DEA or CDS license certificate. Certificates of the applicant or their designee will be verified using the following guidelines: A visual inspection will be done to ensure the certificates are legible, has the applicant’s/designee's name, address, schedules, expiration date and stamp with received date. Oral & Maxillofacial Surgeons are required to have a DEA/CDS license, but it is also verified for any specialty type if indicated on the credentialing application or a copy of the certificate is submitted. The DEA license is verified through the http://www.deadiversion.usdoj.gov/ website and verify the CDS license through the https://secure.pharmacy.la.gov/Lookup/LicenseLookup.aspx. The date stamp must not be older than 180 days at the time of the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>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:</p> <p style="margin-left: 20px;">a. <i>Board certification;</i> b. <i>Residency; or</i> c. <i>Graduation from medical or professional school.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 2, 4th arrow) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: It is the policy of MCNA Dental Plans to verify the education for all applicants interested in joining MCNA’s provider network. Primary source verification of education will be through the following methods: Each State Board of Dentistry verifies each applicant’s education prior to issuing a license. An annual letter from the Louisiana State Board will be kept on file in the Credentialing Department. Contact the college or university which the applicant lists as having graduated from with an appropriate dental degree or their authorized verification display agent, e.g., National Student Clearing House via the web at https://www.studentclearinghouse.org/verify/. Verification of specialized training will be done by contacting the certifying institution. Verifications will not be date-stamped older than 180 days old at the time of initial credentialing. Only new certification will be verified at re-credentialing or if a provider changes specialty during their three-year credentialing cycle. Evidence of Board Certification will suffice in lieu of proof of dental school graduation, residency, and other post graduate training. The date stamp must not be older than 180 days at the time of the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. For credentialing and recredentialing, the MCE verifies the practitioner’s board certification status, if applicable, within 180 calendar days of the credentialing decision.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>a. <i>Verification of board certification does not apply to nurse practitioners (NPS) or other health care professionals unless the MCO communicates board certification to members.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>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</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 2, 4th arrow) Page 4, #17. 	
<p>MCE Description of Process: It is the policy of MCNA Dental Plans to ensure the verification process on provider’s board status when they state and /or document that they are board certified. The board certification will be verified through the appropriate board verbally, via fax, Internet or mail. The American Board of Periodontology, https://www.perio.org/, The American Board of Endodontics, http://www.aae.org/board/find.aspx, The American Board of Oral and Maxillofacial Surgery, website https://www.aboms.org , The American Board of Orthodontics, http://www.americanboardortho.com, The American Board of Pediatric Dentistry, website http://www.abpd.org, The American Board of Prosthodontics, http://www.prosthodontics.org. Verifications will not be older than 180 days old at the time of the credentialing decision. Evidence of Board Certification will suffice in lieu of proof of dental school graduation, residency, and other post graduate training. The credentialing system will be updated with the Board’s certification and expiration dates and sanctions (if applicable) received, as well as the date the verification was received. The date stamp must not be older than 180 days at the time of the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p>a. <i>If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.</i></p> <p>b. <i>If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 2 & 3, 5th arrow) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>MCE documents a verbal clarification or includes the written notice in the practitioner’s credentialing file.</i></p> <p><i>c. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>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</p>	<ul style="list-style-type: none"> 6.312 Education and Work History (Page 1, procedure section) 	
<p>MCE Description of Process: During initial credentialing, it is the policy of MCNA Dental Plans to obtain a minimum of five years of work history and education information from the applicant’s CV or application. The applicant is REQUIRED to clarify any gaps in their work history or education more than six months in length. Work history and education information MUST be current on the application or on the CV at the time of the credentialing decision. The Credentialing staff will visually inspect the applicant’s Curriculum Vitae and application to ensure that education and work history are listed and ensure that there are no work history or education gaps more than six months in length. If gaps are confirmed over 6 months during the credentialing process: a. Request detailed information in writing from the applicant. 4. Document in the file. 5. Enter into the database. The date stamp must not be older than 180 days at the time of the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 2, 1st arrow) (page 4 #17.) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: During initial and re-credentialing, it is policy of MCNA Dental Plans that provider applicants must make known all malpractice cases open or closed within the last five years for initials and 3years (36 months) for re-credentialing. The applicant is required to indicate on the application, and send a narrative of all such incidences, of malpractice cases open or closed within the last five/three years. The National Practitioner Data Bank (NPDB) and the Healthcare Integrity Protection Data Bank (HIPDB) https://www.npdb-hipdb.hrsa.gov and the Louisiana State Board, https://www.member-base.net/lbweb/licenseverification.htm will be queried to verify malpractice history. If an applicant states that he/she has a malpractice case and no reports show on the NPDB or the State Board websites, the staff will send a letter along with the signed attestation form to the liability insurance company for details of the settlement. The Credentialing Manager will review information to identify if any malpractice claims fall within the thresholds listed above. If an applicant has malpractice cases falling within the thresholds listed above, the provider will be presented to the Credentialing Committee for review.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Practitioner Sanction Information		
<p>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.</p> <p style="margin-left: 20px;">a. <i>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.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information (page 2, 3rd arrow-Medicare/Medicaid). Page 4,#17 <p>Additional Documentation:</p> <ul style="list-style-type: none"> MCNA has attached several policies that outline the processes required in this element. The first policy outlines the details around verification of state sanctions, restrictions on licensure, and limitations of scope of practice. The second two 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<p>policies outline that all verifications, including those around sanctions, restrictions, or limitations are done within 180 prior to the credentialing decision.</p> <ul style="list-style-type: none"> Standard VIII-Provider Selection_Element 13. 6.303 State Professional License, please see highlighted paragraphs. Standard VIII-Provider Selection_Elements 13 and 15_6.301 Initial Provider Application, please see highlighted paragraph on page 7. Standard VIII-_Elements 13 and 15_6.401 Recredentialing, please see highlighted paragraph on page 5. 	
<p>MCE Description of Process: During the initial and re-credentialing process, it is the policy of MCNA Dental Plans' Credentialing Department to verify that the applicant holds a current, valid, in good standing State Professional License with no restrictions or limitations in accordance with State requirements. License verifications will be verified through the State Department of Health verbally or via the Internet, e.g., http://www.lsbdo.org/licenseverification.htm. Applicants with restrictions or limitations on their license within the last 5 years or those that show a pattern of quality-of-care problems even if they fall outside the threshold limits of 5 years will be flagged as having an issue and brought before the Credentialing Committee for discussion toward a determination. The License must be current, and the date stamp must not be older than 180 days at the time of the credentialing decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
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: <ul style="list-style-type: none"> 6.302 Validation of Information (page 2, 3rd arrow) Page 4,#17 	
MCE Description of Process:		
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: <ol style="list-style-type: none"> <i>Reasons for inability to perform the essential functions of the position;</i> <i>Lack of present illegal drug use;</i> <i>History of loss of license and felony convictions;</i> <i>History of loss or limitation of privileges or disciplinary actions;</i> <i>Current malpractice insurance coverage; and</i> <i>Current and signed attestation confirming the correctness and completeness of the application.</i> <p style="text-align: right;">42 CFR §438.214(e)</p> 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: <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review Evidence as Submitted by the MCE: <ul style="list-style-type: none"> 15a. 6.301 Initial Credentialing Application, page 3, #8 15b. 6.301 Initial Credentialing Application, page 3, #3 15c. 6.301 Initial Credentialing Application, page 3, #5 15d. 6.301 Initial Credentialing Application, page 3, #9 15e. 6.301 Initial Credentialing Application, page 3, #8 Policy 6.401 Re-Credentialing, page 3 section- The application includes a current signed and 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<p>dated attestation by the provider regarding the following. #1-#10.</p> <p>Additional Documentation: MCNA has attached both our initial and recredentialing policies and highlighted the paragraph that requires providers to have a current and signed attestation confirming the correctness and completeness of the application.</p> <ul style="list-style-type: none"> Standard VIII_Elements 13 and 15_6.301 Initial Provider Application, please see highlighted paragraph on page two. Standard VIII-Provider Selection_Elements 13 and 16_6.401 Recredentialing, please see highlighted paragraph on page one. 	
<p>MCE Description of Process: During the initial and re-credentialing process, staff ensures the application is currently dated and not past 180 days. They verify that all questions are answered and any yes questions, requires a detailed explanation. The answered questions are also verified through the inspection of the State Board, NPDB, or any of the sanction verifications.</p> <p>During the initial and re-credentialing process, it is the policy of MCNA Dental Plans to use LA state approved credentialing applications. The application must include a current signed and dated attestation by the provider regarding the following: Reasons for the inability to perform the essential functions of the position contracted for with or without accommodation; Lack of present illegal drug use and/or impairment due to chemical dependency/substance abuse; History of licensure; History and explanation of any felony convictions; History of loss or limitations of clinical privileges; Disciplinary activity; Current malpractice coverage; and Malpractice history. Any “Yes” answers require an explanation and misrepresentation of any or all the above information at the time of Credentialing, the provider will be asked to make the corrections and initial the change.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Practitioner Monitoring		
<p>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:</p> <p style="margin-left: 20px;">a. <i>Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);</i></p> <p style="margin-left: 20px;">b. <i>Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and</i></p> <p style="margin-left: 20px;">c. <i>Implementing appropriate interventions when it identifies instances of poor quality.</i></p> <p style="text-align: right; margin-right: 20px;">2 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.107 On-Going Monitoring Requirements, page 1-3. <p>Additional Documentation:</p> <ul style="list-style-type: none"> MCNA has supplied sample tracking reports for provider complaints as labeled “Provider Complaint Tracking Report LA Fourth Quarter 2024” and a sample provider adverse events tracking report labeled “Provider Adverse Events Tracking Report LA Fourth Quarter”. Both are PDF copies of the online tracking tools and member PHI has been removed. The quality-of-care attachment is one PDF that includes what would be six tabs within the tool as follows: <ul style="list-style-type: none"> – All potential quality of care cases received in 2024 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> – Four tabs summarizing information for each quarter within 2024 – One tab summarizing 2024 • We have additionally supplied our Fourth Quarter QIC presentation labeled as LA QIC Fourth Quarter 2024, which includes the data trended over time for member complaints and grievances on slide 35, and for adverse events that may be quality of care issues on slide 94. These slides contain the affirmative statements that there were no referrals required for credentialing committee review for trends in provider complaints or quality of care findings. • Lastly, we have supplied two sets of monthly credentialing committee minutes showing committee review of findings identified through ongoing monitoring. “Credentialing Committee Minutes LA May 2024” provides documentation of findings for one provider and “Credentialing Committee Minutes LA July 2024” provides documentation of findings for three providers through ongoing monitoring. The findings, discussion, and outcomes have been highlighted for your convenience. 	
<p>MCE Description of Process: It is the policy of MCNA Dental to monitor participating providers continuing compliance with criteria for network participation. Providers are enrolled within the National Practitioner Data Bank for continuous monitoring so that MCNA is alerted when there is new or changed information from the previously queried information. The Credentialing Manager ensures that any notices of new or changed reports are reviewed and if new adverse issues have been added to the provider’s profile, a letter is sent to the provider requesting an explanation of the events. This information is then presented to the next Committee for discussion and determination OR if the issues appear to cause possible harm to MCNA’s membership, an Ad Hoc Committee will be scheduled for immediate discussion and determination on the</p>		



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Requirement	Supporting Documentation	Score
<p>provider’s participation. It is also the policy to have a mechanism in place to respond to cases where a participating provider ceases to comply with criteria that may result in the provider’s restriction, suspension, termination, or sanctioning. All member complaints concerning specific providers will be monitored daily by the Quality Improvement Department and reported to the Credentialing Committee on a monthly basis. Site Audit visits may be required periodically should quality of care issues/complaints arise concerning a Providers facility or record keeping practices. All providers are verified monthly through the OIG and SAM system, and any matches are verified with the provider's social security number. MCNA will comply with all applicable agencies regarding debarment and/or suspension.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Organizational Verification of Credentials		
<p>17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.302 Validation of Information, page 1, Purpose, Policy section, 1st paragraph & page 3-4, procedure section 1-18 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: It is the policy of MCNA Dental Plans to ensure that the network of providers meet the rules and regulations of the governing Board of Directors (Board) under the direction of the Chief Dental Officer for the Credentialing Program. The Credentialing Program shall meet State and Federal requirements, and National Accreditation standards, in establishing a credentialed network. The Credentialing Program shall include minimal criteria that the Committee shall establish. Providers in the MCNA Network shall meet the criteria established for credentialing and re-credentialing activities. The Credentialing Program shall include an application process, data collection process, primary source verification process, DentalTrac (database) storage process, Credentialing Committee review of all contracted providers</p>		



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Requirement	Supporting Documentation	Score
<p>process and a process of sending written notification to providers of decisions made by the Committee within ten (10) business days of the decision. It shall also ensure database functionality to include activities for initial credentialing, re-credentialing, and on-going monitoring for the network of all dental care providers. It shall also ensure the updating of the database within 48 hours of the Committee’s decision to ensure accuracy of the provider directory</p>		
<p>HSAG Findings: The MCE does not conduct organizational credentialing and recredentialing; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
<p>18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body.</p> <p style="margin-left: 20px;">a. <i>If the provider is not accredited, the MCE conducts an onsite quality assessment.</i></p> <p style="margin-left: 40px;">i. <i>The MCE has a process for ensuring that the provider credentials their practitioners.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Onsite assessment review tool/template HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.301 Initial Credentialing Application, page 2/3, #s 1 -10 6.201 Credentialing Committee 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA Dental Plans appointed the decision-making process to the Credentialing Committee to ensure a fully approved and credentialed network of providers. The Credentialing Committee oversees all activities of the Credentialing Department and is appointed by the Board of Directors, under the responsibility and direction of a senior clinical person, the Chief Dental Officer. The Credentialing Committee meets monthly and is composed of the Chairman, Chief Dental Officer, Co-Chair, appointed by the Chief Dental Officer, a minimum of three (3) including the Chief Dental Officer, dentist, 1 participating dentist that is not employed with MCNA, and representatives from Credentialing, Provider Relations, Quality Improvement, Special Investigations Unit, and Network Development. Only the Dentists will take part in the voting related to clinical decisions and a majority vote will be required for any action taken. The Credentialing Committee has final authority to (a) approve or disapprove initial applications for MCNA network participation status, and/or re-credentialing applications for continued participation including clean initial/re-cred applicant/provider files approved between Committee meeting dates for</p>		



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Requirement	Supporting Documentation	Score
<p>expedited or temporary approvals; or (b) delegate such authority to the senior clinical staff person for approving clean credentialing applications between Committee meeting dates, provided that such designation is documented and provides reasonable guidelines.</p>		
<p>HSAG Findings: The MCE does not conduct organizational credentialing and recredentialing; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
Time Frames		
<p>19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 6.401 Re-Credentialing (page 1, last paragraph) • 6.100 Provider Credentialing Program Description, (page 2, 3rd bullet.) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA will send a minimum of three written notices to the provider with information regarding the re-credentialing process, including the requirements and deadlines for compliance. MCNA sends the initial notice to the provider no later than 6 months prior to the expiration of the provider's current credentialing cycle. The notice will include the effective date of termination if the provider fails to meet the requirements and deadlines of the re-credentialing. The written notices are mailed to the last mailing address and last email address submitted by the provider. If the provider fails to submit all requirements and meets the requirements of the re-credentialing requirements, MCNA will send a written termination notice to the provider with an effective date of termination to be 15 days after the date of the notice.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
Required Actions: No action required.		

