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May 2018
Period of Review: October 1, 2017 – March 31, 2018
DBPM: MCNA

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**	**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 dental providers in sufficient numbers and locations to provide required access to covered services. 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 for Medicaid members with disabilities.	**Documents** Policy/procedure Provider directory Onsite discussion	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	This requirement is addressed on page 10 of the Provider Network Development and Management Program. This requirement is communicated to the providers in the Provider Manual on page 17.	
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	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed on page 1 of the Network Development and Management Plan.	

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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.				
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	This requirement is addressed on page 1 of the Network Development and Management Plan.	
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 f/u actions	Full	This requirement is addressed on page 12 of the Network Development and Management Plan.	
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	This requirement is addressed on page 15 of the Network Development and Management Plan.	
The DBPM must require that providers deliver services in a culturally competent manner to all members, including those with limited English	**Documents** Template provider contract – one per provider type	Full	This requirement is addressed on page 16 of the Network Development and Management	

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proficiency and diverse cultural and ethnic backgrounds and provide for interpreters.	Provider manual		Plan. The plan accepts any willing provider into its network.	
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	This requirement is addressed on page 17 of the Network Development and Management Plan.	
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 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 nonurgent 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	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed on page 11 of the Network Development and Management Plan. The plan surveys providers and performs secret shopper calls and drop-in checks of its providers.	

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and services and/or expanded services which are in accordance with prevailing dental community standards.	Onsite discussion			
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 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	**Documents** Policy/procedure Provider manual Member Handbook **Reports** Evidence of monitoring appointment availability including results and f/u actions	Full	This requirement is addressed on pages 11 and 12 of the Network Development and Management Plan.	

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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 f/u actions	Full	This requirement is addressed on page 13 of the Network Development and Management Plan. The plan utilizes an advocate specialist to reach out to members that are no-shows and to make new appointments.	
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 f/u actions	Full	This requirement is addressed throughout the Network Development and Management Plan. This requirement is communicated to the providers in the Provider Manual.	
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 provider population available to the non-Medicaid population.	**Documents** Policy/procedure Requests for exemption submitted to MLTC **Reports** Evidence of Geo access monitoring including results and f/u actions	Full	This requirement is addressed in the Network Development and Management Plan and through submission of MCNA's geo access Q2 2018 report. The plan has contracted with every willing provider and monitors its network quarterly through the geo access reports. Geo access report results Dentist	

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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.			- *Urban:* 100% - *Rural:* 100% - *Frontier:* 100% Specialist – Oral Surgery - *Urban:* 89% - *Rural:* 50% - *Frontier:* 20% Specialist – Orthodontics - *Urban:* 100% - *Rural:* 79% - *Frontier:* 90% Specialist – Periodontists - *Urban:* 72% - *Rural:* 26% - *Frontier:* 1% Specialist – Pedodontists - *Urban:* 100% - *Rural:* 69% - *Frontier:* 68%	
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	This requirement is addressed on pages 4, 14, and 18 of the Network Development and Management Plan. The plan has contracted with every willing provider and monitors its network quarterly through the geo access reports.	
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	**Documents** Policy/procedure	Full	This requirement is addressed on pages 14 and 15 of the Network Development and Management Plan. The plan has contracted	

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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.	Provider network availability plan **Reports** Evidence of monitoring utilization including results and f/u actions		with every willing provider and monitors its network quarterly through the geo access reports. In addition, MCNA provided the NE Network Sufficiency Plan which details efforts made by the plan for engaging providers for participation. MCNA provided evidence of assertive outreach through submission of their outreach logs for North Platte and Northfolk counties.	
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 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	**Documents** Policy/procedure Template provider contract – one per provider type	Full	This requirement is addressed on page 6 of the Network Development and Management Plan and through its provider contract.	

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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.				
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 surgeons, 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 members in frontier counties.	**Documents** Policy/procedure **Reports** Evidence of Geo access monitoring including results and f/u actions	Full	This requirement is addressed on pages 13 and 14 of the Network Development and Management Plan. The plan has contracted with every willing provider and monitors its network quarterly through the geo access reports.	
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	This requirement is addressed on page 6 of the Network Development and Management Plan.	

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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** Geo access reports Onsite discussion	Full	This requirement is addressed on page 6 of the Network Development and Management Plan. The plan has contracted with all FQHCs that perform dental services and all Indian tribes except for one are in network. Onsite, the DBPM discussed how they have general and specialty dental providers that maintain hospital privileges required for the appropriate performance of MCNA services.	
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 f/u actions	Full	This requirement is addressed on page 12 of the Network Development and Management Plan.	
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	This requirement is addressed in the Provider Credentialing Program Description and in the Recredentialing Policy. Credentialing File Review Results 10/10 files met all requirements. The files were submitted electronically and were well organized.	
The DBPM must develop and implement policies and procedures for approval of new providers, and	**Documents** Policy/procedure	Full	This requirement is addressed in the Network Development and Management Plan. Site visits	

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termination or suspension of providers to assure compliance with the contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.			are performed of provider offices each quarter on a rolling basis.	
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	This requirement is addressed in the Network Development and Management Plan. This is also addressed in the Provider Termination and Suspension Process.	
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	This requirement is addressed in the Provider Termination and Suspension Process.	
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	This requirement is addressed in the Recredentialing Policy. Recredentialing File Review Results File Review is N/A for this review.	
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 Network Development and Management Plan must be submitted to MLTC when significant changes occur and annually thereafter within thirty (30) days of the start of each contract year.	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed in the Provider Network Development and Management Program.	

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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: 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.	**Documents** Policy/procedure Network development plan		This requirement is addressed in the Provider Network Development and Management Program.	
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	**Documents** Policy/procedure Network development plan	Full	This requirement is addressed on page 3 of the Network Development and Management Plan.	

