NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Grievances and Appeals					
State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
GRIEVANCES AND APPEALS **General Requirements** The DBPM must have a grievance system for members that meet all Federal and State regulatory requirements, including a grievance process, an appeal process, and access to the State's fair hearing system. The DBPM must distinguish between a grievance, grievance system, and grievance process, as defined below: 1. A grievance is a member's expression of dissatisfaction with any aspect of care other than the appeal of actions. 2. The grievance system includes a grievance process, an appeal process, and access to the State's fair hearing system. Any grievance system requirements apply to all three (3) components of the grievance system, not just to the grievance process. 3. A grievance process is the procedure for addressing members' grievances.	**Documents** Policy/procedure UM Program Description in place during the review period	Full			
The DBPM must: 1. Give members reasonable assistance in completing forms and other procedural steps, including but not limited to providing interpreter services and toll-free numbers with teletypewriter/telecommunications devices for deaf individuals and interpreter capability.	**Documents** Policy/procedure Member Handbook	Full			
2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	**Documents** Policy/procedure Template	Partial This requirement is addressed in MCNA's Formal Grievance	Partial	This requirement is addressed in the grievance policy, and the appeals policy and procedures, under procedure 6, where the	

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	acknowledgment notice **Onsite File Review** Grievance and appeal file review results	Procedure Policy, and Policy 13.200 Member Appeals. File Review Results Four (4) grievance files were available for review during the measurement period. Ten (10) appeal files were reviewed. All files contained evidence of this requirement. It was suggested on site that the DBPM include the nature of the grievance in the acknowledgment letter, in the event the member has multiple grievances, for instance. Further, the language related to a state fair hearing should be removed from the grievance acknowledgment letter, since state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days). **Recommendation** MCNA should clarify language as to how state fair hearings are reserved for appeals that have been upheld (as opposed to grievances that are not resolved within 90 days). This may mean that the definitions and processes for appeals and grievances are clearly written and included in the associated policies and procedures for members, providers, and for MCNA staff to ensure that all parties understand the differences between the processes, how to access the process, and how to manage the process. It is imperative that any confusion on this process is avoided among MCNA members, providers, and staff. **DBPM Response** The recommended update to remove the state fair hearing language from the grievance acknowledgement letter has been completed. **IPRO Final Findings** No change in review determination.		DBPM outlines its 5-calendar day acknowledgment of receipt policy for grievances and appeals. File Review Results Of the 20 grievance files reviewed for this requirement, all files met the requirement. Of the 10 appeals files reviewed for this requirement, 2 files were not applicable, as they were expedited appeals, 1 file did not meet the requirement, and the remaining 7 files met the requirement. During the previous compliance review, the recommendation was made to clarify the language pertaining to requesting a state fair hearing (SFH) from the grievance acknowledgment letters, as the SFH pertains to the appeals process. MCNA's new grievance acknowledgment letter template was approved by MLTC on December 14, 2018. All of the acknowledgment letters that were dated after this date contained clarified language regarding the SFH. **Recommendation** MCNA should review appeals policies and procedures for timeliness with staff to ensure that all standard appeals received are acknowledged within 10 calendar days of receipt. **DBPM Response**	

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				Staff has been trained to ensure all standard appeals received are acknowledged within 10 calendar days of receipt. Sign in sheet is attached.  Training Sign In.pdf **IPRO Final Findings** No change in review determination.	
Ensure that individuals completing the review of grievances and appeals are not the same individuals involved in previous levels of review or decision-making, nor the subordinate of any such individual. The individual addressing a member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: 1. The denial of service is based on lack of medical necessity. 2. Because of the member's medical condition, the grievance requires expedited resolution. 3. The grievance or appeal involves clinical issues.	**Documents** Policy/procedure **Onsite File Review** Grievance and appeal file review results	Partial This requirement is addressed in Policy 13.200 Member Appeals on pages 6 and 7. This requirement is partially addressed in Policy 13.100 Grievances and Appeals Department Overview on page 2, as follows: "Fairness in the review process based on a requirement that internal reviewers have the necessary and relevant knowledge and expertise to render a decision regarding an appeal or grievance, have not been involved in the initial decision, and have no financial interest in the resolution of the decision." Necessary and relevant knowledge and expertise implies clinical knowledge; however, there is an opportunity to make the type of required knowledge more transparent. File Review Results Ten (10) of 10 appeal files met this requirement (demonstrating that the individual completing the appeal review was not the same individual involved in the initial denial decision, and was an appropriate health care professional with expertise in treating the member's condition). In 1 appeal file, the resolution letter states that the appeal reviewer is a pediatric dentist; however, the appeal reviewer in the case file is listed as a general dentist. Three (3) of 4 grievance files were not applicable, as they did not pertain to a medical issue. The 1 applicable file met this requirement,	Full	This requirement is addressed in the Grievances and Appeals Department Overview, page 2. The DBPM addressed the recommendation made during the last compliance review to include language that the individual addressing the member's grievance must be a health care professional with clinical expertise in addressing the member's condition. File Review Results Of the 20 grievances files reviewed, 18 files were not applicable for this requirement, as they were first-level reviews. The 2 remaining files met the requirement.	

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		demonstrating that the individual addressing the member's grievance was a health care professional with appropriate expertise in treating the member's condition. **Recommendation** MCNA should modify the language in Policy 13.100 Grievances and Appeals Department Overview so that it reflects contractual requirement IV.H.1.b.3, that the individual addressing the member's grievance must be a health care professional with clinical expertise in treating the member's condition or disease if any of the following apply: the denial of service is based on lack of medical necessity; because of the member's medical condition, the grievance requires expedited resolution; or the grievance or appeal involves clinical issues. **DBPM Response** The recommendation to update policy 13.100 with contractual requirement IV.H.1.b.3 has been completed. The policy will be submitted to MLTC for review and approval. **IPRO Final Findings** No change in review determination.			
4. Take into account all comments, documents, records, and any other information submitted by the member or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit decision.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full			
Complaint and Grievance Processes A member may file a grievance either verbally or in writing. A provider may file a grievance when acting as the member's authorized representative.	**Documents** Policy/procedure Member Handbook Provider Manual	Full			

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
A member may file a grievance with the DBPM or the State at any time.	**Documents** Policy/procedure Member Handbook	Full			
The DBPM must address each grievance and provide notice, as expeditiously as the member's health condition requires, within State-established timeframes and not to exceed 90 calendar days from the day on which the DBPM receives the grievance.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Grievance file review results	Full			
MLTC will establish the method the DBPM must use to notify a member of the disposition of a grievance.	**Documents** Policy/procedure Template grievance resolution notice **Onsite File Review** Grievance file review results	Full			
Appeal Process A member may file a DBPM-level appeal. A provider, acting on behalf of the member and with the member's written consent, may also file an appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full			
The member or provider may file a DBPM-level appeal within sixty (60) calendar days from the date on the DBPM's Notice of Action.	**Documents** Policy/procedure Member Handbook Provider Manual	Full			
The member or provider may file an appeal either verbally or in writing and must follow a verbal filing with a written signed appeal.	**Documents** Policy/procedure Member Handbook Provider Manual	Full			

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State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM must: 1. Ensure that verbal inquiries seeking to appeal an action are treated as appeals and confirm those inquiries in writing, unless the member or the provider requests expedited resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full			
2. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member Handbook Provider Manual	Partial This requirement is evidenced within MCNA's practices; however, it is not explicitly stated within the DBPM's policies and procedures. **Recommendation** MCNA should incorporate language pertaining to only one level of member into MCNA's policies and procedures, Member Handbook, and Provider Manual. **DBPM Response** This recommendation was addressed by the addition of appropriate language pertaining to only one level of member appeal to Policies 13.100, 13.200, & 13.203. The revised Member Handbook was submitted and approved by the MLTC on 6/11/2018. The Provider Manual was also updated with the recommended revision. The policies and Provider Manual will be submitted to MLTC for review and approval. **IPRO Final Findings** No change in review determination.	Full	This requirement is addressed in the Grievances and Appeals Department Overview, page 1; the Member Appeals Policy and Procedure, page 3; and the Member Handbook, page 30. File Review Results Of the 10 appeals files reviewed, 9 were not applicable for this requirement, and the remaining 1 file met the requirement.	
3. Provide a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full			

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4. Provide the member and his or her representative (free of charge and sufficiently in advance of the resolution timeframe for appeals) the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by the DBPM (or at the direction of the DBPM) in connection with the appeal of the adverse benefit determination.	**Documents** Policy/procedure Member Handbook **Onsite File Review** Appeal file review results	Full			
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full			
The DBPM must resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within thirty (30) calendar days from the day the DBPM receives the appeal. The DBPM may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the DBPM shows that there is need for additional information and the reason(s) why the delay is in the member's interest. For any extension not requested by the member, the DBPM must: 1. Make reasonable efforts to give the member prompt verbal notice of the delay. 2. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with that decision.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full			

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3. Resolve the appeal as expeditiously as the member's health condition requires but no later than the date on which the extension expires.					
The DBPM must provide written notice of disposition, which must include: 1. The results and date of the appeal resolution. 2. For decisions not wholly in the member's favor: a. The right to request a State fair hearing. b. How to request a State fair hearing. c. The right to continue to receive benefits pending a hearing. d. How to request the continuation of benefits. e. If the DBPM action is upheld in a hearing, that the member may be liable for the cost of any continued benefit received while the appeal was pending.	**Documents** Policy/procedure Template appeal resolution notice **Onsite File Review** Appeal file review results	Full			
Expedited Appeals Process The DBPM must establish and maintain an expedited review process for appeals that the DBPM determines (at the request of the member or his/her provider) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Expedited appeals must follow all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.	**Documents** Policy/procedure	Full			
The member or provider may file an expedited appeal either verbally or in writing. No additional member follow-up is required.	**Documents** Policy/procedure Member Handbook Provider Manual	Full			

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The DBPM must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and/or in writing, in the case of an expedited resolution.	**Documents** Policy/procedure Member Handbook Template notice of action **Onsite File Review** Appeal file review results	Partial This requirement is addressed in Policy 13.200 Member Appeals on page 3, and in Policy 13.203 Expedited Appeals on page 2. File Review Results Ten (10) out of 10 appeal files were not applicable, as there were no expedited appeals. There were 2 requests for expedited resolution that were not processed; as such, given the criteria for expedited resolution, the requirement was not met. There was a recommendation made on site that included a change to the way in which the acknowledgment letter reads in these cases, since it states the DBPM will not approve the member's request, but does not then state "for an expedited (or fast) decision." This language may lead to confusion if the member does not carefully read the remainder of the letter, which states that the "clinical reviewer determined that the request does not meet the rules for a fast appeal" and that they will "give the member a decision in writing in 30 days." The initial reference to MCNA not approving the request does not apply to the appeal request, but rather the expedited portion of it. **Recommendation** MCNA should revise the expedited appeal acknowledgment letter in cases where the request does not meet expedited appeal criteria; the DBPM should state that they will not approve the member's request *for an expedited (or fast) decision*. By adding this additional language (*for an expedited (or fast) decision*) it will help avoid confusion and ensure clarity for the member that their appeal was not necessarily denied, but rather that their request for an expedited resolution was denied. **DBPM Response** The recommendation to revise the expedited appeal	Full	This requirement is addressed in the Member Appeal Policy and Procedure, page 3, and the Expedited Appeals Policy, page 3. File Review Results Of the 10 files reviewed for this requirement, 8 files met the requirement and 2 files were not applicable, as they were expedited appeals and did not contain a written acknowledgment letter.	

