Managed Care Program Annual Report (MCPAR) for Nebraska: Medicaid Dental Benefit Program

Due date	Last edited	Edited by	Status
06/28/2024	06/18/2024	William Morgan	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Nebraska
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Milla Jones
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	DHHS.StrategicInitiatives@nebraska.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	William Morgan
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	william.morgan@nebraska.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/18/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2023
A6	**Program name** Auto-populated from report dashboard.	Medicaid Dental Benefit Program

Add plans (A.7)

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

	Indicator	Response
	Plan name	Managed Care of North America (MCNA)

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Automated Health Services (AHS)

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	386,704
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	384,356

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	EQRO

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	Nebraska Medicaid Program Integrity (NMPI) completed a specific review of the dental benefit manager's (DBM) reimbursement of procedure code D9420 in compliance with regulations and contract requirements. The care reimbursed by the DBM is also included in the standard surveillance and utilization review (SUR) reporting and program integrity algorithms and reports. Dentists are included in reports of Top Paid Billing Provider, Servicing Type by Top Procedures, Service Providers by Top Procedures, and Provider Type Paid Year Over Year by State Fiscal Year. There are two dental specific SUR Reports. Dental care is included in eight of the algorithms as the reports are not limited by procedure code or provider type.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	75640-O4, Section IV.O.18
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The DBM has the right to collect or recoup any overpayments identified by the DBPM from providers of service in accordance with existing laws or regulations.
BX.5	**State overpayment reporting monitoring**	The state monitors the DBM performance in reporting overpayments by reviewing the

	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	required reports and encounter data when a recovery is known.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The state reviews capitation payments regularly to collect erroneous payments from the DBM when the Department learns a client is deceased and a capitation payment should not have been made. Regular "date of death" audits are completed to identify claims that may have been paid after the client's death. Refunds are collected from providers. The DBM is required to report when they become aware that a client has been incarcerated or is deceased. When appropriate, capitation payments would be recovered from the DBM or claim payments from providers. The Department calculates the capitation payments to the DBM and adjustments to the capitation payments should be adjusted systematically.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the	No

	requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	No such audits were conducted during the reporting year

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Contract 75640 O4 Medicaid Dental Managed Care for the State of Nebraska
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	09/01/2017 - 12/31/2023
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://das.nebraska.gov/materiel/purchasing/contracts/pdfs/75640(o4)awd.pdf
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Prepaid Ambulatory Health Plan (PAHP)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Dental
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	383,791

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	There were no major changes to the population or benefits during the reporting year

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Section M.8.a.; R.9.a-v
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality	Section U.4.b.iii

	standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	Quality Performance Measure: Submitted encounters must be accepted 95% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications; submitted encounters must be accepted 98% or greater by MLTC's Medicaid Management Information System pursuant to MLTC specifications to receive the financial incentive; submitted encounters are 15% of payment pool for earn back dollars at the end of each year.
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	The state did not experience any barriers to collecting or validating encounter data during the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	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: •Make reasonable efforts to give the member prompt verbal notice of the delay. •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. •Resolve the appeal as expeditiously as the member's health condition requires but no later than the date on which the extension expires.
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	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.

C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	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.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	The challenges that the state has experienced in maintaining an adequate network and meeting standards are the varying geographical regions of the state, ranging from urban, to rural, to frontier areas. It is difficult to find providers, especially specialists, in the rural and frontier areas. In addition, the pool of dental providers across the state to recruit to join the network in general is low.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The state has worked with the MCP in various ways to address network adequacy gaps during the reporting period. The MCP is contractually required to submit monthly, quarterly, and annual provider network reports. This assists also in discussion and information on the status of the network. The MCP continued to submit reports and participate in discussions with the state to address gaps in network adequacy. If through reporting or discussion a gap is identified, then the state requires adhoc reports. There were no new gaps in the network identified during this reporting period. The MCP develops and maintains an annual provider Network Development and Management Plan which ensures that the provision of core dental benefits and services will occur. The Network Provider Development and Management Plan must identify gaps in the MCP's provider network and describe the process by which MCP must assure all covered services are delivered to DBPM members. Planned interventions to be taken to resolve such gaps must also be included. Monthly operational status updates required of the MCP include number of new providers joining the network; a list of any providers who have requested to close their panels, in addition to the yearly total, and a list of provider outreach and education activities during the reporting period. Status updates were discussed at the monthly operational meetings with the MCP during this reporting period. The state participates in a state-directed payment and process with the University of Nebraska Medical School in an effort to increase access and adequacy of the Medicaid dental provider