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4. Access to Specialists 5. Timely Access 6. Service Area 7. Second Opinion 8. Out-of-Network Providers				
The DBPM must communicate and negotiate with the network regarding contractual and/or program changes and requirements.	**Documents** Policy/procedure	Full	This requirement is addressed in the Network Development and Management Plan and is communicated to the Provider in the Dental Agreement.	
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	This requirement is addressed in the Network Development and Management Plan.	
The DBPM must evaluate the quality of services delivered by the network.	**Documents** Policy/procedure	Full	This requirement is addressed in the Network Development and Management Plan.	
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	This requirement is addressed in the Network Development and Management Plan on page 8.	
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	This requirement is addressed in the Network Development and Management Plan on page 16.	
The DBPM must provide training for its providers and maintain records of such training.	**Documents** Policy/procedure	Full	This requirement is addressed in the Network Development and Management Plan. Training conformation forms and sign-in sheets are used to track training.	

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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 f/u actions	Full	This requirement is addressed in the Network Development and Management Plan. DentalTrac is the system used by MCNA to track and trend provider inquiries, complaints, and requests for information and take systemic action as necessary and appropriate.	
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 adequate access to providers. Other adverse changes to the composition of which impair or deny the members' adequate access to providers.	**Documents** Policy/procedure Examples of notices provided to MLTC	Full	This requirement is addressed in the Network Development and Management Plan on page 18.	

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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	This requirement is addressed in the Network Development and Management Plan on page 3.	
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	This requirement is addressed on page 12 of the Provider Manual.	
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	This requirement is addressed on page 3 of the Master Dental Provider Agreement.	
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	**Documents** Policy/procedure Examples of notices provided to MLTC	Full	This requirement is addressed in the Network Development and Management Plan on page 18.	

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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.				
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	This requirement is addressed in the Network Development and Management Plan on page 17.	
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.	**Documents** Policy/procedure Template provider contract – one per provider type Provider manual	Full	This requirement is addressed on page 2 of the Provider Contract Requirements.	

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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 no interfering with providers' advice to members and information disclosure requirements related to provider incentive plans.				
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 Provider manual	Full	This requirement is addressed in the HIPAA Compliance Program.	

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Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**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	This requirement is addressed in the Provider Relations Policy – Provider Complaint Process. MCNA uses the DentalTrac to capture, track and report the status and resolution of all provider complaints including all associated documentation, and whether they are received by telephone, in person, or in writing.	
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: 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. 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. 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. 4. A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the	**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	This requirement is addressed in the Provider Relations Policy – Provider Complaint Process. This policy includes all requisite requirements. Provider Complaint File Review Ten (10) of 10 files met all requirements.	

Provider Services				
State Contract Requirements	**Suggested Documentation and Instructions for Reviewers**	**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**
number of individual patients or payment claims included in the bundled complaint. 5. A process for thoroughly investigating each complaint using applicable subcontractual provisions, and for collecting pertinent facts from all parties during the investigation. 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. 7. A process for giving providers (or their representatives) the opportunity to present their cases in person. 8. Identification of specific individuals who have authority to administer 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.				
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	This requirement is addressed in the Provider Relations Policy – Provider Complaint Process. This requirement is communicated to the providers in the Provider Manual on page 45.	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**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	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 2017 with one active subcontractor, which is responsible for the fulfillment of member materials. This subcontractor pre-dated the review period and, 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	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 f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	This requirement is addressed in the 1.200MIC Contracting and Oversight of Subcontractors Policy on page 1. The DBPM's Subcontractor Monitoring Report CY 2017 evidenced ongoing monitoring of subcontractor's performance and reporting of this monitoring to UM committees. Onsite, MCNA explained that they also monitor any complaints that come through Member Services and satisfaction surveys regarding the subcontractor's services. The subcontractor mails out materials mainly from their Ohio plant, but these materials are returned to	

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Subcontracting Requirements				
State Contract Requirements (Federal Regulations 438.230)	**Suggested Documentation and Instructions for Reviewers**	**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**
			MCNA's Florida office, which is another built-in check to monitor the subcontractor's real-time activities.	
If necessary, the DBPM must identify deficiencies or areas for improvement, and take corrective action.	**Documents** Policy/procedure **Reports** Evidence of ongoing monitoring and formal reviews of subcontractors including results and f/u actions taken Also includes reviewer completion of subcontractor worksheet	Full	This requirement is addressed in the 1.200MIC Contracting and Oversight of Subcontractors Policy on page 1. The DBPM's Subcontractor Monitoring Report CY 2017 evidenced ongoing monitoring of subcontractor's performance and reporting of this monitoring to UM committees. Onsite, MCNA confirmed that they have not identified any deficiencies in the subcontractor's services. The DBPM explained that if they identify a deficiency in subcontractor's services, they would contact the subcontractor immediately and ask them to correct to deficiency within the timeframe indicated in the contract. If the subcontractor fails to do so, the DBPM would terminate their contract with the subcontractor and contract with another.	

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Member Services and Education				
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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	This requirement is addressed in the policy/procedure Contracting with Public Health Providers on page 1, and in the Provider Network Development and Management Program on pages 7-8. MCNA discussed that currently, they are contracted with 5 Tribes for the counties of Douglas, Madison, Thurston and Knox but if the member is attended to by a provider that is not within the I/T/U, the DBPM still covers for the services rendered to the member.	
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	This requirement is addressed in Member Notification of Terminated Provider on page 1. Further, the DBPM submitted a template for member notification of provider termination.	

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Member Services and Education				
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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	This requirement is addressed in Member Notification of Terminated Provider on page 1.	
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). 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	**Documents** Policy/procedure	Full	This requirement is addressed in Member Services Department Overview.	

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**	**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**
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	This requirement is addressed in Member Materials on page 1.	
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	This requirement is addressed in Member Materials on page 1.	
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 how to obtain written materials if the member does not have access to the website.	**Documents** Policy/procedure Member materials for new members	Full	This requirement is addressed in Member Materials on page 2 which states "Member material will be mailed by the effective enrollment date or within 5 calendar days of receipt of the enrollment file from the applicable state agency, whichever is later". The Member Handbook on page 3 states that the MCNA website contains oral health educational materials that the members can download.	