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

Total Score ÷ Total Applicable	=	100%
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Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
General Rule		
<p>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.</p> <p style="text-align: right;">42 CFR §438.230(b)(1) 42 CFR §457.1233(b)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 1.200MIC Contracting and Oversight of Subcontractors, Page 1, 1st paragraph. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA Insurance Company (MIC) maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the Agency, notwithstanding any relationships that MCNA</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Contract or Written Arrangement		
<p>2. Each contract or written arrangement with a delegate must specify:</p> <p style="padding-left: 20px;">a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.</p> <p style="padding-left: 20px;">b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE’s contract obligations.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 1.200MIC Contracting and Oversight of Subcontractors, Page 1, 1st paragraph & Page 1, 3rd paragraph 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily.</p> <p style="text-align: right;">42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) 42 CFR §457.1233(b)</p> <p>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</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> Subcontractual Relationships and Delegation_Elements 2-4, 6_ Amendment_Fiserv-MCNA_Audit Final 8.30 Subcontractual Relationships and Delegation_Elements 2-4, 6_ Fiserv – MCNA Amendment 2 021323 (Fiserv 02.27.23) Subcontractual Relationships and Delegation_Elements 2-4, 6_ 20160817_154050 – FiServ – Amendment 1 to MSA and BAA – 20140909 Subcontractual Relationships and Delegation_Elements 2-4, 6_ 20140120_154852 FiServ Master Agreement 20081001 Subcontractual Relationships and Delegation_Elements 2-4, 6_ MCNA (11010-A) MCNAIC (EI) LA DASA 070125 – Signed Subcontractual Relationships and Delegation_Elements 2-4, 6_ DASA Conforming Amendment 08.22 	
<p>MCE Description of Process: MCNA Insurance Company (MIC) remains fully responsible for the obligations, services, and functions performed by its Subcontractors or Providers to the same extent as if such obligations, services, and functions were performed by MCNA Insurance Company. MIC’s subcontractors and providers will comply with all activities or obligations under its contract with the state agency. Delegated activities or obligations and related reporting responsibilities, will be specified in a contract or written agreement, which will comply with applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions per 42 CFR 438.230(c)(1)(i) - (iii) and 42 CFR 438.230(c)(2).</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA did not provide evidence of the reporting responsibilities related to the delegated activities or obligations within the contracts or written agreements.</p>		



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>Required Actions: The MCE must specify the reporting responsibilities related to the delegated activities or obligations within each contract or written agreement.</p>		
<p>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:</p> <p style="margin-left: 20px;">a. <i>rules, policies, procedures, manuals, the State Plan, and Waivers.</i></p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.230(c)(2) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 1.200MIC Contracting and Oversight of Subcontractors, Page 1, 1st paragraph Fiserv – MCNA Amendment <p>Additional Documentation:</p> <ul style="list-style-type: none"> Subcontractual Relationships and Delegation_Elements 2-4, 6_ Fiserv – MCNA Amendment 2 021323 (Fiserv 02.27.23) Executed Subcontractual Relationships and Delegation_Elements 2-4, 6_ MCNA (11010-A) MCNAIC (EI) LA DASA 070125 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA’s (MIC) subcontractors and providers will comply with all activities or obligations under its contract with the state agency. Delegated activities or obligations and related reporting responsibilities, will be specified in a contract or written agreement, which will comply with applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions per 42 CFR 438.230(c)(1)(i) - (iii) and 42 CFR 438.230(c)(2).</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA’s submissions did not comport with the required federal and State language of this requirement, which is exacting.</p>		



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>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.</p>		
<p>4. The contract or written arrangement indicates, and the delegate agrees that:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.230(c)(3)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 1.200MIC Contracting and Oversight of Subcontractors, Page 3, 3rd Paragraph "Access to Records". <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Subcontractual Relationships and Delegation_Elements 2-4, 6_ Fiserv – MCNA Amendment 2 021323 (Fiserv 02.27.23) Executed 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1233(b)</p> <p>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</p>		
<p>MCE Description of Process: MCNA (MIC) agrees that the right to audit by state, CMS, the DHHS Inspector General, the Controller General or their designees, will exist through 10 years from the final date of the contract period from the date of completion of any audit, whichever is later.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA’s submissions did not comport with the required federal and State language of this requirement, which is exacting.</p>		
<p>Required Actions: The MCE must ensure that each contract or written arrangement indicates, and the delegate agrees that:</p> <ol style="list-style-type: none"> 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. 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. 		
<p>5. The contract or written arrangement:</p> <p>MCO:</p> <ol style="list-style-type: none"> a. <i>Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.</i> <p style="text-align: right;">42 CFR §438.230 42 CFR §457.1233(b)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • N/A 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA		
MCE Description of Process:		
HSAG Findings: The MCE 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		
<p>6. Monitoring subcontractor’s performance shall be monitored:</p> <p>MCO:</p> <p>a. <i>On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.</i></p> <p>PAHP:</p> <p>a. <i>On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.</i></p> <p>PIHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.230 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Delegation agreement/contract template • Monitoring and audit documentation • Annual formal review • HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 1.200MIC Contracting and Oversight of Subcontractors, Page 6, Ongoing Monitoring <p>Additional Documentation:</p> <ul style="list-style-type: none"> • FiServ Control Sheets • LA QIC Fourth Quarter 2024 • Standard IX Element 6_ LA 2024 QAPI Annual Evaluation 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
MCE Description of Process: MCNA (MIC) will Monitor the subcontractor’s performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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%
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Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
Adoption of Practice Guidelines		
<p>1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field.</p> <p style="text-align: right;">42 CFR §438.236(b)(1) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.100 Clinical Practice Guidelines <ul style="list-style-type: none"> – Page 1 • List of Adopted CPGs • LA Q1 2024 QIC Minutes <ul style="list-style-type: none"> – Page 4 • LA Q2 2024 QIC Minutes <ul style="list-style-type: none"> – Page 4 • CPG for the Pharmacologic Management of Acute Dental Pain • CPG for Patients with Cleft Lip Palate and Other Craniofacial Anomalies 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA’s Clinical Practice Guidelines (CPGs) are derived from reputable sources, including but not limited to the American Dental Association (ADA), the American Academy of Pediatric Dentistry (AAPD), and the Centers for Disease Control and Prevention (CDC). These guidelines incorporate relevant dental evidence, including both clinical research and expert consensus. The Quality Improvement team shares proposed CPGs with clinical staff to gather feedback and secure approval before submission to the Utilization Management Committee (UMC), Dental Advisory Committee (DAC), and the Quality Improvement Committee (QIC).</p>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>During the review period, the CPG, “Policy on the Management of Patients with Cleft Lip/Palate and Other Craniofacial Anomalies,” was approved at the LA Q1 2024 QIC meeting held on April 26, 2024. This guideline is based on valid and reliable clinical evidence from the American Academy of Pediatric Dentistry. The CPG, “Evidence-Based Clinical Practice Guideline for the Pharmacologic Management of Acute Dental Pain in Adolescents, Adults, and Older Adults” was approved at the LA Q2 2024 QIC meeting held on July 24, 2024. This guideline is also based on valid and reliable clinical evidence published by the ADA in the Journal of the American Dental Association (JADA), a recognized peer-reviewed source of dental science and information.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: None.</p>		
<p>2. The MCE adopts practice guidelines that consider the needs of the MCE’s members and:</p> <p>MCO:</p> <p>a. adopts clinical practice guidelines for at least the conditions listed below:</p> <ul style="list-style-type: none"> 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. <p>PIHP:</p> <p>a. develops clinical practice guidelines for:</p> <ul style="list-style-type: none"> i. ADHD ii. Trauma Informed Care 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.100 Clinical Practice Guidelines <ul style="list-style-type: none"> – Page 2, 4th bullet point from the top of the page • List of Adopted CPGs • LA Q1 2024 QIC Minutes <ul style="list-style-type: none"> – Page 4 • LA Q2 2024 QIC Minutes <ul style="list-style-type: none"> – Page 4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>iii. Depression and Conduct Disorder</p> <p style="text-align: right;">42 CFR §438.236(b)(2) 42 CFR §457.1233(c)</p> <p>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</p>		
<p>MCE Description of Process: All clinical practice guidelines (CPGs) are adopted based on the enrolled membership and dictate the provision of acute and chronic dental care services to assist dentists and members in making appropriate dental care decisions to improve quality of care. For the review period, the adopted two new CPGs, “Policy on the Management of Patients with Cleft Lip/Palate and Other Craniofacial Anomalies,” and “Evidence-Based Clinical Practice Guideline for the Pharmacologic Management of Acute Dental Pain in Adolescents, Adults, and Older Adults.”</p> <p>The CPG, “Evidence-Based Clinical Practice Guideline for the Pharmacologic Management of Acute Dental Pain in Adolescents, Adults, and Older Adults”, addresses the specific needs of our members by promoting safe, effective, and accessible pharmacologic strategies for managing acute dental pain following simple and surgical extractions, as well as for the temporary relief of toothaches. It recommends non-opioid medications, specifically nonsteroidal anti-inflammatory drugs (NSAIDs), either alone or in combination with acetaminophen, as the first-line therapy. These medications are not only more effective at targeting the source of pain, but also present fewer risks compared to opioids. Given the increased vulnerability of Medicaid populations to opioid misuse and its associated harms, the guideline strongly discourages routine opioid prescribing. Instead, the guideline urges clinicians to exercise extreme caution, particularly when treating adolescents and young adults, due to the high risk of addiction and other adverse effects.</p> <p>The CPG, “Policy on the Management of Patients with Cleft Lip/Palate and Other Craniofacial Anomalies,” addresses the specific needs of our members by recognizing the complex, lifelong dental challenges these patients face. Developed by the American Academy of Pediatric Dentistry (AAPD), the guideline supports clinicians in delivering comprehensive, coordinated care. Given the unique oral health needs of this population, the involvement of a pediatric dentist, alongside other specialists, is essential. These needs may require adjustments to the standard schedule for dental exams and restorative care. Interdisciplinary collaboration is key to monitoring growth and development and promoting long-term oral health. Importantly, the guideline also considers the needs of Medicaid members, ensuring that its recommendations are accessible and practical for providers serving this population. This approach helps improve care coordination and health outcomes for all children with cleft lip/palate and craniofacial conditions.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: None.</p>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>3. The MCE adopts practice guidelines that are adopted in consultation with network providers.</p> <p style="text-align: right;">42 CFR §438.236(b)(3) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval • Evidence of consultation of network providers <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.100 Clinical Practice Guidelines <ul style="list-style-type: none"> – Page 1, 3rd bullet point • List of Adopted CPGs • LA Q1 2024 QIC Minutes <ul style="list-style-type: none"> – Page 4 • LA Q2 2024 QIC Minutes <ul style="list-style-type: none"> – Page 4 • CPG Consultation Email #1 • CPG Consultation Email #2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Narrative • Fourth Quarter 2024 DAC Minutes 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA adopts Clinical Practice Guidelines (CPGs) in collaboration with network providers who participate in the Dental Advisory Committee (DAC) and/or the Quality Improvement Committee (QIC). Draft guidelines are shared with these providers in advance of meetings to allow for thorough review and input.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: None.</p>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>4. The MCE adopts practice guidelines that are:</p> <p>MCO/PAHP:</p> <p style="margin-left: 20px;">a. reviewed and updated periodically as appropriate.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. Reviewed annually and updated periodically as appropriate.</p> <p style="margin-left: 20px;">b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(b)(4) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract: 7.4.5.4; 7.4.7.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2.100 Clinical Practice Guidelines – Page 2 List of Adopted CPGs List of CPGs for Annual Review LA Q2 2024 QIC Minutes pg. 4 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Narrative Second Quarter 2024 LA QIC Minutes 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA conducts an annual review of all previously adopted Clinical Practice Guidelines (CPGs) to ensure they remain current and evidence-based. The Quality Improvement (QI) team evaluates each guideline to determine whether it has been revised, retired, or remains unchanged. Following this review, the QI team disseminates a comprehensive list of all CPGs to providers and committee members, clearly indicating any updates or confirming if no changes have occurred. Once reviewed and finalized, the updated CPGs are submitted to the Utilization Management Committee (UMC), Dental Advisory Committee (DAC), and the Quality Improvement Committee (QIC) for approval.</p> <p>For the review period, the annual review and approval of CPGs was conducted at LA Q2 2024 meeting held on 07/24/24.</p>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: None.		
Dissemination of Guidelines		
<p>5. The MCE disseminates the guidelines to:</p> <p style="margin-left: 20px;">a. All affected providers</p> <p style="margin-left: 20px;">b. Members and potential members, upon request</p> <p style="margin-left: 40px;">42 CFR §438.236(c)</p> <p style="margin-left: 40px;">42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.5</p> <p>PAHP Contract: 2.5.5.3</p> <p>PIHP Contract: 7.4.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2.100 Clinical Practice Guidelines <ul style="list-style-type: none"> – Page 1 Policy Section 1st paragraph and page 3, procedure #5. MCNA LA Provider Manual-v1.26 <ul style="list-style-type: none"> – Page 59 MCNA Provider Newsletter, “Dental Details” – Fall 2024 <ul style="list-style-type: none"> – Page 2 MCNA Provider Newsletter, “Dental Details” – Winter 2024 <ul style="list-style-type: none"> – Page 2 MCNA Member Newsletter “Tooth Tribune” December 2024 	