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		acknowledgment letter with required language has been completed. **IPRO Final Findings** No change in review determination.			
The DBPM must resolve each expedited appeal and provide notice as expeditiously as the member's health condition requires and in no event longer than seventy-two (72) hours after the DBPM receives the appeal. The DBPM may extend the timeframes by up to fourteen (14) calendar days if the member requests the extension or the DBPM shows that there is need for additional information and the reason(s) why the delay is in the member's interest.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	Full	This requirement is addressed in the Expedited Appeals Policy, page 1. File Review Results There were two expedited appeals files in the universe. The two files met the timeliness requirement.	
For any extension not requested by the member, the DBPM must give the member written notice of the reason for the delay.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	Full	This requirement is addressed in the 14-day Extension Policy, page 1. File Review Results Of the two expedited appeals files reviewed, none were applicable for this requirement, as no extension was requested.	
In addition to written notice, the DBPM must also make reasonable efforts to provide verbal notice of resolution.	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	Full	This requirement is addressed in the 14-day Extension Policy, page 1. File Review Results Of the two expedited appeals files reviewed, two files met this requirement.	
The DBPM must ensure that no punitive action is taken against a provider who either requests an expedited resolution or supports a member's appeal.	**Documents** Policy/procedure	Full			

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If the DBPM denies a request for expedited resolution of an appeal, it must: 1. Transfer the appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the DBPM receives the appeal with a possible extension of fourteen (14) calendar days. 2. Make a reasonable effort to give the member prompt verbal notice of the denial and a written notice within two (2) calendar days.	**Documents** Policy/procedure	Full			
Continuation of Benefits The DBPM must continue a member's benefits if any one of the following apply: 1. The appeal is filed timely, meaning on or before the later of the following: a. Ten (10) calendar days after the DBPM mailing the Notice of Action; or b. The intended effective date of the DBPM's proposed action. 2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. 3. The services were ordered by an authorized provider. 4. The authorization period has not expired. 5. The member requests an extension of benefits.	**Documents** Policy/procedure	Full			
If the DBPM continues or reinstates the member's	**Documents**	Full			

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benefits while the appeal is pending, the benefits must be continued until one of the following occurs: 1. The member withdraws the appeal. 2. The member does not request an appeal within ten (10) calendar days from when the DBPM mails an adverse DBPM decision. 3. A State fair hearing decision adverse to the member is made. 4. The authorization expires or authorization service limits are met.	Policy/procedure				
The DBPM may recover the cost of the continuation of services furnished to the member while the appeal was pending if the final resolution of the appeal upholds the DBPM action.	**Documents** Policy/procedure	Full			
Access to State Fair Hearings A member may request a State fair hearing. The provider may also request a State fair hearing if the provider is acting as the member's authorized representative. A member or his/her representative may request a State fair hearing only after receiving notice that the DBPM is upholding the adverse benefit determination.	**Documents** Policy/procedure Member Handbook Provider Manual Template appeal resolution notice-upheld decision	Full			
If the DBPM takes action and the member requests a State fair hearing, the State must grant the member a State fair hearing. The right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member or the member's	**Documents** Policy/procedure	Full			

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representative (if any) by the DBPM.					
The member or the member's representative (if any) may request a State fair hearing within one hundred twenty (120) calendar days from the date of the DBPM's notice of resolution.	**Documents** Policy/procedure Template appeal resolution notice–upheld decision	Full			
The parties to the State fair hearing include the DBPM, and the member and his/her representative (if any), or (if instead applicable) the representative of a deceased member's estate.	**Documents** Policy/procedure	Full			
Reversed Appeals If the DBPM or the State fair hearing process reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the DBPM must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date the DBPM receives notice reversing the determination.	**Documents** Policy/procedure	Full			
The DBPM must pay for disputed services if the DBPM or State fair hearing decision reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.	**Documents** Policy/procedure	Full			

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Grievance and Appeal Recordkeeping Requirements The DBPM must maintain records of grievances and appeals. The record of each grievance and appeal must contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date the grievance or appeal was received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance process, as applicable. e. Date of resolution at each level of the appeal or grievance process, as applicable. f. Name of the covered person by or for whom the appeal or grievance was filed. The DBPM is required to accurately maintain the record in a manner that is accessible to MLTC and available on request to CMS.	**Documents** Policy/procedure	Full			
Information to Providers and Subcontractors The DBPM must provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time of entering into or renewing a contract: a. The member's right to a State fair hearing, how to obtain a hearing, and representation rules at a hearing. b. The member's right to file grievances and appeals and the requirements and timeframes for	**Documents** Provider Manual Template provider contract Template subcontractor agreement	Full			

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filing them. c. The availability of assistance in filing grievances or appeals, and participating in State fair hearings. d. The toll-free number(s) to use to file verbal grievances and appeals. e. The member's right to timely request continuation of benefits during an appeal or State fair hearing filing and, if the DBPM action is upheld in a hearing, that the member may be liable for the cost of any continued benefits received while the appeal was pending. f. Any State-determined provider appeal rights to challenge the failure of the organization to cover a service.					
Reporting of Complaints, Grievances, and Appeals The DBPM is required to submit to MLTC monthly data for the first six (6) months of the contract period, and then submit data quarterly thereafter, as specified by MLTC, about grievances and appeals.	**Documents** Policy/procedure **Reports** Member Grievance System reports for grievances, appeals, expedited appeals ,and state fair hearings submitted during the review period	Full			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Indian Health Protections Per Section 5006(d) of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, the DBPM must: Provide Indian Health Services/Tribal 638/Urban Indian Health (I/T/U) providers, whether participating in the network or not.	**Documents** Policy/procedure **Reports** Provider adequacy report for I/T/U providers	Full			
Notice to Members of Provider Termination The DBPM must give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member must be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	**Documents** Policy/procedure Template notice of provider termination	Full			
Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice must be issued immediately upon the DBPM becoming aware of the circumstances. The DBPM must document the date and method of notification of termination.	**Documents** Policy/procedure	Full			
Oral and Written Interpretation Services The DBPM must make real-time oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages not just those that Nebraska specifically requires (Spanish).	**Documents** Policy/procedure	Full			

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The member shall not to be charged for interpretation services. The DBPM must notify its members that oral interpretation is available for any language and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish. The DBPM must ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language by more than five percent of the population statewide. Within 90 calendar days of notice from MLTC, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the DBPM and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).					
Requirements for Member Materials The DBPM must comply with the following requirements for all written member materials, regardless of the means of distribution (for example, printed, web, advertising, and direct mail).	**Documents** Policy/procedure	Full			
The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of DBPM members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test.	**Documents** Policy/procedure	Full			
The DBPM must distribute member materials to each new member within 30 calendar days of enrollment. One of these documents must describe the DBPM's website, the materials that the members can find on the website and	**Documents** Policy/procedure Member materials for	Full			

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
how to obtain written materials if the member does not have access to the website.	new members				
Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or, limited reading proficiency.	**Documents** Policy/procedure	Full			
All members and Medicaid enrollees must be informed that information is available in alternative formats and communication modes, and how to access them. These alternatives must be provided at no expense to each member.	**Documents** Policy/procedure	Full			
The DBPM must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. The DBPM must make its written information available in any additional non-English languages identified by MLTC during the duration of the contract.	**Documents** Policy/procedure Examples of member materials in English and Spanish, such as newsletters and other informational materials	Full			
All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise approved by MLTC. The quality of materials used for printed materials must be, at a minimum, equal to the materials used for printed materials for the DBPM's commercial plans, if applicable.	**Documents** Policy/procedure	Full			
The DBPM's name, mailing address, (physical location, if different), and toll-free telephone number must be	**Documents** Policy/procedure	Full			

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
prominently displayed on all marketing materials, including the cover of all multi-page materials.	Sample marketing materials				
All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.	**Documents** Policy/procedure Examples of member materials	Full			
All written materials related to DBPM enrollment and dental home selection must advise members to verify with their usual providers that they are participating providers in the selected DBPM and are available to see the member.	**Documents** Policy/procedure Member materials for new members	Full			
Member Handbook The DBPM must develop, maintain, and post to the member portal of its website a member handbook in both English and Spanish. The DBPM must publish the member handbook on its website in the member portal. It must also have hard copies available and inform members how to obtain a hard copy member handbook if they want it. At a minimum, the DBPM must review and update the member handbook annually. The DBPM must submit the updated handbook to MLTC for review and approval a minimum of 45 calendar days before it is to be implemented. If the DBPM wishes to make changes to the handbook more frequently than annually, the revised language must still be submitted to MLTC a minimum of 45 calendar days prior to proposed implementation.	**Documents** Policy/procedure Member handbook View website onsite Onsite discussion	Full	Full	This requirement is addressed in the Member Materials – Approval Process Policy on page 1 and in the Member Materials Policy on pages 3, 5, and 6. The handbooks are accessible on the DBPM's website and are up to date. The handbook has the DHHS logo on cover that signifies that it is for Medicaid and FFS members.	

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM's updated member handbook must be made available to all members on an annual basis, through its website. When there is a significant change in the Member Handbook, the DBPM must provide members written notice of the change a minimum of 30 calendar days before the effective date of the change, that they may receive a new hard copy if they want it, and the process for requesting it.					
At a minimum, the member handbook must include: 1. A table of contents.	**Documents** Member handbook should address all sub-elements	Full			
2. A general description of basic features of how the DBPM operates and information about the DBPM in particular.		Full			
3. A description of the Member Services department, what services it can provide, and how member services representatives (MSRs) may be reached for assistance. The member handbook shall provide the toll-free telephone number, fax number, email address, and mailing address of the Member Services department as well as its hours of operation.		Full			
4. A section that stresses the importance of a member notifying Medicaid Eligibility of any change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.		Full			
5. Member rights/protections and responsibilities.		Full			
6. Appropriate and inappropriate behavior when seeing a DBPM provider. This section must include a statement		Full			

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
that the member is responsible for protecting his/her ID cards and that misuse of the card, including loaning, selling, or giving it to another person, could result in loss of the member's Medicaid eligibility and/or legal action.					
7. Instructions on how to request no-cost multi-lingual interpretation and translation services. This information must be included in all versions of the member handbook.		Full	Full	On site, there was a discussion of translation services. MCNA explained that they typically identify a potential language barrier, for example, in an inbound call from a member; they ask the member if they prefer to communicate in another language. If so, they patch in TransPerfect, a vendor that provides ISO-compliant translation services in over 200 languages. The DBPM also explained that once a language preference is identified for a member, they try to find a medical office that can accommodate the language preferred by the member, if possible. This helps keep translation requests down. The DBPM has in-house interpreters for Spanish, Arabic, and a few other languages, and does not require translation requests for these languages. MCNA found that there is sometimes an opportunity for provider education about how translation services work, especially at the time translation services are requested; services should be requested for a specified member, wherein that member must be an MCNA beneficiary. During translation service requests, MCNA reiterates their education about how the translation services work, so providers can utilize the service in the correct way for the correct patients. MLTC had observed that the total requests for translation services in the annual QAPI report was not	

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
				accurate and did not match the number of requests reported in quarterly reports. The DBPM explained that both types of reports were indeed accurate; however, the QAPI report included all translation requests, including those for canceled appointments, while the quarterly reports included only successful appointments where member and translator were present, which caused the discrepancy. The DBPM indicated that they will adjust their QAPI reporting to also include only successful appointments. The member handbook indicates, on page 4, that MCNA staff speaks English and Spanish and can help members with other languages. On page 23, the member handbook indicates that the member has the right to receive oral interpretation services for free and in all non-English languages, not just those that are the most common. In addition, page 36 of the member handbook explains that sign language interpreters, qualified interpreters for other languages, and written materials in other languages are available for members.	
8. A description of the dental home selection process and the dental home's role as coordinator of services.		Full			
9. The member's right to select a different dental home within the DBPM network.		Full			
10. Any restrictions on the member's freedom of choice of DBPM providers.		Full			
11. A description of the purpose of the Medicaid and DBPM ID cards, why both are necessary, and how to use them.		Full			
12. The amount, duration and scope of benefits available		Full			