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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	This requirement is addressed in Member Materials on page 1 which states "Large print, braille and audiotapes (materials are free of charge)".	
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	This requirement is addressed in Member Materials on page 1. Further, the DBPM has it indicated in their Welcome Letter that is sent to members that the Handbook is available in audio, larger print, Braille and other languages.	
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	This requirement is addressed in Member Materials on page 1 which states "All member material will be available in English, Spanish & other language spoken by approximately 5% or more of the total population". The DBPM also has educational materials for the pediatric population such as: Effects of Thumb Sucking, Tooth Fairy and Why Do I Need X-Rays. These are all available in both English and Spanish. The member newsletters are also available in English and 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 approved by MLTC. The quality of materials used for printed materials must be, at a minimum, equal to the	**Documents** Policy/procedure	Full	This requirement is addressed in Member Materials on page 1	

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materials used for printed materials for the DBPM's commercial plans, if applicable.				
The DBPM's name, mailing address, (physical location, if different), and toll-free telephone number must be prominently displayed on all marketing materials, including the cover of all multi-page materials.	**Documents** Policy/procedure Sample marketing materials	Full	This requirement is addressed in Member Materials on page 2. The requirement is also addressed per evidence contained within the Member Handbook; page 1 has the member hotline email and the back cover contains the mailing address, website and the toll free number. Further, page 4 of the Member Handbook provides all information.	
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	This requirement is addressed in Member Services Department Overview. The requirement is also addressed on page 22 of the Member Handbook where it provides the language line toll free number for interpreters.	
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	This requirement is addressed on page 10 of the Member Handbook.	
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.	**Documents** Policy/procedure Member Handbook View website onsite Onsite discussion	Full	All 3 requirements are addressed in Member Materials. The DBPM's website for Nebraska provided a link for members to easily access the Member Handbook for both English and Spanish, without having to log into the Member Portal. The website also provided the information on how to request a new version of the Member Handbook as well as the version written in a language other than English or Spanish.	.

IPRO
Improving Healthcare for the Common Good

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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.			The DBPM's Member Handbook is found on their website (English version last updated September 13, 2017 and Spanish version last updated September 9, 2017). The DBPM's Member Handbook is made accessible outside the member portal which is easily accessible to every individual.	
At a minimum, the member handbook must include: 1. A table of contents.	**Documents** Member Handbook should address all sub-elements	Full	This requirement is addressed on page 2 of the Member Handbook	
2. A general description of basic features of how the DBPM operates and information about the DBPM in particular.		Full	This requirement is addressed in the Member Handbook on the back of the cover page.	
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	This requirement is addressed on pages 3-4 of the Member Handbook.	
4. A section that stresses the importance of a member notifying Medicaid Eligibility of any		Full	This requirement is addressed on page 5 of the Member Handbook.	

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change to its family size, mailing address, living arrangement, income, other health insurance, assets, or other situation that might affect ongoing eligibility.				
5. Member rights/protections and responsibilities.		Full	This requirement is addressed on pages 23-25 of the Member Handbook.	
6. Appropriate and inappropriate behavior when seeing a DBPM provider. This section must include a statement 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.		Full	This requirement is addressed on page 6 of the Member Handbook.	
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	This requirement is addressed on page 22 of the Member hand book.	
8. A description of the dental home selection process and the dental home's role as coordinator of services.		Full	This requirement is addressed on page 12 of the Member Handbook.	
9. The member's right to select a different dental home within the DBPM network.		Full	This requirement is addressed on page 13 of the Member Handbook.	
10. Any restrictions on the member's freedom of choice of DBPM providers.		Full	This requirement is addressed on page 23 of the Member Handbook.	
11. A description of the purpose of the Medicaid and DBPM ID cards, why both are necessary, and how to use them.		Full	This requirement is addressed on page 6 of the Member Handbook.	

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12. The amount, duration and scope of benefits available 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.		Full	This requirement is addressed on pages 7-9 of the Member Handbook.	
13. Procedures for obtaining benefits, including authorization requirements.		Full	This requirement is addressed on pages 9-10 of the Member Handbook.	
14. The extent to which, and how, members may obtain benefits, including from out-of network providers.		Full	This requirement is addressed on page 10 of the Member Handbook. Out-of-network provider benefit is found on page 15.	
15. Information about health education and promotion programs, including chronic care management.		Full	This requirement is addressed on page 3 of the Member Handbook.	
16. Appropriate utilization of services including not using the ED for non-emergent conditions.		Full	This requirement is addressed on page 6 of the Member Handbook.	
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	This requirement is addressed on page 15 of the Member Handbook.	
18. Information about a member’s right to a free second opinion and how to obtain it.		Full	This requirement is addressed on page 18 of the Member Handbook.	
19. The extent to which, and how, after-hours and emergency coverage are provided, including: a. What constitutes an emergency medical condition, emergency services, and post-		Substantial	Requirements “a” through “d” are addressed on page 19 of the Member Handbook. Requirement “e” is not fully addressed; there is only reference made to Heritage Health in the context of prescription coverage.	

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**	**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**
stabilization services, as defined in 42 CFR 438.114(a) and 42 CFR 422.113(c). b. That prior authorization is not required for emergency services. c. The process and procedures for obtaining emergency services, including use of the 911-telephone system. d. That, subject to provisions of 42 CFR Part 438, the member has a right to use any hospital or other setting for emergency care. e. That, when necessary, members should refer to their Heritage Health member information for emergencies relating to the member's physical, behavioral or pharmaceutical services as those benefits would not be reimbursed by the DBPM.			**Recommendation** The Member Handbook should contain language that the member should contact their Heritage Health Plan for information regarding emergencies relating to the member's physical and behavioral services in addition to the pharmaceutical services as those benefits are not reimbursed by the DBPM. **DBPM Response** Content was added on page 21 of the Member Handbook. **IPRO Final Findings** No change in review determination.	
20. The policy about referrals for specialty care and for other benefits not furnished by the member's dental home.		Full	This requirement is addressed on page 21 of the Member Handbook.	
21. How to obtain emergency and non-emergency medical transportation.		Full	This requirement is addressed on page 4 of the Member Handbook.	
22. Information about the EPSDT program and the importance of children obtaining these services.		Full	This requirement is addressed on page 17 of the Member Handbook.	
23. Information about member copayments.		Substantial	This requirement is partially addressed on page 10 of the Member Handbook, wherein reference is made to services that are not	