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • CPG MCNA Member Website Screenshot • CPG MCNA Provider Website Screenshot • CPG Announcement on MCNA Provider Website Screenshot 	
<p>MCE Description of Process: Once approved by both the Utilization Management Committee (UMC), Dental Advisory Committee (DAC), and the Quality Improvement Committee (QIC), Clinical Practice Guidelines (CPGs) are published on MCNA’s member-and provider-facing websites. They are also incorporated into the provider manual and featured in both member and provider newsletters.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: None.</p>		
Application of Guidelines		
<p>6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p style="text-align: right;">42 CFR §438.236(d) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.100 Clinical Practice Guidelines <ul style="list-style-type: none"> – Page 1 Policy Section, 1st paragraph last sentence – Page 4, procedures #1-4 • Healthy Holiday Member Postcard 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • Preventive Superstar Member Postcard • Pregnant Member Flyer – Healthy Smiles for Mom and Baby • Member Gingivitis Flyer • Examples of coverage denial notices: <ul style="list-style-type: none"> – Example 1 initial PA periodontal therapy #6 – Example 1 subsequent PA periodontal therapy #6 – Example 2 pulpal therapy #6 – Example 3 claim history fluoride #6 – Example 3 fluoride #6 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Cases audited in 2024 • IRR Instructions 	
<p>MCE Description of Process: MCNA has implemented several strategies to ensure alignment with clinical practice guidelines across its operations. These guidelines are consistently applied in utilization management reviews, member education, service coverage approvals, and other relevant areas. To maintain quality and consistency in communication, MCNA has established an internal Communications Committee composed of multidisciplinary leadership, including the Chief Dental Officer and Directors of Utilization Management (UM), Case Management (CM), Quality Improvement (QI), and Member and Provider Services. This committee reviews all member and provider materials such as handbooks, manuals, bulletins, and outreach content, prior to distribution, ensuring they reflect the adopted clinical guidelines. Additionally, MCNA leverages technology within its claims and medical management systems to enforce benefit limitations and clinical protocols. The member services system is integrated with clinical guidelines and linked to current claim data, enabling staff to receive care gap alerts and encourage members to seek appropriate care. To further ensure consistency, MCNA conducts Inter-Rater Reliability (IRR) audits on clinical reviews. The Chief Dental Officer and UM leadership monitor these audits and trends in overturned appeals to identify areas needing additional training or refinement of the guidelines for greater clarity and effectiveness.</p>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: None.		

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

Total Score ÷ Total Applicable	=	100%
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Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
General Rule		
<p>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:</p> <ul style="list-style-type: none"> a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. <p style="text-align: right;">42 CFR §438.242(a) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • MIS_Data Flow, page 1 • 12.300 Management Information System Overview, Page 1 • Process Flowcharts and System Diagrams - Enrollment and Eligibility 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Process Flowcharts System Diagrams- DentalTrac System Architecture <p>Additional Documentation:</p> <ul style="list-style-type: none"> Standard XI-Element 1_Disenrollment codes 	
<p>MCE Description of Process: MCNA’s management information system (MIS) is DentalTrac™, a proprietary software solution integrating all business operations. It collects information across systems shown in the logical diagram above and uses a centralized database and well as data aggregation to surface information to end users, reports and business intelligence teams so they may perform their business functions. The DentalTrac™ system has many software modules that are made available to the end users so they may perform critical business functions. Access to these systems and the capabilities inside each of these functions is controlled by user roles configured in the systems. Some screenshots are attached. These were taken from the QA system that matches production.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Basic Elements of a Health Information System		
<p>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.</p> <p style="text-align: right;">42 CFR §438.242(b)(2) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 12.300 Management Information Systems Overview, Page 1-2 & 11 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> MIS_Data Flow, page 3 	
<p>MCE Description of Process: MCNA collects enrollee data directly from the state via x.12 834 format. It then uses the DentalTrac™ system to format and insert into the DentalTrac™ for business functions. The policy and procedure for the state of Iowa is attached in the evidence section. MCNA also has an enrollment specialist that works with the call center to update enrollee information as needed. Provider information is collected through our Network Development and Credentialing process and MCNA also receives a Master Provider File from Iowa which it stored in the storage subsystem of DentalTrac™ data and archives it for any business function necessary.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE ensures that data received from providers is accurate and complete by:</p> <ol style="list-style-type: none"> Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. Screening the data for completeness, logic, and consistency. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. <p style="text-align: right;">42 CFR §438.242(b)(3) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> MIS data flow 12.300 Management Information Systems Overview, Page 4-5 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The DentalTrac™ System has many checks and balances for validating standard formats (such as x.12 837 claim data and x.12 834 Enrollment data). It also employs cross walking of formatted datafiles to ensure they meet the form and format designated by the State. The DentalTrac™ System has many checks and balances for validating standard formats (such as x.12 837 claim data</p>		



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Requirement	Supporting Documentation	Score
<p>and x.12 834 Enrollment data). It also employs cross walking of formatted datafiles to ensure they meet the form and format designated by the State. The description of this can be reviewed in the document in the evidence section (Specifically pages 3 – 16) .</p> <p>MCNA receives data from providers in three ways, from clearing houses, from the MCNA provider portal and from regular mail. These files use industry standard file formats (X12 from clearing houses), customized (from DentalTrac™ Provider Portal) and standard claim forms when sent via postal mail. Once the data is received in any of these formats, the DentalTrac™ system formats it for inserting into the DentalTrac™ database for use by many sub systems</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>4. The MCE makes all collected data available to the State and upon request to CMS.</p> <p style="text-align: right;">42 CFR § 438.242(b)(4) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 12.300 Management Information Systems Overview, page 5 • 12.600LA Reporting Requirements, page 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: All DentalTrac™ data is held in a transactional database, in Object Storage or in digitized paper files and can be reproduced for any requestor including CMS.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
Claims Processing		
<p>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).</p> <p style="text-align: right;">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)</p> <p>MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> MIS data flow Claim_SystemEdits_2024 12.300 Management Information Systems Overview, page 14 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA provides for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS). This includes detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine. MCNA sends multiple encounter files based upon contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Application Programming Interface		
<p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>to its current members or the members’ personal representatives through the API as follows:</p> <ol style="list-style-type: none"> 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 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. <p style="text-align: right;">42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: None</p>	<ul style="list-style-type: none"> • List of registered third-party applications • HSAG will use the results from the API demonstration <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 12.800 Website Development & Maintenance, page 2 	
<p>MCE Description of Process: The request API’s were not a CMS Requirement for Dental at the time of this review, nor were they a contractual requirement from LDH. Per CMS new Carin Blue Button requirements have been finalized for Dental Organizations – with an</p>		



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effective date of Jan 1, 2027, MCNA is has project plan to have the API’s implemented in test environment – with progress to have in the live production environment Dec 31, 2026.		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p> <p>Recommendations: HSAG recommends that the MCE prioritize continued Application Programming Interface (API) development as it is essential not only to enabling valuable business functions but also meeting federal regulatory requirements.</p>		
Required Actions: No action required.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 12.800 Website Development & Maintenance, page 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA implemented the Provider Directory API and the patient access API in July 2021. Additionally, the information was posted on MCNA’s website to provide further information. It can be found at the bottom of “Our Privacy Practices” https://www.mcna.net/en/privacy.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		



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<p>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).</p>		
<p>Required Actions: No action required.</p>		
Member Encounter Data		
<p>8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.</p> <p style="text-align: right;">42 CFR §438.242(c)(1) 42 CFR §457.1233(d)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 12.300 Management Information System, Page 11 • 12.101LA Encounter Data, page 4 (procedures 1 & 2) • MIS data flow 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA collects LDH specified data in the agreed upon format and submits it to the Agency as required by the contract and systems companion guide.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>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.</p> <p style="margin-left: 20px;">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.</p> <p style="margin-left: 20px;">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.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>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</i></p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>Submit complete and accurate encounter data at least monthly.</i></p> <p>PIHP:</p> <p style="margin-left: 20px;">a. <i>Submit complete and accurate encounter data at least weekly</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 12.101LA Encounter Data Submission, Pages 1-2 & 4 12.600LA Reporting Requirements, Page 3 12.300 Management Information System, Page 11 & 13 MIS data flow LA-ENC-Subset_24 Process Flowcharts and System Diagrams - Encounter_Submission 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA produces encounter data via the DentalTrac™ and creates them a part of an automated process as claims are processed.</p>		



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Requirement	Supporting Documentation	Score
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%



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Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
General Rules		
<p>1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members.</p> <p style="text-align: right;">42 CFR §438.330(a)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description – Page 1 • 2024 LA QI Work Plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCNA has developed and implemented a Quality Improvement (QI) Program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care, resolving identified issues in accordance with prevailing professional standards. The program is grounded in the Institute for Healthcare Improvement’s (IHI) Triple Aim framework, which focuses on optimizing the health system by improving care quality and delivery. MCNA has expanded this model to a Quadruple Aim by adding a fourth goal: enhancing the dentist experience. This recognizes that achieving QI goals requires active participation from dental providers. By prioritizing provider satisfaction, MCNA aims to ensure a positive patient experience, improved oral health outcomes, and reduced healthcare costs. The QI Program uses assessments of standards, objectives, and outcomes to continuously evaluate and improve patient care for the benefit of both members and practitioners. It demonstrates accountability for dental care quality and is reviewed by MCNA’s Quality Improvement Committee (QIC) as well as state and federal regulatory bodies. The program is supported by a set of written policies and procedures that outline multidisciplinary processes for effective healthcare management and ongoing quality monitoring. QI staff also track key areas of dental care delivery to identify issues early and drive improvements. Additionally, MCNA’s QAPI objectives incorporate key performance indicators and departmental activities, which are reported quarterly to the QIC.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
Basic Elements of QAPI Programs		
<p>2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services.</p> <p style="text-align: right;">42 CFR §438.330(b)(3) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan • 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) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description <ul style="list-style-type: none"> – Page 5 • 2024 LA QI Work Plan • 2024 LA QAPI Annual Evaluation <ul style="list-style-type: none"> – Pages 13 and 24 • 3.602 Monitoring for Over and Under Utilization <ul style="list-style-type: none"> – Page 1 Purpose and Policy Section • LA Q2 2024 UM Committee minutes <ul style="list-style-type: none"> – Pages 1 – 2 • Overutilization Report – Pulps to Crowns 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA utilizes Key Performance Indicators (KPIs) to measure, analyze, and improve performance. Indicators are selected and defined by developing standards for performance, which take into account contractual requirements that are to be met. The</p>		



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Requirement	Supporting Documentation	Score
<p>selection and definition of indicators also includes the review of contract and state-specific and national standard publications (i.e., Healthy People 2030, NCQA Quality Compass, National Health Interview Survey, US Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), and state-contracted external quality review organizations (EQROs). The KPIs are approved and monitored for both under and overutilization by the Utilization Management (UM) Committee and QIC and then reported to the Board of Directors. MCNA’s Special Investigations Unit (SIU) also collects and trends data (practice and utilization patterns) for provider profiling to identify irregularities and possible fraud, waste and abuse an example is the overutilization report attached that was run during the review period for overutilization of pulps to crowns.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.330(b)(4) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description – Page 8 • 2024 LA QI Work Plan • 2024 LA QAPI Annual Evaluation 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> – Page 16 • 3.303 Coordination of Care <ul style="list-style-type: none"> – Pages 1 – 5 • 2.108LA Dental Record Review <ul style="list-style-type: none"> – Dental Record Audit Tools on pages 7-10 • Clinical Practice Guideline “Management of Dental Patients with Special Health Care Needs” • Q3 2024 UM Committee minutes detailing 2024 IRR score <ul style="list-style-type: none"> – Page 5 • Pre-authorization included in the 2024 IRR that was for a member with special health care needs <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 3.804 Members with Special Healthcare Needs and Catastrophic Dental Conditions policy 	
<p>MCE Description of Process: MCNA’s Case Management Unit has mechanisms in place to assess each member identified as having special health care needs in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment mechanisms use appropriate Health Care Professionals. MCNA allows members with special healthcare needs, who have been identified as requiring a course of treatment or regular care monitoring, to have direct access to a specialist as appropriate for the member's condition and identified needs. Once a member is identified as having special healthcare needs, a Case Management Coordinator (CMC) conducts a dental health assessment and assists by locating a provider to accommodate the members’ needs. The CMC also assists with scheduling an appointment, transportation, and translation services if needed. The CMC follow-up post the dental appointment to confirm attendance and obtain future appointment dates. The Chief Dental Officer, clinical reviewers, and primary dental provider are charged with the responsibility of developing a treatment plan based on realistic goals for the optimal dental status of the member. Once treatment is complete, the CMC evaluates and reviews the services and member’s progress after every dental visit and the primary dental provider or specialty provider updates the treatment plan as needed. Members with special health care needs remain in the Case Management Program until a</p>		