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
to the member under the contract between the DBPM and MLTC in sufficient detail to ensure that members understand the benefits for which they are eligible.					
13. Procedures for obtaining benefits, including authorization requirements.		Full			
14. The extent to which, and how, members may obtain benefits, including from out-of network providers.		Full			
15. Information about health education and promotion programs, including chronic care management.		Full			
16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full			
17. How to make, change, and cancel dental appointments and the importance of cancelling or rescheduling an appointment, rather than being a “no show”.		Full			
18. Information about a member’s right to a free second opinion and how to obtain it.		Full			
19. Information that describes the transition of care policies for enrollees and potential enrollees.		New requirement	Full	This requirement is addressed in the Continuity of Care for New Members Policy that the DBPM provided on site, and in the member handbook on page 13.	
20. The policy about referrals for specialty care and for other benefits not furnished by the member’s dental home.		Full			
21. How to obtain emergency and non-emergency medical transportation.		Full			
22. Information about the EPSDT program and the importance of children obtaining these services.		Full			

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
23. Information about member copayments.		Partial This requirement is partially addressed on page 10 of the member handbook, wherein reference is made to services that are not covered, as well as how members under age 21 do not have to pay for medically necessary dental services. The handbook further specifies that dental coverage is limited to $750 per fiscal year for individuals aged 21 years and older. **Recommendation** MCNA should add language pertaining to copayments to the member handbook. **DBPM Response** There are no copayments. This language can be found on page 11 of the Member Handbook. **IPRO Final Findings** Page 11 of the member handbook does not explicitly indicate to the member that there are no copayments. No change in review determination.	Full	This requirement is addressed in the member handbook on page 11 under "How much do I have to pay for my dental care?" The handbook explicitly states that there are no copayments. The rest of the information about payments regarding members less than 21 years of age and coverage limit of $750 remain as noted in the prior year's review.	
24. The importance of notifying the DBPM immediately if the member files a workers' compensation claim, has a pending personal injury or medical malpractice lawsuit, or has been involved in an accident of any kind.		Full			
25. How and where to access any benefits that are available under the Medicaid State Plan that are not covered under the DBPM's contract with MLTC, either because the service is carved out or the DBPM will not provide the service because of a moral or religious objection.		Full			

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
26. That the member has the right to refuse to undergo any medical service, diagnosis, or treatment or to accept any health service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds.		Full			
27. Member grievance, appeal, and state fair hearing procedures and timeframes, as follows: a. For grievances and appeals: i. Definitions of a grievance and an appeal. ii. The right to file a grievance or appeal. iii. The requirements and timeframes for filing a grievance or appeal. iv. The availability of assistance in the filing process. v. The toll-free number(s) the member can use to file a grievance or an appeal by telephone. vi. The fact that, when requested by a member, benefits can continue if the member files an appeal within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.		Full			
b. For state fair hearing: i. Definition of a state fair hearing. ii. The right to request a hearing.		Full			

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
iii. The requirements and timeframes for requesting a hearing. iv. The availability of assistance to request a fair hearing. v. The rules on representation at a hearing. vi. The fact that, when requested by a member, benefits can continue if the member files a request for a state fair hearing within the timeframes specified for filing. The member should also be notified that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.					
28. How a member may report suspected provider fraud and abuse, including but not limited to, the DBPM's and MLTC's toll-free telephone number and website links created for this purpose.		Full			
29. Any additional information that is available upon request, including but not limited to: a. The structure and operation of the DBPM. b. The DBPM dentist incentive plan (42 CFR 438.6). c. The DBPM service utilization policies. d. How to report alleged marketing violations to MLTC. e. Reports of transactions between the DBPM and parties in interest (as defined in section 1318(b) of the Public Health Service Act) provided to the State.		Partial This requirement is addressed on page 34 of the member handbook for sub-element d only. **Recommendation** MCNA should include all the sub-elements of this requirement in the member handbook to ensure members are aware that they can request information related to the structure/operation of the DBPM, the dentist incentive plan, service utilization policies, and reports of transactions between the DBPM and parties of interest. **DBPM Response**	Partial	Parts a through d of this requirement are addressed in the member handbook on page 34. Although members are informed that they can call the member hotline if they want to know more about the structure and operations of MCNA, it is not explicitly indicated that members can request reports of transactions between the DBPM and parties in interest provided to the state. On site, the DBPM indicated that they have drafted a new handbook including this requirement and that this new handbook is currently under MLTC evaluation. **Recommendation** The DBPM should provide the new member handbook,	

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		The language was added to the Member Handbook on page 36. **IPRO Final Findings** No change in review determination.		including the requirement that members can request these reports, in the next review cycle upon MLTC approval. **DBPM Response** The member handbook has been updated and was submitted to MLTC for review and approval on May 13, 2019. **IPRO Final Findings** No change in review determination.	
30. A minimum of once a year, the DBPM must notify members of the option to receive the Member Handbook and the provider directory in either electronic or paper format.		Full			
Provider Directory for Members The DBPM must develop and maintain a Provider Directory in two (2) formats: 1. Web-based, searchable, online directory for members and the public. 2. A hard copy directory for members upon request only.	**Documents** Policy/procedure Provider directory View website onsite	Full	Full	This requirement is addressed in the Member Materials Policy on pages 3 and 4. The provider directory for members is searchable and available to members and the public.	
The hard copy directory for members must be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill only requests. The web-based online version must be updated in real time, however no less than weekly.	**Documents** Policy/procedure	Full			
In accordance with 42 CFR §438.10, the provider directory must include, but not be limited to:	**Documents** Policy/procedure	Full			

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Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, dental homes, specialists, and providers that are not accepting new patients at a minimum. 2. Identification of dental homes, specialists, and dental groups in the service area. 3. Identification of any restrictions on the enrollee's freedom choice among network providers. 4. Identification of hours of operation including identification of providers with nontraditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	Provider directory View website onsite				
Member Website The DBPM must maintain a website that includes a member portal. The member portal must be interactive and accessible using mobile devices, and have the capability for bi-directional communications (i.e., members can submit questions and comments to the DBPM and receive responses). The DBPM website must include general and up-to-date information about the Nebraska Medicaid program and the DBPM. The DBPM must remain compliant with applicable privacy and security requirements (including but not limited to HIPAA) when providing member eligibility or member identification information on its website.	**Documents** Policy/procedure View website onsite	Partial All the requirements are addressed in the Website Development and Maintenance Policy. The DBPM's website is accessible from a mobile device. The privacy policies are all visible and accessible at the bottom of the home page, as well as the TTY (for the hearing impaired) number. The DBPM has a mobile application named MyMCNA for both Android and Apple device users that can be downloaded for free for all members. In addition, the DBPM has utilized social media ,such as Facebook, Twitter, and YouTube, as another means of communication and to provide updates, information, and education to members in both their pediatric and adult populations. The DBPM's website did not provide an accessibility feature for members with visual impairments, nor the capability for bi-directional communications. The DBPM has discussed that	Partial	This requirement is addressed in the Website Development and Maintenance Policy on pages 1 and 2. On site, MCNA confirmed that their mobile device app, MyMCNA, is still in use for Android and iOS platforms ,as well as their social media accounts. MCNA confirmed that they do not have bi-directional communication in their public website or member portal. Members are directed to call the member hotline, which includes TTY options. However, there is no in-browser live or delayed bi-directional communication for members. MCNA also confirmed that they rely on members to use keyboard shortcuts to increase font size in their browser for viewing the DBPM's website. The	

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The DBPM website must follow all written marketing guidelines included in Section IV G - Member Services and Education. Use of proprietary items that would require use of a specific browser or other interface is not allowed.		most of their members call the office if they have questions. Some members also email MCNA. If the email is submitted during off hours, the DBPM will respond the next business day. **Recommendation** MCNA should add an easily accessible feature to MCNA's website to accommodate the visually impaired who are not able or have difficulty reading regular print (an onsite demonstration showed how the member can enlarge font by pressing "control" and "+" at the same time on their keypads; however, there is an opportunity to provide this instruction on the website, in the event members are not well-versed in how to manipulate font size digitally). MCNA should also consider incorporating a bi-directional communication capability for members to obtain real-time answers to questions. **MCO Response** N/A (no response received). **IPRO Final Findings** No change in review determination.		Frequently Asked Questions (FAQ) section, #12, describes how members can use these shortcuts to increase font. However, this does not resolve the problem that some members may not be able to see the pre-set font size on their browser to be able to utilize the FAQ or that some members might not have sufficient computer literacy to know which type of browser or device they are using, which would affect the shortcuts they need to utilize. **Recommendation** The DBPM should include functional buttons on their website that members can click to increase/decrease font easily without having to utilize device/platform-specific keyboard shortcuts. The DBPM should also implement a website function for members to initiate bi-directional communication, either as live chat or as an in-browser message/email section. **DBPM Response** MCNA's IT team is currently evaluating options for the bidirectional communication for our members through our websites. The addition of functional buttons to increase font size will be implemented by the team within the next 45 days. **IPRO Final Findings** No change in review determination.	
The DBPM must provide the following information on its website, and such information must be easy to find, navigate among, and be reasonably understandable to all members:	**Documents** Policy/procedure View website onsite	Full			

Final Findings

Member Services and Education					
State Contract Requirements (Federal Regulations 438.6, 438.10, 438.56, 438.100, 438.114, 438.206, 438.218, 438.226)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
1. The most recent version of the member handbook in both English and Spanish. 2. Telephone contact information for the DBPM, including the toll free customer service number prominently displayed and a telecommunications device for the deaf (TDD) number. 3. A searchable list of network providers, with a designation of open or closed panels. This directory must be updated in real time, for changes to the DBPM network. 4. (#4 intentionally omitted) 5. A link to the Medicaid Eligibility website (http://accessnebraska.ne.gov) for questions about Medicaid eligibility. 6. Information about how to file grievances and appeals.					