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**	**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**
			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** Language pertaining to copayments should be added in 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.	
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	This requirement is addressed on page 11 of the Member Handbook.	
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	This requirement is addressed on page 5 of the Member Handbook, wherein MCNA provides the member hotline number as well as the Medicaid customer service toll free number for inquiries about covered services, resolving problems, and access to care. Further, page 3 provides the customer service number as well,	

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**	**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**
			indicating they will give member information on covered services *and limitations*. Lastly, page 11 indicates members must call DHHS or their Heritage Health plan for assistance with prescriptions.	
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	This requirement is addressed on page 23 of the Member Handbook.	
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		Full	All of these requirements are addressed on pages 24 to 31 of the Member Handbook.	

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**	**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**
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.				
b. For state fair hearing: i. Definition of a state fair hearing. ii. The right to request a hearing. 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.		Full	These requirements are addressed on pages 31 to 33 of the Member Handbook.	
28. How a member may report suspected provider fraud and abuse, including but not limited to, the DBPM's and MLTC's toll-free		Full	This requirement is addressed on page 34 of the Member Handbook.	

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**	**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**
telephone number and website links created for this purpose.				
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.		Minimal	This requirement is addressed on page 34 of the Member Handbook for sub-element "d" only. **Recommendation** All the sub-elements of this requirement should be included 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** The language was added to the Member Handbook on page 36. **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	This requirement is addressed on page 3 of the Member Handbook.	
Provider Directory for Members The DBPM must develop and maintain a Provider Directory in two (2) formats:	**Documents** Policy/procedure Provider directory View website onsite	Full	This requirement is addressed in Member Materials on page 3. The DBPM's website has a link on the main page titled "Find a Dentist near you". Links to narrow down a search for a dentist based on gender, area of specialty and	

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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**	**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. Web-based, searchable, online directory for members and the public. 2. A hard copy directory for members upon request only.			language spoken are also available on their website. In their printed copy of the Provider Directory, MCNA includes the provider's area of specialization, phone number, office address, office hours, additional language spoken and if new patients are being accepted.	
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	This requirement is addressed in Member Materials on page 3.	
In accordance with 42 CFR §438.10, the provider directory must include, but not be limited to: 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.	**Documents** Policy/procedure Provider directory View website onsite	Full	This requirement is addressed in Member Materials on page 3. Further, all requirements are evidenced by navigating the link on the main page of the website titled "Find a dentist near you". The website search for providers can be narrowed down according to the provider's board certification, gender, specialization, language spoken and if the provider is accepting new members. In their printed copy of the Provider Directory, MCNA includes the provider's area of specialization, phone number, office address, office hours, additional language spoken and if new patients are being accepted.	

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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).				
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. 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.	**Documents** Policy/procedure View website onsite	Substantial	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 (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 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** An easily accessible feature should be added to MCNA's website to accommodate the visually	

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Use of proprietary items that would require use of a specific browser or other interface is not allowed.			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). It is also recommended that a bi-directional communication capability be considered for members to obtain real-time answers to questions. **MCO Response** N/A (no response received). **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: 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.	**Documents** Policy/procedure View website onsite	Full	All the requirements are addressed in the Website Development and Maintenance policy. The DBPM's website addressed all the requirements by having the latest version of their Member Handbook in both English and Spanish, their contact information, capability to search for providers and all information to be able to file grievances and appeals including the necessary forms to do so.	

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Member Services and Education				
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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.				

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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: 30 calendar days following 12th month of contract year	**Documents** QAPI Program Description	Full	This requirement (including each sub-element) is addressed in MCNA's QI Program Description.	

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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 care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	**Documents** QAPI Program Description Policy/procedure	Full	This requirement is addressed in the QI Program Description on page 3.	
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	This requirement is addressed in the QI Program Description on page 3.	
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	This requirement is addressed in the QI Program Description on page 5.	
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 QAPIC QAPIC membership	Full	This requirement is addressed in the QI Program Description on page 13.	

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QAPI Committee Responsibilities The committee must: a. Meet on a quarterly basis. b. Direct and review quality improvement (QI) activities. 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	**Documents** QAPI Program Description Agendas and meeting minutes for all committee meetings held during review period QAPI Program Evaluation	Full	This requirement (including each sub-element) is addressed in the QI Program Description. QAPIC meetings are being held appropriately; meeting minutes were submitted for 1/12/18 and 2/15/18, reflecting Q4 activities in 2017. There was a meeting in April 2018 (outside of the review period) reflecting review of the Q1 2017 activities. MCNA is reaching out to providers with closed panels to further improve access, per meeting minutes from 2/15/18.	

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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 Work Plan 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: 30 calendar days following 12th month of contract year	**Documents** QAPI work plan QAPI department organizational chart	Full	MCNA's Program Description includes these four elements. IPRO received the QAPI work plan 8/10/18, which MCNA had indicated was submitted and approved by MLTC. This work plan appropriately reflects each of the four elements associated with this requirement. Key performance indicators are being monitored, and have been included in the working draft of the DBPM's QI work plan. Responsible/accountable parties have been assigned to each indicator to oversee data collection and integrity.	

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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: 30 calendar days following 12th month of contract year	**Documents** QAPI Program Description QAPI Program Evaluation	Full	This requirement is addressed in the QI Program Description. QAPI reporting to MLTC annually cannot be evaluated within the time period of this review, as a full year has not elapsed since the DBPM has gone live.	
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.	**Reports** Annual and quarterly reports of state-required performance measures HEDIS final audit report and IDSS rates Onsite discussion	Full	This requirement is addressed in Monitoring and Reporting of Performance Measures. Dental Quality Alliance Measures are being assessed, and stratified by age group (analysis performed cumulatively and non-cumulatively for members aged <1 to 20 years of age). The DBPM is also evaluating administrative measures quarterly, per evidence submitted on their call center statistics. MCNA confirmed these measures are being sent quarterly to MLTC, in compliance with contract requirements.	