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Requirement	Supporting Documentation	Score
<p>Primary Dental Provider is established and all medically necessary treatment is complete. Quality of care concerns identified by the clinical reviewer are submitted to the Quality Improvement department for further investigation.</p> <p>Additionally, MCNA has adopted clinical practice guidelines such as “Management of Dental Patients with Special Health Care Needs” and the quality of care assessed to members is monitored through routine dental record and preventive care audits. MCNA assess the quality and appropriateness of care furnished to members with special health care needs through dental record reviews, KPI audits of case management coordinators, and Inter-rater Reliability audits.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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:</p> <p style="margin-left: 20px;">a. Assessment of care between care settings; and</p> <p style="margin-left: 20px;">b. Comparison of services and supports received with those set forth in the member’s treatment/service plan, if applicable.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b)</p> <p>MCO Contract: NA PAHP Contract: None PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: N/A</p>		
<p>HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		



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Performance Measurement		
<p>5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually:</p> <ul style="list-style-type: none"> a. Measures and reports to the State on its performance, using the standard measures required by the State; 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). <p style="text-align: right;">42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Performance measures reports • Evidence of submission of performance measurement reports to the State <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description – Pages 5-6 • 2024 LA QI Work Plan • 2024 LA QAPI Annual Evaluation • 2.701LA Performance Measures – Pages 1-3 <p>Additional Documentation: MCNA’s contractual performance measure reporting was included in the submission of the 2024 QAPI Annual Evaluation on pg. 24 which was submitted to the state on 03/31/25.</p> <ul style="list-style-type: none"> • Standard XII_Quality Assessment and Performance Improvement_Element 5_Evidence of Upload_2024 QAPI Annual Evaluation 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>MCE Description of Process: MCNA annually reports on performance measures (PMs) required by LDH. The PMs are monitored monthly and quarterly by the quality team via the quality metrics dashboard and performance is tracked to measure progress toward goals. The dashboard reflects each indicator’s performance against the compliance standard or goal. The VP of Business Intelligence and Data Analytics transfers the data onto templates provided by LDH. Prior to the reporting due date, leaders of the Quality Improvement department conduct a pre-submission quality review to ensure accuracy and completeness of information. After the quality review, the VP of Business Intelligence and Data Analytics compiles the report(s) and submits to LDH.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Performance Improvement Projects		
<p>6. The QAPI program includes performance improvement projects (PIPs).</p> <p style="margin-left: 20px;">a. The MCE conducts PIPs that focus on both clinical and nonclinical areas.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.</i></p> <p>PIHP:</p> <p style="margin-left: 20px;">a. <i>The PIHP shall perform a minimum of one LDH approved PIP.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2.103LA QI Program Description <ul style="list-style-type: none"> – Page 2 2024 LA QI Work Plan <ul style="list-style-type: none"> – Pages 2 – 3 2024 LA QAPI Annual Evaluation <ul style="list-style-type: none"> – Pages 23 – 24 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> 2.102LA Performance Improvement Projects <ul style="list-style-type: none"> – Page 1 LA Dental PAHP PIP Charter EPSDT Preventative Services LA Dental PAHP PIP Design Charter Dental Visit by 1st Birthday 	
<p>MCE Description of Process: MCNA’s QAPI program includes Performance Improvement Projects (PIPs) that address both clinical and non-clinical focus areas. During the review period, the clinical PIP topic was “Increase the Percentage of EPSDT Enrollees, Ages 1–20, Receiving at Least One Preventive Dental Service,” while the non-clinical PIP topic was “Increase the Percentage of Children Receiving an Annual Dental Visit by Their First Birthday.” Both topics were selected by LDH. Initial PIP charters were submitted to HSAG on 10/25/24, and the final signed charters were submitted outside the review period on 01/17/25. The corresponding PIP forms were submitted to HSAG on 01/31/25.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements:</p> <ol style="list-style-type: none"> 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. <p style="text-align: right;">42 CFR §438.330(d)(2) 42 CFR §457.1240(b)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> QAPI program description QAPI program work plan QAPI program evaluation Policies and procedures Documentation for all active PIPs <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2.103LA QI Program Description <ul style="list-style-type: none"> – Page 2 2024 LA QI Work Plan <ul style="list-style-type: none"> – Pages 2 – 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3	<ul style="list-style-type: none"> • 2024 LA QAPI Annual Evaluation <ul style="list-style-type: none"> – Pages 23 – 24 • 2.102LA Performance Improvement Projects <ul style="list-style-type: none"> – Page 7, procedure #10 • LA Dental PAHP PIP Charter EPSDT Preventative Services • LA Dental PAHP PIP Design Charter Dental Visit by 1st Birthday 	
<p>MCE Description of Process: MCNA’s Performance Improvement Projects (PIPs) were selected by LDH, and the PIP charters were provided by HSAG. The PIPs are designed to drive significant improvements in health outcomes and member satisfaction. HSAG established the PIP indicators and goals, which include a target improvement of 2.5 percentage points over baseline. PIP interventions were implemented in January 2025, as CY 2024 served as the baseline year. The Plan-Do-Study-Act (PDSA) methodology is utilized for continuous quality improvement and to evaluate the effectiveness of the interventions. The QI Director also reports the status and results of the interventions quarterly to the QIC where opportunities for improvement are identified and the committee provides feedback such as retiring interventions that are not impactful and initiating a new intervention or enhancing the current intervention to increase or sustain improvement.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year. <div style="text-align: right; margin-right: 50px;"> 42 CFR §438.330(d)(3) 42 CFR §457.1240(b) </div> MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Evidence of annual submission of all PIPs to the State <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.102LA Performance Improvement Projects <ul style="list-style-type: none"> – Page 2 • LA Dental PAHP PIP Charter EPSDT Preventative Services 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<ul style="list-style-type: none"> LA Dental PAHP PIP Design Charter Dental Visit by 1st Birthday Email Confirmation Submission and Receipt of PIP Charters 	
<p>MCE Description of Process: MCNA submitted the requested PIP Charters to HSAG on 10/25/24. The PIP forms were submitted to HSAG outside of the review period on 01/31/25.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Critical Incidents		
<p>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).</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> N/A 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p>MCE Description of Process: N/A</p>		
<p>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.</p>		
<p>Required Actions: No action required.</p>		



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QAPI Program Reviews, Analysis, and Evaluation		
<p>10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes:</p> <ul style="list-style-type: none"> 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. <p>MCO:</p> <ul style="list-style-type: none"> a. <i>The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.</i> <p style="text-align: right;">42 CFR §438.330(e) 42 CFR §457.1240(b)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Committee meeting minutes (with discussion of QAPI evaluation) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description <ul style="list-style-type: none"> – Page 14 • LA Q1 2024 QIC Minutes <ul style="list-style-type: none"> – Pages 5-7 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Under the direction of the Chief Dental Officer (CDO), Dental Director, and Vice President of Dental Management and Quality Improvement—and with input from department heads—the Director of Quality Improvement prepares a formal, written annual assessment of the Quality Improvement (QI) Program’s effectiveness. This assessment reviews the prior year’s quality projects, initiatives, measurement techniques, prevention activities, and outcomes. It serves as a foundation for developing the QI Program for the upcoming year and informs departmental QI plans.</p> <p>The evaluation helps staff identify priority areas for study, annual quality improvement initiatives, required resources, and timelines for implementation and completion. The Quality Improvement Committee (QIC) reviews the evaluation report to assess the adequacy of the program assessment. Upon approval, the QIC’s recommendations are incorporated into the new annual work plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>11. QAPI Committee Requirements:</p> <p>MCO:</p> <p>a. <i>The MCO forms a QAPI Committee that at a minimum includes:</i></p> <p style="margin-left: 20px;">i. <i>The MCO's Medical Director who must serve as either the chairman or co-chairman;</i></p> <p style="margin-left: 20px;">ii. <i>The MCO's Behavioral Health Director;</i></p> <p style="margin-left: 20px;">iii. <i>Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;</i></p> <p style="margin-left: 20px;">iv. <i>Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and</i></p> <p style="margin-left: 20px;">v. <i>An Enrollee representative(s) and/or advocate(s).</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall form a QAPI Committee that shall, at a minimum include:</i></p> <p style="margin-left: 20px;">i. <i>The Dental Director who must serve as either the chairman or co-chairman;</i></p> <p style="margin-left: 20px;">ii. <i>Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and</i></p> <p style="margin-left: 20px;">iii. <i>The PAHP shall include an enrollee advocate representative on the QAPI Committee.</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall form a QAPI committee that shall, at a minimum include:</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • QAPI committee meeting minutes <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description – Pages 7 – 8 • LA Q1 2024 QIC Minutes • LA Q2 2024 QIC Minutes • LA Q3 2024 QIC Minutes 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>i. <i>The PIHP’s Medical Director, who must serve as the chair or co-chair and</i></p> <p>ii. <i>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.</i></p> <p>MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1</p>		
<p>MCE Description of Process: MCNA’s Quality Improvement Committee (QIC) is an interdisciplinary team composed of administrative staff from each department and practicing dentists. The committee meets quarterly and is chaired by the Chief Dental Officer, with the Dental Director serving as co-chair. The QIC also includes the Member Advocate Outreach Specialist (MAOS) Manager, who serves as the enrollee advocate representative. In this role, the MAOS Manager represents the voice of the member community, drawing on insights gained through outreach events and partnerships with various community organizations to ensure that member perspectives are reflected in quality improvement initiatives.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>12. QAPI Committee Responsibilities:</p> <p>MCO:</p> <p>a. <i>The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:</i></p> <p>i. <i>Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;</i></p> <p>ii. <i>Ensure that QAPI activities take place throughout the MCO’s organization and ensure that providers are involved in the QAPI Program;</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<ul style="list-style-type: none"> iii. <i>Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;</i> iv. <i>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;</i> v. <i>Designate evaluation and study design procedures;</i> vi. <i>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;</i> vii. <i>Report findings to appropriate executive authority, staff, and departments within the MCO's organization;</i> viii. <i>Direct and analyze periodic reviews of Enrollees' service utilization patterns;</i> ix. <i>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 review upon request and during EQRO reviews and during NCQA accreditation reviews;</i> x. <i>Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;</i> 	<ul style="list-style-type: none"> • Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members' service utilization patterns <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2.103LA QI Program Description <ul style="list-style-type: none"> – Pages 7 – 9 • LA Q1 2024 QIC Minutes • LA Q2 2024 QIC Minutes • LA Q3 2024 QIC Minutes • QIC Minutes Upload Evidence Q1 2024 • QIC Minutes Upload Evidence Q2 2024 • QIC Minutes Upload Evidence Q3 2024 • Practice Site Performance Summary Report Example • Member Preventive Service Utilization Report 	



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<ul style="list-style-type: none"> xi. <i>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;</i> xii. <i>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</i> xiii. <i>Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.</i> <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The QAPI Committee shall:</i> <ul style="list-style-type: none"> i. <i>Meet on a quarterly basis;</i> ii. <i>Direct and review quality improvement (QI) activities;</i> iii. <i>Ensure that QAPI activities are implemented throughout the PAHP;</i> iv. <i>Review and suggest new and/or improved QI activities;</i> v. <i>Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;</i> vi. <i>Designate evaluation and study design procedures;</i> vii. <i>Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;</i> 		



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<ul style="list-style-type: none"> viii. <i>Report findings to appropriate executive authority, staff, and departments within the PAHP;</i> ix. <i>Direct and analyze periodic reviews of enrollees' service utilization patterns;</i> x. <i>Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and</i> xi. <i>Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>QAPI committee responsibilities shall include:</i> <ul style="list-style-type: none"> i. <i>Directing and reviewing QI activities;</i> ii. <i>Ensuring that QAPI activities take place throughout the organization;</i> iii. <i>Suggesting new and/or improved QI activities;</i> iv. <i>Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;</i> v. <i>Conducting provider quality performance measure profiling;</i> vi. <i>Reporting findings to appropriate executive authority, staff, and departments within the PIHP;</i> vii. <i>Directing and analyzing periodic reviews of members' service utilization patterns; and</i> viii. <i>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.</i> 		