network. Dental students serve managed care dental members and some fee-for-service members. The university dental college campuses and clinics serve Medicaid members across the state. This continued during the reporting period. The state encourages the MCP to offer more contracts to dental providers with increased rates on a regular basis. The MCP reports to the state monthly on their current negotiations with providers and the number of contracts with increased rates at the operational meetings. This continued during the reporting period.

Access Measures

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

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

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

Access measure total count: 17

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 17

C2.V.2 Measure standard

2 providers within 45 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 17

C2.V.2 Measure standard

1 provider within 45 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Oral Surgeon	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 17

C2.V.2 Measure standard

1 provider within 45 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthodontist	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 17

C2.V.2 Measure standard

1 provider within 45 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Periodontist	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 17

C2.V.2 Measure standard

1 provider within 45 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pedodontist	Urban	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 17

C2.V.2 Measure standard

1 provider within 60 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 17

C2.V.2 Measure standard

1 provider within 60 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Oral Surgeon	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 17

C2.V.2 Measure standard

1 provider within 60 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthodontist	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

9 / 17

C2.V.2 Measure standard

1 provider within 60 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Periodontist	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

C2.V.1 General category: General quantitative availability and accessibility standard

10 / 17

C2.V.2 Measure standard

1 provider within 60 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pedodontist	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

C2.V.1 General category: General quantitative availability and accessibility standard

11 / 17

C2.V.2 Measure standard

1 provider within 100 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 17

C2.V.2 Measure standard

1 provider within 100 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Oral Surgeon	Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

13 / 17

C2.V.2 Measure standard

1 provider within 100 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Orthodontist	Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

14 / 17

C2.V.2 Measure standard

1 provider within 100 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Periodontist	Frontier	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 17

C2.V.2 Measure standard

1 provider within 100 miles for all members

C2.V.3 Standard type

Maximum distance to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pedontontist	Frontier	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

16 / 17

C2.V.2 Measure standard

Members are able to receive routine/preventative services within 6 weeks

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Sampling of provider availability

C2.V.8 Frequency of oversight methods

Quarterly

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 17

C2.V.2 Measure standard

Members are able to receive urgent care services within 24 hours

C2.V.3 Standard type

Ease of getting a timely appointment

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dentist	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Sampling of provider availability

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://neheritagehealth.com
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The BSS is accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested. The BSS allows members to select a preferred communication method, such as e-mail, text, mail, etc., and confirms selection via the member's chosen method. The BSS provides for electronic communications regarding enrollment. Communication must be sent via the member's preferred communication method. The BSS has the capability for bi-directional communications including real-time chat to be available Monday – Friday 7:00 AM to 7:00 PM Central Time, excluding State holidays (i.e., members can submit questions and comments to the BSS and receive responses. The BSS complies with contractual requirements for all written materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.), including that the reading level must not exceed a 6.9 grade level, as determined by the Flesch-Kincaid Readability Test; distributes introductory materials to each new member within two (2) business days. The introductory materials packet describes the BSS website, the materials that members can find on the website, and how to obtain written materials in the event the member does not have access to the website. Material is available in alternative formats and communication modes, in an appropriate manner that considers the special needs of those who may have a visual, speech, or hearing impairment; physical or developmental disability; and/or limited reading proficiency. The BSS maintains a provider directory in three (3) formats: a hard copy directory for members who request it; a web-based, searchable, online directory for members and the general public; and an electronic file of the directory to be submitted and updated weekly to MLTC or its designee. The BSS operates a member call center with a