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
PROVIDER NETWORK REQUIREMENTS **General Provider Network Requirements** The DBPM must maintain a network of qualified, appropriate dental providers in sufficient numbers and locations to provide required access to all covered services for all enrollees, including those with limited English proficiency or physical or mental disabilities. The DBPM is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network must be designed to reflect the needs and service requirements of the DBPM's member population. The DBPM must design its dental provider network to maximize the availability of primary dental services and specialty dental services.					
All providers must be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access, reasonable accommodations and accessible equipment for Medicaid members with physical or mental disabilities.	**Documents** Policy/procedure Provider Directory Onsite discussion	Full	Full	This requirement is addressed on page 10 of the Provider Network Development and Management Program.	
The DBPM must not discriminate with respect to participation in the DBP, reimbursement or indemnification against any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the provider's type of licensure or certification. In addition, the DBPM must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.	**Documents** Policy/procedure Provider Manual	Full			
For the first year of the contract period, the DBPM must accept into its network any dental provider participating in the Medicaid program provided the dental provider is licensed and enrolled with DHHS and accepts the terms and conditions of the contract offered to them by the DBPM. This provision also does not interfere with measures established by the DBPM to control costs and quality consistent with its responsibilities under this contract nor does it preclude the DBPM from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.	**Documents** Policy/procedure Onsite discussion	Full			

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM must also meet the following requirements: Provide core dental services directly or enter into written agreements with providers or organizations that must provide core dental services to the members.	**Documents** Policy/procedure Template provider contract – one per provider type	Full			
Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The DBPM must conduct appointment availability surveys annually. The surveys must be submitted within thirty (30) calendar days after the conclusion of each contract year.	**Documents** Policy/procedure **Reports** Appointment availability survey results including follow-up actions	Full	Full	This requirement is addressed on pages 12 and 13 of the Provider Network Development and Management Program.	
If a member requests a provider who is located beyond access standards, and the DBPM has an appropriate provider within the DBPM who accepts new patients, it must not be considered a violation of the access requirements for the DBPM to grant the member's request.	**Documents** Policy/procedure	Full			
The DBPM must require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters.	**Documents** Template provider contract – one per provider type Provider Manual	Full			
The DBPM must at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers.	**Documents** Policy/procedure Onsite discussion	Full	Full	This requirement is addressed on page 18 of the Provider Network Development and Management Program.	
General Provider Access Requirements The DBPM must ensure access to dental services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. The DBPM must provide available, accessible, and adequate numbers of service locations, service sites, and dental professionals					

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
for the provision of core dental benefits and services, and must take corrective action if there is failure to comply by any provider.					
Appointment Availability and Referral Access Standards Nebraska's appointment availability standards are included in Attachment 4 – Dental Access Standards. MLTC will monitor each DBPM's compliance with these standards through quarterly reporting per Attachment 5 – Reporting Requirements. Additionally, walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with appointment availability standards.					
Attachment 4 Dental Access Standards Waiting Times and Timely Access The DBPM must ensure that its network providers have an appointment system for core dental benefits and services and/or expanded services which are in accordance with prevailing dental community standards.	**Documents** Policy/procedure Template provider contract – one per provider type Provider Manual Onsite discussion	Full			
Formal policies and procedures establishing appointment standards must be submitted for initial review and approval during the readiness review process. Revised versions of these policies and procedures should be submitted to MLTC for record keeping purposes as they become relevant. If changes to policies and procedures are expected to have a significant impact on the provider network or member services, MLTC staff must be notified in writing 30 calendar days prior to implementation. Methods for educating both the providers and the members about appointment standards must be addressed in these policies and procedures. The DBPM must disseminate these appointment standard policies and procedures to its in-network providers and to its members. The DBPM must monitor compliance with appointment standards and must have a corrective action plan when appointment standards are not met. Urgent Care must be provided within twenty-four (24) hours; urgent care may be	**Documents** Policy/procedure Provider manual Member Handbook **Reports** Evidence of monitoring appointment availability including results and follow-up actions	Full			

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
provided directly by the primary care dentist or directed by the DBPM through other arrangements. Routine or preventative dental services within six (6) weeks. Wait times for scheduled appointments should not routinely exceed forty-five (45) minutes, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency. If a provider is delayed, the member should be notified immediately. If a wait of more than ninety (90) minutes is anticipated, the member should be offered a new appointment.					
The DBPM must establish processes to monitor and reduce the appointment "no-show" rate for primary care dentists.	**Documents** Policy/procedure **Reports** Evidence of monitoring of appointment "no-show" rate, including results and follow-up actions	Full			
The DBPM must have written policies and procedures about educating its provider network about appointment time requirements. The DBPM must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider. Appointment standards must be included in the Provider Manual. The DBPM is encouraged to include the standards in the provider contracts.	**Documents** Policy/procedure Provider Manual **Reports** Evidence of monitoring appointment availability, including results and follow-up actions	Full	Full	This requirement is addressed in the Network Development and Management Program on page 12, and in the 2018 QAPI Program Evaluation on page 6. This requirement is communicated to the providers in the Provider Manual on page 23.	
Geographic Access Standards The DBPM must comply with maximum travel times and/or distance requirements per Attachment 4 – Dental Access Standards. Requests for exceptions as a result of prevailing community standards or lack of available providers must be submitted to MLTC in writing for approval. Such requests should include data on the local	**Documents** Policy/procedure Requests for exemption submitted to MLTC	Full	Full	This requirement is addressed in the Network Development and Management Program on pages 13 and 14, and in the submission of MCNA's Geographic Access Q4 2018 Report.	

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
provider population available to the non-Medicaid population. **Attachment 4** Dentists The DBPM must, at a minimum, contract with: Two (2) Dentists within forty-five (45) miles of the personal residences of members in urban counties. One (1) Dentist within sixty (60) miles of the personal residences of members in rural counties. One (1) Dentist within one hundred (100) miles of the personal residences of members in frontier counties.	**Reports** Evidence of geographic access monitoring, including results and follow-up actions			MCNA has contracted with every willing provider and monitors its network quarterly. MCNA submitted the Network Development Action Plan as evidence of how it is addressing gaps in care.	
If there are gaps in the DBPM's provider network, the DBPM must develop a provider network availability plan to identify the gaps and describe the remedial action(s) that will be taken to address those gaps. When any gap is identified, the DBPM must document its efforts to engage any available providers (three good-faith attempts, for example) and must incorporate the circumstances of, and information to be gained by, this gap into its written plan to ensure adequate provider availability over time.	**Documents** Policy/procedure Provider Network Availability Plan	Full	Full	This requirement is addressed on pages 14 and 15 of the Network Development and Management Program and in the Network Adequacy and Recruitment Plan.	
The DBPM must establish a program of assertive outreach to rural areas where covered services may be less available than in more urban areas, and must include any gaps in its availability plan. The DBPM must monitor utilization across the State to ensure access and availability, consistent with the requirements of the contract and the needs of its members.	**Documents** Policy/procedure Provider Network Availability Plan **Reports** Evidence of monitoring utilization, including results and follow-up actions	Full	Full	This requirement is addressed on page 14 of the Network Development and Management Program. MCNA provided evidence of assertive outreach through submission of their outreach logs for North Platte and Norfolk in western Nebraska, and statewide recruiting efforts began in Q1 2019.	
Access to Specialty Providers The DBPM must ensure the availability of access to specialty providers. The DBPM must ensure access standards and guidelines to specialty providers are met, as	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Network Development and Management Program on page 6, and in the provider agreement.	

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Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
specified in this Section in regard to timeliness and service area. The DBPM must establish and maintain a provider network of dentist specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the dental needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: The DBPM has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis. The DBPM must ensure, at a minimum, the availability of the following providers: 1. Endodontists 2. Oral Surgeons 3. Orthodontists 4. Pedodontists 5. Periodontists 6. Prosthodontists The DBPM must use specialists with pediatric expertise when the need for pediatric specialty care is significantly different from the need for a general dentist.	Template provider contract – one per provider type				
The DBPM must meet standards for timely access to all specialists. The DBPM must, at a minimum, contract with following dental specialists: One (1) oral surgeon, One (1) orthodontist, One (1) periodontist, and One (1) pediadontist within forty-five (45) miles of the personal residences of members in urban counties. One (1) oral surgeon, One (1) orthodontist, One (1) periodontist, and One (1) pediadontist within sixty (60) miles of the personal residences of members in rural counties. One (1) oral surgeon, One (1) orthodontist, One (1) periodontist, and One (1) pediadontist within one hundred (100) miles of the personal residences of	**Documents** Policy/procedure **Reports** Evidence of geographic access monitoring, including results and follow-up actions	Full	Full	This requirement is addressed in the Network Development and Management Plan on page 13.	

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Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
members in frontier counties.					
For members determined to need a course of treatment, the DBPM must have a mechanism in place to allow members to directly access a specialist as appropriate for the member's condition and identified needs.	**Documents** Policy/procedure Member Handbook	Full			
Contracting with FQHCs and RHCs A DBPM must offer to contract with all FQHCs and RHCs in the State. If a contract cannot be reached between the DBPM and a FQHC or RHC, the DBPM must notify MLTC.	**Reports** Geographic access reports Onsite discussion	Full	Full	This requirement is addressed in the Network Development and Management Plan on page 7. MCNA's Geographic Access Report also provided evidence of compliance with this requirement.	
The DBPM must monitor the practice of placing members who seek any covered services on waiting lists. If the DBPM determines that a network provider has established a waiting list and the service is available through another network provider, the DBPM must stop referrals to the network provider until such time as the network provider has openings, and take action to refer the member to another appropriate provider.	**Documents** Policy/procedure Template provider contract – one per provider type Provider Manual **Reports** Evidence of monitoring of waiting lists, including results and follow-up actions	Full	Full	This requirement is addressed in the Network Development and Management Plan on page 12.	
Credentialing and Re-credentialing of Providers and Clinical Staff The DBPM must have a written credentialing and re-credentialing process for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. Changes to the process are permissible on an annual basis following review and approval by MLTC.	**Documents** Policy/procedure **Onsite file review** Credentialing file review results	Full	Full	This requirement is addressed in the Credentialing Department Program Description, first paragraph. MCNA submitted their credentialing and re-credentialing applications. **Credentialing File Review Results** Ten (10) of 10 files met all requirements.	
The DBPM must develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the contract. The policies and procedures should include but are not limited	**Documents** Policy/procedure	Full			

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
to the encouragement of applicable board certification.					
The DBPM must develop and implement a mechanism, with MLTC's approval, for reporting quality deficiencies which result in suspension or termination of a network provider(s).	**Documents** Policy/procedure	Full			
The DBPM must develop and implement a provider dispute and appeal process, with MLTC's approval, for sanctions, suspensions, and terminations imposed by the DBPM against network provider(s) as specified in the contract.	**Documents** Policy/procedure	Full			
The process for periodic re-credentialing must be implemented at least once every thirty-six (36) months.	**Documents** Policy/procedure **Onsite file review** Re-credentialing file review results	Full	Full	This requirement is addressed in the Re-credentialing Policy. **Re-credentialing File Review Results** Ten (10) of 10 files met all requirements.	
Provider Network Development Management Plan The DBPM must develop and maintain a provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur. The DBPM must submit documentation as specified by the State within the Network Development and Management Plan but no less frequently than: 1. At the time it enters into a contract with the State 2. On an annual basis 3. At any time there has been significant changes (as defined by the State) in the DBPM's operations that would affect the adequacy of capacity and services, including changes in MCP services, benefits, geographic service area, composition of or payments to its provider network, or at the enrollment of a new populations in the MCP.	**Documents** Policy/procedure Network Development Plan	Full	Full	This requirement is addressed in the Network Development and Management Program.	
The Network Development and Management Plan must include the DBPM's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the contract. When designing the network of providers, the DBPM must consider the following:	**Documents** Policy/procedure Network Development Plan	Full	Full	This requirement is addressed in the Network Development and Management Plan on pages 1 and 8.	

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Anticipated maximum number of Medicaid members. Expected utilization of services, taking into consideration the characteristics and healthcare needs of the members in the DBPM. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core dental benefits and services. The numbers of DBPM providers who are not accepting new DBPM members. The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.					
The Network Provider Development and Management Plan must demonstrate the ability to provide access to core benefits and services, access standards and must include: 1. Assurance of Adequate Capacity and Services 2. Establishing Dental Homes 3. Access to Dental Homes 4. Access to Specialists 5. Timely Access 6. Service Area 7. Second Opinion 8. Out-of-Network Providers	**Documents** Policy/procedure Network Development Plan	Full			
The DBPM must communicate and negotiate with the network regarding contractual and/or program changes and requirements.	**Documents** Policy/procedure	Full			
The DBPM must monitor network compliance with policies and rules of MLTC and the DBPM, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Network Development and Management Plan on page 7.	