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<p style="text-align: center;"><i>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.</i></p> <p>MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2</p>		
<p>MCE Description of Process: MCNA’s Quality Improvement Committee (QIC) meets on a quarterly basis and minutes are reported quarterly to LDH. The committee is responsible for directing and reviewing QI activities, ensuring that QAPI initiatives are implemented throughout the plan and recommending new or enhanced quality improvement efforts. The QIC may establish task forces or subcommittees to address specific areas of concern in the delivery of care to enrollees. It also designates evaluation and study design procedures, conducts individual and group provider performance profiling, and analyzes periodic reviews of enrollee service utilization patterns. Findings are reported to appropriate executive leadership, staff, and departments within the PAHP.</p> <p>As part of its ongoing performance monitoring efforts, the QI team utilizes the Power BI dashboard to monitor member utilization rates on a monthly basis. This dashboard provides real-time access to key utilization metrics and enables the team to conduct comparative analyses across different time periods. Each month, the QI team reviews current utilization rates and compares them to the same month in previous years. This longitudinal analysis helps identify emerging trends, seasonal patterns, and shifts in member behavior or service delivery. Identified trends are compiled and reported on a quarterly basis to both the Utilization Management (UM) Committee and the QIC.</p> <p>The QI team also conducts facility and provider performance profiling. This includes the dissemination of MCNA’s Provider Scorecard and Performance Summary (PSPS) Report on a quarterly basis. The PSPS Report offers MCNA’s network of primary dental providers (PDPs) comparative operational and clinical performance data. It is designed to help providers understand how their performance aligns with that of their peers and to encourage continuous improvement. The report includes actionable recommendations and best practices drawn from MCNA’s highest-performing providers. These insights are intended to support providers in enhancing clinical outcomes, improving operational efficiency, and reducing time spent correcting administrative errors. This performance profiling process complements the member utilization review by ensuring that both member behavior and provider practices are regularly evaluated and aligned with quality standards.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>13. QAPI Plan Requirements:</p> <p>MCO:</p> <p>a. <i>The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.</i></p> <p>b. <i>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.</i></p> <p>c. <i>The QAPI Plan, at a minimum, shall:</i></p> <p style="margin-left: 20px;">i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i></p> <p style="margin-left: 20px;">ii. <i>Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;</i></p> <p style="margin-left: 20px;">iii. <i>Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;</i></p> <p style="margin-left: 20px;">iv. <i>Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;</i></p> <p style="margin-left: 20px;">v. <i>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</i></p> <p style="margin-left: 20px;">vi. <i>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.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • QAPI Plan • Evidence of submission to the State <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2024 LA QI Work Plan • 2.103LA QI Program Description 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.</i> b. <i>The QAPI plan shall be submitted to LDH annually, and prior to revisions.</i> c. <i>The QAPI plan, at a minimum, shall:</i> <ul style="list-style-type: none"> i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i> ii. <i>Include processes to evaluate the impact and effectiveness of the QAPI Program;</i> iii. <i>Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and</i> iv. <i>Describe the role of providers in giving input to the QAPI Program.</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>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).</i> b. <i>The QAPI program description at a minimum, shall:</i> 		



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<ul style="list-style-type: none"> i. <i>Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.</i> ii. <i>Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.</i> iii. <i>Specify the remediation actions that will be implemented when system performance is less than the required threshold.</i> iv. <i>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.</i> v. <i>Describe how the Contractor will obtain feedback from providers and members.</i> vi. <i>Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.</i> vii. <i>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.</i> 		



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<p>c. <i>The QAPI work plan at a minimum shall:</i> <i>Include objectives for the Contract year, inclusive of associated action steps and timelines.</i></p> <p>i. <i>Include metrics and associated benchmarks for the wraparound agency scorecard.</i></p> <p>ii. <i>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.</i></p> <p>iii. <i>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.</i></p> <p>MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3</p>		
<p>MCE Description of Process: The Quality Improvement (QI) Department, in collaboration with the Quality Improvement Committee (QIC), develops an Annual Work Plan that outlines the strategic direction and activities of the QI Program. This plan is updated annually with input</p>		



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from contracted entities and department leaders, and the results are reported to the QIC. The QIC and the Board of Directors review the plan on an annual basis. The plan remains flexible and may be expanded at any time to incorporate newly identified opportunities for quality improvement.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XII—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1	=	11
	Not Met	=	0	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	11	Total Score		=	11
Total Score ÷ Total Applicable		=					100%



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Standard XIII—Grievance and Appeal Systems

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievance System General Requirements		
<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.100 Grievances and Appeals Department Overview, page 9 • Policy 13.105 Formal Grievance Procedure (page 4) • MCNA_mh-la-adult-en-v2.5, page 19 • MCNA_mh-la-adult-waiver-en-v1.2, page 21 • MCNA_mh-la-epsdt-en-v2.3, page 28 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA's definition of a grievance is; An expression of dissatisfaction about any matter other than an adverse benefit determination. 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 enrollee's rights regardless of whether remedial action is required.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>2. A member may file a grievance with the MCE at any time.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 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)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Member consent form template HSAG will also use the results of the Grievances File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy13.105 Formal Grievance Procedure (page 1) MCNA_mh-la-adult-en-v2.5, page 19 MCNA_mh-la-adult-waiver-en-v1.2, page 21 MCNA_mh-la-epsdt-en-v2.3, page 28 MCNA_LA GA Form[1.6] 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA allows members the right to file a grievance orally or in writing at any time. Members are notified of the grievance process in the member handbook. Member consent is located on the MCNA Member Grievance Form for LA</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The member may file a grievance either orally or in writing.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook HSAG will also use the results of the system demonstration <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy13.105 Formal Grievance Procedure (Page 1. Policy section, paragraph 1) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> MCNA_mh-la-adult-en-v2.5, page 19 MCNA_mh-la-adult-waiver-en-v1.2, page 21 MCNA_mh-la-epsdt-en-v2.3, page 28 	
<p>MCE Description of Process: MCNA allows members the right to file a grievance orally or in writing at any time. Members are notified of the grievance process in the member handbook.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Handling of Grievances		
<p>4. The MCE acknowledges receipt of each grievance.</p> <p>MCO and PAHP:</p> <p>a. <i>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.</i></p> <p>PIHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Grievance acknowledgment notice template Tracking and reporting mechanisms HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy13.105 Formal Grievance Procedure. Pg 1, para 2 LA-Member Grievance Acknowledgment Letter <p>Additional Documentation:</p> <ul style="list-style-type: none"> Case File Notes Case #4 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The G&A staff receives a grievance request by the member or representative acting on behalf of the member orally or in writing. Within 5 business days of receiving the grievance, the G&A staff will log receipt of the grievance and/or appeal and acknowledge the grievance by preparing a written acknowledgment letter to send to the member or provider or member’s authorized representative filing on behalf of the member.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE ensures that the individuals who make decisions on grievances are individuals:</p> <p>a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.</p> <p>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:</p> <p>i. A grievance regarding denial of expedited resolution of an appeal.</p> <p>ii. A grievance that involves clinical issues.</p> <p>c. Who take into account all comments, documents, records, and other information submitted by the member or their representative.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 5.a -Policy 13.100 Grievances and Appeals Department Overview (page 2, bullet 6) • 5.b.i.ii -Policy 13.100 Grievances and Appeals Department Overview (page 2, bullet 7) • 5.c -Policy 13.100 Grievances and Appeals Department Overview (pages 2/3, bullet 9) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: All member grievances concerning medical necessity determinations are made by MCNA Clinical Reviewers who are licensed general dentists and specialists who did not participate in the initial decision making process, and a clinical peer of the requesting provider. To ensure that decision makers on grievances involving clinical issues were not involved in any previous level of review or decision-making or subordinates of any individual who was involved in a previous level of review or decision-making, as part of G&A’s investigation, the G&A Administrator will review the pre-authorization to identify the initial reviewer and document the case summary form. The G&A Administrator will route the grievance to a clinical reviewer who is not a subordinate of the initial reviewer.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Timely Resolution and Notification of Grievances		
<p>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.</p> <p>MCO and PAHP Standard Grievances</p> <p>a. <i>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.</i></p> <p>PIHP Standard Grievances</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.105 Formal Grievance Procedure (2nd table on page 1) • LA-Member Grievance Resolution Letter <p>Additional Documentation:</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1	<ul style="list-style-type: none"> Grievance case resolution notices Case #6 and Case #10 Grievance Case File Notes Case #4 	
<p>MCE Description of Process: Upon completion of the investigation of the member’s grievance, the G&A staff will complete the grievance determination letter and mail it to the member. The grievance determination letter will be written at 6th grade language and include the results of the resolution and the date it was completed, a reference to the benefit provision, guideline, protocol or other similar criterion on which the grievance determination was based (if applicable), notification that the member is entitled to receive reasonable access to and copies of all documents relevant to the member’s grievance, upon request and notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the grievance was based, upon request. MCNA provides notification of the grievance resolution using the Agency approved template which complies with the contract and 42 CFR 438.10.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. For the case file review, MCNA did not include the resolution notice for two case files.</p>		
<p>Required Actions: The MCE must resolve each grievance, and provide notice, as expeditiously as the member’s health condition requires, within state-established time frames that do not exceed the time frames specified in 42 CFR §438.408. Additionally, the MCE must review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than 90 calendar days from the date the MCE receives the grievance.</p>		
<p>7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">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.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
PIHP Contract: 11.4.8.4	<ul style="list-style-type: none"> Policy 13.205 14-day Extensions, pg. 1, para 1 	
<p>MCE Description of Process: Upon receipt of a request for a 14 day extension from the member, the G&A staff logs the request into the grievance and appeals database for tracking purposes and sends a letter to the member notifying receipt of their request. If the time frame is extended other than at the member’s request, MCNA will give the member written notice of the reason for the delay and make reasonable efforts to provide verbal notice of the resolution. MCNA will notify the member via phone by the close of business of the day of the determination and in writing within 2 calendar days of the determination of the reason for the delay and the right to file a grievance if the member disagrees with the extension. MCNA has resolved all grievances within the 30 day contractual timeframe. No examples to provide.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following:</p> <ol style="list-style-type: none"> Makes reasonable efforts to give the member prompt oral notice of the delay. 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. <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.205 14-day Extensions, pg. 1, para 2 LA 14 Day Extension Letter (Grievance) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Upon receipt of a request for a 14 day extension from the member, the G&A staff logs the request into the grievance and appeals database for tracking purposes and sends a letter to the member notifying receipt of their request. If the time frame is extended other than at the member’s request, MCNA will give the member written notice of the reason for the delay and make reasonable efforts to provide verbal notice of the resolution. MCNA will notify the member via phone by the close of business of the day of the</p>		



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Requirement	Supporting Documentation	Score
determination and in writing within 2 calendar days of the determination of the reason for the delay and the right to file a grievance if the member disagrees with the extension. MCNA has resolved all grievances within the 30 day contractual timeframe. No examples to provide.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Appeals General Requirements		
<p>9. The MCE defines an appeal as a review by the MCE of an ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.100 Grievances and Appeals Department Overview (page 8) • Policy 13.201 Provider Claims Appeals (page 2) • MCNA_mh-la-adult-en-v2.5, page 21 • MCNA_mh-la-adult-waiver-en-v1.2, page 23 • MCNA_mh-la-epsdt-en-v2.3, page 31, 32 • MCNA_LA-P_PM[1.26] bottom of page 73 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: An Appeal is defined by MCNA “ as a review of the adverse benefit determination by MCNA” found in polices 13.100, 13.201 and the member and provider handbook as referenced in the supporting documentation listed.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>10. The MCE has only one level of appeal for members.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.200 Member Appeals (pg 1, last sentence of para 1) Policy 13.100 Grievances and Appeals Department Overview (pg. 2, para 2) MCNA_mh-la-adult-en-v2.5, page 21, 22 MCNA_mh-la-adult-waiver-en-v1.2, page 23, 24 MCNA_mh-la-epsdt-en-v2.3, page 31, 32 MCNA_LA-P_PM[1.26] page74 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA provides all members one level of appeal that allows them the right to file an appeal orally, in writing or in person for any adverse benefit determination taken by MCNA regarding a pre-authorization in accordance with applicable regulatory agencies and contractual requirements. If a member requests a second level of appeal, the G&A staff will inform them that there is only one level of appeal through MCNA and inform them of their State Fair Hearing rights.</p>		
<p>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.</p>		
<p>Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.</p>		