toll-free telephone number to respond to applicants, enrollees, and member's questions, concerns, and inquiries, regarding Heritage Health, managed care, choice counseling, MCO enrollment, and PCP assignment. The call center must have the ability to access and provide current information and assistance, including Medicaid eligibility and enrollment status, member enrollment, and potential transfer between MCOs. The BSS provides ongoing education about managed care, the enrollment process, and the member's MCO/PCP options, as necessary in all written and verbal communications with members. This includes, the outreach packet, the notice of anniversary letter, the BSS website, other member mailings, and communications with choice counselors and other BSS staff that interact with members The BSS provides real-time oral interpretation services free of charge to members. This applies to all non-English languages. The BSS notifies members that oral interpretation is available for any language and written information is available in Spanish. The BSS also notifies members how to access these services. Materials that provide this information are written in English and Spanish. The BSS ensures that translation services are provided for all written materials in any language that is spoken as a primary language for four (4) percent or more of members. Within 90 calendar days of notice from MLTC that an additional language is necessary, materials are translated and available, upon request. Members may not be charged for these materials. The BSS website is in compliance with Section 508 of the Americans with Disabilities Act (ADA), and it meets all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The BSS website includes the telephone contact information for the BSS, including the toll-free member services number prominently displayed and a telecommunications device for the deaf (TDD) number. It also contains links to the MCPs and to the Medicaid Eligibility website. The BSS offers a secure online portal to facilitate member MCO enrollment and PCP selection. The BSS has policies and processes in place to address enrollee and member grievances.

C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The BSS has contractually required performance measures, reporting and deliverable requirements, and state and independent entity audits. Annual operational reviews by the state are also required. Contract monitoring of policies and procedures are also required and performed by the state.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Managed Care of North America (MCNA)** 383,791
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Managed Care of North America (MCNA)** 99.2%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Managed Care of North America (MCNA)** 99.9%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Managed Care of North America (MCNA)** 87%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Managed Care of North America (MCNA)** Program-specific statewide
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Managed Care of North America (MCNA)** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Managed Care of North America (MCNA)** Yes
N/A	Enter the start date.	**Managed Care of North America (MCNA)**

		07/01/2022
N/A	Enter the end date.	**Managed Care of North America (MCNA)** 06/30/2023

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Managed Care of North America (MCNA)** Within two (2) business days of the end of a payment cycle, the DBPM must generate encounter data files for that payment cycle from its claims management system(s) and/or other sources. If the DBPM has more than one (1) payment cycle within the same calendar week, the encounter data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week. The DBPM must submit encounter data accurately, meeting the standard of ninety-five percent (95%) correct encounters.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	**Managed Care of North America (MCNA)** 99%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed	**Managed Care of North America (MCNA)** 99%

care plan for the reporting year.

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Managed Care of North America (MCNA)** 62
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Managed Care of North America (MCNA)** 0
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Managed Care of North America (MCNA)** N/A
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already	**Managed Care of North America (MCNA)** N/A

	submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Managed Care of North America (MCNA)** 61
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Managed Care of North America (MCNA)** 1

D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Managed Care of North America (MCNA)** 62
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Managed Care of North America (MCNA)** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Managed Care of North America (MCNA)** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Managed Care of North America (MCNA)** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's	**Managed Care of North America (MCNA)** 0

	failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Managed Care of North America (MCNA)** 0
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Managed Care of North America (MCNA)** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that	**Managed Care of North America (MCNA)** N/A

	were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Managed Care of North America (MCNA)** 62

D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i paid primarily by Medicaid, enter "N/A".	**Managed Care of North America (MCNA)** N/A

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Managed Care of North America (MCNA)** 2
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Managed Care of North America (MCNA)** 0
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Managed Care of North America (MCNA)** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Managed Care of North America (MCNA)** 2
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Managed Care of North America (MCNA)** N/A

D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Managed Care of North America (MCNA)** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Managed Care of North America (MCNA)** 28
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Managed Care of North America (MCNA)** 0
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Managed Care of North America (MCNA)** N/A
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the	**Managed Care of North America (MCNA)** N/A

	critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Managed Care of North America (MCNA)** 28

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or	**Managed Care of North America (MCNA)** N/A

	substance use services. If the managed care plan does not cover this type of service, enter "N/A".	
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** 28

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Managed Care of North America (MCNA)** N/A
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Managed Care of North America (MCNA)** N/A