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM must evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full			
The DBPM must provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area.	**Documents** Policy/procedure	Full			
The DBPM must monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Network Development and Management Plan on page 7.	
The DBPM must provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full			
The DBPM must track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.	**Documents** Policy/procedure **Reports** Evidence of tracking/trending of provider inquiries/complaints/ requests for information, including results and follow-up actions	Full			
Material Change to Provider Network The DBPM must provide written notice to MLTC, no later than seven (7) business days, of any network provider contract termination that materially impacts the DBPM's provider network, whether terminated by the DBPM or the provider, and such notice must include the reason(s) for the proposed action. A material change includes but is not limited to: Any change that would cause more than five percent (5%) of members to change the location where services are received or rendered. A decrease in the total of individual dental homes by more than five percent (5%). A loss of any participating specialist which may impair or deny the member's	**Documents** Policy/procedure Examples of notices provided to MLTC	Full			

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Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
adequate access to providers. Other adverse changes to the composition of which impair or deny the member's adequate access to providers.					
The DBPM must also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Network Development and Management Plan on page 18.	
When the DBPM has advance knowledge that a material change will occur, the DBPM must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	**Documents** Policy/procedure	Full			
Changes and alternative measures must be within the contractually agreed requirements. The DBPM must within thirty (30) calendar days give advance written notice of provider network material changes to affected members. The DBPM must notify MLTC of emergency situation and submit request to approve material changes. MLTC will act to expedite the approval process.	**Documents** Policy/procedure	Full			
The DBPM must notify MLTC within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the DBPM, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification must include: Information about how the provider network change will affect the delivery of covered services. The DBPM's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	**Documents** Policy/procedure Examples of notices provided to MLTC	Full			

Final Findings

Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Coordination with Other Service Providers The DBPM must encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members in the coordination and delivery of health care services. Such other service providers may include: Heritage Health MCOs; FQHCs and RHCs; dental schools; dental hygiene programs; school systems; and non-emergency transportation providers.	**Documents** Policy/procedure	Full			
Provider-Patient Communication/Anti-Gag Clause Subject to the limitations described in 42 CFR §438.102(a)(2), the DBPM must not prohibit or otherwise restrict a health care provider, acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following: a. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. b. Any information the member needs in order to decide among relevant treatment options. c. The risks, benefits, and consequences of treatment or non-treatment. d. The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment or to express preferences about future treatment decisions. If the DBPM violates the anti-gag provisions set forth in 42 U.S.C. §438.102(a)(1), it will be subject to intermediate sanctions. The DBPM must comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including not interfering with providers' advice to members and information disclosure requirements related to provider incentive plans.	**Documents** Policy/procedure Template provider contract – one per provider type Provider Manual	Full			
Confidentiality The DBPM must establish and implement procedures consistent with the confidentiality requirements in 45 CFR Parts 160 and 164 for health records and any other health and enrollment information that identifies a particular member, as well as any and all other applicable provisions of privacy law.	**Documents** Policy/procedure Template provider contract – one per provider type	Full			

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Provider Network Requirements					
State Contract Requirements (Federal Regulations 438.102, 438.206, 438.207, 438.208, 438.214, 438.224)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
	Provider Manual				

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Provider Complaint System The DBPM must establish a Provider Complaint System (PCS) for in-network and out-of- network providers to dispute the DBPM's policies, procedures, or any aspect of the DBPM's administrative functions.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Provider Complaint Process.	
The DBPM must have and implement written policies and procedures which detail the operation of the provider complaint system. The policies and procedures must include, at a minimum:	**Documents** Policy/procedure Provider Manual Template complaint resolution notice **Reports** Provider Complaint System Reports produced during the review period **Onsite File Review** Provider complaint file review results	Full	Full	This requirement is addressed in the Provider Complaint Process. **Provider Complaint File Review Results** Eight (8) of 8 files met all requirements.	
1. Allowing providers thirty (30) calendar days to file a written complaint and a description of how providers file complaint with the DBPM and the resolution time.		Full	Full	This requirement is addressed in the Provider Manual.	
2. A description of how and under what circumstances providers are advised that they may file a complaint with the DBPM for issues that are DBPM provider complaints and under what circumstances a provider may file a complaint directly to MLTC for those decisions that are not a unique function of the DBPM.		Full	Full	This requirement is addressed in the Provider Manual.	
3. A description of how provider relations staff are trained to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf with the member's written consent.		Full	Full	This requirement is addressed in the Provider Complaint Process.	
4. A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of		Full	Full	This requirement is addressed in the Provider Complaint Process and is communicated to the	

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Provider Services					
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
the number of individual patients or payment claims included in the bundled complaint.				providers in the Provider Manual.	
5. A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.		Full	Full	This requirement is addressed in the Provider Complaint Process and is communicated to the providers in the Provider Manual.	
6. A description of the methods used to ensure that DBPM executive staff with the authority to require corrective action are involved in the complaint process, as necessary.		Full	Full	This requirement is addressed in the Provider Complaint Process.	
7. A process for giving providers (or their representatives) the opportunity to present their cases in person.		Full	Full	This requirement is addressed in the Provider Complaint Process.	
8. Identification of specific individuals who have authority to administer the provider complaint process.		Full	Full	This requirement is addressed in the Provider Complaint Process.	
9. A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing.		Full	Full	This requirement is addressed in the Provider Complaint Process.	
The DBPM must include a description of the PCS in the Provider Handbook and include specific instructions regarding how to contact the DBPM's Provider Relations staff; and contact information for the person from the DBPM who receives and processes provider complaints.	**Documents** Policy/procedure Provider Manual	Full	Full	This requirement is addressed in the Provider Complaint Process and is communicated to the providers in the Provider Manual.	
The DBPM must adjudicate each disputed claim to a paid or denied status within 30 business days of receipt.	**Documents** Policy/procedure Provider Manual **Onsite File Review** Provider appeal of claim/service denial file review	New requirement	Full	This requirement is addressed in the Claims Reconsideration Policy. **Provider Appeals File Review Results** Ten (10) of 10 files met all requirements.	

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Quality Assessment and Performance Improvement (QAPI) Program The DBPM must establish and implement a Quality Assessment and Performance Improvement (QAPI) Program to: 1. Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities. 2. Incorporate improvement strategies that include, but are not limited to: a. Performance improvement projects. b. Dental record audits. c. Performance measures. d. Surveys. 3. Detect underutilization and overutilization of services. 4. Assess the quality and appropriateness of dental care furnished to enrollees with special healthcare needs. QAPI Program Description due date: 45 calendar days following 12th month of contract year.	**Documents** QAPI Program Description	Full	Full	This requirement is addressed in MCNA's QI Program Description.	
The QAPI Program's written policies and procedures must address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of	**Documents** Policy/procedure QAPI Program Description	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
care. High-risk and high-volume areas of patient care should receive priority in selection of QAPI activities.					
The QAPI Program must define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	**Documents** QAPI Program Description	Full			
The DBPM's governing body must oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the DBPM's governing body must include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the DBPM.	**Documents** QAPI Program Description QAPI Program Evaluation Onsite discussion	Full			
QAPI Committee The DBPM must form a QAPI Committee that must, at a minimum, include: 1. The DBPM Dental Director must serve as either the chairman or co-chairman. 2. DBPM staff representing the various departments of the organization will have membership on the committee. 3. The DBPM is encouraged to include a member advocate representative on the QAPI Committee.	**Documents** QAPI Program Description Description of QAPI Committee (QAPIC) QAPIC membership	Full			
QAPI Committee Responsibilities The committee must: a. Meet on a quarterly basis. b. Direct and review quality improvement (QI) activities.	**Documents** QAPI Program Description Agendas and meeting minutes for all committee meetings held during review period	Full	Partial	This requirement is partially addressed in MCNA's QI Program Description and in the QAPI Program Evaluation. The Quality Improvement Committee (QIC) oversees the QI program and assesses its effectiveness. Evidence of quarterly meetings is apparent within the meeting minutes that were submitted. Requirement "k. Report an evaluation of the impact and effectiveness of the QAPI Program to MLTC annually. This report must include, but	