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<p>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.</p> <p>a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Element 11-Policy 13.203 Expedited Appeals (page 1, para 1) • Element 11a-Policy 13.203 Expedited Appeals (page 1, para 2) • MCNA_mh-la-adult-en-v2.5, page 23 • MCNA_mh-la-adult-waiver-en-v1.2, page 25 • MCNA_mh-la-epsdt-en-v2.3, page 33 • MCNA_LA-P_PM[1.26] page 75 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Upon receipt of an expedited appeal the G&A Administrator will communicate the decision to the member, authorized representative, or provider on behalf of the member, within 24 hours of receipt or by close of business the next business day, followed by written notification. If a determination is made not to process the appeal as expedited, the appeal will be transferred to the standard appeal process. MCNA administrator will notify the member, member AR within 1 calendar day of the decision not to process the appeal as expedited and a written communication will follow to member, member AR or requesting provider within 2 business days of disposition.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.200 Member Appeals (Page. 1, See the table) • MCNA_mh-la-adult-en-v2.5, page 21 MCNA_mh-la-adult-waiver-en-v1.2, pages 23, 24 • MCNA_mh-la-epsdt-en-v2.3, pages 31, 32 • LA Member Notice of Denial Letter • MCNA_LA-P_PM[1.26] page 74 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA utilizes a Date Calculator on each appeal received to determine if a member, members AR, or provider on behalf of the member has submitted the appeal request timely, within 60 days from date of ABD to date of appeal request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>13. The member may file an appeal orally or in writing.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeals File Review 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>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</p>	<p>42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Element 13: Policy 13.200 Member Appeals (page 1, para 1) • Element 13,a: Policy 13.200 Member Appeals (Pg 2, para 2) • MCNA_mh-la-adult-en-v2.5, page 21, 22 • MCNA_mh-la-adult-waiver-en-v1.2, pages 23, 24 • MCNA_mh-la-epsdt-en-v2.3, pages 31, 32 • MCNA_LA GA Form[1.6] 	
<p>MCE Description of Process: MCNA allows members the right to file an appeal orally or in writing within 60 calendar days from the date of the notice of adverse benefit determination. Members are notified of the grievance process in the member handbook. Member consent is located on the MCNA Member Grievance Form for IA. Provider’s submitting an appeal request on behalf of the member are required to submit a written consent to MCNA via email/mail/fax in order for MNCA to start the appeal process.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The Adult Denture Program member handbook and the EPSDT member handbook included a requirement that a verbal appeal must be followed up in writing.</p>		
<p>Required Actions: The MCE must revise the Adult Denture Program member handbook and the EPSDT member handbook to remove the requirement that a verbal appeal must be followed up in writing.</p>		
Handling of Appeals		
<p>14. If the MCE denies a request for expedited resolution of an appeal, it:</p> <p style="margin-left: 20px;">a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).</p> <p style="margin-left: 20px;">b. Follows the requirements in 42 CFR §438.408(c)(2), including:</p> <p style="margin-left: 40px;">i. Makes reasonable efforts to give the member prompt oral notice of the delay.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Denied expedited resolution letter template • HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.203 Expedited Appeals (page. 2, para 1) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>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 grievance if the member disagrees with that decision.</p> <p style="text-align: right;">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)</p> <p>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</p>	<ul style="list-style-type: none"> LA-Denied Expedited Resolution (Upheld) Letter <p>Additional Documentation:</p> <ul style="list-style-type: none"> Policy 13.203 Grievance and Appeals Policy and Procedure Member Expedited Acknowledgement (Not Urgent Regular Process) Template Fair Notice Companion Guide 	
<p>MCE Description of Process: If the request for an expedited appeal is denied, the appeal will be handled according to the standard appeal process and timeframes. The G&A staff notifies the member via phone within 1 calendar day of the decision not to process the appeal as expedited and notify them of the decision and provide written notice of the reason to the member within two (2) calendar days. Should the member disagree with the determination, information regarding the member’s additional rights including the right to file grievance is contained in the notice of decision.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. The MCE acknowledges receipt of each appeal.</p> <p>MCO and PAHP:</p> <p>a. <i>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.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Appeal acknowledgment template Tracking and reporting mechanisms HSAG will also use the results of the Appeals File Review 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>PIHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.200 Member Appeals (pg. 9, <i>acknowledgement Process, #1</i>) LA-Member Appeal Acknowledgment Letter 	
<p>MCE Description of Process: The G&A staff receives an appeal request by the member, member’s AR, or provider on behalf of the member orally or in writing. Within 5 business days of receiving the appeal, the G&A staff will log receipt of the appeal and acknowledge the appeal by preparing a written acknowledgment letter to send to the member, member’s AR, or provider on behalf of the member.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>16. The MCE ensures that the individuals who made decisions on appeals are individuals:</p> <p>a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.</p> <p>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:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Organizational chart of appeal staff members, including credentials HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>i. An appeal of a denial that is based on lack of medical necessity.</p> <p>ii. An appeal that involves clinical issues.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3</p>	<ul style="list-style-type: none"> Policy 13.100 Grievances and Appeals Department Overview (page. 2, Bullets 6 & 7; p. 2, Bullet 9) 	
<p>MCE Description of Process: All member appeals concerning medical necessity determinations are made by MCNA Clinical Reviewers who are licensed general dentists and specialists who did not participate in the initial decision making process, and a clinical peer of the requesting provider. To ensure that decision makers on appeals of adverse benefit determinations were not, involved in any previous level of review or decision-making, or subordinates of any individual who was involved in a previous level of review or decision-making, as part of G&A’s investigation, the G&A Administrator will review the pre-authorization to identify the initial reviewer and document the case summary form. The G&A Administrator will route the appeal to a clinical reviewer who is not a subordinate of the initial reviewer.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. The MCE treats oral inquiries seeking to appeal an ABD as appeals.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook HSAG will also use the results of the Appeals File Review 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Policy 13.200 Member Appeals (pg. 2, para 2, last sentence) MCNA_mh-la-adult-en-v2.5, page 21 MCNA_mh-la-adult-waiver-en-v1.2, pages 23, 24 MCNA_mh-la-epsdt-en-v2.3, pages 31, 32 Additional Documentation: <ul style="list-style-type: none"> EPSDT Member Handbook Example Language 	
MCE Description of Process: It is MCNA’s policy to provide all members, authorized representatives, or legal representatives and appeal process that allows them the right to file an appeal orally, in writing, or in person for any adverse benefit determination taken by MCNA regarding pre-authorization in accordance with regulatory agencies and contractual requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA’s Member Appeals policy included the requirement that oral inquiries seeking to appeal an ABD will be treated as appeals. However, the Adult Denture Program member handbook stated that the verbal request must be followed up in writing.		
Required Actions: The MCE must revise the Adult Denture Program member handbook to state that an oral inquiry seeking to appeal an ABD is an appeal.		
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. <div style="text-align: right;"> 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) </div>	HSAG Required Evidence: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Policy 13.203 Expedited Appeals (page. 3, “Access to records” section) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p style="text-align: right;">42 CFR §457.1260(d)</p> <p>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</p>	<ul style="list-style-type: none"> LA Member Notice of Denial Letter LA-Member Appeal Acknowledgment Letter <p>Additional Documentation:</p> <ul style="list-style-type: none"> Member Expedited Acknowledgement (Not Urgent Regular Process) Template Fair Notice Companion Guide Appeal Acknowledgement Template 	
<p>MCE Description of Process: At any time during the grievance and/or appeals process, MCNA will allow members to present evidence and allegations of fact or law, including written comments, documents or other information relating to the grievance in person, in writing, via phone or fax or email. Upon receipt of additional information, the G&A staff will add that information to the case file and send the additional information to the appropriate reviewer to review for the final determination. Additionally, when a member submits an expedited appeal, G&A staff inform members of the limited time available to present evidence and testimony, in person or in writing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p>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:</p> <p>a. <i>Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.200 Member Appeals (pg. 5, “Access to Records,” section) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p><i>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.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3</p>	<ul style="list-style-type: none"> Policy 13.203 Expedited Appeals (pg. 3, “Access to Records,” section) LA-Member Appeal Acknowledgment Letter <p>Additional Documentation:</p> <ul style="list-style-type: none"> Member Expedited Acknowledgement (Not Urgent Regular Process) Template Fair Notice Companion Guide Appeal Acknowledgement Template 	
<p>MCE Description of Process: Within 5 days upon request for standard appeals and 72 hours for expedited appeals, the G&A staff will provide members access to and copies of all documents relevant to their appeal. Members and their authorized representative have an opportunity before and during the process to examine the case file, including dental records, new or additional evidence, and any other materials considered during the appeals process free of charge and sufficiently in advance of the resolution.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Resolution and Notification of Appeals		
<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking documentation HSAG will use the Universe File to evaluate timeliness 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1 <div style="text-align: right;"> 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) </div>	<ul style="list-style-type: none"> HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.200, Page 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Business Rules GA 2024 (Job Aid) 	
<p>MCE Description of Process: MCNA resolves standard appeals within 30 calendar days upon receipt of the appeal. Upon receipt of the final determination, the G&A staff will complete the resolution letter and mail it to the member in 6th grade language which includes the appeal determination, principal reason for the appeal determination and date it was completed. MCNA tracks standard appeals via Dentaltrac reporting and Cognos reporting.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal. <div style="text-align: right;"> 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) </div> MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking and reporting mechanisms HSAG will use the Universe File to evaluate timeliness HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.200, Page 1 Policy 13.203, Pages1-2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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	Additional Documentation: <ul style="list-style-type: none"> Policy 13.203 Grievance and Appeals Policy and Procedure 	
<p>MCE Description of Process: When an appeal is received by the Grievances and Appeals (G&A) Department, the G&A Administrator immediately researches the issue, assesses the nature and urgency of the case to determine the appropriate resolution path, and coordinates with dental offices, involved parties, and the staff of other MCNA departments. If it is determined that the turnaround timeframe for a standard appeal or a delay in the delivery of the service could jeopardize the life, health or ability of the member to attain, maintain or regain maximum function, the appeal is processed within 72 hours. MCNA tracks expedited appeals via Dentaltrac reporting and Cognos reporting.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if:</p> <p>a. The member requests the extension; or</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.203, Page 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Upon receipt of a request for a 14-day extension from the member, the G&A staff logs the request into the grievance and appeals database for tracking purposes and sends a letter to the member notifying receipt of their request. If the time frame is extended other than at the member’s request, MCNA will give the member written notice of the reason for the delay and make reasonable efforts to provide verbal notice of the resolution. MCNA will notify the member via phone by the close of business of the day of the determination and in writing within 2 calendar days of the determination of the reason for the delay and the right to file a grievance if the</p>		



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<p>member disagrees with the extension. MCNA has resolved all appeals within the contractual timeframes and has no extended timeframe examples to provide.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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:</p> <ol style="list-style-type: none"> 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. <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2)</p> <p>MCO Contract: 2.15.3.5.2 PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.203, Pages 2-3 • LA Member Appeal 14day Extension Letter 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: Upon receipt of a request for a 14-day extension from the member, the G&A staff logs the request into the grievance and appeals database for tracking purposes and sends a letter to the member notifying receipt of their request. If the time frame is extended other than at the member’s request, MCNA will give the member written notice of the reason for the delay and make reasonable efforts to provide verbal notice of the resolution. MCNA will notify the member via phone by the close of business of the day of the determination and in writing within 2 calendar days of the determination of the reason for the delay and the right to file a grievance if the</p>		



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member disagrees with the extension. MCNA has resolved all appeals within the contractual timeframes and has no extended timeframe examples to provide.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>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).</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.200, Page 2 • Policy 13.100, Page 4 • MCNA_LA Member Appeal Untimely Filing 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: If MCNA fails to adhere to the notice and timing requirements, the member is deemed to have exhausted MCNA’s appeals process. The member may initiate a State fair hearing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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<p>25. For all appeals, the MCE provides written notice of the appeal resolution that includes:</p> <ol style="list-style-type: none"> a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: <ol style="list-style-type: none"> 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. <p>MCO:</p> <ol style="list-style-type: none"> a. <i>The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.</i> b. <i>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.</i> c. <i>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 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.</i> 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.200, Page 3 • Policy 13.203, Page 8 • Element 25a. MCNA_LA Member Appeal Resolution Overturned Letter • Element 25b: MCNA_LA Member Appeal Resolution Letter Upheld 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.</i> b. <i>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.</i> c. <i>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.</i> <p style="text-align: right;">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)</p> <p>MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13</p>		
<p>MCE Description of Process: Upon receipt of the final determination, the G&A staff will complete the resolution notice and mail it to the member which includes information on the right to request a state fair hearing and how to do so, the right to request to receive benefits while the hearing is pending and how to do so and that they may have to pay for the cost of the benefits if the state fair hearing upholds MCNA’s action.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice.</p> <p>MCO and PAHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.203, Page 1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Upon receipt of an expedited appeal the G&A Administrator will communicate the decision to the member, authorized representative, or provider on behalf of the member, within 24 hours of receipt or by close of business the next business day, followed by written notification.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
State Fair Hearings and State External Review		
<p>27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal.</p> <p>a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(f)(1)(i)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice <hr/> <p>Evidence as Submitted by the MCE:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p style="text-align: right;">42 CFR §457.1260(e)(5) Contract H.4.03</p> <p>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</p>	<ul style="list-style-type: none"> Policy 13.200, Page 4-5 Policy 13.207, Page 1 MCNA_LA Member Appeal Resolution Letter Upheld MCNA_mh-la-en-v2.5, page 25-26 MCNA_mh-la-adult-waiver-en-v1.2, page 28 MCNA_mh-la-epsdt-en-v2.3(3), page 36 	
<p>MCE Description of Process: Upon receipt of SFH request, MCNA G&A will verify if the member has exhausted their appeals, if they have not, they will notify the state agency that MCNA does not have an appeal on file and request how they would like us to proceed. If MCNA does have an appeal on file and an adverse benefit determination has been made, MCNA G&A will prepare and submit the evidence packet to the Agency with the required timeframes and to the member free of charge.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>28. The member has <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p> <p>MCO:</p> <p>a. <i>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.</i></p> <p>PAHP:</p> <p>a. <i>An enrollee or authorized representative, who has completed the PAHP’s appeal process, may request a</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.100, Page 3 Policy 13.200, Page 11 MCNA_LA Member Appeal Resolution Letter Upheld 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p><i>state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in whole or in part, the adverse benefit determination, or after the PAHP fails to adhere to the notice and timing requirements applicable to appeals.</i></p> <p>PIHP:</p> <p>a. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2</p>	<ul style="list-style-type: none"> MCNA_mh-la-en-v2.5, page 25-26 MCNA_mh-la-adult-waiver-en-v1.2, page 28 MCNA_mh-la-epsdt-en-v2.3(3), page 36 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Business Rules GA 2024 GA Job Aid Louisiana Appeals and SFH 	
<p>MCE Description of Process: MCNA allows members and their authorized representatives the opportunity to file state fair hearing within 120 calendar days of receipt of MCNA's notice of Appeal Determination. The G&A staff will also instruct the member on how to file a state fair hearing request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA's Grievance and Appeals Policy—Grievances and Appeals Department Overview and the Grievance and Appeals—Member Appeals policy stated that the member may file for a Medicaid State Fair Hearing (SFH) within no less than 90 calendar days and no more than 120 days of receipt of MCNA's notice of ABD. The requirement is that the member has <i>120 calendar days</i> from the date of the MCE's notice of appeal resolution to request an SFH. MCNA's GA Job Aid Louisiana Appeals and SFH document included the requirements of this element.</p>		