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Managed Care of North America (MCNA)** 3
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Managed Care of North America (MCNA)** 0
D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.	**Managed Care of North America (MCNA)** 7

	Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Managed Care of North America (MCNA)** 9
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Managed Care of North America (MCNA)** 3
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Managed Care of North America (MCNA)** 6
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that	**Managed Care of North America (MCNA)** 0

	were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Managed Care of North America (MCNA)** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Managed Care of North America (MCNA)** 1
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.	**Managed Care of North America (MCNA)** 0

	Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Managed Care of North America (MCNA)** 6

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 15

Complete

D2.VII.1 Measure Name: PDENT-CH: Percentage of Eligibles Who Received Preventive Dental Services

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of members 1–20 years of age who received at least one preventive dental service by or under the supervision of a dentist during the measurement year.

Measure results

Managed Care of North America (MCNA)

50.42%

Complete

D2.VII.1 Measure Name: UTL-CH-A: Percentage of Enrolled Children Under Age 21 Who Received at Least One Dental Service Within the Reporting Year

D2.VII.2 Measure Domain

Dental and oral health services

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

2511

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

DQA

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of enrolled children under age 21 who received at least one dental service within the reporting year.

Measure results

Managed Care of North America (MCNA)

50.41%

Complete

D2.VII.1 Measure Name: TRT-CH-A: Percentage of Enrolled Children Under Age 21 Who Received a Treatment Service as a Dental Service Within The Reporting Year

3 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

DQA

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of enrolled children under age 21 who received at least one treatment service within the reporting year.

Measure results

Managed Care of North America (MCNA)

17.63%

Complete

D2.VII.1 Measure Name: OEV-CH-A: Percentage of Enrolled Children Under Age 21 Who Received a Comprehensive or Periodic Oral Evaluation as a Dental Service Within the Reporting Year

4 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

2517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

DQA

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

The percentage of enrolled children under age 21 who received at least one comprehensive oral evaluation within the reporting year.

Measure results

Managed Care of North America (MCNA)

48.24%

Complete

D2.VII.1 Measure Name: CCN-CH-A: Percentage of Children Enrolled in Two Consecutive Years Who Received a Comprehensive or Periodic Oral Evaluation as a Dental Service in Both Years

5 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

DQA

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

38.39%

Complete

D2.VII.1 Measure Name: Claims Processing Timeliness

6 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percent of clean claims that are processed by the plan within 15 days of the date of receipt.

Measure results

Managed Care of North America (MCNA)

99.20%

Complete

D2.VII.1 Measure Name: Encounter Acceptance Rate

7 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percent of encounters submitted to Nebraska MLTC that are accepted by MLTC's Medicaid Management Information System pursuant to MLTC specifications.

Measure results

Managed Care of North America (MCNA)

99.98%

Complete

D2.VII.1 Measure Name: Appeal Resolution Timeliness

8 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

State-specific

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

Yes

D2.VII.8 Measure Description

Percent of appeals that are resolved within 20 calendar days.

Measure results

Managed Care of North America (MCNA)

100.00%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit 2 to 3 Years

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

49.82%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit 4 to 6 Years

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

65.65%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit 7 to 10 Years

11 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

69.25%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit 11 to 14 Years

12 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

61.11%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit 15 to 18 Years

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

48.52%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit 19 to 20 Years

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

30.03%

Complete

D2.VII.1 Measure Name: ADV: Annual Dental Visit Total

15 / 15

D2.VII.2 Measure Domain

Dental and oral health services

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

1388

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Managed Care of North America (MCNA)

57.73%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Managed Care of North America (MCNA)** 2
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Managed Care of North America (MCNA)** 3
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Managed Care of North America (MCNA)** 0.01:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Managed Care of North America (MCNA)** 3
D1X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Managed Care of North America (MCNA)** 0.01:1,000

D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Managed Care of North America (MCNA)** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Managed Care of North America (MCNA)** 0
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Managed Care of North America (MCNA)** 0:1,000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Managed Care of North America (MCNA)** 2023 $18,506.82
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Managed Care of North America (MCNA)** Promptly when plan receives information about the change

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Automated Health Services (AHS)** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Automated Health Services (AHS)** Enrollment Broker/Choice Counseling