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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 Eligible members 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. 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 (PIPs) 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	This requirement is addressed in Monitoring and Reporting of Performance Measures. The DBPM stated they will work with MLTC and IPRO to establish PIP topics. When asked about when MCNA anticipates starting their PIP, they indicated that a date had not yet been established with MLTC, but that they'd request	

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			some more time to collect performance measure data, in order to better inform the topic selection.	
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	This requirement is addressed in Monitoring and Reporting of Performance Measures. Individual dental home clinical quality profile reports are being developed. These are being drafted based on MCNA's experiences in LA and TX. The tool starts with claims (examining paper vs. electronic vs. portal submissions) and average billing time. Billing lag-time vs. time in which claims are paid allows the DBPM to determine where the gaps are and if they can be mitigated (e.g., time in which claims are paid can be directly mitigated by the DBPM). The report also examines denial trends, and the nature of these denials (clinical, administrative, etc.). Further, this report allows the providers to better understand how they are performing clinically, based on their patient load relative to other providers. The report captures whether services provided were truly medically necessary, for instance.	
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.	**Documents** Corrective action plans required during the review period	Full	This requirement is addressed in Monitoring and Reporting of Performance Measures. No performance measure corrective action plans were issued during the review period (10/1/17 – 3/15/18).	

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Within thirty (30) calendar days of receiving the CAP, 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 time frames 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	This requirement is addressed in the Performance Improvement Policy.	
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.	**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 this audit.	

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3. A study population. 4. Measurements of performance using quality indicators 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	**Documents** QAPI Program Description QAPI work plan	Not applicable	The Program Evaluation was not applicable during the review period of this audit.	

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appropriate, in the QM Program Description and Work Plan.	QAPI Program Evaluation			
Each PIP must be completed in a reasonable time period to allow the results to guide its quality improvement 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.	**Reports** PIP proposals and status reports	Not applicable	PIP reporting was not applicable during the review period of this audit.	
CMS, in consultation with the State and other stakeholders, may specify additional performance measures and PIPs to be undertaken by the DBPM.	Onsite discussion	Not applicable	It was confirmed onsite that no additional performance measures or PIPs have been requested by CMS.	
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 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	

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			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, poor is used instead of always, usually, sometimes, 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 to assessing member satisfaction surveys in our proposal which was accepted. **IPRO Final Findings** Being that 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	

Quality Management				
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			vendor conducting these surveys, and so there is the opportunity for bias. **Recommendation** Survey processes should be aligned with CAHPS, to ensure a statistically valid random sample is utilized, and that responses are anonymous. Further, a vendor should 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 our approach to assessing member satisfaction surveys in our proposal which was accepted. **IPRO Final Findings** Being that 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 in an email inquiry pertaining to this requirement, that on a quarterly basis, they generate a list of active members who have claims history in the previous 9 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.	

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			This document ("Annual Member Satisfaction Survey Analysis for NE") 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, where the latter is not designed around a statistically random sampling. Further, both of these methods do not allow for anonymity of the member providing the response to the DBPM. **Recommendation** Communication related to the survey methodology should be 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, the qualitative 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, as three of the five response options are above average.	

Quality Management				
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			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** Being that 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	MCNA indicated in the RFP response that their member satisfaction survey would provide valid and reliable data for results statewide and by county. In their Annual Member Satisfaction Survey Analysis document, MCNA of NE indicates that the Director of Call Center Operations will complete a formal analysis of results that includes stratification by geographic region. Further, this document outlines a template table for results by county. Actual survey results will be reviewed upon the next compliance audit, to ensure this requirement was successfully addressed.	
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	

Quality Management				
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			benchmarks, they conduct analysis against results for other states managed by MCNA and against internally developed goals. **Recommendation** There is no mention of how MCNA will conduct analysis to detect statistically significant differences between states. Further, being that there are no comparison data available at a national level, and among other states which do not contract with MCNA, there are inherent limitations in data analysis. In order to effectively compare states that MCNA is operating in 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** Being that 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	**Documents** Provider satisfaction survey tool	Full	This requirement is addressed in Policy 5.111 MIC Provider Satisfaction Survey.	

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State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**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**
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.	Onsite discussion		A provider satisfaction survey was developed to reflect tools developed in other states that MCNA holds contracts with. The survey will be distributed during Q3 of 2018.	
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 f/u actions taken Onsite discussion	Full	This requirement is addressed in Policy 5.111 MIC Provider Satisfaction Survey. Provider Satisfaction Survey Report is not applicable during the review period of this audit.	
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 is not be limited to, annual operational reviews, PIP assessments, encounter data validation, focused studies, and other tasks requested by MLTC.	Onsite discussion	Full	External quality review of MCNA was conducted May 16, 2018 – May 17, 2018. Policy 2.213 Collaboration with EQRO and State Agencies conveys these requirements.	
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	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	Onsite discussion	Full	MCNA complied with the required review elements associated with QAPIC meeting minutes and demonstrating quality and accessible healthcare to their members. No	

Quality Management				
State Contract Requirements (Federal Regulations 438.240, 438.242)	**Suggested Documentation and Instructions for Reviewers**	**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**
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.			corrective action plans were issued during the review period (10/1/17 – 3/15/18).	
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. The DBPM must institute processes to ensure the validity and completeness of the data it submits to MLTC.	**Documents** Process for verifying the accuracy and completeness of provider and vendor reported data Process for screening data for completeness, logic and consistency Evidence of collecting service utilization data using MLTC specifications Evidence of timely and accurate reporting of encounter data to MLTC	Full	This requirement is addressed in MCNA's Encounter Data policy on page 1.	