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<p>Required Actions: The MCE’s Grievance and Appeals Policy—Grievances and Appeals Department Overview and the Grievance and Appeals—Member Appeals policy must be revised to include that the member has <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p>		
<p>Continuation of Benefits</p>		
<p>29. The MCE continues the member’s benefits if all of the following occur:</p> <ol style="list-style-type: none"> a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). 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. <p>MCO/PAHP/PIHP:</p> <ol style="list-style-type: none"> a. <i>Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.</i> <p><i>Timely files</i> 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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(a-b)</p> <p>MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.209, Page 1 • MCNA_LA Member Notice of Denial Letter • MCNA_LA Member Appeal Resolution Overturned Letter <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Member Appeal Resolution Overturned Notice Template • Member Expedited Appeal Decision Notice Template 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>MCE Description of Process: MCNA policy is to continue member benefits if the member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). The appeal involves the termination, suspension, or reduction of previously authorized services. The services were ordered by an authorized provider. The period covered by the original authorization has not expired. The member timely files for continuation of benefits. If the appeal is upheld MCNA will notify the member that the appeal was upheld, and that the member may be liable for payment of the services furnished while the appeal was pending as a result of the continuation of benefits in accordance with 42 CFR & 431.230 (b).</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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:</p> <ul style="list-style-type: none"> 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. <p>MCO and PAHP:</p> <ul style="list-style-type: none"> a. Appeals <ul style="list-style-type: none"> i. <i>The time period or service limits of a previously authorized service has been met.</i> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(c)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.209, Page 1 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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<p>MCE Description of Process: If MCNA continues or reinstates the member’s benefits while the appeal is pending, the G&A staff will inform the Utilization Management Department via email to continue the member’s benefits. The benefits will be continued until one of the following occurs;</p> <ul style="list-style-type: none"> • Withdraws the appeal • 10 days pass after MCNA mails the notice resolving the appeal against the member, unless the member, within the 10 day, has requested a Fair Hearing with continuation of benefits. in this case, the benefits will continue until a fair hearing decision has been reached • The Medicaid fair hearing office issues a hearing decision adverse to the member if the time period or a service limit of a previously authorized service has been met, the benefits will not be continued. <p>If one of the above occurs, the G&A staff will inform the Utilization Management Department to discontinue the member’s benefits. MCNA has had no requests for continuation for benefits, so no examples to provide</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The Grievance and Appeals policy did not include the requirement of “the time period or service limits of a previously authorized service has been met.”</p>		
<p>Required Actions: The MCE must revise the Grievance and Appeals policy to include the requirement of “the time period or service limits of a previously authorized service has been met.”</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(d)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.209, Page 2 • MCNA_LA Member Appeal Resolution Overturned Letter 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>MCE Description of Process: If the state fair hearing affirms MCNA’s determination, MCNA may request that the member pay MCNA for the cost of the services as outlined in the notification sent to the member that explains that if the resolution of the appeal is adverse to the member they may be liable for the cost. No examples to provide.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(b)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.209, Page 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: For services not furnished while the appeal is pending: Upon receiving notification that the hearing decision was reversed, the G&A staff will submit a request to the Utilization Management department via email to authorize the services. The Utilization Management department will authorize the requested services within 72 hours and respond to the G&A staff that the services have been authorized and the authorization updated. MCNA does not have any examples to provide as we have not discontinued any services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Reinstatement of Services		
<p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking mechanisms • HSAG will also use the results of the Appeals File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>hours from the date it receives notice reversing the determination.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i)</p> <p>MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.209, Page 2 Policy 13.207, Page 2 	
<p>MCE Description of Process: For services furnished while the appeal is pending, upon receiving notification that the hearing decision was reversed, the G&A staff will not hold the member liable for payment of services and document the case accordingly. MCNA will be responsible for payment of the overturned services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Grievances, Appeals, and State Fair Hearings		
<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Example of assistance to members on filing a grievance <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.100, Page 3 Policy 13.200, Page 5 MCNA_mh-la-en-v2.5, page 32 MCNA_mh-la-adult-waiver-en-v1.2, page 34 MCNA_mh-la-epsdt-en-v2.3(3), page 42 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA's Grievance and Appeals and Call Center Operations Departments are able to assist all members in understanding and navigating the MCNA appeals processes, including their right to have representation at various stages of the grievance and</p>		



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<p>appeal processes; and the understanding of any time limits that may apply. If a member files a grievance and/or appeal, the G&A staff will give the member their grievances and or appeal rights. The staff will offer to mail, fax or email the form to the member and instruct them on where to find it online. If requested, MCNA will complete the forms for the members. Appeal forms are mailed to members for their signature or may be obtained online. MCNA identifies and removes any communication barriers that may impede members or their representatives from effectively filing a grievance or an appeal. This includes assisting the member with filling out forms or explaining the grievance and appeals procedures. MCNA will also facilitate the request to file a grievance or an appeal for all members by utilizing a toll-free TDD line for all hearing impaired members, translation service used for members who are unable to speak English, if MCNA does not have an in-house translator, and any other additional accommodations for any member with special needs who is unable to follow the standard process.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1)</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievances and Appeals File Reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.200, Pages 2-3 • MCNA_LA Member Appeal Resolution Overturned Letter • MCNA_LA-X_LANGUAGE-SERVICES-TAGLINES 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	Additional Documentation: <ul style="list-style-type: none"> Development of Member Materials Policy and Procedure 	
<p>MCE Description of Process: MCNA's Grievance and Appeals and Call Center Operations Departments are able to assist all members in understanding and navigating the MCNA appeals processes, including their right to have representation at various stages of the grievance and appeal processes; and the understanding of any time limits that may apply. If a member files a grievance and/or appeal, the G&A staff will give the member their grievances and or appeal rights. The staff will offer to mail, fax or email the form to the member and instruct them on where to find it online. Appeal forms are emailed to members for their signature or may be obtained online. MCNA identifies and removes any communication barriers that may impede members or their representatives from effectively filing a grievance or an appeal. This includes assisting the member with filling out forms or explaining the grievance and appeals procedures. MCNA will also facilitate the request to file a grievance or an appeal for all members by utilizing a toll-free TDD line for all hearing impaired members, translation service is used for members who are unable to speak English, if MCNA does not have an in-house translator, and any other additional accommodations for any member with special needs who is unable to follow the standard process.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g)</p> <p>MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider manual Provider contract Subcontractor agreement template <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy 13.100, Page 3 MCNA <u>LA-P</u> <u>PM</u> [v1.26], Page 26, Provider Rights, Bullet 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Louisiana Provider Manual – MCNA Dental 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>MCE Description of Process: DWP and DWP Kids members or authorized representatives acting on behalf of a member may request an appeal or file a grievance and utilize the Iowa Department of Human Services state fair hearing process. At no time will a member be discriminated against because he or she has filed an appeal. All information contained within a grievance or appeal and anything that comes to light throughout the grievance and appeal process is kept strictly confidential. A provider acting on behalf of a member or a member’s representative may submit grievances and appeals on behalf of members with their written consent. All appeals submitted by a provider on behalf of a member or by a member’s representative must be submitted in writing with a signed copy of the member consent form. If you would like to file a grievance or appeal on behalf of a member, please call or send it to MCNA’s Grievances and Appeals Department. Phone numbers and addresses are located in Section 2: MCNA Contact Information in this manual. The member must first exhaust MCNA’s appeal process before requesting a State Fair Hearing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>37. The MCE includes as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. <p style="text-align: right; margin-right: 50px;"> 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5) </p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook and/or notice templates <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.100, Page 2 • MCNA_mh-la-en-v2.5, page 25-26 • MCNA_mh-la-adult-waiver-en-v1.2, page 28 • MCNA_mh-la-epsdt-en-v2.3(3), page 36 	<p> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA </p>
<p>MCE Description of Process: A member, or his or her authorized representative or the legal representative of a deceased member’s estate, who has completed the MCNA’s appeal process may file for a Medicaid Fair Hearing in accordance with the state and federal laws. Parties to the Medicaid Fair Hearing include MCNA as well as the member, or the member’s authorized representative.</p>		



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<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. MCNA did not include in its policies, procedures, member handbooks, or member communications that it ensures that members are aware of the MCE including as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. 		
<p>Required Actions: The MCE must ensure members are aware of the MCE including as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. 		
Recordkeeping Requirements		
<p>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:</p> <ul style="list-style-type: none"> 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. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Policy 13.103, Pages 1 & 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>PIHP:</p> <ol style="list-style-type: none"> 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; 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. <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h)</p> <p>MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2</p>		
<p>MCE Description of Process: MCNA’s proprietary software, DentalTrac™, has a customized module for tracking Grievances and Appeals. The activities involved in researching and resolving cases, including all documentation and communications exchanged, are recorded in the DentalTrac™ system for easy reference and superior tracking. The DentalTrac™ Grievances and Appeals module includes the following details in each grievance and appeal record:</p> <ul style="list-style-type: none"> • Complete description of the nature of the grievance or appeal • Member’s name and address • Provider’s name and address • Name of person filing the grievance 		



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> Priority status (standard or expedited) Complete description of MCNA’s findings Reason for the pre-authorization denial Name of the Administrator or Clinical Reviewer that conducted the review Final dispositions at each level, if applicable and recommendations Date of receipt, resolution at each level, if applicable, and the member notification of the disposition In addition, MCNA provides monthly, quarterly and annual reporting to the State Agency (IME) that includes the above criteria. 		
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	=	31	X	1	=	31
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	Total Score		=	31

Total Score ÷ Total Applicable	=	84%
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Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Certification		
<p>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 or Chief Financial Officer 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.</p> <p>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.</p> <p>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).</p> <p style="text-align: right;">42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o)</p> <p>MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures to certify the data specified in 42 CFR §438.604 • Position and job description of individual responsible for certification <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 12.600LA Reporting Requirements <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 12.600LA Reporting Requirements • Narrative response • MCNA Organizational Chart June 2024 • Policy 12.600LA 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA Dental Plans to comply with all the reporting requirements established by the LDH for the Dental Benefit Management Program Contract. As per 42 CFR 438.242(a)(b)(1)(2) and (3), MCNA maintains a health information system MCNA will certify all submitted data, documents, and reports., DentalTrac™, that collects, analyzes, integrates and reports data that complies with LDH and federal reporting requirements. MCNA will certify all submitted data, documents, and reports.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Required Actions: No action required.		
Compliance Program/Program Integrity Plan		
<p>2. The MCE develops a compliance program that includes:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>MCO and PAHP:</p> <p>a. <i>Fraud, waste, and abuse training shall include, but not be limited to:</i></p> <p style="margin-left: 20px;">i. <i>Annual training of all employees; and</i></p> <p style="margin-left: 20px;">ii. <i>New hire training within thirty (30) Calendar Days of beginning date of employment.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.400 HIPAA Compliance Program, page 1, page 7, Procedure,1 & page 10 (whistleblower), • 7.101 Standards of Conduct, page 1 • 7.303 Lines of Communication, page 1. • 7.311 Compliance and Fraud and Abuse Programs, page 1 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>b. <i>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></p> <ul style="list-style-type: none"> i. <i>MCO/PAHP Code of Conduct Training;</i> ii. <i>Privacy and Security - Health Insurance Portability and Accountability Act;</i> iii. <i>Fraud, Waste, and Abuse identification and reporting procedures;</i> iv. <i>The False Claims Act and employee whistleblower protections;</i> v. <i>Procedures for Timely consistent exchange of information and collaboration with LDH;</i> vi. <i>Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and</i> vii. <i>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.</i> <p>c. <i>Effective lines of communication between the compliance officer and the organization's employees.</i></p>	<ul style="list-style-type: none"> • 7.101a Compliance Program Employee Education and Training, page 1 & page 2 • 2025-2026 LA FWA Compliance Program (page 5, 6-12) <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program • Chief Compliance Officer JD • 7.203 Compliance Committee Charter • Louisiana Training Contract (Identified in virtual review) • 7.101a Compliance Program Employee Education and Training (Identified in virtual review) • UHG Compl Training Summary_2025 (Identified in virtual review) 	



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>d. <i>Enforcement of standards through well-publicized disciplinary guidelines.</i></p> <p>e. <i>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.</i></p> <p>PIHP:</p> <p>a. <i>Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program 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;</i></p> <p>b. <i>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;</i></p> <p>c. <i>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</i></p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;</i></p> <p>d. <i>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</i></p> <p>e. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.608(a)(1)</p> <p>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</p> <p>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</p> <p>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</p>		
<p>MCE Description of Process: The Program applies to the Company, its employees, Board of Directors, and its business partners. Additionally, the Company encourages, and in some cases may require, its business partners, including independent contractors, to adhere to the Program’s values. The Company considers our business partners to include our service vendors (e.g., entities that provide basic services to the Company), delegated entities (e.g., vendors who manage operational functions), and contracted providers (e.g., primary care dentists and dental specialists). Finally, the Company believes that members also benefit from the Program because they deserve to have their oral care needs served by a company with the highest standards and business ethics.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP:</p> <p style="margin-left: 20px;">a. <i>The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.</i></p> <p>MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 7.311 Compliance and Fraud and Abuse Programs, page 1 • 7.802 Reports of Suspected Misconduct- Compliance Violation, Investigations_Problem Resolution, page 1 & 2 • 2025-2026 LA FWA Compliance Program (page 12-13) <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>4. Additional compliance program requirements: MCO:</p> <p style="margin-left: 20px;">a. <i>The MCO's compliance program shall incorporate the following requirements:</i></p> <p style="margin-left: 40px;">i. <i>Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and abuse overpayments through data matching,</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 15.305 Provider Investigations, page 1 - 3 (procedures) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.</i></p> <p>ii. <i>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.</i></p> <p>iii. <i>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.</i></p> <p>iv. <i>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.</i></p> <p>PAHP:</p> <p>a. <i>Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing</i></p>	<ul style="list-style-type: none"> • 15.305a Member Investigations – page 1 & 3 Procedure #4. • 15.313 Claims Profiling - Fraud and Abuse Detection, page 1 • 7.311 Compliance and Fraud and Abuse Programs, page 1 • 15.312 SIU - Identifying and Recovering Overpayments, page 1 • 2025-2026 LA FWA Compliance Program for PAHP, pages 20-22, 28- 29, 31, 44 (a-e) • Claims CARC • Report FW and Abuse _ MCNA Dental_ LA Medicaid and CHIP • MCNA Prov Manual_louisiana-v1.25, page 52 &53, section 11.16.1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program 	