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Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
c. Ensure that QAPI activities are implemented throughout the DBPM. d. Review and suggest new and or improved QI activities. e. Direct task forces and committees to review areas of concern in the provision of healthcare services to members. f. Designate evaluation and study design procedures. g. Conduct individual dental home and dental home practice quality performance measure profiling. h. Report findings to appropriate executive authority, staff, and departments within the DBPM. i. Direct and analyze periodic reviews of members' service utilization patterns. j. Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to MLTC with other quarterly reports. k. Report an evaluation of the impact and effectiveness of the QAPI Program to MLTC annually. This report must include, but is not limited to, all care management activities.	QAPI Program Evaluation			is not limited to, all care management activities" is not evidenced within the evaluation that was submitted. On site, the DBPM indicated that their members are referred to case management (CM) through their MCO. All requests are sent to one centralized email address at MCNA, and then assigned to CM staff. All departments are trained to field calls received by the MCOs as they relate to member referrals into CM. Once a referral is received, it is the goal of MCNA to contact member within 48 hours, unless it is an emergency request (in which case, the member is contacted sooner). MCNA's CM coordinators call members after receiving the referral and a dental health assessment is completed. If the DBPM is unsuccessful at contacting the member at initial outreach, they call twice within a two-week period during different times of the day. After no contact via phone, a letter is sent to the member's home. If a member has special health care needs, they will remain in CM; otherwise, each case is closed following receipt of needed services. Quarterly meetings take place with designated MCO CM staff, and MLTC is copied on all email communications between MCNA and MCO CM staff. **Recommendation** MCNA should ensure that all care management activities are summarized and evaluated within their QI Program Evaluation. **DBPM Response** We agree with this statement and will include additional detail in future evaluations. **IPRO Final Findings** No change in review determination.	
QAPI Work Plan	**Documents**	Full	Full	This requirement is addressed in MCNA's QI Program Description, QI	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The QAPI Committee must develop and implement a written QAPI Plan which incorporates the strategic direction provided by the governing body. The QAPI Plan must be submitted to MLTC by the DBPM annually. The QAPI Plan, at a minimum, must: 1. Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention, and assessment of results. 2. Include processes to evaluate the impact and effectiveness of the QAPI Program. 3. Include a description of the DBPM staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities. 4. Describe the role of its providers in giving input to the QAPI Program. QAPI Work Plan due date: 45 calendar days following 12th month of contract year.	QAPI Work Plan QAPI Department organizational chart			Program Evaluation, and QI Work Plan.	
QAPI Reporting Requirements The DBPM must submit QAPI reports annually to MLTC which, at a minimum, must include: a. Quality improvement (QI) activities. b. Recommended new and/or improved QI activities. c. Evaluation of the impact and effectiveness of the QAPI Program. QAPI Program Evaluation due date: 45 calendar days following 12th month of contract year.	**Documents** QAPI Program Description QAPI Program Evaluation	Full	Full	This requirement is addressed in the QI Program Description and QI Program Evaluation. The 2018 QAPI Program Evaluation was submitted Q1 2019, per the CY 2017-2018 QI Work Plan.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Performance Measures The DBPM must report clinical and administrative performance measure (PM) data on at least an annual basis, as specified by MLTC. The DBPM must report on PMs listed in Attachment 6 – Performance Measures which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS measures, Dental Quality Alliance (DQA) measures, and other measures as determined by MLTC. The DBPM must have processes in place to monitor and report all performance measures. Clinical PM outcomes must be submitted to MLTC at least annually and upon MLTC request. Administrative PMs must be submitted to MLTC at least quarterly and upon MLTC request. The reports and data must demonstrate adherence to clinical practice guidelines and must demonstrate changes in patient outcomes. **Attachment 6** Child Core Measures Percentage of Eligibles Who Received Preventive Dental Services (PDENT) HEDIS Measures Annual Dental Visit Dental Quality Alliance 1. Percentage of enrolled children who received at least one dental service within the reporting year.	**Reports** Annual and quarterly reports of state-required performance measures HEDIS final audit report and IDSS rates Onsite discussion	Full	Full	This requirement is addressed in Monitoring and Reporting of Performance Measures, and evidenced within the quality performance measures submitted to MLTC for CY 2018.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
2. Percentage of enrolled children who received a treatment service as a dental service within the reporting year. 3. Percentage of enrolled children who received a comprehensive or periodic oral evaluation as a dental service within the reporting year. 4. Percentage of children enrolled in two consecutive years who received a comprehensive or periodic oral evaluation as a dental service in both years.					
Performance measures may be used to create Performance Improvement Projects (PIP) which are the DBPM's activities to design, implement and sustain systematic improvements based on their own data.	**Reports** PIP proposals and status reports Reports of state-required performance measures HEDIS final IDSS rates Onsite discussion	Full			
Performance Indicator Reporting Systems The DBPM must provide individual dental home clinical quality profile reports.	**Reports** Sample dental home clinical quality profile reports Onsite discussion	Full			
Performance Measure Corrective Action Plan A CAP must be required for performance measures that do not reach the Department's performance benchmark. The DBPM must submit a CAP, within thirty (30) calendar days of the date of notification or as specified by MLTC, for the deficiencies identified by MLTC. Within thirty (30) calendar days of receiving the CAP,	**Documents** Corrective Action Plans required during the review period	Full	Full	MCNA submitted the Quality Performance Program (QPP) measures that demonstrate each of the MLTC benchmarks have been met. No corrective action plans were warranted.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
MLTC will either approve or disapprove the CAP. If disapproved, the DBPM must resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by MLTC. Upon approval of the CAP, whether the initial CAP or the revised CAP, the DBPM must implement the CAP within the timeframes specified by MLTC. MLTC may impose liquidated damages and/or sanctions pending attainment of acceptable quality of care.					
Performance Improvement Projects The DBPM must conduct a minimum of one clinical and one non-clinical PIP. PIPs must meet all relevant CMS requirements and be approved by MLTC prior to implementation.	**Reports** PIP proposals and status reports	Full	Full	This requirement is outlined in Policy 2.102NE Performance Improvement Projects, and evidenced within the PIPs that were submitted to IPRO and MLTC for implementation beginning January 2019.	
PIPs must be addressed in the DBPM's annual QAPI Program Description, Work Plan, and Program Evaluation. The DBPM must report the status and results of each project to MLTC as outlined in the Quality Strategy. PIPs must comply with CMS requirements, including: 1. A clear study topic and question as determined or approved by MLTC. 2. Clear, defined, and measurable goals and objectives that the DBPM can achieve in each year of the project. 3. A study population. 4. Measurements of performance using quality indicators	**Documents** QAPI Program Description QAPI Work Plan QAPI Program Evaluation	Not applicable PIPs are addressed within the QI Program Description. The Program Evaluation was not applicable for review during the review period of the 2018 audit.	Full	This requirement is addressed in the QI Work Plan, QI Program Description, QAPI Program Evaluation, and evidenced within the PIPs that were submitted to IPRO and MLTC.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
that are objective, measurable, clearly defined, and allow tracking of performance over time. The DBPM must use a methodology based on accepted research practices to ensure an adequate sample size and statistically valid and reliable data collection practices. The DBPM must use measures that are based on current scientific knowledge and clinical experience. Qualitative or quantitative approaches may be used as appropriate. 5. The methodology for evaluation of findings from data collection. 6. Implementation of system interventions to achieve quality improvement. 7. A methodology for the evaluation of the effectiveness of the chosen interventions. 8. Documentation of the data collection methodology used (including sources) and steps taken to ensure the data is valid and reliable. 9. Planning and initiation of activities for increasing and sustaining improvement.					
The DBPM must submit to MLTC the status or results of its PIPs in its annual QAPI Program Evaluation. Next steps must also be addressed, as appropriate, in the QM Program Description and Work Plan.	**Documents** QAPI Program Description QAPI Work Plan QAPI Program Evaluation	Not applicable The Program Evaluation was not applicable during the review period of this audit.	Full	This requirement is addressed in the QAPI Program Evaluation. Next steps are not yet applicable, as the PIP started Q1 2019.	
Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement	**Reports** PIP proposals and status reports	Not applicable	Full	The PIPs are being carried out over a two-year time period, to ensure sufficient time to carry out improvement activities and conduct	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
activities. Information about the success and challenges of PIPs must be also available to MLTC for its annual review of the DBPM's Quality Assessment and Performance Improvement Program.		PIP reporting was not applicable during the review period of this audit.		ongoing PDSA analysis. Information about the challenges and successes of the PIP will be included within the update summaries and annual reports.	
CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the DBPM.	**Documents** Onsite discussion	Not applicable It was confirmed on site that no additional performance measures or PIPs have been requested by CMS.	Not applicable	No additional performance measures or PIPs have been requested by CMS or MLTC.	
Annual Member Satisfaction Survey The DBPM must conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members each contract year. The most current CAHPS DBPM Survey for Medicaid-enrolled individuals must be used and include: 1. Getting Needed Care 2. Getting Care Quickly 3. How Well Providers Communicate 4. DBPM Customer Service 5. Global Ratings Member Satisfaction Survey Reports are due 120 calendar days after the end of the contract year.	**Documents** Identity of CAHPS vendor **Reports** CAHPS survey report Onsite discussion	Not applicable MCNA is utilizing a member satisfaction survey based on the CAHPS survey, which is not in accordance with the contractual requirement of utilizing the CAHPS survey and methodology. Their rationale is that there is not a CAHPS dental survey for children, and the adult dental survey is not applicable for their members over 21, due to their limited service structure (given $750 cap on services per year). MCNA indicated that following being awarded the DBPM contract and going live in Nebraska, they obtained approval from MLTC to use their own survey. This survey is outlined in Part 2 – Technical	Non-compliant	MCNA is not utilizing either a CAHPS survey or methodology that is consistent with CAHPS. **Recommendation** MCNA should utilize the dental CAHPS survey *or* a methodology that is consistent with this survey instrument in order to adequately assess the quality and appropriateness of care for members. The domains outlined in the requirement should be reflected within this survey, and mirror the questions (and response scale) utilized within the CAHPS survey. The scale used to record member responses should be revised to reflect the CAHPS scale. The scale MCNA is currently using is skewed in a positive/favorable direction, since it assigns scores to Likert values and calculates performance based on those scores. For instance; a satisfaction level of 1 is equal to a score of 60; 2 is 75; 3 is 83; 4 is 95; and 5 is 100. The aggregate of these scores is difficult to evaluate, as the difference between each level varies (15 units from 1 to 2; 8 units from 2 to 3; 12 units from 3 to 4; and 5 units from 4 to 5). Upon aggregation of survey findings, results will be skewed in a favorable direction (given the small difference between the 4th and 5th levels, and the fact that the lowest possible score is 60, as opposed to 0).	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		Approach of MCNA's RFP response (see attachment below for reference). MCNA submitted survey results titled "NE Q3 2018 Call Center Operations Analysis" (attached below), which included items in each of the domains outlined in the requirements. This survey utilizes a qualitative scale that differs from the scale used in CAHPS (i.e., excellent, very good, good, average, and poor, instead of always, usually, sometimes, and never). This scale is skewed in a positive/favorable direction, as three of the five response options are above average. MCNA_RFP-5427-Z1 _ CAHPS Response NE Q3 2018 Call Center Operations Ar **DBPM Response** This item warrants further discussion as MCNA communicated the absence of a CAHPS survey and our approach		**DBPM Response** A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members. https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html. We will wait on further direction since this population doesn't have a corresponding survey. **IPRO Final Findings** No change in review determination.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		to assessing member satisfaction surveys in our proposal, which was accepted. **IPRO Final Findings** Because MCNA's proposal was approved ahead of the measurement period of this compliance audit, this determination has been changed to "Not applicable."			
Survey results and a description of the survey process must be reported to MLTC separately for each required CAHPS survey.	**Reports** CAHPS Survey Report Onsite discussion	Not applicable In the document provided post-onsite review ("Annual Member Survey Analysis for NE"), only one member satisfaction survey was referenced, with a corresponding description of the process. This process is not aligned with CAHPS, as it does not appear to utilize a statistically valid random sample, nor are responses anonymous. Further, there is no vendor conducting these surveys, and so there is the opportunity for bias. **Recommendation** MCNA should apply survey processes that are aligned with CAHPS to ensure a statistically	Non-compliant	Survey results were reported to MLTC; however, they were not reflective of CAHPS. **Recommendation** MCNA should align their survey process with CAHPS to ensure a statistically valid random sample is utilized and that responses are anonymous. Further, the DBPM should engage a vendor to distribute the survey and collect responses. **DBPM Response** A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members. https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html. We will wait on further direction since this population doesn't have a corresponding survey. **IPRO Final Findings** No change in review determination.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		valid random sample is utilized, and that responses are anonymous. Further, MCNA should engage a vendor to distribute the survey and collect responses to further align with CAHPS methodology. **DBPM Response** This item warrants further discussion as MCNA communicated the absence of a CAHPS survey and their approach to assessing member satisfaction surveys in their proposal, which was accepted. **IPRO Final Findings** Because MCNA's proposal was approved ahead of the measurement period of this compliance audit, this determination has been changed to "Not applicable."			
The survey must be administered to a statistically valid random sample of clients who are enrolled in the DBPM at the time of the survey.	**Reports** CAHPS Survey Report Onsite discussion	Not applicable MCNA responded to an email inquiry pertaining to this requirement and indicated that on a quarterly basis, they generate a list of active members who have claims history in the previous nine	Non-compliant	Member services representatives attempt to conduct a member satisfaction survey on each inbound call received. This methodology is not consistent with statistically valid random sampling of members enrolled in the DBPM. **Recommendation** In order to be consistent with CAHPS methodology, MCNA should ensure a statistically random sample is drawn, based on members who have had a dental visit with an MCNA provider.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		months from the reporting date. A random sample consisting of approximately 5% of members is included in an outbound call campaign. These calls are conducted by MCNA's Care Connections team. A document outlining survey administration was received 7/27/18. This document ("Annual Member Satisfaction Survey Analysis for Nebraska") indicates that member services representatives will attempt to conduct a member satisfaction survey on every inbound call, and that outbound calls will supplement as needed to compile results from a statistically signification portion of the population. There is a discrepancy between the ways in which the survey methodology was communicated (inbound versus outbound calls) in that the way in which the survey was conducted is not designed around a statistically random sampling. Further, neither of these methods allow for anonymity of the member providing the response to the DBPM.		**DBPM Response** A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members. https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html. We will wait on further direction since this population doesn't have a corresponding survey. **IPRO Final Findings** No change in review determination.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		Recommendation MCNA should ensure that communication related to the survey methodology is consistent. It appears that one approach relies on outbound calls, whereas the other (outlined in Annual Member Satisfaction Survey Analysis for Nebraska) relies on inbound calls. This latter approach is not designed with statistically random sampling in mind. In order to keep as consistent with CAHPS methodology as possible, the DBPM should ensure a statistically random sample is drawn, based on members who have had a dental visit with an MCNA provider. To further align with CAHPS methodology, MCNA should utilize a qualitative scale to record member responses that has been revised to reflect the CAHPS scale. The scale MCNA is currently using is skewed in a positive/favorable direction, as three of the five response options are above average. **DBPM Response** This item warrants further			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		discussion as MCNA communicated the absence of a CAHPS survey and our approach to assessing member satisfaction surveys in our proposal, which was accepted. **IPRO Final Findings** Because MCNA's proposal was approved ahead of the measurement period of this compliance audit, this determination has been changed to "Not applicable."			
The surveys must provide valid and reliable data for results statewide and by county.	**Reports** CAHPS Survey Report Onsite discussion	Full	Non-compliant	The DBPM did not follow CAHPS or CAHPS-like methodology; thus, the validity and reliability of survey results should be interpreted with caution. **Recommendation** In order to ensure survey results are valid and reliable, MCNA should utilize CAHPS or CAHPS-like methodology. Results should be stratified by county, and include an overall statewide average. **DBPM Response** A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members. https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html. We will wait on further direction since this population doesn't have a corresponding survey.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
				IPRO Final Findings No change in review determination.	
Analysis must provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	**Reports** CAHPS Survey Report Onsite discussion	Not applicable MCNA indicated in the RFP response that their member satisfaction survey would include analysis for targeting improvement efforts and comparison to national and state benchmarks. In their Annual Member Satisfaction Survey Analysis document, MCNA of NE indicates that in the absence of national and state benchmarks, they conduct analysis against results for other states managed by MCNA and against internally developed goals. **Recommendation** MCNA should describe how MCNA will conduct analysis to detect statistically significant differences between states. Further, because there are no comparison data available at a national level, and among other states that do not contract with MCNA, there are inherent limitations in data analysis. In order to effectively compare	Non-compliant	Although MCNA conducts member satisfaction surveys across various states, it is not possible to assess results against national and state benchmark standards since the CAHPS survey was not utilized. **Recommendation** MCNA should evaluate their survey methodology and ensure it aligns with CAHPS. The DBPM should have a procedure in place that outlines how they will evaluate survey results to ensure appropriate statistical analysis is employed in order to target improvement efforts. **DBPM Response** A pediatric dental survey is currently unavailable. The only survey related to dental is designed for an adult plan with cost sharing. It does not relate to a Medicaid limited adult benefit where members are capped at an annual amount of $750. The website describes that the survey was developed for TRICARE members. https://www.ahrq.gov/cahps/surveys-guidance/dental/index.html. We will wait on further direction since this population doesn't have a corresponding survey. **IPRO Final Findings** No change in review determination.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
		states in which MCNA is operating to one another, the DBPM should create a procedure that outlines how they will provide statistical analysis and which standards they will use to measure their progress against. **DBPM Response** This item warrants further discussion as MCNA communicated the absence of a CAHPS survey and our approach to assessing member satisfaction surveys in our proposal, which was accepted. **IPRO Final Findings** Because MCNA's proposal was approved ahead of the measurement period of this compliance audit, this determination has been changed to "Not applicable."			
Provider Satisfaction Surveys The DBPM must conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes. The Provider Satisfaction Survey tool and methodology must be submitted to MLTC for approval prior to administration.	**Documents** Provider Satisfaction Survey tool Onsite discussion	Full	Full	MCNA's survey methodology, along with Policy 5.111, indicates the survey is administered annually and assesses satisfaction with provider enrollment, provider communication and education, claims processing, utilization management, and member services. These elements are evidenced within the survey tool (attachment B of Policy 5.111). Policy 5.111 indicates that the survey tool and methodology are	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
				submitted to MLTC prior to administration, and annually no later than 120 days after the plan year and upon request.	
The DBPM must submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due 120 days after the end of the plan year.	**Reports** Provider Satisfaction Survey results, including follow-up actions taken Onsite discussion	Full	Partial	Per the QI Work Plan, there were 137 Provider Satisfaction surveys completed in CY 2018, with an overall satisfaction rate of 93.88%, exceeding MCNA's goal of 80%. All surveys were conducted in-person by provider relations representative, following their site visit. Not all provider offices were targeted. This may bias results. On site, discussion took place that entailed the biases that exist around in-person surveying, as well as the limitations associated with mailed surveys (in terms of low response rate). **Recommendation** The DBPM should explore alternate modes of Provider Satisfaction Survey distribution, in order to reach more practitioners and limit the inherent bias associated with in-person survey methodology following a site visit. Mailed surveys allow for anonymity, and low response rate can be mitigated by sending out several waves of the survey, supplying an incentive for completion, and/or communicating the importance of the survey in provider newsletters, mailings, etc. **DBPM Response** We will evaluate alternate survey delivery options. **IPRO Final Findings** No change in review determination.	
External Quality Review The DBPM is subject to annual, external, independent reviews of the quality outcomes of, timeliness of, and access to, services covered under the contract, per 42 CFR §438.350. The EQR is conducted by MLTC's contracted EQRO or other designee. The EQR will include, but will not be limited to, annual operational reviews, PIP	Onsite discussion	Full	Full	External quality review of MCNA was conducted May 15, 2019.	