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Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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	This requirement is addressed in the Utilization Management Program Description on page 1.	
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	This requirement is addressed in the Utilization Management Program Description on page 1. The plan provided UM committee meetings that evidenced the participation of contracting dental care professionals in the review and adaptation of policies and practice guidelines.	
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	This requirement is addressed in the Utilization Management Program Description on pages 5 and 10 and in the Utilization Management (UM) Criteria and Updates Policy. The clinical practice guidelines included in the Provider Handbook also evidenced this requirement.	

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Utilization Management				
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Are considering the needs of the members.	**Documents** Policy/procedure Onsite discussion	Full	This requirement is addressed in the Utilization Management Program Description on pages 11, 14, and 23. Onsite, MCNA explained that the members can search for providers who can accommodate those with special needs in the Provider Directory. MCNA reports that Member Services call and assist as well as the Case Management Unit and member advocates are avenues for the DBPM to hear and channel the needs of the members directly. Case Management also directly collaborates with the advocate groups which many MCNA members are tied to. The UM Director also explained that she participates in regular meetings with other health plans in Nebraska to facilitate communication of members needs across the dental and physical/mental health spectrum.	
Are reviewed annually and updated periodically as appropriate.	**Documents** Policy/procedure	Full	This requirement is addressed in the Utilization Management Program Description on pages 3, 6, 10, and 26.	
The policies and procedures must include, but not be limited to: 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.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in the Utilization Management Program Description on pages 3, 5, 9-13, and 23. The process for conducting informal reconsiderations for adverse determinations is detailed in the Informal Reconsideration Process Policy.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
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				
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	This requirement is addressed in the Utilization Management Program Description on page 25 under section XXXII. Utilization Management Reporting and Data Analysis. The sample utilization reports provided by the DBPM also evidenced the implementation of this requirement. Onsite, MCNA explained that most of the underutilization would be for preventive services, for which they monitor potential underutilization for each practice. MCNA emphasized that their #1 priority with regards to underutilization is increased access to care, especially for children. Onsite, the DBPM explained that the use of the prior-authorization is effective in limiting overutilization. Utilization reporting is done monthly and any required drill downs are done, for example, by codes or by procedure types. The DBPM explained that if they identify over- or underutilization, the Dental Director and clinical directors	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
			review and call for more records to investigate further or make recommendations for corrective action.	
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 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.	**Documents** Policy/procedure Identification of criteria/vendor used Identification of individuals making medical necessity determinations	Full	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on page 9, Request for Utilization Management (UM) Criteria Policy on pages 2–3, and in the Adverse Determinations/Denials on page 8.	
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	This requirement is addressed in the Utilization Management Program Description on page 10 and in the Provider Manual on page 47. During pre-onsite communication, the DBPM indicated that there have not been any specific requests for clinical	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
			practice guidelines from providers, though a few peer-to-peer discussions between reviewers and providers included discussion of various guidelines. Onsite, MCNA showed that the Provider Manual includes the clinical practice guidelines. Providers can access the Provider Manual on the provider portal. Whenever there is a change or update to the Manual, including to any of the clinical practice guidelines, the DBPM puts a real-time banner in the provider portal that alerts providers to the changes, including a detailed version history.	
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	This requirement is addressed in The Utilization Management Program Description on page 11, the Adverse Determinations/Denials Policy on page 6, and in the Service Authorizations including Retrospective Reviews Policy on page 9.	
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	This requirement is addressed in the Adverse Determinations/Denials Policy on page 5, and in the Service Authorizations including Retrospective Reviews Policy.	

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Utilization Management				
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The DBPM must identify the qualification of staff who will determine medical necessity.	**Documents** Policy/procedure	Full	This requirement is addressed in the Utilization Management Program Description on pages 3, 5 and 11.	
Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	**Documents** Policy/procedure	Full	This requirement is addressed in the Utilization Management Program Description on pages 2–3, 5 and 11	
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	This requirement is addressed in the Utilization Management Program Description on pages 5 and 12–13 and in the Utilization Management (UM) Staff Responsibilities for UM Decision Making on page 1. File Review Results Ten (10) of ten 10 UM denial files were reviewed and met this requirement.	
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	This requirement is addressed in the Utilization Management (UM) Staff Responsibilities for UM Decision Making Policy on page 1.	
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	This requirement is addressed in the Utilization Management (UM) Staff Responsibilities for UM Decision Making Policy on page 2. Onsite, MCNA provided a template for the attestations.	

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Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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 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 achieve their purpose.	**Documents** Policy/procedure **Reports** Evidence of monitoring including results and f/u actions taken	Full	This requirement is addressed in the Utilization Management Program Description on page 10. The DBPM provided sample provider profiling reports that evidence the implementation of this requirement. Onsite, MCNA explained that these utilization reports are generated monthly and reviewed by Dental Director and clinical reviewers as needed to make sure services are appropriate and necessary. Any potential problems are investigated further and reviewers make recommendations for corrective action.	
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	This requirement is addressed in the Utilization Management Program Description on page 3 and in the Service Authorizations including Retrospective Reviews Policy on page 2.	
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.	**Documents** Policy/procedure UM Program Description	Full	This requirement is addressed in the Utilization Management Program Description on page 24 and in the Dental Record Review Policy on page 1. The “plan of care” requirement is addressed as a “treatment plan” and the “date of operating room reservation” is addressed as “appointment times.” Onsite, MCNA indicated that	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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 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.			"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. 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.	**Documents** UM Committee description List of membership Agendas and meeting minutes for all committee meetings held during review period **Reports** UM reports for review period UM Program Evaluation	Full	This requirement is addressed in the Utilization Management Program Description on pages 9 and 20–21 and in the Utilization Management Committee Policy. The DBPM provided UM committee meeting minutes and sample UM reports to evidence the implementation of the requirement.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
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.				
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	This requirement is addressed in the Dental Record Review Policy on page 1 and in the Provider Manual on pages 23–25.	
The DBPM must maintain a written strategy for conducting dental record reviews,	**Documents** Policy/procedure	Full	This requirement is addressed in the Dental Record Review Policy on page 2.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
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.)				
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 f/u actions	Full	This requirement is addressed in the Dental Record Review Policy on page 1.	
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 f/u actions	Full	This requirement is addressed in the Dental Record Review Policy on page 2.	