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Requirement	Supporting Documentation	Score
<p><i>patterns, monitoring claims edits, and other data mining techniques.</i></p> <p>b. <i>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.</i></p> <p>c. <i>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.</i></p> <p>d. <i>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.</i></p> <p>e. <i>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.</i></p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <ul style="list-style-type: none"> a. <i>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> <ul style="list-style-type: none"> i. <i>The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP’s senior management.</i> b. <i>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</i> c. <i>A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.</i> <p>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</p>		
<p>MCE Description of Process: MCNA has an established Special Investigative Unit (SIU) that is responsible for detecting, investigating, and reporting suspected and/or confirmed cases of fraud, waste or abuse. Ongoing computer-based analysis of provider s (both participating and non-participating) and member claims/encounter data is continual. Patterns of over utilization, exorbitant billing, or other unusual billing practices are addressed.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>5. Publicized email address: MCO and PAHP:</p> <p style="margin-left: 20px;">a. <i>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.</i></p> <p style="margin-left: 20px;">b. <i>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.</i></p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>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.</i></p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>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.</i></p> <p>MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan • Evidence of publicized email address <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Report FW and Abuse _ MCNA Dental_ LA Medicaid and CHIP <ul style="list-style-type: none"> – FWA@mcna.net • 2025-2026 LA FWA Compliance Program, page 45 • 7.311 Compliance and Fraud and Abuse Programs, page 2, Procedures #4b • 15.305 Provider Investigations, page 3, Procedures • 15.305a Member Investigations, Page 1 • 7.303 Lines of Communication, Procedures, Page 1 - 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: In addition to provider, member and third-party reporting of fraud through a designated website, there is also an email address to report fraud.</p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Overpayments and Treatment of Recoveries		
<p>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.</p> <p style="text-align: right;">42 CFR §438.608(a)(2)</p> <p>MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 15.305 Provider Investigations, page 2 15.305a Member Investigations, page 1 2025-2026 LA FWA Compliance Program, page 21 MCNA_la-prov contract-v1.3 MCNA Prov Manual_louisiana-v1.25 (page 53) Any fraud, waste or abuse overpayments are reported quarterly on the 145 reports. (145 FWA Report_Q4) PI SIU Annual Training - Reporting Lead MCNA FWA Annual Training 2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program • 15.312 SIU - Identifying and Recovering Overpayments, page 1 & 2 (identified in virtual review) 	
MCE Description of Process: The process for the prompt reporting of identified or recovered overpayments is contained in the policies and procedures and LA FWA Compliance Plan.		
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. <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 15.312 SIU - Identifying and Recovering Overpayments, page 1 & 2 • 9.109 Recoupment of Overpayments, page 1, page 2 • 15.305 Provider Investigations, page 1 & page 7 - #11 • MCNA Prov Manual_louisiana-v1.25 (page 53) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>MCO:</p> <p>a. <i>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.</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.</i></p> <p>b. <i>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.</i></p> <p>PIHP:</p> <p>a. <i>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.</i></p> <p>b. <i>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.</i></p> <p style="text-align: right;">42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3)</p> <p>MCO Contract: 2.20.2.2.15; 2.20.7.3 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</p>	<ul style="list-style-type: none"> Any fraud, waste or abuse overpayments are reported quarterly on the 145 reports. (145 FWA Report_Q4) 147 MCNA 2024 Q4 PI SIU Annual Training - Reporting Lead MCNA_la-prov contract-v1.3 	



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA will diligently engage in efforts to recover overpayments. Overpayments may be in the form of fraud, abuse, or waste.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p style="text-align: right;">42 CFR §438.608(d)(2)</p> <p>MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
		<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 9.109 Recoupment of Overpayments, page 2 • MCNA Provider Manual, page 53
<p>MCE Description of Process: When MCNA identifies an overpayment, a refund request letter (“Notification of Overpayment”) is sent to the provider following the discovery of the overpayment. The letter will include the reason for the refund and a remittance form.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Notification of Member and Provider Changes		
<p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
		<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 11.300LA Enrollment File Processing, page 2



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<p>circumstances that may affect the member’s eligibility including all of the following:</p> <ul style="list-style-type: none"> a. Changes in the member’s residence; b. The death of a member. <p style="text-align: right;">42 CFR §438.608(a)(3)</p> <p>MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10 PIHP Contract: 14.8.1.4</p>	<ul style="list-style-type: none"> • 4.001MIC Member Personal Information Change Request, page 1 • 15.305 Provider Investigations, page 1 	
<p>MCE Description of Process: MCNA will report in writing to LDH’s Medicaid Customer Service Unit any changes in contact information or living arrangements for families or individual members, including changes in mailing address, residential address if outside Louisiana, email address, telephone number and insurance coverage and death.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>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.</p> <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>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</i> 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 10.107LA Material Changes to the Provider Network, page 1 & page 3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p><i>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></p> <ul style="list-style-type: none"> <i>i. Information about how the provider network change will affect the delivery of covered services; and</i> <i>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.</i> <p>PIHP:</p> <ul style="list-style-type: none"> <i>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> <i>i. Information about how the provider network change will affect the delivery of covered services, and</i> <i>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.</i> <p style="text-align: right;"><i>42 CFR §438.608(a)(4)</i></p> <p>MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5</p>		
<p>MCE Description of Process: MCNA has procedures to address changes in the MCNA network that negatively affect the ability of Members to access services, including access to a culturally diverse Provider network.</p>		



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HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Verification of Services Provided		
<p>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.</p> <p>MCO:</p> <p>a. <i>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></p> <ul style="list-style-type: none"> i. <i>Description of the service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> iii. <i>The date on which the service was furnished;</i> iv. <i>The amount of the payment made for the service; and</i> v. <i>The method for notifying the Contractor of services not rendered.</i> 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 15.306 Verification of Services Billed by Providers, page 1, page 2 (selection criteria), page 4-5 • Reported Quarterly on the 147 EOB Verification Reports. See 147 MCNA 2024 Q4 • Louisiana Member Verification Letter Plan 59 and 60 • 2025-2026 LA FWA Compliance Program MCNA, page 37 , component #2 • FWA Annual Training <hr/> <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program • IT Process to Stratify Sample 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>b. <i>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.</i></p> <p>c. <i>The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).</i></p> <p>d. <i>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.</i></p> <p>e. <i>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 MCO’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>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</i></p>		



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<p><i>related to resolution, and number of responses referred to LDH for further review.</i></p> <p>PAHP:</p> <p>a. <i>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 manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:</i></p> <ul style="list-style-type: none"> i. <i>Description of the service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> iii. <i>The date on which the service was furnished; and</i> iv. <i>The amount of the payment made for the service.</i> <p>b. <i>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 (2%) percent of claims paid per month to be reported on a quarterly basis.</i></p> <p>c. <i>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</i></p>		



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<p>d. <i>Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.</i></p> <p>e. <i>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.</i></p> <p>f. <i>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.</i></p> <p>PIHP:</p> <p>a. <i>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></p> <ul style="list-style-type: none"> i. <i>The service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> iii. <i>The date on which the service was furnished; and</i> iv. <i>The amount of the payment made for the service.</i> <p>b. <i>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</i></p>		



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<p><i>Contractor shall submit the methodology to LDH for prior approval.</i></p> <p>c. <i>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.</i></p> <p>d. <i>The Contractor shall over sample particular provider groups upon request by LDH.</i></p> <p>e. <i>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.</i></p> <p>f. <i>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.</i></p> <p>g. <i>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 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.</i></p> <p style="text-align: right;">42 CFR §438.608(a)(5)</p> <p>MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4</p>		



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<p>MCE Description of Process: MCNA has a process in place for verifying with members whether services billed by providers were received in accordance with 42 CFR 455.20. On a monthly basis, the SIU will run a random sampling and select a predetermined percentage of members. The verification process will be conducted by sending members a copy of their Explanation of Benefits (EOB) or by member phone interviews. MCNA will report all member verification activities to:</p> <ul style="list-style-type: none"> • MCNA’s Fraud, Waste and Abuse Committee quarterly; and • As contractually required, to the appropriate regulatory agency 		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Recommendations: HSAG recommends that MCNA revise its 15.306 Verification of Services Billed by Providers policy to include requirement 11(a)(v): The method for notifying the Contractor of services not rendered.</p>		
<p>Required Actions: No action required.</p>		
Whistleblower Protection		
<p>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.</p> <p>MCO:</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program integrity/compliance plan • Staff, Provider, and Subcontractor training/informational materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 2025-2026 LA FWA Compliance Program, page 18, 40, 48, & 54. • 7.311 Compliance and Fraud and Abuse Programs, page 2 <hr/> <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2023-2024 LA FWA Compliance Program • 2024-2025 LA FWA Compliance Program 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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<p>policies and procedures for detecting and preventing fraud, waste and abuse.</p> <p style="text-align: right;">42 CFR §438.608(a)(6)</p> <p>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</p>		
<p>MCE Description of Process: MCNA makes available its written fraud and abuse policies and procedures to all employees. Our employee handbook provides information about our fraud and abuse policies and employees’ rights to be protected as whistleblowers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Fraud, Waste, and Abuse		
<p>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:</p> <p>a. That are designed to detect and prevent fraud, waste, and abuse.</p> <p>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).</p> <p>PAHP:</p> <p>a. <i>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</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Fraud, waste, and abuse plan • SIU workflow • Reporting mechanisms • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 15.305 Provider Investigations, page 1 • 15.305a Member Investigations, page 2 • 2024_2025 LA FWA Compliance Program, page 38 • Compliance Training for Covered Persons-LDH PowerPoint • PI SIU Annual Training – Louisiana • MCNA FWA Annual Training 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>actions and cooperating with LDH in its investigation of the matter(s).</i></p> <p>PIHP:</p> <p>a. <i>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 standardized referral process should be developed to expedite information for appropriate disposition.</i></p> <p style="text-align: right;">42 CFR §438.608(a) 42 CFR §438.608(a)(7)</p> <p>MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> 2023-2024 LA FWA Compliance Program 2024-2025 LA FWA Compliance Program 	
<p>MCE Description of Process: SIU Investigators document case reports and prepare cases for referral to State and Federal agencies as appropriate. Additionally, SIU Investigators coordinate with internal departments to further fraud investigations, including periodic review of claims and supporting documents to enhance fraud detection.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Suspension of Payments		
<p>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.</p> <p style="text-align: right;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Payment suspension workflow Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 15.305 Provider Investigations, page 2 15.316 SIU Initiated Program Payment Hold, pg 1 2025_2026 LA FWA Compliance Program, page 38 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> 2023-2024 LA FWA Compliance Program 2024-2025 LA FWA Compliance Program 	
MCE Description of Process: Within 1 business day of notification from the State’s OIG or MPI that a provider is placed on payment hold, MCNA will implement the hold until notified by OIG of the outcome of the investigation. MCNA will notify OIG or MPI within 3 business days of the notice of payment hold that MCNA has implemented the hold.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>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).</p> <p style="text-align: right;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19</p>	HSAG Required Evidence: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 2025_2026 LA FWA Compliance Program, page 38 15.316 SIU Initiated Program Payment Hold, pg 2 <i>Attachment A</i> (Notice of payment suspension letter template) Additional Documentation: <ul style="list-style-type: none"> 2023-2024 LA FWA Compliance Program 2024-2025 LA FWA Compliance Program 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: MCNA will place a Provider or facility on a payment hold when it has been determined there is a credible allegation of fraud, willful misrepresentation, or abuse for which an investigation is pending against that Provider or facility.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Provider Screening and Enrollment Requirements		
<p>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.</p> <p style="text-align: right;">42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E</p> <p>MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications • Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 6.100 Provider Credentialing Program Description, page 2 & page 7 • 10.300LA Provider Network Development and Management, page 12 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Medicaid Enrollment Verification 1 • Medicaid Enrollment Verification 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Louisiana providers that submit an initial or re-credentialing application will have their enrollment status verified through the following website, https://www.lamedicaid.com/portalenrollmentstatus/search. Results will show the provider’s status as either enrollment complete, action required, application not submitted or currently in process by Gainwell Technologies. Providers that are not shown in the results search, are not required to enroll until their invitation is received and staff will proceed with the credentialing process.</p>		



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<p>Provider that has completed their enrollment will have their Medicaid ID verified through the following website, https://www.lamedicaid.com/apps/applications.aspx and continue with the initial/re-credentialing process.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days.</p> <p style="margin-left: 20px;">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.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.602(b)(2)</p> <p>MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Medicaid enrollment timeliness tracking mechanisms Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 6.100 Provider Credentialing Program Description, page 7 10.106LA Provider Selection and Retention, page 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> LA QIC Fourth Quarter 2024, slides 24-28 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: MCNA will execute provider agreements and complete the credentialing/re-credentialing process for providers that have been invited to enroll but has a status of action required, application not submitted or currently in process by Gainwell Technologies. Once the credentialing process has been completed, the credentialing staff will notify MCNA’s Provider Relations (PR) department of the providers pending status. PR will monitor the providers enrollment status using the bi-monthly PES file and Gainwell’s working list. If providers are confirmed on the PES file as exceeding their 120-day deadline, the providers will be excluded/terminated from participating on the MCNA LA Medicaid network.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Disclosures and Prohibited Affiliations		
<p>18. The MCE, and any subcontractors:</p> <p style="margin-left: 20px;">a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610.</p> <p style="margin-left: 20px;">b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104.</p> <p style="margin-left: 20px;">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.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>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.</i></p> <p style="text-align: right; margin-left: 20px;">42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610</p> <p>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</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> 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 <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 16.202 Review of OIG and SAM, page 1 & page 5 15.305 Provider Investigations, page 18 1.200MIC Contracting and Oversight of Subcontractors, page 2 & page 3 2025_2026 LA FWA Compliance Program, pg 18-19 & page 37 <p>Additional Documentation:</p> <ul style="list-style-type: none"> 2024 Evidence of Submission 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The Company’s organizational policies prohibit hiring or entering into contracts with individuals who have been debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation, or from participating in non-procurement activities under regulations issued in Executive Order No. 12549 and under guidelines implementing</p>		



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Executive Order No. 12549. The Company will comply with all applicable provisions of 42 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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

Total Score ÷ Total Applicable	=	100%
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Appendix C. 2025 Corrective Action Plan Template

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