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
assessments, encounter data validation, focused studies, and other tasks requested by MLTC.					
The DBPM must provide the necessary information requested for these reviews, provide working space and Internet access for EQRO staff, and make its staff available for interviews.	Onsite discussion	Full	Full	MCNA provided adequate working space, Internet access, and made its staff available throughout the pre-onsite, onsite, and post-onsite components of the review.	
The DBPM must comply with the EQR review of the QAPI Committee meeting minutes and annual dental audits to ensure that it provides quality and accessible healthcare to DBPM members, in accordance with standards contained in the contract. Such audits must allow MLTC or its duly authorized representative to review individual dental records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment. The standards by which the DBPM must be surveyed and evaluated will be at the sole discretion and approval of MLTC. If deficiencies are identified, the DBPM must formulate a CAP, incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. MLTC must prior approve the CAP and will monitor the DBPM's progress in correcting the deficiencies.	Onsite discussion	Full	Full	MCNA complied with the required review elements associated with QIC meeting minutes, and demonstrated quality and accessible healthcare to their members. No corrective action plans were issued during the review period (4/1/18 – 3/31/19).	
Encounter Data The DBPM must collect and submit to MLTC complete and accurate data on member characteristics, provider characteristics, and services furnished to members through an encounter data system, per the State's specifications.	**Documents** Process for verifying the accuracy and completeness of provider and vendor reported data Process for screening data for completeness, logic, and consistency	Full			

Final Findings

Quality Management					
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM must institute processes to ensure the validity and completeness of the data it submits to MLTC.	Evidence of collecting service utilization data using MLTC specifications Evidence of timely and accurate reporting of encounter data to MLTC				

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Subcontracting Requirements					
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Subcontracting Requirements As required by 42 CFR §§438.6 and 438.230, the DBPM is responsible for oversight of all subcontractors' performance and must be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to: The DBPM must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	**Documents** Policy/procedure List of subcontractors, including scope of services provided and date of initial delegation **Reports** Pre-delegation evaluation report for each subcontractor Also includes reviewer completion of subcontractor worksheet	Full	Not applicable	This requirement is addressed in the 1.200MIC Contracting and Oversight of Subcontractors Policy on page 1. The DBPM submitted the Subcontractor Monitoring Report CY 2018 with one active subcontractor, which is responsible for the fulfillment of member materials. This subcontractor pre-dated the review period; therefore, the requirement for pre-delegation evaluation was not applicable.	
The DBPM must have a written contract between the DBPM and the subcontractor that specifies the activities and reporting responsibilities delegated to the subcontractor; it must provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	**Documents** Contract with each subcontractor Also includes reviewer completion of subcontractor worksheet	Full	Full	This requirement is addressed in the 1.200MIC Contracting and Oversight of Subcontractors Policy on page 1. The DBPM provided the contract with the one active subcontractor, FiServ, which met this requirement.	
The DBPM must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors, including results and follow-up actions taken Also includes reviewer completion of subcontractor worksheet	Full			
If necessary, the DBPM must identify deficiencies or areas for improvement, and take corrective action.	**Documents** Policy/procedure **Reports**	Full			

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Subcontracting Requirements					
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
	Evidence of ongoing monitoring and formal reviews of subcontractors, including results and follow-up actions taken Also includes reviewer completion of subcontractor worksheet				

NE EQRO ANNUAL COMPLIANCE REVIEW
May 2019
Period of Review: April 1, 2018 – March 31, 2019
DBPM: MCNA

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Utilization Management The DBPM must develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) Program that incorporates Utilization Review and Service Authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM must submit an electronic copy of the UM policies and procedures to MLTC for written approval annually, and prior to any revisions.	**Documents** Policy/procedure UM Program Description	Full	Full	This requirement is addressed in the Service Authorization Including Retrospective Reviews policy, page 7, and in the UM Program Description.	
The UM Program policies and procedures must meet all NCQA standards or equivalent and include medical management criteria and practice guidelines that: Are adopted in consultation with contracting dental care professionals.	**Documents** Policy/procedure Evidence of participation of dental care professionals	Full	Full	This requirement is addressed in the UM Criteria and Updates Policy, page 1.	
Are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field.	**Documents** Policy/procedure List of practice guidelines developed/adopted by DBPM Examples of practice guidelines	Full	Full	This requirement is addressed in the UM Criteria and Updates Policy, page 1.	
Are considering the needs of the members.	**Documents** Policy/procedure Onsite discussion	Full	Full	This requirement is addressed in the UM Criteria and Updates Policy, page 1.	
Are reviewed annually and updated periodically as appropriate.	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the UM Criteria and Updates Policy, page 1.	
The policies and procedures must include, but not be limited to:	**Documents** Policy/procedure	Full	Full	This requirement is addressed in the Informal Reconsideration Process	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
1. The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services. 2. The data sources and clinical review criteria used in decision making. 3. The appropriateness of clinical review must be fully documented. 4. The process for conducting informal reconsiderations for adverse determinations. 5. Mechanisms to ensure consistent application of review criteria and compatible decisions.	UM Program Description			Procedure and the UM Program Description, pages 12 and 19.	
6. Data collection processes and analytical methods used in assessing utilization of dental care services.	**Documents** Policy/procedure **Reports** UM Utilization Reports for review period	Full	Full	This requirement is addressed in the UM Program Description, page 24.	
The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to: 1. The vendor must be identified if the criteria were purchased. 2. The association or society must be identified if the criteria are developed/ recommended or endorsed by a national or state dental care provider association or society. 3. The guideline source must be identified if the criteria	**Documents** Policy/procedure Identification of criteria/vendor used Identification of individuals making medical necessity determinations	Full	Full	This requirement is addressed in the UM Criteria and Updates Policy, page 2.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
are based on national best practice guidelines. 4. The individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM Dental Director or other qualified and trained professionals.					
UM Program dental management criteria and practice guidelines must be disseminated to all affected providers and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	**Documents** Policy/procedure Evidence of dissemination to providers Member Handbook	Full	Full	This requirement is addressed in the Request for UM Criteria Policy, page 1.	
The DBPM must have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures must be given verbally to the covered person or healthcare provider when requested. The procedures must outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.	**Documents** Policy/procedure	Full			
The DBPM must have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the DBPM may deny authorization of the requested service(s).	**Documents** Policy/procedure	Full			
The DBPM must identify the qualification of staff who will determine medical necessity.	**Documents** Policy/procedure	Full			
Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	**Documents** Policy/procedure	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM must ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease must determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
The individual(s) making these determinations must have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	**Documents** Policy/procedure	Full			
The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.	**Documents** Policy/procedure Sample attestation forms	Full			
The DBPM must provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services must be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration, or scope for the same services furnished to Medicaid eligible individuals under the Medicaid State Plan. The DBPM must not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of diagnosis, type of illness, or condition of the member. The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
achieve their purpose.					
The DBPM must ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.	**Documents** Policy/procedure UM Program Description	Full			
The DBPM Utilization Review Plan must provide that each enrollee's record includes information needed for the UR Committee to perform UR required under this section. This information must include, but not limited to the following: 1. Identification of the enrollee. 2. The name of the enrollee's dentist. 3. Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission. 4. The plan of care required under 42 CFR §456.80 and §456.180. 5. Initial and subsequent continued stay review dates. 6. Date of operating room reservation, if applicable. 7. Justification of emergency admission, if applicable.	**Documents** Policy/procedure UM Program Description	Full Onsite, MCNA indicated that "emergency admission" is not applicable to their providers, which is why this element is not included in their policies. MCNA will discuss this issue internally and with the MLTC to resolve it, either at the contractual level or at the policy level. For this review, this sub-element was deemed not applicable.			
Utilization Management Committee 1. The UM program must include a Utilization Management (UM) Committee that integrates with other functional units of the DBPM as appropriate and supports the QAPI Program.	**Documents** UM Committee description List of membership	Full	Full	This requirement is addressed in the UM Program Description, pages 9 and 20.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
2. The UM Committee must provide utilization review and monitoring of UM activities of both the DBPM and its providers and is directed by the DBPM Dental Director. The UM Committee must convene no less than quarterly and must submit a summary of the meeting minutes to MLTC with other quarterly reports. UM Committee responsibilities include: a. Monitoring providers' requests for rendering healthcare services to its members. b. Monitoring the dental appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling. c. Reviewing the effectiveness of the utilization review process and making changes to the process as needed. d. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task. e. Monitoring consistent application of "medical necessity" criteria. f. Application of clinical practice guidelines. g. Monitoring over- and under-utilization. h. Review of outliers. i. Dental Record Reviews.	Agendas and meeting minutes for all committee meetings held during review period **Reports** UM Reports for review period UM Program Evaluation				