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State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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 Reports **Annual Requirements** Utilization Management Program Review Data and analysis summarizing the DBPM's annual evaluation of its UM program. Due 30 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.	
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	This requirement is addressed in the Utilization Management Program Description on pages 11–13 and in the Service Authorizations including Retrospective Reviews Policy. MCNA provided a template for the notice of action, which evidenced implementation of the Service Authorizations including Retrospective Reviews Policy. It would be beneficial for the DBPM to review the Service Authorizations including Retrospective Reviews Policy for grammar and format. It may also be useful, for clarity, to present timeframes in a table that is either entirely on one page or with repeated column headers if table breaks across pages.	
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 f/u actions taken	Full	This requirement is addressed in the Utilization Management Program Description on page 19 and in the Adverse Determinations/Denials Policy on page 9.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
	Onsite File Review UM file review results		File Review Results Ten (10) of 10 UM denial files were reviewed and evidenced consistent application of review criteria for authorization decisions. None (0) of the 10 files reviewed required consultation with the requesting provider; therefore, this part of the requirement was not applicable for this file review.	
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	This requirement is addressed in the Utilization Management Program Description on page 22. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
4. Provide a mechanism in which a member may submit, whether oral 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	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on page 1 and in the Member Handbook on pages 20, 23, 29 and 34.	
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	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on page 1.	
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	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on page 1.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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 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	This requirement is addressed in the Adverse Determinations/Denials Policy on page 1.	
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 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	**Documents** Policy/procedure **Onsite File Review** UM file review results	Substantial	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, 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 determination within 14 calendar days. Nine (9) out of 10 files were given a determination within two business days, which shows that the plan exceeded the requirement of 80% of standard service authorizations getting a determination within two days.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
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.			**Recommendation** The policy should clearly state that all service authorizations require a determination within 25 calendar days of receipt of the request, regardless of the type of service authorization (standard vs. 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.	
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	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on page 3 and in The Utilization Management Program Description on page 12. File Review Results Ten (10) of 10 UM denial files were reviewed and none were expedited service authorizations; therefore, this requirement was not applicable for this file review.	

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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	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on pages 4 and 9.	
Timing of Notice Approval 1. For service authorization approval for a non-emergency admission, procedure or service, the DBPM must notify the provider of as expeditiously as the member's health condition requires but not more than 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.	**Documents** Policy/procedure Template notice of authorization	Full	This requirement is addressed in the Service Authorizations including Retrospective Reviews Policy on page 8.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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. 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.				
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	This requirement is addressed in the Adverse Determinations/Denials Policy on pages 1–2. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
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	This requirement is addressed in the Adverse Determinations/Denials Policy on page 2. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	

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2. The reason(s) for the action.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results Ten (10) of ten (10) UM denial files were reviewed and met this requirement.	
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	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
4. The member's or the provider's right to file an appeal.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
5. The member's right to request a State fair hearing.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
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	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
			Ten (10) of 10 UM denial files were reviewed and met this requirement.	
7. Circumstances under which expedited resolution is available and how to request it.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
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	This requirement is addressed in the Adverse Determinations/Denials Policy on page 3. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	
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.	**Documents** Policy/procedure **Onsite File Review** UM file review results	Full	This requirement is addressed in the Adverse Determinations/Denials Policy on page 2 and in the Member Materials Policy. File Review Results Ten (10) of 10 UM denial files were reviewed and met this requirement.	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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 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 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	**Documents** Policy/procedure **Onsite File Review** UM file review results	Substantial	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**	

Utilization Management				
State Contract Requirements (Federal Regulations 438.210, 438.228, 438.236, 438.404)	**Suggested Documentation and Instructions for Reviewers**	**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**
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.			The notice of action to the member and the provider should 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.	
Exceptions to Requirements 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.	**Documents** Policy/procedure	Full	1. This requirement is addressed in The Utilization Management Program Description on page 14, Service Authorizations including Retrospective Reviews Policy on page 2, and in the Member Handbook on page 21. 2. This requirement is addressed in The Utilization Management Program Description on page 10. 3. This requirement is addressed in The Utilization Management Program Description on page 30.	

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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**	**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	This requirement is addressed in MCNA's policy Grievances and Appeals Department Overview on page 1 and on pages 5 and 6.	
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	This requirement is addressed in MCNA's policy Grievances and Appeals Department Overview on page 4, and in Policy 13.200 Member Appeals on page 3. The Member Handbook also provides the member with a toll-free number to call, and advises that a Member Advocate can be requested to help file the grievance or appeal.	

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2. Acknowledge receipt of each grievance and appeal in writing to the member within ten (10) calendar days of receipt.	**Documents** Policy/procedure Template acknowledgement notice **Onsite File Review** Grievance and appeal file review results	Substantial	This requirement is addressed in MCNA's Formal Grievance 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 onsite that the DBPM include the nature of the grievance in the acknowledgement 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 acknowledgement 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** Language should be clarified 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 additionally that the definitions of appeal and grievance, and the processes for both, are clearly defined in writing 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	

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**	**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 any confusion on this process is clarified 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.	
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	Substantial	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 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	

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**	**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**
			professional with expertise in treating the member's condition). It should be noted that within 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 (demonstrating that the individual addressing member's grievance was a health care professional with appropriate expertise in treating their condition). **Recommendation** The language in Policy 13.100 Grievances and Appeals Department Overview should reflect 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.	

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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**	**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.	
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	This requirement is addressed in Policy 13.200 Member Appeals on pages 3 and 4. File Review Results Ten (10) of 10 appeal files met this requirement.	
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	This requirement is addressed in Policy 13.100 Grievances and Appeals Department Overview on page 1.	
A member may file a grievance with the DBPM or the State at any time	**Documents** Policy/procedure Member Handbook	Full	This requirement is addressed in MCNA's Formal Grievance Policy on page 1.	
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	This requirement is addressed in MCNA's Formal Grievance Policy on page 1. File Review Results Four (4) of 4 grievance files met this requirement.	
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	MCNA's Formal Grievance Policy contains a template grievance resolution letter within Appendix B. File Review Results Four (4) of 4 grievance files demonstrated an appropriate method by which the DBPM	

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			notified members of the disposition of a grievance.	
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	This requirement is addressed in Policy 13.200 Member Appeals on page 2, and within MCNA's Member Handbook on page 31.	
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	This requirement is addressed in Policy 13.200 Member Appeals on page 1, and within MCNA's Member Handbook on page 30.	
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	This requirement is addressed in Policy 13.200 Member Appeals on page 2. There is an opportunity in the Member Handbook on page 30 to convey the need to send a written request following a call to member services hotline. This is implied by stating "After we receive your appeal in writing…", however there is an opportunity for more explicit guidance/instructions.	
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	This requirement is addressed in Policy 13.200 Member Appeals on page 2. File Review Results Ten (10) appeal files were reviewed. None of these files were applicable, as they did not contain a verbal inquiry to appeal, but rather an inquiry in writing.	

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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**	**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. Ensure that there is only one level of appeal for members.	**Documents** Policy/procedure Member Handbook Provider Manual	Substantial	This requirement is evidenced within MCNA's practices, however not explicitly stated within the DBPM's policies and procedures. **Recommendation** Language pertaining to only one level of member appeal should be incorporated into MCNA's policies and procedures and in their 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.	
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	This requirement is addressed in Policy 13.100 Grievances and Appeals Department Overview on page 2. File Review Results Ten (10) out of 10 appeal files contained evidence of this requirement.	

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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**	**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**
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	This requirement is addressed in Policy 13.200 Member Appeals on page 3, and within MCNA's Member Handbook on page 30. File Review Results Ten (10) out of 10 appeal files contained evidence of this requirement.	
5. Consider the member, representative, or estate representative of a deceased member as parties to the appeal.	**Documents** Policy/procedure	Full	This requirement is addressed in Policy 13.100 Grievances and Appeals Department Overview on page 1.	
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	This requirement is addressed in Policy 13.200 Member Appeals. File Review Results Ten (10) out of 10 appeal files demonstrated evidence that the appeal was resolved within 30 days. There were no files in the sample that represented an extension.	

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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**	**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**
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	This requirement is addressed in Policy 13.200 Member Appeals within Appendix C. File Review Results Ten (10) out of 10 appeals files contained the results and date of appeal resolution. Nine (9) out of 10 appeals files contained the required information regarding decisions not wholly in the member's favor (1 file was not applicable, as the appeal was overturned). It should be noted that the resolution letters state that "MCNA has looked at your grievance *sent on* [date]…" however this date instead appeared to represent the date the grievance was *received*. Thus, it is recommended that the resolution template be updated to reflect the following language; "MCNA has looked at your grievance *received on* [date]", to provide a more accurate account of the details associated with the case.	
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	**Documents** Policy/procedure	Full	This requirement is addressed in Policy 13.203 Expedited Appeals on page 1.	

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**	**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**
all standard appeal regulations for expedited requests, except to the extent that any differences are specifically noted in the regulation for expedited resolution.				
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	This requirement is addressed in Policy 13.200 Member Appeals on page 2, and in Policy 13.203 Expedited Appeals on page 1.	
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	Substantial	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. It should be noted that there were 2 requests for expedited resolution that were not processed as such given the criteria for expedited resolution was not met. There was a recommendation made onsite that included a change to the way in which the acknowledgement 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 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	

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**	**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**
			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 clarify for the member that their appeal was not necessarily denied, but rather their request for an expedited resolution was. **DBPM Response** The recommendation to revise the expedited appeal 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	**Documents** Policy/procedure **Onsite File Review** Appeal file review results	Full	This requirement is addressed in Policy 13.203 Expedited Appeals on pages 1 and 2. File Review Results Ten (10) out of 10 appeal files were not applicable, as there were no expedited appeals.	

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**	**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**
and the reason(s) why the delay is in the member's interest.				
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	This requirement is addressed 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 extensions made.	
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	This requirement is addressed 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.	
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	This requirement is addressed in Policy 13.200 Member Appeals on page 3 and in Policy 13.203 Expedited Appeals on page 3.	
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	This requirement is addressed in Policy 13.203 Expedited Appeals on page 1.	

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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**	**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**
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	Addressed in Policy 13.209 Continuation of Authorized Services on page 1.	
If the DBPM continues or reinstates the member's 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.	**Documents** Policy/procedure	Full	Addressed in Policy 13.209 Continuation of Authorized Services on page 1.	

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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**	**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**
3. A state fair hearing decision adverse to the member is made. 4. The authorization expires or authorization service limits are met.				
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	Addressed in Policy 13.209 Continuation of Authorized Services on page 1.	
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	Addressed in Policy 13.200 Member Appeals on page 8, and within the Member Handbook on page 33.	
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 representative (if any) by the DBPM.	**Documents** Policy/procedure	Full	This requirement is addressed in the Member Handbook on page 33, and in Policy 13.200 Member Appeals.	
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	This requirement is addressed in Policy 13.100 Grievances and Appeals Department Overview on page 3.	

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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**	**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 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	This requirement is addressed in Policy 13.100 Grievances and Appeals Department Overview on page 3.	
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	Addressed in Policy 13.209 Continuation of Authorized Services on page 2.	
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	Addressed in Policy 13.207 Effectuation Process on page 1.	

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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	Addressed in Policy 13.103 Grievance and Appeal File Maintenance on page 2.	

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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 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.	**Documents** Provider Manual Template provider contract Template subcontractor agreement		This requirement is addressed in the Provider Manual. Both providers and subcontractors have access to this manual via the Provider Portal.	

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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	This requirement is addressed in Policy 13.100 Grievances and Appeals Department Overview on page 4. MCNA submitted two reports containing the necessary information pertaining to grievances and appeals to report to MLTC according to Attachment 38 of the Heritage Health contract.	