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Dental record reviews must be conducted to ensure that Dental Homes provide high-quality healthcare that is documented according to established industry standards. The DBPM must establish and distribute to providers standards for record reviews that include all dental record documentation requirements addressed in the contract.	**Documents** Policy/procedure Provider Manual	Full			
The DBPM must maintain a written strategy for conducting dental record reviews, reporting results, and the corrective action process. The strategy must be provided within thirty (30) calendar days from the date of award for MLTC review and approval, and annually thereafter. The strategy must include, but not limited to, the following: 1. Designated staff to perform this duty. 2. The method of case selection. 3. The anticipated number of reviews by practice site. 4. The tool the DBPM must use to review each site. 5. How the DBPM must link the information compiled during the review to other DBPM functions (e.g. QI, credentialing, peer review, etc.).	**Documents** Policy/procedure	Full			
The DBPM must conduct reviews at all primary dental services providers that have treated more than 100 unduplicated members in a calendar year, including individual offices and large group facilities. The DBPM must review each site at least one (1) time during each five (5)-year period.	**Documents** Policy/procedure **Reports** Dental Record Review Reports demonstrating evidence of monitoring and follow-up actions	Full	Full	This requirement is addressed in the Dental Record Review Policy, page 1.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The DBPM must review a reasonable number of records, in a random process, at each site to determine compliance. A minimum of ten percent (10%) or up to ten (10) records per site must be reviewed.	**Documents** Policy/procedure **Reports** Dental Record Review Reports demonstrating evidence of monitoring and follow-up actions	Full	Full	This requirement is addressed in the Dental Record Review Policy, page 2.	
Utilization Management Reports **Annual Requirements** Utilization Management Program Review Data and analysis summarizing the DBPM's annual evaluation of its UM Program. Due 45 calendar days following the 12th month of the contract year.	**Reports** UM Program Evaluation	Not applicable This requirement is addressed in the Utilization Management Program Description on page 27 as a policy; however, since the 12th month of the contract year has not yet arrived for MCNA in Nebraska, the DBPM does not yet have a UM Program Evaluation. Therefore, this element is not applicable for this review period.	Full	This requirement is addressed in the UM Program Description, page 26. The UM Program Evaluation is currently embedded in the QM Program Evaluation. MLTC has asked MCNA to extract the UM Program Description as a stand-alone document. The DBPM requested an extension for May 27, which MLTC has accepted. May 27 falls outside of the review period. IPRO will review this requirement during the next compliance review.	
Service Authorization Service authorization includes, but is not limited to, prior authorization. The DBPM UM Program policies and procedures must include service authorization policies and procedures for initial and continuing authorization of services that include, but are not limited to, the following: 1. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a provider does not request a service in a timely manner or refuses a service.	**Documents** Policy/procedure Template notice of action	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
2. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate.	**Documents** Policy/procedure **Reports** Evidence of monitoring, including results and follow-up actions taken **Onsite File Review** UM file review results	Full			
3. Requirement 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 is made by the DBPM Dental Director.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
4. Provide a mechanism in which a member may submit, whether orally or in writing, a service authorization request for the provision of services. This process must be included in its member manual and incorporated in the grievance procedures.	**Documents** Policy/procedure Member Handbook	Full			
5. The DBPM's service authorization system must provide the authorization number and effective dates for authorization to participating providers and applicable nonparticipating providers.	**Documents** Policy/procedure	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
6. The DBPM's service authorization system must have capacity to electronically store and report all service authorization requests, decisions made by the DBPM regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	**Documents** Policy/procedure	Full			
The DBPM must not deny continuation of higher level services for failure to meet medical necessity unless the DBPM can provide the service through an in-network or out-of-network provider at a lower level of care.	**Documents** Policy/procedure	Full			
Timing of Service Authorization Decisions **Standard Service Authorization** 1. The DBPM must make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate dental information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations must be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. 2. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the DBPM justifies to MLTC a need for additional information and the extension is in the member's best interest. In no instance must any determination of standard service authorization be made later than twenty-five (25) calendar days from	**Documents** Policy/procedure **Onsite File Review** UM file review results	Partial This requirement is addressed in the Service Authorizations Including Retrospective Reviews Policy on page 3 and in the Utilization Management Program Description on pages 12 and 19. Although the Service Authorization Including Retrospective Reviews Policy clearly outlines the 14-calendar day requirement for standard service authorization and the additional 14 calendar days for the extension, neither this policy (nor any other policy submitted by the plan) indicated that the maximum cap for a service authorization to reach a determination is 25 calendar days. File Review Results Ten (10) of 10 UM denial files were reviewed and all were standard service authorizations. Of these, all 10 met the requirement of	Full	This requirement is addressed in the Service Authorization Including Retrospective Review Policy, page 3. The DBPM has addressed the recommendation to clarify the language that all service authorizations require a determination within 25 calendar days.	

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
receipt of the request. If the DBPM extends the timeframe, the member must be provided written notice of the reason for the decision to extend the timeframe and the right to file an appeal if he or she disagrees with that decision. The DBPM must issue and carry out its determination as expeditiously as the member's health condition requires but no later than the date the extension expires.		determination within 14 calendar days. Nine (9) out of 10 files were given a determination within 2 business days, which shows that the plan exceeded the requirement of 80% of standard service authorizations getting a determination within 2 days. **Recommendation** MCNA should ensure the policy clearly states that all service authorizations require a determination within 25 calendar days of receipt of the request, regardless of the type of service authorization (standard versus extended). File review evidences that the DBPM is indeed meeting this requirement; however, policies must also include this requirement. **DBPM Response** The recommended update was completed after the onsite comments were received from the EQRO. The policy was updated and approved by the UM Committee and QIC. **IPRO Final Findings** No change in review determination.			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Expedited Service Authorization In the event a provider indicates, or the DBPM determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the DBPM must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	Full	This requirement is addressed in the Service Authorization Including Retrospective Review Policy, page 3. File Review Results Of the five expedited UM files, all files met the requirement for timeliness.	
Post-authorization 1. The DBPM may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the DBPM justifies to MLTC a need for additional information and how the extension is in the member's best interest. 2. The DBPM must make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate dental or medical information that may be required, but in no instance later than one hundred eighty (180) calendar days from the date of service. 3. The DBPM must not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	**Documents** Policy/procedure	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
Timing of Notice **Approval** 1. For service authorization approval for a non-emergency admission, procedure or service, the DBPM must notify the provider as expeditiously as the member's health condition requires but not more than within one (1) business day of making the initial determination and must provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification. 2. For service authorization approval for extended stay or additional services, the DBPM must notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.	**Documents** Policy/procedure Template notice of authorization	Full			
Adverse Action The DBPM must notify the member, in writing, using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in this RFP. The notice of action to members must be consistent with notice of action requirements and the language and format requirements for member written materials. The DBPM must notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.	**Documents** Policy/procedure Template notice of action	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
The notice of adverse action must explain: 1. The action the DBPM or its subcontractor has taken or intends to take.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
2. The reason(s) for the action.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
3. The member's right to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's claim for benefits. Such information includes medical-necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
6. Procedures for exercising a member's rights to appeal or grieve a decision.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
8. The member's rights to have benefits continue pending the resolution of an appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			
The notice must be in writing and must meet the language and format requirements. [The DBPM must write all member materials in a style and reading level that will accommodate the reading skill of DBPM members. In general, the writing should be at no higher than a 6.9 grade level, as determined by the Flesch–Kincaid Readability Test. Written material must be available in alternative formats, communication modes, and in an appropriate manner that considers the special needs of those who, for example, have a visual, speech, or hearing impairment; physical or developmental disability; or limited reading proficiency. The DBPM must make its written information available in the prevalent non-English languages in the State. Currently, the prevalent non-English language in the State is Spanish. All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of member identification (ID) cards, or as otherwise	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
approved by MLTC.					
Informal Reconsideration 1. As part of the DBPM appeal procedures, the DBPM must include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. 2. In a case involving an initial determination, the DBPM must provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the dentist or clinical peer making the adverse determination. 3. The informal reconsideration should occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the DBPM's dentist authorized to make adverse determinations or a clinical peer designated by the Dental Director if the dentist who made the adverse determination cannot be available within one (1) business day. The Informal Reconsideration will in no way extend the 30-day required timeframe for a Notice of Appeal Resolution.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Partial This requirement is addressed in the Member Handbook on page 30, the Provider Manual on page 59, and in the Informal Reconsideration Process Policy. File Review Results Ten (10) of 10 files were reviewed and none (0) had an informal reconsideration; therefore, this requirement was not applicable for the files reviewed. However, since informal reconsideration is a potential immediate next step after an adverse determination, the notice of action letters should include information about informal reconsideration. None (0) of the 10 files reviewed included information about informal reconsideration in the notice of action letter. **Recommendation** MCNA should modify the notice of action to the member and the provider to include information about informal reconsideration. **DBPM Response** Informational denial information will be added to the letter and submitted to MLTC for approval. **IPRO Final Findings** No change in review determination.	Full	This requirement is addressed in the Informal Reconsideration Process policy, pages 1 through 3. File Review Results Of the 5 expedited UM files reviewed, 2 of the files met the requirement. During the previous compliance review, IPRO made the recommendation to include language in the letter to inform members of the opportunity to request an informal reconsideration. Three (3) of the 5 files did not contain language providing the member the opportunity to request an informal reconsideration. Two (2) of the 5 files did have this language. The date of the 3 files that did not contain the language preceded the date of the approval of the new template containing the language (October 2018). Therefore, all 5 files pass.	
Exceptions to Requirements	**Documents**	Full			

Final Findings

Utilization Management					
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**Prior Determination**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**DBPM Response and Plan of Action**
1. The DBPM must not require service authorization for emergency dental services as described in this Section whether provided by an in-network or out of- network provider. 2. The DBPM must not require service authorization or referral for EPSDT dental screening services. 3. The DBPM must not require service authorization for the continuation of covered services of a new member transitioning into the DBPM, regardless of whether such services are provided by an in-network or out-of-network provider; however, the DBPM may require prior authorization of services beyond thirty (30) calendar days.	Policy/procedure				